2018

Reimbursement practices and budgetary implications in the implementation of waivers and maternity care exemption policy in a Sub-County referral Hospital

Joan N. Kinyanjui
Strathmore Business School (SBS)
Strathmore University

REIMBURSEMENT PRACTICES AND BUDGETARY IMPLICATIONS IN THE IMPLEMENTATION OF WAIVERS AND MATERNITY CARE EXEMPTION POLICY IN A SUB-COUNTY REFERRAL HOSPITAL

JOAN NJERI KINYANJUI

MBA HCM 093055/16

A Dissertation submitted to the Strathmore business school as partial fulfilment of the requirements for the award of Master of Business Administration in Healthcare Management at Strathmore Business School.

Strathmore Business School

JUNE 2018

DECLARATION

I declare that this dissertation is my original work and has never been presented in any other university or college for an assessment and award of a master's degree. To the best of my knowledge and belief, the research proposal contains no material previously published or written by another person except where due reference is made in the proposal itself.

Joan Njeri Kinyanjui

June 2018

Approval

The dissertation of Joan Njeri Kinyanjui was reviewed and approved by:

Dr. Vincent Okungu

Institute of Healthcare Management

Strathmore Business School

Dr. George Njenga

Dean, Strathmore Business School

Prof. Ruth Kiraka

Dean, School of Graduate Studies

Strathmore University

ABSTRACT

The waiver and free maternity policies play a major role in enhancing equity and access to health care services among the poor and the pregnant mothers respectively. However, for the policies to be successful, there is need for regular and sustainable reimbursement practices to cater for the loss of the user fees exempted or waived. Lack of reliable reimbursement practices have huge budgetary implications on hospital management and results to hospitals adopting to coping mechanisms that are dysfunctional to the public health system. A mixed methodology was carried out qualitatively amongst five key respondents directly involved in the implementation process of both waiver and free maternity policy and quantitatively to obtain data on reimbursement practices of both waivers (23) and maternity services exemptions (1,151) within the study period. The data was analyzed through content analysis for qualitative data and descriptive analysis for quantitative data. The study revealed that the implementation status of waivers and exemptions faces financial challenges at the hospital studied. The waiver policy was neither funded nor budgeted for resulting to the facility issuing waivers to approximately 10% of eligible patients. The exemption policy for maternal care received irregular reimbursements which caused inefficiencies in the facility including shortage of drugs and consumables, late payments of utility bills, huge debts with suppliers, budgetary deficits, and decreased available revenue for hiring more staff to cater for increased service utilization. The employees cited demotivation and dissatisfaction due to the increased workload and lack of a compensation mechanism. The annual costs of waivers and exemptions relative to the reimbursement rate was very high and if this is not reevaluated, it would cripple the financial status of the hospital. The hospital had no sustainable coping mechanism besides operating on huge debts and cutting costs while allocating resources. In conclusion, irregular reimbursement of exemptions or lack of them in waivers have huge budgetary implications that have contributed to a dysfunctional public health care facility.

ACKNOWLEDGEMENT

I thank the Almighty God for the unending favor and grace that he has bestowed me throughout the process.

My sincere appreciation to my Research Supervisor Dr Vincent Okungu, whose advice, guidance, support and encouragement has made this entire process be enlightening and thought provoking.

My deep appreciation goes out to the hospital administration of Ruiru Sub County Hospital and my colleagues for their tremendous support throughout my two and a half years of Studying at Strathmore Business School. The relationships have immensely contributed to both my personal and professional growth.

DEDICATION

I dedicate this thesis to my two boys who gave me the purpose to relentlessly push forward despite the challenges and commitment that the course entailed.

A special dedication to Maxwell, mum and dad, Shiru, Paul, Esther and my nanny who held my hand in their own special way. May God bless you abundantly.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ACRONYMS

A

AOP6 - Annual Operation Plan 6.

G

GDP - Gross Domestic Product.

H

HISP - Health Insurance Subsidy Program.

M

MOH - Ministry Of Health.

N

NHA - National Health Accounts.

NHIF - National Hospital Insurance fund.

NPISH - Non-Profit Institutions Serving Households.

O

OECD - Organization for Economic cooperation and Development.

OOP - Out Of Pocket.

P

PAYE - Pay As You Earn.

T

THE - Total Health Expenditure.

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Kenya has an existing health policy on waivers and exemptions which was formulated after reintroduction of user fees in 1990. Utilization rate had decreased since cost posed as a barrier to access of care (Yates, 2009). Despite availability of the policy, the adoption process has been faced by several challenges and complexities during implementation. For the policy to function efficiently, there is need for compensation to the providers for the costs incurred to ensure service delivery is not interrupted. This however has not been the case in Kenya which has led to the hospital administration being reluctant in offering the benefits thus not offering the safety net initially targeted with the waivers (Bitran & Ursula, 2003) and exemptions of maternity services (Wamalwa, 2015).

Unfortunately, many health systems in Africa and other low- and middle-income countries majorly fund healthcare through out-of-pocket payment (Hopkins, 2010). This method of health financing does not offer financial protection resulting to impoverishment and catastrophic spending (Chuma & Maina, 2012). Catastrophic spending may be measured in relation to ability to pay. However, when households spend a large portion of their budget on health care thus foregoing their other basic needs, this would have negative implications on their living standards and this can be referred to as catastrophic spending(O'Donnell, van Doorslaer, Wagstaff, & Lindelow, 2008). Impoverishment is because of high health expenditure and health care costs (Chuma & Maina, 2012). This has resulted to some households failing to seek health care when they need it because they cannot afford to pay. These households can opt for other coping strategies which are short term and can further push them to impoverishment or deepen poverty in households that are already poor. Such households are not captured in the national poverty estimates since the health expenditures further raise their poverty threshold and thus referred to as non-poor (Preker et al., 2002). The waivers and exemptions policy targets such a population to enhance equity and access of health care services which cannot be achieved by other sources of health financing.

The four main sources of health care funding in Kenya are: public sources including the government through treasury budgets and social insurance scheme under the National

Hospital Insurance fund (NHIF); private sector which includes private health insurance, employer self-funded schemes and community-based health financing schemes; households through out-of-pocket payments; donors. OOP expenditures are regressive and represent the worst form of health financing because the greater burden of cost is felt by individual households (Gilson, 2005). Direct out of pocket payments include direct charges for private health services and user fees in public facilities (Gilson, 2005). In Kenya, household OOP expenditure accounted for 32% of THE in 2012/13 and increased to 32.8% in 2015/16 (Ministry of Health, 2017).

To mitigate the effects of OOP payments particularly for households, the Government of Kenya initiated measures of exemptions and waivers. Waivers are rights conferred to individuals that entitles them to access health care at no direct charge or at a reduced fee due to their inability to afford the cost of healthcare. It is a form of financial protection most commonly granted in public health facilities and seeks to improve equity in both accessing healthcare and equity in financing healthcare by reducing the out of pocket payments by individuals. Waivers are granted to individuals (Bitran & Ursula, 2003). Exemptions are granted to specific services. When a service is exempted, the patients seeking it do not incur any direct costs on it or pay a subsidized fee. Exemptions are adopted mainly for efficiency purposes for example in exemptions of maternity services, the policy was formulated to reduce maternal mortality and morbidity (Wamalwa, 2015). The main functions of exemptions include: promoting consumption of specific health services especially those that are undervalued by the populations, those having externalities and those that are purely public goods (Bitran & Ursula, 2003).

In Kenya, the waiver policy formulated for financial protection of the poor has failed to serve their purpose due to: lack of compensation to the health care providers, difficulty in determining the beneficiaries, patients have little knowledge of the waiving mechanisms and the process of acquiring a waiver being complex and time consuming for both the patients and providers (Chuma & Okungu, 2011); e.g. in the case of waivers, the policy indicates that upon visiting a public health facility, to be eligible for a waiver, the following is required for an inpatient: The hospital management should be notified to initiate the

process of issuing a waiver, the hospitals social/ community worker is requested to do a background check on the patient by doing a home visit through which their observations during the visit will determine if the patient is capable of meeting the cost. In some instances, a home visit is not necessary especially if the health providers are capable of judging the financial capability of the patient by observing them during their stay in the hospital. For example, if during their stay in the hospital no family member came to visit and even if they came to visit they were observed not to have any capability to pay. Other attributes include: clothing, mode of transport to the hospital, number of dependents, recommendation by local administration and length of stay after discharge. If the patient has made the category of poor and vulnerable, a waiver form is filled and signed by the hospital management and consequently the fee is waived. Supporting documentations should later be made and filed on the patient file and at the hospital accounts office for accountability. For an outpatient, the patient is interviewed by the social worker and if they are eligible for the waiver, the same process is followed.

The process of designing and implementing a waiver system is very complex since it imposes the adoption of different rules/ engagements on different patients. It is faced by different challenges which include the need to classify patients as beneficiaries and non-beneficiaries of waivers along with identifying them at the point of service which imposes major administrative demands on the health system which consequently increase the administrative costs. It is also highly likely to be faced by fraud and corruption while determining the eligibility of the beneficiaries. Eligibility in form of income is also difficult to interpret and implement and is a major hurdle which leads to the health staff to use income proxies for waiver eligibility. However due to insufficient resources allocated to public health facilities, the waiver system has been diminishing with time (Bitran & Ursula, 2003).

For exemptions, eligibility is clearly stated which makes it easier to grant the exemptions to patients who qualify. The exemption systems require one initial basic decision that determines which services will be offered for free or at a reduced price. When the process of exemptions is designed, it should be determined by the organization that will deliver the

exempt services i.e. both public, private non-profit or private for profit and how the cost of service delivery should be financed by payers of the services. For instance, in public facilities, the exemptions of are financed through the fixed quarterly budget. In generalized systems of exemptions where the government is financing services free of charge to all government facilities, it is easier since they are financed through historical budgets. However, in some instances e.g. the free maternity, the funding to the provider is paid through a previously agreed on payment mechanism in which the case mechanism may become more complex (Bitran & Ursula, 2003).

1.2 Problem statement

Since the devolution of health services in 2013, county governments are charged with financing the bulk of health care, which means that the implementation of waivers and exemptions of maternity services depends a lot on how each county prioritizes the health sector. Under devolution, efficiency in the implementation of waivers and exemptions of maternity services as well as the cost and budgetary implications on hospital management, to the best of our knowledge, has not been explored. The public health systems mainly serve low-income and the indigents who depend on the government subsidy on health costs to meet their demand. Even with the subsidies, many of them still cannot afford to pay. For poor and the vulnerable population visiting the public hospitals and are unable to raise the fee, the hospital management should waive it following the process that determines the eligibility of the patient for a waiver. The major challenges faced during the process are lack of reimbursement of the costs by the government, ensuring efficiency especially in determining eligibility, untrained personnel, fraud and corruption, laxity of the health care workers, scanty or no proper documentation and complexities of the waiver process.

The maternity services exemption policy aims to eliminate all the charges for intra-partum care in public health facilities. The government allocated KES 4 billion in the 2013/2014 budget for implementation of the program where health centers and dispensaries are reimbursed KES 2,500 for every delivery through the Hospital Sector Services Fund and hospitals should be reimbursed KES 5,000 for every delivery conducted in the facility, through the Hospital Management Service Fund. However, the allocated funds on

deliveries have not been regular. When waivers and exemptions on maternity services are not reimbursed, hospitals result to using their resources to manage the patients. While preparing the budget, all anticipated expenditures inclusive of the waivers and exemptions should be considered and should not exceed the expected income.

Reimbursement of waivers and exemptions should contribute to reliable and efficient health systems; i.e. no stock outs on drugs and consumables, improved revenue and service delivery. Besides the government reimbursing the funds, other measures ought to be taken to ensure efficiency of the system. These measures include: proper eligibility criteria to determine the beneficiaries has to be followed with no fraud, corruption or favor; proper documentation to enhance accountability, the hospital management has to work as a team to ensure that during departmental budgeting every expense is captured to avoid under quoting or over quoting figures and, choosing a focal person in the hospital who oversees the process and is responsible in underlining the barriers experienced during the process. There is an evident gap in all these processes. A properly functioning and efficient waivers and exemptions system is not only beneficial to the government through reaching out to its vulnerable categories and improving the country's health indicators but also to the hospital management, the society being served and the country's economic development and growth.

1.3 Objectives

1.3.1 Main Objective

The main aim of this study is to assess the implementation inefficiencies of waivers and maternity exemptions policy under a devolved governance system to inform policy interventions.

1.3.2 Specific Objectives

1 To assess the implementation status of the policy on waivers and maternity exemptions at a sub-county referral hospital after devolution;

2 To estimate the annual cost of waivers and maternity care exemptions relative to reimbursement trends at a sub-county referral hospital;
3 To examine the budgetary implications brought about by waivers and maternity exemptions and assess how hospitals cope with the costs.

1.4 Research Questions

i. What is the implementation status of waivers and maternity exemptions policy at Ruiru sub-county referral hospital?
ii. What is the total annual cost of the waivers and maternity exemptions for the sub-county referral hospital relative to reimbursement practices?
iii. What are the budgetary implications of the waivers and maternity exemptions and how do sub-county referral facilities cope with the costs?

1.5 Scope of the study

The focus of this study is on maternity services at the point of delivery to the point of discharge. We have used the reimbursable fixed cost of these services as determined by the government. All waivers will be considered in the study. Cost data are assessed over a three-month period and projected to estimate annual reimbursable costs.

1.6 Significance of the study

An efficient waiver and exemption function will be beneficial to its target population ensuring there is equity and access to health care irrespective of their economic status or vulnerability. Efficiency is determined by ensuring the eligibility criteria used is just and services to be sought in the health care facility are available to them when they need them. Countries that have had success in the implementation of waivers and exemption policies are those that their governments have a system for reimbursing the hospitals the costs incurred during the process of waiving and exempting to ensure continuum of services.

The government in attempt to protect the poor and vulnerable introduced waivers policy in that, health care would still be provided to them in absence of any fee if they met the eligibility criteria. This however has been diluted as years pass by, despite the high poverty level, the numbers, if any, of patients seeking the waivers is dwindling. The patients who

benefit in most cases are not documented for accountability and their costs are not included in the quarterly budgets and most often may not necessarily have met the eligibility criteria.

The exemption policy on maternity services was formulated to reduce maternal mortalities and morbidities through increasing skilled deliveries and access emergency obstetrics care (Campbell & Graham, 2006). Studies have reported evidence that proves that inclusion of user fees and financing health care through out-of-pocket payments creates a significant barrier in accessing maternal health services especially among the poorest populations (Wamalwa, 2015). In attempt of breaking the barrier, government formulated the policy. However, public hospitals have been facing challenges during implementation of the policy due to irregular reimbursements therefore affecting the quality of services offered. The reimbursement practices should be regular as indicated in the policy to cater for the costs incurred during service delivery. If not reimbursed, a gap in resources available is realized and consequently result in efficiencies in service delivery and poor implementation of the policies. The hospital management is disrupted by the huge budgetary implications realized from the lack or irregular reimbursements.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The chapter discusses various forms of health financing in Kenya and their effect on equity and access to healthcare in Kenya. The major forms of health financing include: government revenue; social health insurance; private health insurance; donor funding and household out of pocket payments. However, neither of the sources addresses access and equity of care for the poor and the vulnerable pregnant mothers Studies have concluded that people from low and middle-income countries have limited access to healthcare due to the financial barrier. This has resulted to delayed health seeking behavior that consequently leads to deaths, lost incomes and higher health costs due to worsened health outcomes (Peters et al., 2008). The government realized the gaps in health financing and through the Ministry of Health formulated policies to cater for waivers for the poor and exemptions for maternity services due to the increased incidences of maternal deaths. The implementation process of these two policies have been faced by challenges which have rendered the processes inefficient and the desired outcomes have not been realized. Literature for the review was sourced from PubMed, google scholar, World Health Organization reports, and Ministry of Health reports among others.

2.2 Sources of funding for health care

Most Organization for Economic cooperation and Development (OECD) countries finance majority of their essential health services from public sources and endorse the equity principle that these services ought to be allocated on the basis of need and not willingness or ability to pay (Van Doorslaer, Masseria, & Koolman, 2006). This is in contrast of developing countries where essential health services are significantly financed through out of pocket expenditure (Chuma & Maina, 2012). In Kenya, the main sources of financing for health care include the following: public sources (general government revenue and public insurance), private insurance (for-profit and non-profit), donor financing and household out-of-pocket.

2.2.1 General government revenues

Government spending on health from domestic sources is an important indicator of a government's commitment to the health of its people and is essential for the sustainability of health programs (Lu et al., 2010). According to Kenya National Health Accounts 2012/13 by the Ministry of Health (2015), the total health expenditure (THE) in Kenya was KES 234 billion in 2012/13 up from KES 163billion in 2009/10. The general health spending in 2012/13 accounted for 6.8 percent of the gross domestic product (GDP) up from 5.4 percent in 2009/10. The government health expenditure as a percent of the total government expenditure increased from 4.6 percent in 2009/10 to 6.1 percent in 2012/13 (Ministry of Health, 2017). The allocation is relatively low and does not meet international benchmarks e.g. the Abuja Declaration which recommends at least 15% of the government budget is allocated to health care (Govender, Mcintyre, & Loewenson, 2008).

Taxation is the main source of government revenue in Kenya. Revenue collected through taxation is used by the government to finance public expenditure for goods and services e.g. health care. The main taxes include: value added tax, excise duty tax, customs duty and income tax. Income tax is the primary contributor. Performance of income tax between FY 2011/12 to 2012/13 reflected a decline in the Pay As You Earn (PAYE) from 21% to 14% followed by a significant increase in 2013/14 of 11% and thereafter declining by 5%. Other income tax similarly declined between FY 2011/12 to 2012/13 from 21% to 12%, followed by a steady increase in 2013/14 of 3% and 6% in 2014/15. VAT recorded a negative growth in the FY 2010/11 of -9.6% but the trend was reversed in 2012/13 with a positive growth of 11.3 % and a further 18.7 % in 2014/15. Customs and excise duty tax for the last 5 years has averaged to 7.2 % and 11.4% respectively (institute of certified public accountants of Kenya, 2016).

The Kenyan government plays a crucial role in health care financing and service delivery. There are approximately 9,696 health facilities where around 4616 are public health facilities, 3696 are privately owned and 1384 are faith based, community based or NGOs (Netherlands Enterprise Agency, 2016). The Kenyan government funds health care through: non-contributory mechanism (general taxation) and through a prepaid

contributory mechanism (National Hospital Insurance Fund). The Cost of healthcare in public health facilities is cheaper in comparison to the private sector due to subsidization by the government. This enables the majority of Kenyans to have some access health care Financing from government revenues is quite equitable since health care payments largely reflect ability to pay (at least proportionate or progressive payments). General budget revenues and social health insurance contributions perform similarly and are close to proportionate in principle.

2.2.2 Social health insurance: The National Hospital Insurance Fund

The National Hospital Insurance Scheme (NHIF) was established in 1966 through an act of parliament. The fund was to provide a compulsory contributory hospital-based cover for formal employees earning above KES.1, 000. In 1972, NHIF introduced voluntary membership which included anyone who could pay the premiums. NHIF aimed to increase inpatient financial protection for its members since its coverage was comprehensive for members seeking inpatient care in public and low-cost faith-based facilities (Ong'uti, 2012).

In 2003, there was a pressing need to move to the social health insurance which was accelerated by continued decline in support by the government on health financing and the rise of the out of pocket expenditure. The social insurance scheme reform involved restructuring NHIF to extend and diversify the range of benefits. A task force chosen recommended the establishment of National Social Health Insurance Scheme whereby in 2004, parliament passed its bill but was not assented to. The reason for the rejection was sited to be unsustainable (Kimani., et al 2012).

The National Hospital Insurance Fund (NHIF), the oldest government-supported insurance scheme in Africa, currently covers 6.9 million Kenyans (2.9 million formally employed and 4 million informal sector) (Netherlands Enterprise Agency, 2016). It is mandatory for all formal sector employees (public and private) and voluntary for those in the informal sector. Premium contributions are calculated on a graduated income scale for the formal sector and at a fixed rate for the informal sector. The NHIF recently introduced capitated

outpatient care as part of the insurance benefit package, which is only available to contributing members (Health Policy Project, 2016).

The government through NHIF introduced Health Insurance Subsidy Program (HISP) to subsidize the NHIF insurance cover to the poor and the vulnerable (old and disabled). These programs would also increase NHIF coverage thus with the aim of achieving universal health coverage. HISP provided financial risk protection to the indigents by subsidizing their health insurance which covers both inpatient and outpatient services in public and private hospitals. This was done in phases with the first phase covering 125,000 Kenyans (23,500 families) selected from a poverty list developed by the Ministry of Labor, Social Protection and Services across all counties (World Bank, 2014).

2.2.3 Private Health Insurance

The private sector (households and private insurance) is the greatest financier of health, contributing 40 percent of THE in 2012/13 up from 37 percent in 2009/10 (Ministry of Health, 2017). The different mechanisms of private health financing include: households' direct out of pocket payments, prepayments of community financing schemes, private medical insurance and indirect payments for health services by employers and local charitable groups. For each and every mechanism distributes benefits and financial burdens differently, affects who will access health care and has different exposure to catastrophic financial risks. Individuals prescribe to a private medical scheme to protect themselves from catastrophic spending that maybe realized when they fall sick. The future health is unpredictable; they either will be well or unwell.

The cost drivers for the private insurances include: the small size of the private health market, high technology that escalates costs e.g. CT/MRI scans, limited supply of high quality healthcare providers, demand for equipment and devices in Africa is lower leading to increase in prices, number of qualified health care professionals/specialists is far below the WHO recommendations, inflation is quite high where the cost of service increases by 15 % per year which is attributed to majority of the health care supplies being imported (Health Policy Project, 2016). In return to premium prepayment, the insurer protects them

from financial hardship, provides access to needed medical services and transfers resources from the healthy to the sick and in the case of social insurances risks are transferred from the rich to the poor.

The country's health insurance coverage stands at approximately 26 percent. Most of the people that are covered are in the formal sector. This largely excludes the informal sector which rarely enrolls for prepaid health schemes. An estimated 1.5 percent of the indigent have some form of cover in comparison to 41.5 percent of the affluent having a private medical cover insurance cover (Netherlands Enterprise Agency, 2016).

Private health financing schemes may vary in design and implementation but share a common characteristic of being based on prepayment funding. There are three types of private health insurance providers in Kenya: (1) General insurance companies that are involved in a wide range of insurance, not related to health, but who to a small extent insure people against ill health; (2) those that run medical schemes and are also health care providers operating their own clinics and hospitals where their clients seek care, although the same facilities are open to non-premium holders; (3) those that provide health care through third party facilities, also known as health management organizations, which are widely used for employer based insurance (Chuma & Okungu, 2011).

The size of the private healthcare market is about KES 20.7b (about USD 260 million): Two-thirds of the money spent in the private sector is on health services rendered in hospitals, private sector owns and manages almost two-thirds of all Kenya's health facilities and it's the largest employer of healthcare professionals in Kenya. (Barnes, et al., 2010). The voluntary health insurance schemes coverage has been minimally increasing where the CHE by voluntary insurance schemes in 2009/10 was 7%, 2012/13 was 9% and 2015/16 was 10.8%(Ministry of Health, 2017).

Employer based schemes are offered by both public and private sector companies through their own employer managed facilities. The employer can either pay for its employee's healthcare from: lump sum payment to contracted health providers, reimbursing the

employee's health expenditure or enrolling them under a group health insurance policy (Mwai, 2017).

Community based financing is common in low income countries and it's based on three principles: community cooperation, local self-reliance and prepayments of the premiums. For them to function optimally, some factors have to be considered which include: technical strength and the institutional capacity of the local group, financial control in local management and control of health care services, external support from other organizations and individuals, linkages with other local organizations, diversity of funding, responding to other non-health development needs of the community and adapting to a changing environment (Mwai, 2017).

2.2.4 Donor Funding

Donor health financing is on a decline globally. The donors funded about 39% of Kenya's health expenditure by 2012 and have declined to about 25% in 2013 (Netherlands Enterprise Agency, 2016). They mostly fund vertical programs which are in their interest and may not necessarily align with the national/county Ministry of Health interests. For the vertical programs that they fund and implement, the services are equitable to every individual that seeks care. The success of the vertical programs is provision of infrastructure while the disadvantages include: internal brain drain where the stuff prefer working in donor funded programs, inequality within the national health system and inability to coordinate and control external sources (Mussa, Pfeiffer, Gloyd, & Sherr, 2013).

In Kenya, the donors have been highly involved in programs e.g. HIV/AIDS and TB which have been highly beneficial to the population because they save them the high cost of seeking healthcare in managing those conditions. Every individual who is a beneficiary of the program seeks care for free and they access quality health care which is equitable to all that are in the program but unequal in the national health system (Wexler, Valentine, & Kates, 2013).

As much as the donor participation plays a major role in financing health care especially to the poor population, it is an unsustainable way of financing health care because; the donors may fail to fulfill their promise in funding which can lead to inefficiency especially if their pledge had been budgeted for, the national/county government may fail to maintain the healthcare agenda due to manipulation of the donors to work on projects which are not of priority to the health agenda, the funding is dependent on economic performance of the donor countries in that, if performance drops, the funding is cut. As much as it provides equity within the programs, donor funding may not support equity within the national health systems whereby a patient seeking HIV care may need to pay for other costs within the hospital (Mussa et al., 2013).

2.2.5 Household Out-of-Pocket (OOP) payments

Household out of pocket payments, in form of user fees to government facilities or direct payments to private providers, significantly finance healthcare in Africa and other low income countries (Chuma & Maina, 2012).The household out of pocket expenditure accounted for 26.6 % of THE in 2012/13, an increase from 24.5 % as reported in 2009/10. (Netherlands Enterprise Agency, 2016). Households' out-of-pocket (OOP) (excluding cost sharing) and non-profit institutions serving households (NPISH) financing schemes mobilized 27 percent and 21 percent of THE in 2012/13, respectively. The MOH estimated that 60 % of the sick do not seek care due to financial constraints while 38 % must sell their assets or go in debt so that they can pay their medical bills. (Ministry of Health, 2015). Out of pocket expenditure exposes people to both catastrophic health expenditures around 4.1 % of Kenyans and impoverishing health expenditures around 1.5 %. Catastrophic out of pocket spending (OOPS) has severe economic impact on families; it's measured as OOPS exceeding a defined threshold of a household's non subsistence spending i.e. excluding spending on basic needs like food, clothing and shelter. There is no single threshold for catastrophic health expenditure but two commonly used thresholds include 10 % of the total income or 40% of non-food income (referred to capacity to pay) which is also used by WHO (Chuma & Maina, 2012).

As of 2005, about 150 million individuals (44 million households) face financial catastrophe annually due to out of pocket payments for health services (WHO, 2015). Household OOP includes payment of user fees in public health facilities and direct payments to private health sector providers. It is an inequitable method of payment where the individual bears the whole financial burden while seeking healthcare and to the larger extent could cause loss of income due to ill health. The affluent may not have a challenge accessing healthcare since they can afford but for the indigents, cost plays a major barrier to accessing healthcare. This causes delays in health seeking behavior which would cause them to visit the hospitals when the health condition has deteriorated and reduces productivity for the period they have been unwell which would have a negative effect on the economy (Gilson, 2005).

Financing health care through out of pocket payments is unsustainable as there is no financial protection and population can be driven into poverty through sale of assets, use of savings, high interest loans, etc. (Leive & Xu, 2008). The payment method is regressive whereby the financial burden is higher among low- income households relative to their income. The rising of income is matched with the rising fraction of income being paid to health care (Gilson, 2005).

The high prevalence of OOP payments is an indicator of lack of financial protection which could be obtained from payment of health care through premiums and taxes. The population especially the poor are vulnerable and would result to impoverishment and catastrophic spending while seeking health care. This limits utilization of health care which has been witnessed during the introduction of user fees in both Kenya and Uganda. The population has sited cost of health care as the major barrier to them seeking healthcare (Lagarde & Palmer, 2008). Health care expenditure is unique in that no one can predict illness in terms of timeliness and the cost they would incur if a person was to fall sick. Therefore, for the indigents who lack savings or tradable assets to mobilize at short notice, they are more likely to be pushed further into poverty while paying for health care with the little they have. When the individual falling sick is an adult and is the main wage earner, this pushes the household he or she is supporting to impoverishment. Prolonged illness can be

economically devastating not only to the poor but to any household regardless of their income levels.

Lack of funds to finance health care when need arises could lead to postponement of treatment, encourage inappropriate self-treatment and use of partial drug doses or may act as a barrier to early use, or perhaps any use, of health facilities. This is done with the hope they would raise the money at a later date. The postponement could also to lead very costly interventions or even death due to disease progression. It would also deter individuals from seeking preventative care that would protect them from falling sick on a later date. Preventative medical care is much cheaper than curative. OOP payments also affect the quality of care sought in case of illness, many people especially the poor would opt for cheaper alternatives so as to cut costs that would be associated with seeking care in institutions which offers quality care but at a cost (Gilson, 2005).

Kenya has tried to improve the health of its population by putting in place policies such as abolishing user fees at public dispensaries and health centers, abolishing charges associated with maternal health services at all public healthcare institutions and also working towards achieving the universal health coverage by expanding national health insurance coverage (Ong'uti, 2012).

Despite abolition of user fee at public dispensaries and health centers, the majority of outpatient services in the country are still consumed at tertiary and secondary facilities in the public health sector, as well as at private facilities, all of which still charge their patients for healthcare services. However, the reality is that the direct and indirect costs of healthcare remain an important barrier to better health for Kenya's low income groups (Chuma, Musimbi, Okungu, Goodman, & Molyneux, 2009).

According to the 2013 Kenya Household Health Expenditure and Utilization Survey (KHHEUS) conducted by the Ministry of Health, an average Kenyan, including both adult and children visits a health provider about three times a year. The estimated median cost per outpatient visit is KES 400 (Kenya Financial Diary, 2012-13) which at a glance it may

seem low, but it constitutes a significant financial barrier to healthcare access in a country where the 45.9% of the population lives below the poverty line. The costs in public healthcare institutions are prone to go even higher due to: shortages in drugs and other much needed services forcing the poor to purchase them externally from private facilities which are much more expensive, may have poor quality services resulting to patients not getting proper diagnosis or the right treatment in a timely manner causing repeated visits to hospitals, additional tests and drugs which then increase cost of healthcare and also carrying high opportunity costs in terms of income lost (Ministry of Health, 2014).

Various reforms have been instituted since independence with the intention of protecting households from OOP payments. A summary of the healthcare reforms according to (Chuma & Okungu, 2011).

Table 1: Summary of Healthcare Reforms

Years	Policy	Target and impact
Colonial period	User fees in all public facilities	This targeted all Kenyans but limited utilization due unaffordability of the user fees.
1963-1965	User fees initially introduced continued to exist for two years after independence	This targeted all Kenyans but limited utilization due unaffordability of the user fees.
1965	User fees removed at all public health facilities. Health services provided for free and funded predominantly through tax revenue	Target was all Kenyans accessing public health care. There was in adequate healthcare due to the rising cost burden for government.
1966	Establishment of National Health Insurance Fund (NHIF)	It was compulsory for all in the formal sector but voluntary for informal sector. It increased financial protection for members only and offered comprehensive coverage in public and low cost faith based organizations.
1989	User fees introduced in all levels of care.	Targeted all Kenyans seeking care in public health facilities. Led to decrease of utilization of healthcare services.
1990	User fees suspended in all public health facilities. Waivers and exemption put in place to protect the poor and vulnerable. Failure linked	User fees created a barrier to access to care. The waivers and exemptions increased access of care of the indigents and

Years	Policy	Target and impact
	to poor policy design and implementation.	vulnerable categories though the utilization rate was low.
1991-1993	User fees were re-introduced in 1991, through a phased implementation approach stating from hospital level. Children under five, special conditions/services like immunization and tuberculosis were exempted from payment. User fees continued to exist in Kenya at all levels of care.	Targeted all Kenyans. User fees created a barrier to access to care and gave negative implications on equity. The exempted categories were able to access healthcare services thus improving associated health care indicators.
2002/2003	User fees abolished at dispensaries and health centers (the lowest level of care), and instead a registration fees of Kenya shillings 10 and 20 respectively was introduced under the 10/20 policy but remained unaltered in the higher-level facilities.	It targeted all Kenyans. It resulted to increased utilization but also increased informal charges because there was no buffer fund that would compensate the user fees.
2003	The National Social Health Insurance Fund was proposed as a pathway to universal health coverage.	It was targeted for all Kenyans in a mix of tax and social insurance scheme funding. The bill to establish the fund was rejected on sustainability grounds.
2005	Establishment of the Health Sector Service Fund (HSSF) as a buffer fund to compensate for the reduced user fee revenue. It was piloted though not implemented.	It targeted all Kenyans. The HSSF was to increase utilization and lower out of pocket payments which were increasing.
2010	The established HSSF was implemented.	The fund compensated for the lost revenue associated with user fees. Dispensaries and health center receive funds directly into their bank accounts from the treasury.
2013	Government introduced free primary care in dispensaries and health centers which eliminated user fees at these facilities. Free maternity services were introduced in every health facility. Devolution of health services. Health insurance for the elderly and the disabled.	Removal of user fees increased utilization of health services. Increased numbers of births assisted by skilled health workers.

Table 1: Summary of Healthcare Reforms

2.3 Challenges facing healthcare financing in Kenya

According to (Deloitte East Africa Limited, 2011), Kenya's healthcare financing system, as in other developing countries, faces several major challenges including: High and ever escalating poverty levels, high disease burden from preventable infectious diseases and an emerging epidemic of non-communicable diseases, inadequate funding of the health system, Inefficient and ineffective allocation and use of scarce resources, an estimated 20 to 40% of healthcare spending is wasted through inefficiencies, high out of pocket expenditure (OOP) as a result of a weak risk pooling system, significant inequality in access to healthcare services largely due to financial barrier, most of the healthcare funds are not in any risk pooling mechanism hence reducing effectiveness and efficiency, weak health systems and high dependence on development partners.

2.4 Waivers Policy

Funding health care OOP is not sustainable. The waivers and exemption policy was introduced in 1990 after the reintroduction of user fees as a financial risk protection mechanism to the poor and the vulnerable which aimed to increase utilization rates and access to health care. However, failure of the policy has been linked to poor policy design and implementation. The waivers and exemptions are meant to ensure Kenyans are not denied essential services due to inability to pay (Chuma & Okungu, 2011).

The waiving policy aimed in protecting the indigents and the children under the age of five. This was instigated by the wide difference in health utilization that existed among people of different socioeconomic status and between urban and rural dwellers. However, waivers and exemptions have failed to benefit the poor due to little knowledge on the waiving and exemption mechanisms and the processes involved being complex and time consuming for both providers and the patient (Chuma & Okungu, 2011). An exemption is an automatic pardon from payment based on the patient meeting some certain preset criterion /qualifications as stipulated by the Ministry of Health and distributed in form of circulars to public health facilities. A waiver is when a patient is released from payment of health expenses due to inability to meet costs. They are put in place to ensure that no

Kenyan is denied essential services (Ministry of Health, 2002).

Currently in Kenya exemptions include: pregnant women seeking maternity services deliver for free, persons seeking treatment in HIV/AIDs and TB, and children under the age of five do not incur any treatment. Health care facilities offering the waivers and exemptions are tiers level 4 escalating to the national referral hospitals. The hospital administration is responsible in determining if the patients are eligible for the waivers and exemptions. Ideally, during the preparation of the budgets, the costs incurred should be included and compensated by the county government to enhance both financial protection and continuum of health services. The facility in charges (medical superintendent, matrons, hospital secretaries and administrators) determine the waivers and exemptions locally based on both the health status and the level of income (Bitran & Ursula, 2003).

According to a study by (Bitran & Ursula, 2003) on Waivers and Exemptions for Health Services in Developing Countries, which was conducted in Kenya, results concluded that: the government had no mechanism to monitor or evaluate the performance of waivers and exemptions policy resulting to lack of data on coverage of the target group; due to inadequate compensation or lack of compensation in Kenya, the coverage of the poor was extremely low; the health care providers in Kenya had practically no available information on administrative cost of waiver system which prevented assessment on its efficiency; despite national waiver policy been clear on the different categories to be exempted, there was a problem in determining the eligibility criteria especially when distinguishing the poor from the non-poor. They lacked guidelines describing the poor resulting to every facility interpreting it differently thus interfering with the identification criteria which needed a clear definition of the target beneficiaries; the poor were embarrassed of their situation therefore were discouraged to claim waivers; there was no focal person responsible for the waiving process. However, there was need of those responsible to be aware of the eligibility criteria, be adequately trained and be fully aware on the limitations affecting the waiver process; although the waiving and exemption protection mechanism would promote access to care to the most vulnerable , other barriers existed that included transportation cost, lodging cost, food cost and the cost of being away from home or work (opportunity cost);

there was need to periodically adjust the fee level and income-eligibility threshold to cover the most vulnerable. For example if eligibility was based on income brackets that are nominally constant, inflation would reduce the number of beneficiaries; health care providers needed explicit written guidelines on how the implementation process of waivers and exemptions should work, with enough flexibility to allow for regional or local variation if necessary; the staff responsible for administering waiver systems lacked the necessary training and supplies to carry out their job; there was need to educate the poor on their eligibility on waivers so as to promote access of health care and likewise the beneficiaries of exemptions. This information would be spread to all even the special characteristics of the poor that lived away from urban towns, have no access of formal media, illiterate and work long hours.

The study (Bitran & Ursula, 2003), concluded that Kenya had an improvised approach with waivers and exemptions which was not carefully designed thus the failure during implementation. They highlighted that the key to a waiver system's success is adequate financing that compensate providers for the revenue they must forego in granting waivers and exemptions. This was in contrast with Kenya which expects providers to absorb the cost of waivers and exemptions.

A study reported by (Owino & Were, 1999) showed that waivers rarely exceeded two persons per month which is an insignificant figure compared to the 45.9% living below the poverty line. Beneficiaries of the waivers and exemptions are mainly the inpatients and outpatients with simple medical conditions and seldom include patients with costly treatments. This finding may reflect the reluctance of medical providers to forego significant revenue through costly exemptions. It also indicates absence of waivers and exemptions where they are most needed: costly treatments have the most detrimental impact on the poor. The low level of waivers and exemptions contrasts with the high level of poverty; it reveals serious problems of under coverage thus pointing out major deficiencies in the protection mechanism.

In a survey conducted by (Owino & Were, 1999), 80 percent of inpatients and 86 percent of outpatients were not aware of waivers and exemptions. Even those who were aware about them were unclear about eligibility criteria. The staff attitude towards waivers and exemptions was usually negative and they had been reluctant to publicize about the protection mechanisms. Fearing about the revenue loss, staff felt that information about waivers and exemptions should not be easily accessible to patients and that relatives should assume the burden of the fees. According to (Owino & Were, 1999) , there is some reluctance by facilities to create awareness about the waiver system where in the same study 70 percent of the facility clerks interviewed were against publicizing the system.

There have also been reports of leakage, especially in the form of exemptions for civil servants and personnel (Owino & Were, 1999). According to (Newbrander, Njau & Auma, 1995), only a third of all waivers and exemptions were accounted for by the poor, and a full two third accrued to the non-poor.

2.5 Exemptions on maternity services

Kenya has suffered from high maternal mortalities. It is among the few sub-Saharan countries who despite improvement of other health indicators has had the maternal mortality rise from 414 per 100, 000 live births in 2003 to estimates of 488 deaths in every 100, 000 live births by 2015 which is way above the MDG target of 147 deaths in 100000 live births(Bourbonnais, 2013). Maternal death as defined by WHO is death by an expecting mother or death within 42 days of termination of pregnancy by any cause related or exacerbated by pregnancy or its management (Gacheri, 2016). Its estimated that for every maternal death, approximately 20-30 women suffer complications related to pregnancy or delivery (KNHCR, 2012). Several factors have led to increased maternal deaths in Kenya: limited availability of health services especially in the rural areas; poor access to skilled birth attendance sometimes contributed by considerable distance to health facilities; low utilization of skilled birth attendance during pregnancy, childbirth, and the postnatal period due to the financial barrier of user fees; limited availability of basic emergency obstetric care; delay in seeking skilled care; and limited allocation of resources for maternal health (NCPD, 2015).

On 1st June 2013, the government took the much needed action to address maternal mortality by initiating formulation of a policy whose implementation was to be effective immediately in all public health facilities. This was done through a presidential declaration to encourage mothers to give birth in health facilities with assistance of skilled health professionals The move by the government saw an increase in hospital deliveries by approximately 10% by July the following month across the country with some counties having increases of about 50% (Bourbonnais, 2013). Kenya had been a signatory at a regional level to several mandates in promoting health in general health and reproductive and maternal health which include: the Abuja declaration which recommended that the government should allocate at least 15% of the government expenditure on health; the African Union's Campaign on Accelerated Reduction on Maternal Mortality in Africa that had been launched in November 2010 with the slogan that "no woman should die while giving birth" (Gacheri, 2016).

To support the implementation of the policy, the government committed some funds to facilitate the process: 3.8 billion to fund the free maternal health care; additional 700 million for free access to health centers and dispensaries; 3.1 billion for recruitment of 30 community nurses per constituency; 1.2 billion for provision of housing units for health care providers; 522 million for recruitment of 10 community health workers per constituencies and 60 billion allocated to county governments to be used on health (Bourbonnais, 2013). From the funds allocated for free maternal services, health services should be reimbursed KES 2,500 for every delivery through the Hospital Sector Service Fund while hospitals were reimbursed KES 5,000 through the Hospital Management Service (Wamalwa, 2015).

Several exemptions given in low and middle-income countries are effective in lifting the financial barrier to access but are always faced by the challenge of implementation in a dysfunctional health system which results to undesirable results. Some disruptions on the health systems have been studied whenever an exemption has been introduced and they include: immediate and notable increase in service utilization; perceived heavier and

increased workload for health workers which is accompanied with feelings of being exploited, overworked and demotivated; lack of available information on services being exempted and their reimbursement; inadequate or unavailable medical supplies e.g. drugs and delay in distribution of consumables; insufficient and unpredictable or irregular funding, loss of revenue for health facilities and delays in reimbursements; multiple actors in policy implementation and difficulty in identifying persons responsible; inadequate planning and communication on the policy implementation. The expected disruptions should sensitize on expected if exemption policies are not properly executed in terms of preparation, planning and complementary measures (Ridde, Robert, & Meessen, 2012).

Despite the political support and a conducive policy environment for maternal health in Kenya, several challenges have continued to face maternal health which include: inadequate access to quality maternal health services during antenatal, delivery and postnatal with women still having to travel long distances to access maternal health services; access to skilled birth attendants; and low funding to health care with the government allocating an estimated 6% of its total expenditure to health care which is below the recommended 15% or above in the Abuja declaration (Gacheri, 2016).

According to a study by (Wamalwa, 2015), the implementation of the free maternity policy has been faced by several challenges which include: shortage of staff to cater for increased utilization of maternal services, the facilities had not received additional staff to cater for the increased workload; shortage of medical supplies due to underfunding of the policy; delay of disbursement of funds; inadequate reimbursements; dissatisfaction and demotivation of health workers. The study recommended employee motivation and satisfaction through trainings in maternal health services, allowances and support supervision.

2.6 Conceptual Framework

Both waiver/exemption target a specific population which they protect from incurring costs and enhance their access in seeking health care thus promoting equity in health. Identification of the beneficiaries is vital. With exemptions, identification of beneficiaries is simple since the category of patients or services is predetermined. However,

identification of beneficiaries of waivers is more complex and requires adoption of different rules for different individuals. To ensure proper identification at the point of service requires major administrative demands on the health system therefore incurring administrative costs. Other costs incurred will be costs of medicines, diagnostics, consumables, cost of paying the health providers among other operational costs.

For effective implementation, each of these costs need to be compensated to ensure continuum of services at the health facility. Efficiency can be enhanced when timely and adequate reimbursement is provided for services offered to the beneficiaries. This will ensure that there is no interruption in delivering of services in the health services. Effectiveness in protecting the vulnerable is enhanced when there are clear guidelines to determine eligibility thus ensuring the targeted groups can access healthcare.

The cost implications per patients if not reimbursed could lead to health facilities ignoring the waivers and exemption policy therefore creating barriers in accessing health care. The hospital could also come up with other coping mechanisms which would include: borrowing from other health facilities to bridge the gap created, rationing services which are eligible for waivers and exemptions and also limiting the cases that are eligible for waivers/exemptions. The coping mechanisms adopted due to lack of compensation have led to poor implementation of this policy whose intention was to promote equity and access of health care among the poor and vulnerable population.

Figure 1: Conceptual Framework

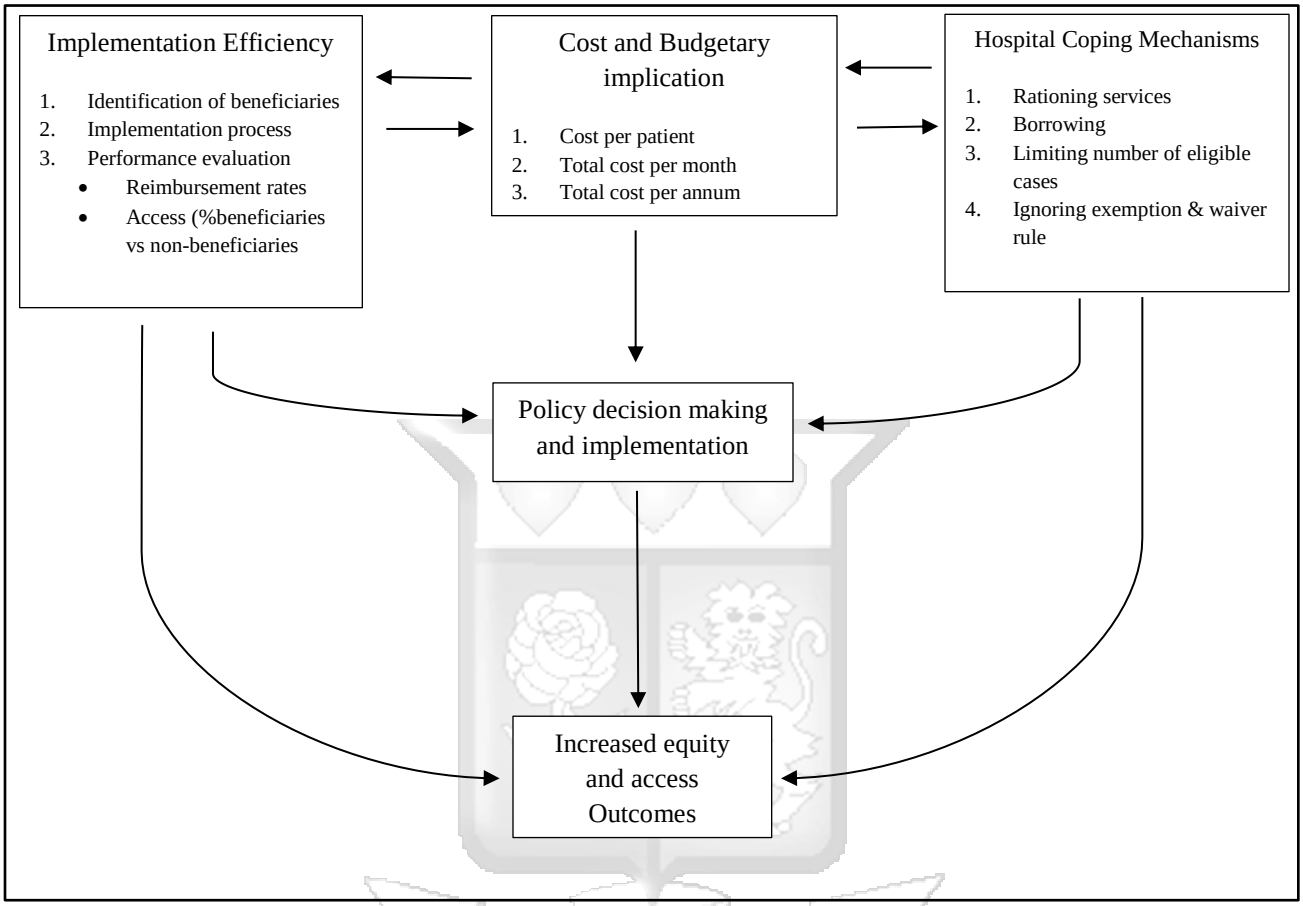

Figure 1: Conceptual Framework 1

2.7 Conclusion

Given the literature review above, the knowledge gap that my study will try to fill is on evaluating efficiency in the implementation of waivers policy and free maternity policy, examining the effects of policies on hospital management and the coping mechanisms adopted by hospitals when user fees are exempted or waived.

CHAPTER THREE: METHODOLOGY

3.1 Study Design

Two approaches were used in the study: a cross-sectional design was used to determine the status and budgetary implications of waivers and exemptions on maternal services. A retrospective approach collected cost data to allow for annual cost estimates of deliveries. The mixed methodology generated detailed information on how efficient the processes of waivers and exemption of maternal services are. Mixed methodology involves integrating both quantitative and qualitative approaches of research to provide a better understanding of research question and increasing the comprehensiveness of the overall findings(Chow, Quine, & Li, 2010)

3.2 Sampling

3.2.1 Study setting/area and population

The study was carried out in Ruiru Sub-County Hospital, a level 4 facility located in Kiambu County, which neighbors Nairobi to the North and North East. The hospital serves a catchment population of about 300,000 people. The facility has grown from a 10-bed capacity to approximately 50 bed capacity, owing to the construction of a 30-bed maternity block, with a maternity theatre, and renovation of the general and pediatric wards. Specialized clinics were also expanded and run for 4 days in a week. The study population were hospital management (medical superintendent, hospital administrator and head of departments and the social worker in charge of waivers and exemptions).

3.3 Sample size determination

Data for patients who received waivers and were exempted for maternity services at Ruiru Sub-county Hospital for a period of three months, that is, from 1st December 2017 to 28th February 2018 were collected. Data on exemptions of maternity services was obtained from the Ministry of Health registers which included normal deliveries in December (n=325) and cesarean sections (n=51); normal deliveries in January (n=376) and cesarean sections (n=58); normal deliveries in February (n=293) and cesarean sections (n=48). Waivers in December were 7, January were 11 and February were 6 which totaled to 24. The study

population totaled to 1,175 as per the registers. This formed the entire sample size - that is, all the deliveries and waivers issued in the month on December 2017, January 2018 and February 2018.

3.4 Data collection approaches

3.4.1 Initiating contacts

Initial discussions with the hospital administration and management committee was carried out, followed by a formal request to undertake to the study. Since the study involved contact with human subjects, ethical approval was sought from Strathmore University Ethics Review Committee. A list of healthcare providers who are involved in the process of waivers and exemptions of maternity services were asked to sign a consent form given to them by the researcher.

3.5 Data collection tools

3.5.1 Data abstraction instrument

A data abstraction instrument designed by the researcher was created to record the waivers and exemptions on maternity services from December 2017 to February 2018. The data abstraction tool for exemptions captured the following: number of patients, method of child delivery, reimbursement rates for the deliveries, expected reimbursements per month, eligibility status on the reimbursements and the reimbursement status of the deliveries. The data abstraction tool of waivers captured: number of patients waived per month, cost of waivers per patient and the reimbursement status. A procedure manual was set in place to ensure accuracy, consistency, validity and reliability of the data. The procedure manual will involve a clear definition, protocols and steps for data extraction.

In capturing the cost of waivers and exemption, the study assumed that the reimbursement rates as set by the government are the true costs of waivers and exemptions. The costs were used in the analysis of the budgetary implications of waivers and exemptions.

3.5.2 Semi-structured interview

Semi-structured interview guide was used to collect data from the key informants (hospital administrator, medical superintendent, matron, accountant and social worker). This is because this type of tool offer high response quality, takes advantage of the facilitators' presence and combines questioning, cross-examination and probing approaches (Owens, 1991).

3.6 Data analysis

Thematic content analysis was used in qualitative data analysis. Key themes were identified in the transcripts and coded. Analytical procedure used was summary, explication and structuring to document all information from the key respondents. The emerging themes were conceptualized, classified, categorized and meaningful descriptions and interpretations made.

Descriptive statistics was presented in tables, mean, and percentages. Cost data was presented on annual basis. The assumption is that, given the same catchment area, on average, patients seeking waivers and exemptions present with the same disease patterns over a period of three months that informed the annual costs. Rather than do a full cost of waivers and maternity exemptions, we used government agreed reimbursement rates as the direct cost of maternity exemptions; i.e. a flat rate of KES 5000 per delivery (whether normal or C-section) and hospital records on direct cost of waivers.

Reimbursement practices over a three-month period were retrospectively analyzed and their implications on hospital budgets analyzed from interviews at the facility.

Data collected from the interviews were transcribed and organized at the first stages of analysis. This was followed by systematically analyzing of the transcripts, grouping together comments on similar themes and interpreting them to draw conclusions.

3.7 Measures of reliability and validity

Data to be used for the study was obtained from Ministry of Health Medical reports on the number of waivers and number of exemptions of maternity services. The data abstracted manually was reliable and was free from human error as it was peer reviewed by the medical superintendent, matron and the hospital administrator. Content validity was assured in that, the data abstraction tool and the in depth interviews captured all the relevant data that would reveal the challenges faced in implementation of the two policies and the budgetary implication on hospital management.

CHAPTER FOUR: RESULTS

4.1 Description of study participants

The study respondents included five key informants who were responsible for implementing policies of exemptions on maternity services and waivers. They included selected members of the hospital management team (CHMT), technical staff and administrative officers, social workers. They were largely concerned with hospital management and administration as well as ensuring that policies such as waivers and exemptions are implemented. The HMT which plays a role in budget preparation and determines prioritization and utilization of funds, holds the mandate of Authority to Incur Expenditure (AIE) and are a signatory to the hospital's bank account. The social workers play the vital role in the process of waivers which includes: when a patient is recommended by the matron for waivers, the social worker is contacted to carry out a back ground check on the patient so as to assess their socio-economic status thus determining their ability to afford to pay. There were 3 females and 2 males in the study.

4.2 Status of implementation of waivers and maternity service exemptions

4.2.1 Implementation context

The hospital's quarterly budget is approximately 3-4 million KES. However, the hospital has not been able to have the budget funded externally and has depended on user fees to finance the entire budget. The hospital collects approximately 750,000 KES on user fees per month which is pooled to the county treasury. The user fees are released in quarters such that, user fees collected in the first quarter is released for use in the second quarter and user fees for the second quarter is released in the third quarter, etc. The user fees collected can only cater for approximately 64% of the overall budget leaving approximately 36% of the budget not funded. The medical superintendent and /or the health administrator are the signatories to the hospital account where the user fees are deposited. However, only the medical superintendent has the mandate of Authority to Incur Expenditure (AIE) thus determines how the user fees in the hospital level are prioritized and used. This is the context that defines implementation of waivers and exemptions at the Ruiru Sub-County Referral Hospital.

4.2.2 Implementation procedure

The key informants (KI) reported that not every patient who requested for waivers was been issued with waivers directly but have been subjected to a process of identifying extremely deserving cases. A social worker explained the process as when a patient was being prepared for discharge and they raise the concern of them not been able to raise the bill, the hospital cashier would notify the matron who then notified the social worker. Upon notification, the social worker would probe the patient about their socio-economic status which then requires them to do a home visit to confirm if what the patient is reporting is true. A KI highlighted that in some instances, it was not possible to do home visits, for example, if the patient is a street child/adult who has been rescued from the streets, they just recommend for waiving. During the home visit, they would use personal judgement to identify the poverty level. The judgement would be influenced by the type or nature of the home i.e. is it a mud house, wooden, brick or any other; is there anything in the homestead that can generate income, e.g. livestock etc.

An interview with the household's breadwinner is conducted to get to know what they do for a living and how many dependents they have and if there was any other members of the extended family who supports them financially. In other instances, the KIs indicated that they would consult the area chief if they were available to give an independent background of the family in question. With the information gathered from the interviews and observation, they would fill the socio- economic assessment form and present to the hospital matron. The social worker's view on the home visit process is captured here:

> *"It is a very cumbersome process that requires adequate resources because sometimes the patient lives far from the hospital. It also requires promptness since the more the patient is in the hospital, additional costs are incurred. It is also quite challenging when you don't have precise guidelines to measure the degree of poverty. However, our biggest challenge has been inadequate resources."*

The socio- economic assessment form has the patient's bio-data, physical address, social background, and the reason of consideration for waivers, the intended plan of action / recommendations on the eligibility status, the total bill to the patient and the amount the

patient can raise. The form is filled and signed by a social worker. The social worker then consults the ward nurse, matron and hospital administrator for the final decision on whether to issue the waiver. A waiver authority form is then filled which contains basic patient information i.e. name, card number, age, sex, marital status, occupation, date of admission, date of discharge, physical location, amount to be waived, reasons for recommendation, officer recommending the patient and officer approving the waiver.

The social worker highlighted that proper documentation of costs incurred and the processes involved were done as per recommended. The respondents reported that they believed that all the waivers issued were to deserving patients. The social worker added that approximately only 10% of the recommended patients benefited from the waivers. Reasons for not granting waivers to all requested cases included: the hospital was operating on a very lean budget and could only waive if the patient is extremely deserving; the social worker's assessment on poverty indicated there was a chance for the patient to raise the fees; the patient had had previous waivers from the hospital and had not made any effort to settle any part of the bill; relatives to the patient are known to be capable of paying and; if before the home visit the patient had given unsatisfactory responses of why they were requesting for a waiver The respondents stated that there was a knowledge gap on the waiver process since the staff had not been trained on the implementation process. The social worker was the focal person in the hospital who oversaw the waiver process.

The hospital acknowledged that it had no measures that had been put in place to ensure that the process was free from leakages neither were there penalties to anyone who was involved in cheating the system. In some circumstances, there is a likelihood of non-deserving cases benefiting from waivers. A KI said:

> *"There may be many undocumented cases of waivers especially among health care providers and their immediate families when they visit the hospital for out-patient visits. They plan with fellow colleagues to assist in attending to their social patients at no cost. It is never a case of inability to raise money but familiarity of the system and knowing no punishment awaits them. It's more of a culture among most health care providers. However, it would be difficult to trace such incidences because they happen among colleagues who are peers so would not go reporting each other and in most cases, they reciprocate favors."*

For the exemptions on maternity care, all deliveries were properly documented in the Ministry of Health report book MOH 333 and the matron was the focal person who oversaw the process of implementation of exemptions on maternity services. The KIs reported that the exemptions on maternity services was almost straight forward since the only criteria for eligibility they used was evidence of pregnancy. They highlighted that every expectant mother who walked into the facility benefited from the policy. They pointed out that the implementation process was almost free from leakages and had no cases of cheating the system.

Overall, the respondents thought the process of both waivers and maternity services exemptions if well-funded would play a major role in ensuring that everyone had access to medical care and would be a step towards universal health coverage. The KIs suggested that with adequate funding and proper implementation of exemptions on maternity services, maternal and child deaths would significantly reduce.

4.2.3 Costs incurred on waivers and maternity exemptions versus reimbursement practices

The free maternity services policy indicates that all deliveries should be reimbursed regularly and timely to ensure continuum of services. However, the respondents reported that it has not been the case at Ruiru sub-county hospital. They had not received funds on free maternity services from August 2017, which has led to service disruption and the hospital operating on cash-crisis mode. As a result, the hospital has not been able to purchase adequate consumables and pharmaceuticals and hire more staff to improve service delivery of maternity services. Maternity services (79%) take up the largest fraction of all inpatient cases as indicated in Table 4.1:

Table 4.1: Proportion of inpatient services

Month	Maternity ward	Pediatric ward	Surgical ward	Total inpatient
December 2017	313	57	31	401
January 2018	433	70	29	532
February 2018	351	67	35	453
Total patients per ward	**1097 (79%)**	**194 (14%)**	**95 (7%)**	**1386 (100%)**

Table 2: 4.1 Proportion of inpatient services

The maternity services exemptions policy indicates that the reimbursement rates of normal deliveries is KES 2,500 and KES 5,000 for cesarean sections. However, Ruiru sub-county hospital received a flat rate of KES 5,000 for every delivery that was performed in the hospital.

Table 4.2: Costs incurred on normal deliveries versus reimbursement practices

Data abstraction tool for exemptions on maternity services (normal deliveries)					
Month	**Number of normal deliveries**	**Cost of normal delivery**	**Total cost of normal deliveries**	**Eligible for reimbursement**	**Reimbursed amount**
December 2017	325	5000	1,625,000	yes	nil
January 2018	376	5000	1,880,000	yes	nil
February 2018	293	5000	1,465,000	yes	nil
Total reimbursable			**4,970,000**	yes	nil

Table 3:4.2 Costs incurred on normal deliveries versus reimbursement practices

Table 4.3: Costs incurred on caesarian deliveries versus reimbursement practices

Month	Number of cesarean sections	Cost of each cesarean section	Total cost of cesarean section births	Eligible for reimbursement (yes/no)	Reimbursed amount in KES
December 2017	51	5000	255,000	yes	nil
January 2018	58	5000	290000	yes	nil
February 2018	48	5000	240000	yes	nil
Total reimbursable			**785,000**	yes	nil

Table 4: 4.3 Costs incurred on caesarian deliveries versus reimbursement practices

From the data abstraction tool for exemptions on maternity services, the total amount of costs incurred in the duration of December 2017 to February 2018 was: KES 4,970,000 on normal deliveries and KES 785,000 on cesarean sections. A total of KES 5,755,000 for the three months.

The average cost of exemptions per month is

$$\frac{5{,}755{,}000(\text{total costs of exemptions in Dec, Jan, Feb})}{3\text{ months}}$$
$$= 1{,}918{,}333(\text{average cost per month})$$

If exempted maternity services were regularly reimbursed it would see the hospital raise an average revenue of KES 1,918,333 per month and in three months, the revenue collected from maternity services would be approximately KES 5,755,000. This would lead to a surplus of the hospital budget by KES 2,255,000 since the hospital budget per quarter is approximately KES 3.5 million (without staff salaries).

The estimated total annual cost of exemptions on maternity costs would be: KES 1,918,333 (average cost per month) ×12 months= 23,020,000 KES (estimated average cost of exemptions per year)

The respondents of the study reported that the last time they had received funds for exempted maternity services was September, 2017.

Table 4.4: Costs incurred on waivers

Date	Age (years)	Sex	Diagnosis	Cost of treatment (KES)	Reason for eligibility	Reimbursement status
1/12/2017	65	F	X	1900	Poverty	nil
11/12/2017	22	M	X	500	Poverty & homelessness	nil
11/12/2017	11months	M	X	1000	Poverty	nil
14/12/2017	30	M	X	1570	Poverty	nil
19/12/2017	65	M	X	2010	Poverty & homelessness	nil
21/12/17	3	F	X	7220	poverty	nil
29/12/17	49	F	X	3440	Poverty-sole breadwinner	nil
10/1/2018	40	M	X	3880	Not claimed by family in hospital	nil
12/1/2018	55	F	X	100	Poverty	nil
12/1/2018	20	F	X	180	Poverty and delayed illness	nil
12/1/2018	59	F	X	490	poverty	nil
17/1/2018	16	F	X	100	student	nil
17/1/2018	6	M	X	4150	Disabled	nil
19/1/2018	36	F	X	560	Poverty could not raise full amount	Nil
22/1/2018	18	F	X	170	Poverty	Nil
22/1/2018	40	M	Dog bite	780	Poverty	Nil
25/1/2018	40	M	Dog bite follow up	700	Poverty	Nil
29/1/2018	40	M	Dog bite follow up	500	Poverty	Nil
1/2/2018	11 months	F	X	12480	Poverty	Nil
5/2/2018	37	M	X	4000	Prisoner	Nil
5/2/2018	40	M	Dog bite follow up	700	Poverty	Nil
15/2/2018	23	M	X	400	Prisoner	Nil
TOTAL WAIVERS				**46,830**		

Table 5:4.4 Costs incurred on waivers

The total costs of waivers for the period of December 2017 to end of February 2018 was KES 46,830. The average cost per patient was approximately;

$$\frac{46{,}830\ (\text{total cost of waivers})}{22(\text{total number of patients})} = \ 2{,}129\text{KES (average cost per patient)}$$

The average cost per month;

$$\frac{46{,}830\ (\text{total costs of waivers})}{3\ \text{months}} = 15{,}610(\text{average cost per month})$$

The estimated annual cost of waivers;

15,610(average cost per month) ×12 months=187,320 KES

The respondents of the study reported that waivers are not funded and the hospital has to absorb the costs on its own irrespective of the amount. This makes it difficult to grant as many waivers as would be merited because of the potential for budgetary constraints.

4.3 Budgetary implications and coping mechanisms

The free maternity policy has attracted a significant increased work load in the hospital with no complimentary budgetary allocation to cope with the workload. Health workers such as nurses are therefore forced to work longer hours and are taking up extra shifts to bridge the gap created by increased work load. A key informant reported that:

> *"The county has been promising to add us more nurses but this has not been forthcoming. Generally, most of us are exhausted and demotivated…."*

According to all the key informants, the increased work load without a compensation mechanism contributed to labor strife since the free maternal care policy was rolled out.

Initially, user fees collected from maternity services was helping in running the hospital by paying for current expenses including monthly utility bills, paying salaries for casuals, buying pharmaceuticals and consumables, etc. Said a KI:

> *"Through user fees, we raised sufficient user fee to sustain us- patients paid KES 1,200 for normal deliveries and KES 7,000 for cesarean sections. We always met*

the target for the budget. When the government introduced the policy, we were to receive a constant rate of KES 5,000 for every delivery and we were promised that they would hire more staff to cater for the workload …we thought the policy would be of great benefit to the facility …"

The key informants indicated a major financial crisis at the hospital but a government institution, is not authorized to borrow loans from banks, SMEs, government or development partners to bridge the budget's deficits. Said a KI:

"…We have huge debts from local suppliers of pharmaceuticals, consumables and we are always late to pay for the utility bills and have experienced disconnection of power supply or water. Some of the suppliers have black listed us due to the late payments while some have issued us with demand letters...."

Noting that the hospital budget keeps growing but without regular reimbursement or lack of it in totality, has affected the management of the hospital through loss of revenue and has created hostility with suppliers, and patients who demand for free services that are not compensated by the government. A KI stated:

"*We currently operate on a deficit of approximately KES 1.5 million per quarterly budget…. There are times that the hospital operates on very minimal resources and lacks basic consumables such as gloves and essential medicines."*

A key issue in the delivery of free maternity policy in the hospital is that several services were not exempted. The exemptions include antenatal services, delivery costs and postnatal services in the hospital to every expectant mother who visited the hospital. However, some services were not catered for in the exemption thus requiring the mothers to pay for them. These services include: the antenatal profile which requires tests like hemoglobin level, urinalysis, VDRL, HIV and blood grouping. The pregnant mothers pay a bracket cost of KES 300 for those tests. Ultrasounds costs of 800 for complicated pregnancies and medications prescribed to the pregnant mothers is not catered for either e.g. supplements, anti-hypertensive for pregnancy induced hypertension, insulin for pregnancy induced diabetes or any antibiotics for infections related to pregnancies. These charges are relatively high for some patients and have formed a financial barrier to access for most mothers visiting the hospital. The implication is that the hospital would be required to administer

waivers when in actual fact these are services that could have been covered under the free maternal care policy.

The hospital is forced to operate on a very thin budget with implications on critical service delivery beyond maternal care services. The hospital has resulted to rationing of services where it issues waivers to only 10% of eligible beneficiaries and has introduced some informal payments for pregnant mothers seeking care. A KI observed:

> *"Our coping mechanisms due to the reduced funds have included rationing of services and introduce additional charges require pregnant mothers pay for some services including antenatal profile, ultrasounds and pharmaceuticals that they would require during pregnancy."*

In cutting costs as a coping mechanism, the first casualty is the administration of waivers. The waivers in themselves come with high administrative costs including home visits. The eligibility criteria are therefore highly narrowed down to include extremely deserving cases only. A key informant said of the waivers:

> "*Waivers are neither reimbursed nor considered during the process of budgeting; so the hospital absorbs all the costs incurred. The hospital's waiver system has no limitations on waived costs as long as the patient has proved that they cannot afford after the necessary assessment, the hospital is obliged to absorb the costs….so it can be costly and we have to limit waivers given our financial circumstances."*

CHAPTER FIVE: DISCUSSION, RECOMMENDATIONS AND AREAS FOR FURTHER RESEARCH

5.1 Discussion

The study sought to highlight the challenges faced during the process of issuing waivers and exemptions on maternity services and the budgetary implications to the hospital management because of the costs incurred by the hospital while implementing the policies. For an exemption or a waiver policy to be implemented, financing of the policies plays a major role in enhancing its success.

The study indicated that lack of timely and regular reimbursements led to a dysfunctional system where the hospital lost substantial revenue and had major budgetary deficits which compromised the quality of services rendered and reduced access of major services in the hospital. This agrees with findings of a literature review of 16 scientific articles by (Ridde et al., 2012) which reported that user fee exemption policies in health systems causes disruptions in the health systems since they are rolled out in unstable health care system with inadequate financing mechanisms. The study specified the disruptions as: immediate and notable increase in service utilization; heavier workload for the healthcare providers and decrease in work satisfaction and motivation among employees; unavailable information on the exempted services and the their reimbursements; unavailable pharmaceuticals and delay in distribution of consumables; unpredictable and insufficient funding, loss of revenues and reimbursement delays; multiple actors in the formulation of the policy and none of them are ready to take responsibilities while presented to them; and inadequate planning and communication on the policies. A similar study on exemptions on maternity services in Ghana by (Witter, Arhinful, Kusi, & Zakariah-Akoto, 2007) had similar findings where the exemption policy was readily accepted by the people thus increasing utilization but had faced challenges in its implementation that included: problems in disbursing and sustaining the funds; budgetary implications and interruptions in the hospital management; increased workload for the staff and there was need for formulating a compensation mechanism to the health care providers to ensure that they had employee motivation and job satisfaction.

A study by Mubyazi, (2004) reported that even though a waivers policy in Tanzania was formulated to financially protect the poor while seeking health care services, the policy just like in Kenya had some grey areas. The identifying of beneficiaries of waivers had been left in the hands of health care providers with no proper guidelines on how to assess the level of poverty that would qualify one from benefiting from waivers. The lack of proper guidelines has been used as a loophole by health administrators to deny eligible cases from accessing health care. In this current study, only around 10 % of patients in Ruiru Hospital that had been recommended for waivers were granted the waivers. The major barrier to issuing waivers was that the hospital's administration was hesitant to approve waivers due to loss of revenue to the hospital since there was no funding allocated to the implementation of the policy.

The cost of exemptions on maternity services if regularly and timely reimbursed would lead to the hospital meeting their target for the budget. In a quarter, the study highlights that reimbursement of the exemptions would fetch revenues of approximately 5.8 Million KES which plus the user fees of approximately 2.3 million KES in total is approximately 8 million KES which is more than double the hospital budget of 3-4 million per quarter. A study conducted by (Witter, Khadka, Nath, & Tiwari, 2011) supports that regular reimbursements can benefit the health facilities, it reported benefits arising from the fee reimburses intended to replace user fees for free deliveries as they noted that the regular reimbursements improved utilization and efficiency and that the additional revenue collected could be used to subsidize other services. Available revenue in form of user fee compensation in Ruiru Sub-County Hospital would fund various activities in the hospital to ensure that service delivery is not disrupted. The activities to be funded would include: hiring of more staff to help with the increased workload; purchasing of drugs and consumables; timely payment of utility bills, development of the hospital by constructing wards and other facilities that would cater for increased levels of service utilization; compensating health providers to improve motivation and job satisfaction; the surplus budget could also cater for waivers to the poor population. Generally, running of hospitals require adequate financing as its very capital intensive. The major expenses are usually realized in purchasing medical equipment, purchasing of pharmaceuticals and consumables

and hiring of specialized workforce. There is always an increase in demand in health care as it is an essential service and therefore there is need for an effective and sustainable allocation of appointed hospital resources (Shtereva, Naseva, & Goranova, 2015).

Abolishing of user fees in the free maternity services policy was aimed to increase service utilization, reduce impoverishment and ultimately reducing neonatal and maternal deaths (Hatt, Makinen, Madhavan, & Conlon, 2013). However, a study done by (Xu et al., 2006) reported that even though abolishing user fees as in the case of waivers and exemptions increases utilization of health services, the out of pocket payments continued to be high because the inefficiencies in the health facilities caused by inadequate funding led to patients having to buy drugs and seek other services e.g. imaging services from the private practices which costs more. The study also reported higher informal payments to health workers to offset the lost revenue from fees. This is similar with the current study in that, the irregular reimbursement practices of maternity services exemptions and lack of funding of waivers, have led to inefficiencies and disruptions in service delivery and has seen pregnant mothers pay for some services like the antenatal profile, ultrasounds and medication. A study conducted by (Witter et al., 2007) had similar findings on the impact realized due to loss of revenue after introduction of the exemption policy on maternity services. The findings included frequent stock outs of pharmaceuticals and consumables and increase in inefficiencies which interfered with quality of services delivered thus prompting some health facilities to reinstate user fees.

Studies have been done which support the need for charging minimal user fees so as to ensure that the hospitals have additional revenue to cater for their costs while others prove the amount collected as user fees is not adequate to sustain the health systems. A study done by Ufuoma (2013) highlights various benefits of user fees which include enhancing efficiency through ensuring reduced unnecessary hospital visits and increasing accountability of healthcare providers to the community since they are paying for the services; resources collected can be used to improve quality of services provided; and reduces the financial burden from the government funding which in most cases is not reliable. User fees are a source of facility revenues in many low income countries and is

used in purchasing drugs and supplies and paying incentives to health workers (Hatt et al., 2013). Besides the government funding public health care system directly, other sources of funding in Kenya include income generating activities, direct facility grants and collaboration with development partners and related agencies (Munge & Briggs, 2014). If the exempted or waived user fee is not reimbursed, this means the available resources would be reduced and the policy implementation process may be faced with many challenges as reported in this study.

This study reveals systemic problems which reflect an ailing public health system that would need review of the policies to avoid further inefficiencies. The hospital has had to identify with internal coping mechanisms which include rationing of services as a result of lack of reimbursement of costs incurred on exemptions. Similarly, a study conducted by (Nyonator & Kutzin, 1999) reported that if costs incurred during exemption policies are not replaced and facilities are forced to recoup costs from patients using alternative ways, the policy then negates the financial access benefits. This is similar to this study where patients are still incurring informal costs which act as a barrier to access health care. For an exemption policy to succeed, the government ought to; timely and regularly reimburse lost earnings ; increase facility resources to respond to increased workload; improve transportation network and increase the human resource for health (Hatt et al., 2013).

This has not happened in Ruiru Hospital and therefore contributing to the challenges been faced in implementation of the policy and the huge budgetary implications on the hospital management. A study conducted in Uganda (Nabyonga-Orem et al., 2008) identified coping interventions which were successful after the abolishment of user fees and led to improved service delivery. The interventions included additional budget transfers to facilities, increase in local flexibility in government allocation of funds and pooling of health care commodities. These interventions would probably be a suggestion to our county governments who have reduced allocation to health care instead of increasing them. As financial sustainability of the exemption and waiver policy is crucial, some countries have adopted various sources of funding for example, domestic funding through government revenue, and external through donors, out-of-pocket payment or insurances (both private

and social insurances). However, no conclusion has been realized which method of financing is sustainable in the long run for successful financing of exemption policies (Hatt et al., 2013).

Ruiru sub-county Hospital has adopted cost reduction as a coping mechanism, it has not hired additional staff to cater for the reported increase in work load after introduction of the policy. This has led to overworked and demotivated staff. A study conducted by (Galadanci, Idris, Sadauki, & Yakasai, 2010), had similar findings wherein with the introduction of a free maternity service exemption policy, the health care providers did not receive an increase in remuneration, the human resource was not increased to cater for the increased utilization which ultimately resulted to a demotivated workforce yielding poor performance in service delivery and poor quality of services delivered. The study also reported shortage of pharmaceuticals and consumables just as it is the case in this study. These coping mechanisms may not be sustainable in the long term and if better planning, skilled management and oversight is not done, the maternity services exemption policy and the waiver policy will ultimately fail with facilities failing to implement the policies due to the budgetary implications.

5.2 Conclusion

Lack of regular and timely reimbursement of costs of waivers and exemptions on maternity services have major budgetary implications on hospital management. Despite that the waiver policy and free maternity policy were formulated to increase access and equity to the poor and the vulnerable groups seeking care, the health care institutions have been burdened with financing the policies. Consequently, this has led to a dysfunctional health system that affects the quality of services rendered and has limited the same services that the policies aim to give access to

5.3 Recommendations

Both the waiver and exemptions policy of maternity services is meant to improve access and equity of health care services to both categories of people i.e. the poor and the pregnant mothers. However, the implementation process requires funding by the government. This

has not been regular and sustainable and has led to inefficiencies in the health system. The hospital needs to inform, consult and engage all stakeholders who would push the agenda of adequate, sustainable and reliable health financing mechanisms. The hospital administration needs to stop being comfortable with the status quo and push for better quality services from the county government.

Proper documentation of costs incurred and inclusion of the costs of all waivers and exemptions on maternity services in the quarterly budget would shine some light on the effects of the policies on the budget and hospital management to the administration and consequently to the county government.

5.4 Limitation of the study

The study had the following limitation: it was done in one health facility and five key informants who were directly involved in the implementation process of the two policies were interviewed. Their method of enhancing implementation and addressing challenges involved at an institutional level may not be similar to other hospital administration heads. There is need to carry out similar studies in different county governments to find out if different counties have similar or different challenges in the implementation of the policies.

5.5 Areas for further research

The study has brought out challenges faced in Ruiru sub-county hospital in implementation of the two policies. Further studies could be carried out in other hospitals in the same county such that, if similar findings are realized, a common agenda could be pushed to address the challenges.

BIBLIOGRAPHY

Agency, N. E. (2016). Kenyan Healthcare Sector. *Kenyan Healthcare Sector*, 86. Retrieved from https://www.tfhc.nl/wp-content/uploads/2016/09/2016-Kenyan-Healthcare-Sector-Report.pdf%0Ahttps://www.rvo.nl/sites/default/files/2016/10/2016_Kenyan_Healthcare_Sector_Report_Compleet.pdf%0Ahttp://www.khf.co.ke/wp-content/uploads/2016/10/2016-Kenyan-Health

Anneceta Gacheri. (2016). *Tackling High Maternal Deaths in Kenya*. Retrieved from https://www.afidep.org/download/research-briefs/policy-briefs/Anneceta-Gacheri.pdf

Bank, W. (2014). Improving Health Care for Kenya's Poor. Retrieved March 26, 2018, from http://www.worldbank.org/en/news/feature/2014/10/28/improving-healthcare-for-kenyas-poor

Bitran, Ricardo; Giedion, U. (2003). *Waivers and exemptions for health services in developing countries*. Retrieved from http://documents.worldbank.org/curated/en/763021468761984508/Waivers-and-exemptions-for-health-services-in-developing-countries

Bourbonnais, N. (2013). Implementing Free Maternal Health Care in Kenya Challenges, Strategies, and Recommendations. Retrieved from http://www.knchr.org/Portals/0/EcosocReports/Implementing Free Maternal Health Care in Kenya.pdf

Campbell, O. M. R., & Graham, W. J. (2006). Strategies for reducing maternal mortality: getting on with what works. *Lancet (London, England)*, *368*(9543), 1284–1299. https://doi.org/10.1016/S0140-6736(06)69381-1

Chow, M. Y. K., Quine, S., & Li, M. (2010). The benefits of using a mixed methods approach – quantitative with qualitative – to identify client satisfaction and unmet needs in an HIV healthcare centre. *AIDS Care*, *22*(4), 491–498. https://doi.org/10.1080/09540120903214371

Chuma, J., & Maina, T. (2012). Catastrophic health care spending and impoverishment in Kenya. *BMC Health Services Research*, *12*, 3–4. https://doi.org/10.1186/1472-6963-12-413

Chuma, J., Musimbi, J., Okungu, V., Goodman, C., & Molyneux, C. (2009). Reducing user fees for primary health care in Kenya: Policy on paper or policy in practice? *International Journal for Equity in Health*, *8*. https://doi.org/10.1186/1475-9276-8-15

Chuma, J., & Okungu, V. (2011). Viewing the Kenyan health system through an equity lens: Implications for universal coverage. *International Journal for Equity in Health*, *10*, 6. https://doi.org/10.1186/1475-9276-10-22

Galadanci, H., Idris, S., Sadauki, H., & Yakasai, I. (2010). Programs and policies for reducing maternal mortality in Kano State Nigeria: a review. *African Journal of Reproductive Health*, *14*(3s1), 31–36. Retrieved from http://www.bioline.org.br/abstract?id=rh10045&lang=en

Gilson, L. (2005). Removing user fees for primary care in Africa: the need for careful action. *BMJ*, *331*(7519), 762–763. https://doi.org/10.1136/bmj.331.7519.762

Govender, V., Mcintyre, D., & Loewenson, R. (2008). Progress towards the Abuja target for government spending on health care in East and Southern Africa southern Africa (EQUINET). *EQUINET DISCUSSION PAPER 60*, (April).

Hatt, L. E., Makinen, M., Madhavan, S., & Conlon, C. M. (2013). Effects of user fee exemptions on the provision and use of maternal health services: A review of literature. *Journal of Health, Population and Nutrition*, *31*(4 SUPPL.2).

Health Policy Project. (2016). Health Financing Profile - Kenya. *Health Policy Project*, (May), 1–2. https://doi.org/10.1093/heapol/czs005

Hopkins, S. (2010). Health Expenditure Comparisons: Low, Middle and High Income Countries. *The Open Health Services and Policy Journal*, *3*, 111–117. Retrieved from

https://pdfs.semanticscholar.org/53e6/ccd75f6c1c87548d571f565798dddb5a2c65.pdf

Kenya, I. of C. P. A. of. (2016). kenya revenue analysis 2010-2015.

Kimani, J. K., Ettarh, R., Kyobutungi, C., Mberu, B., & Muindi, K. (2012). Determinants for participation in a public health insurance program among residents of urban slums in Nairobi, Kenya: results from a cross-sectional survey. *BMC Health Services Research*, *12*(1), 2. https://doi.org/10.1186/1472-6963-12-66

KNHCR. (2012). *Realising Sexual and Reproductive Health Rights in Kenya: A myth or reality? A Report of the Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya*. Retrieved from http://www.knchr.org/portals/0/reports/reproductive_health_report.pdf

Lagarde, M., & Palmer, N. (2008). The impact of user fees on health service utilization in low- And middle-income countries: How strong is the evidence? *Bulletin of the World Health Organization*, *86*(11), 839–848. https://doi.org/10.2471/BLT.07.049197

Leive, A., & Xu, K. (2008). Coping with out-of-pocket health payments: Empirical evidence from 15 African countries. *Bulletin of the World Health Organization*, *86*(11), 849–856. https://doi.org/10.2471/BLT.07.049403

Lu, C., Schneider, M. T., Gubbins, P., Leach-Kemon, K., Jamison, D., & Murray, C. J. (2010). Public financing of health in developing countries: a cross-national systematic analysis. *The Lancet*, *375*(9723), 1. https://doi.org/10.1016/S0140-6736(10)60233-4

Ministry of Foreign affairs Kenya with the Embassy of the Kingdom Netherlands. (2016). Kenyan Healthcare Sector. *Kenyan Healthcare Sector*, 86.

Ministry of Health. (2017). National Health Account, 1–5. https://doi.org/10.1039/an9224700476

MOH. (2002). Guidelines for District Health Management Boards, Hospital Management

Boards, and Health Centre Management Committees. Retrieved from http://www.policyproject.com/pubs/policyplan/KENGuidelines.pdf

MOH. (2014). *2013 KENYA HOUSEHOLD HEALTH EXPENDITURE AND UTILISATION SURVEY*. Retrieved from https://www.healthpolicyproject.com/pubs/745_KHHUESReportJanuary.pdf

Mubyazi, G. M. (2004). The Tanzanian policy on health-care fee waivers and exemptions in practice as compared with other developing countries: evidence from recent local studies and international literature. *East African Journal of Public Health*, *1*(1), 11–17. Retrieved from http://www.bioline.org.br

Munge, K., & Briggs, A. H. (2014). The progressivity of health-care financing in Kenya. *Health Policy and Planning*, *29*(7), 912–920. https://doi.org/10.1093/heapol/czt073

Mussa, A. H., Pfeiffer, J., Gloyd, S. S., & Sherr, K. (2013). Vertical funding, non-governmental organizations, and health system strengthening: Perspectives of public sector health workers in Mozambique. *Human Resources for Health*, *11*(1), 5–6. https://doi.org/10.1186/1478-4491-11-26

Mwai, D. (2017). The role of private sector in financing (& provision) of health care in Africa: a debate.

Nabyonga-Orem, J., Karamagi, H., Atuyambe, L., Bagenda, F., Okuonzi, S. A., & Walker, O. (2008). Maintaining quality of health services after abolition of user fees: A Uganda case study. *BMC Health Services Research*, *8*. https://doi.org/10.1186/1472-6963-8-102

NCPD. (2015). Reducing Maternal Deaths in Kenya. Retrieved from http://www.ncpd.go.ke/wp-content/uploads/2016/11/Policy-Brief-46-Maternal-Deaths-in-Kenya-1.pdf

Newbrander, Njau, A. (1995). Equity and coverage of health care provision in Kenya. Arlington Virginia Partnership for Child Health Care Basic Support for Institutionalizing Child Survival [BASICS] 1995 Jul. Retrieved from

https://www.popline.org/node/313095

Nyonator, F., & Kutzin, J. (1999). Health for some? The effects of user fees in the Volta Region of Ghana. *Health Policy and Planning*, *14*(4), 329–341. https://doi.org/10.1093/heapol/14.4.329

O'Donnell, O., van Doorslaer, E., Wagstaff, A., & Lindelow, M. (2008). *Analyzing Health Equity Using Household Survey Data,. Washington. ... Health Equity Using ...*. https://doi.org/10.2471/BLT.08.052357

Ong'uti, E. (2012a). *Health care reforms in Kenya*.

Ong'uti, E. (2012b). Stakeholders Mee.ng on Healthcare Financing in Kenya. Retrieved from https://www.healthpolicyproject.com/ns/docs/Kenya_HealthFinanceReforms_Presentation.pdf

Owino, W., & Were, M. (1999). Enhancing access to health care among vulnerable groups: The questions of waivers and exemptions. Retrieved from https://scholar.google.com/scholar?hl=en&as_sdt=0%2C5&q=Enhancing+Acess+to+Health+Care+Among+Vulnerable+Groups.+The+Questions+of+Waivers+and+Exemptions%2C+Discussion+Paper+No.+14%2F99&btnG=

Peters, D. H., Garg, A., Bloom, G., Walker, D. G., Brieger, W. R., & Hafizur Rahman, M. (2008). Poverty and access to health care in developing countries. *Annals of the New York Academy of Sciences*. https://doi.org/10.1196/annals.1425.011

Preker, A. S., Carrin, G., Dror, D., Jakab, M., Hsiao, W. C., & Arhin-Tenkorang, D. (2002). Rich-Poor Differences in Health Care Financing. Retrieved from http://ssrn.com/abstract=1026850

Ridde, V., Robert, E., & Meessen, B. (2012). A literature review of the disruptive effects of user fee exemption policies on health systems. *BMC Public Health*, *12*(1), 289. https://doi.org/10.1186/1471-2458-12-289

Shtereva, D. T., Naseva, E., & Goranova, R. (2015). CRITICAL ANALYSIS OF

HOSPITAL FINANCING SYSTEMS. *Journal of International Scientific Publications*, *9*. Retrieved from https://www.scientific-publications.net/get/1000012/1440159997410080.pdf

Ufuoma John, E. (2013). The Impacts of User Fees on Health Services in Sub-Saharan African Countries: A Ctirical Analysis of the Evidence. *American Journal of Public Health Research*, *1*(8), 196–202. https://doi.org/10.12691/ajphr-1-8-1

Van Doorslaer, E., Masseria, C., & Koolman, X. (2006). Inequalities in access to medical care by income in developed countries. *CMAJ*, *174*(2), 177–183. https://doi.org/10.1503/cmaj.050584

Wamalwa, E. W. (2015). Implementation challenges of free maternity services policy in kenya: The health workers' perspective. *Pan African Medical Journal*, *22*. https://doi.org/10.11604/pamj.2015.22.375.6708

Wexler, A., Valentine, A., & Kates, J. (2013). *DONOR FUNDING FOR HEALTH IN LOW AND MIDDLE-INCOME COUNTRIES, 2002-2010*. Retrieved from http://www.who.int/workforcealliance/knowledge/resources/KFF_Jan2013.pdf

WHO. (2015). Global Health Expenditure Database. Retrieved from http://apps.who.int/nha/database/

Witter, S., Arhinful, D. K., Kusi, A., & Zakariah-Akoto, S. (2007). The Experience of Ghana in Implementing a User Fee Exemption Policy to Provide Free Delivery Care. *Reproductive Health Matters*, *15*(30), 61–71. https://doi.org/10.1016/S0968-8080(07)30325-X

Witter, S., Khadka, S., Nath, H., & Tiwari, S. (2011). The national free delivery policy in Nepal: Early evidence of its effects on health facilities. *Health Policy and Planning*, *26*(SUPPL. 2). https://doi.org/10.1093/heapol/czr066

Xu, K., Evans, D. B., Kadama, P., Nabyonga, J., Ogwal, P. O., Nabukhonzo, P., & Aguilar, A. M. (2006). Understanding the impact of eliminating user fees: Utilization and catastrophic health expenditures in Uganda. *Social Science and*

Medicine, *62*(4), 866–876. https://doi.org/10.1016/j.socscimed.2005.07.004

Yates, R. (2009). Universal health care and the removal of user fees. *The Lancet*, *373*(9680), 2078–2081. https://doi.org/10.1016/S0140-6736(09)60258-0

APPENDIX 1: PARTICIPANT INFORMATION AND CONSENT FORM

REIMBURSEMENT PRACTICES AND BUDGETARY IMPLICATIONS IN THE IMPLEMENTATION OF WAIVERS AND EXEMPTIONS POLICY IN A SUB-COUNTY REFERRAL HOSPITAL.

SECTION 1: INFORMATION SHEET

Investigator: Dr Joan Kinyanjui

Institutional affiliation: Strathmore Business School (SBS)

You are invited to take part in this research project in regard to the topic above. The study will involve health administrators involved in the process of waivers and exemptions in Ruiru Sub-County hospital. This Participant Information Sheet will help you decide if you'd like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends. We will go through this information with you and answer any questions you may have. You do not have to decide today whether or not you will participate in this study, feel free to take your time.

SECTION 2: INFORMATION SHEET-THE STUDY

2.1: Why is this study being carried out?

The study is being carried out because previous studies have proved that in countries where waivers and exemptions policy is efficient in the implementation process and successful, it is because the government has prioritized reimbursement of the costs incurred. When the costs are reimbursed to the healthcare facilities, there will be no interruption of health care services in the health facilities. As a result, the poor and the vulnerable people will access healthcare promoting equity in healthcare.

2.2: Do I have to take part?

No. Taking part in this study is entirely optional and the decision rests with you. If you decide to take part in the study, you will be asked to complete a questionnaire to get information on knowledge, attitudes and practices concerning implementation of waivers and exemptions in a hospital setting. You are free to decline to take part in the study at any time without giving explanations.

2.3: Who is eligible to take part in the study?

Health care management that is involved in the process of issuing waivers and exemptions.

2.4: Who is not eligible to take part in this study?

Healthcare workers who are not involved in the process of implementing the waivers and exemptions policy.

2.5 What will taking part in this study involve for me?

You will be approached by the principle investigator and requested to take part in the study. If you are satisfied that you fully understand the goals behind this study, you will be asked to sign the informed consent and then taken through a questionnaire to complete.

2.6: Are there any risks or dangers in taking part in this study?

No. There are no risks in taking part in this study. All the information you provide will be treated as confidential and will not be used in any way without your express permission.

2.7: Are there any benefits of taking part in this study?

The study will be used to improve quality of service delivery in the hospital. Offering services at no costs is not sustainable in running a healthcare facility. As a result, facilities which do not receive reimbursement have disruptive services due to rationed services, unavailable drugs among other utilities. The hospital management will equally shy away from offering waivers and exemptions to people who really deserve which would even cause death of the patients due to lack of access of healthcare due to poverty. In addition, it will add to the growing wealth of research knowledge in low and middle income countries such as Kenya.

2.8: What will happen to me if I refuse to take part in his study?

Participation in this study is entirely voluntary. There are no repercussions for withdrawing from the study even if at first you had decided to take part.

2.9: Who will have access to my information during this research?

All research records will be stored in securely locked cabinets. That information may be transcribed into our database but this will be sufficiently encrypted and password protected. Only the people who are closely concerned with this study will have access to your information. All your information will be kept confidential.

2.10: Who can I contact in case I have further questions?

You can contact me, Dr Joan Kinyanjui, via phone (0722638192), or email (jojokin06@gmail.com). You can also contact my supervisor Dr Vincent Okungu at the Strathmore Business School, Nairobi, or by email (vokungu@starthmore.edu).

If you want to ask someone independent anything about this research, please contact:

The Secretary-Strathmore University Institutional Ethics Review Board, P.O.BOX 59857-00200, Nairobi. Email: ethicsreview@stratmore.edu Telephone number +254703034375

5.6 CONSENT FORM

Please tick to indicate you consent to the following:

I have read, and I understand the Participant Information Sheet.	Yes ☐	No ☐
I have been given sufficient time to consider whether or not to participate in this study.	Yes ☐	No ☐
I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.	Yes ☐	No ☐
I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without this affecting my job and workplace relations.	Yes ☐	No ☐
I consent to the research staff collecting and processing my information.	Yes ☐	No ☐
I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.	Yes ☐	No ☐
I know who to contact if I have any questions about the study in general.	Yes ☐	No ☐
I understand my responsibilities as a study participant.	Yes ☐	No ☐
I wish to receive a summary of the results from the study.	Yes ☐	No ☐

Declaration by participant:

I hereby consent to take part in this study.

Participant's name: _____

Signature: _____ Date: _____

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher's name: _____

Signature: _____ Date: _____

APPENDIX 2: DATA COLLECTION TOOLS

QUESTIONNAIRE

Data Collection Tool for the Interviews

PART A: EFFICIENCY IN IMPLEMENTATION OF WAIVERS AND EXEMPTIONS

(General Questions)

1. How much in revenue do you raise from user fees per month? KES_____
2. What percentage of your budget comes from user fees? About_____%
3. Do you get to keep all the user fee revenues? 1. YES 2. NO
4. How much of your budget estimates actually get funded? About _____%
5. Are waivers funded? 1. YES 2. NO
6. Are exemptions funded? 1. YES 2. NO
7. In case of reimbursement of the above (5 & 6)
    I. How long does compensation take?
    II. What payment mechanism is used to compensate health care providers?
    III. Does the compensation cover administration costs? 1. YES 2. NO
    IV. Are compensation amounts revised regularly to keep up with the costs? 1. YES 2. NO
    V. If YES above, how often?
    VI. Is the compensation amount significant to the actual amount? 1. Yes 2. NO
8. What do you see as the main advantages of user fees?
    a. _____
    b. _____
    c. _____
    d. _____

WAIVERS

9. In practice, does your facility waive fees for all who cannot pay? 1. YES / 2. NO
10. Please describe the process of identifying candidates for waivers?

_____

_____

_____

_____

_____

11. In your opinion, do you think waivers get to the right people? 1. YES / 2. NO
12. If NO, how should we ensure that waivers benefit only those who deserve them?
    a. _____
    b. _____
    c. _____
    d. _____
13. On average, what percentage of patients benefit from waivers? _____%
14. Are all the costs arising from fee waivers documented? 1. YES / 2. NO
15. Are these costs incurred included in the quarterly budget? 1. YES / NO
16. Are the staff trained on the process of implementing the waiver policy? 1. YES / NO
17. Are there measures used to ensure that the process is free from leakages? 1. YES / NO
18. Are there penalties placed on persons involved in cheating the system? 1. YES / NO
19. Is there a focal person in the hospital who oversees the process of waivers? 1. YES / 2. NO

EXEMPTIONS

20. Could you list all the services that are exempted from payment through the free maternity policy in your facility?
    a. _____
    b. _____
    c. _____
    d. _____
    e. _____
21. In practice, does your facility exempt all the pregnant mothers who qualify? 1. YES / 2. NO

22. If NO, who among them is exempted and who is not?

    _____

23. Are there services or items that exempted pregnant women have to pay for before they can be treated? 1. YES / 2. NO
24. If YES, which are these services or items?
    a. _____
    b. _____
    c. _____
25. Are these services (*above)* affordable? 1. YES / 2. NO
26. In case of reimbursement on costs incurred in issuing exemptions, are all the costs reimbursed? 1. YES / 2. NO
27. If NO, what are the reasons for lack of reimbursement?
    a. _____
    b. _____
    c. _____
    d. _____
28. On average, what percentage of patients benefit from exemptions? _____%
29. Are all the costs arising from the exemptions documented? 1. YES / 2. NO
30. Are these costs incurred included in the quarterly budget? 1. YES / NO
31. Are the staff trained on the process of implementing the free maternity exemption policy?

    1. YES / NO
32. Are there measures used to ensure that the process is free from leakages?

    1. YES / NO
33. Is there penalties placed on persons involved in cheating the system? 1. YES / NO
34. Is there a focal person in the hospital who oversees the process of exemptions?

    1. YES / 2. NO
35. Overall, what is your general opinion on waivers and free maternity exemptions?
36. What specific barriers are experienced during the process of issuing waivers and free maternity exemptions?

DATA ABSTRACTION TOOL FOR EXEMPTIONS						
DATE	**AGE**	**SEX**	**DIAGNOSIS**	**COST OF TREATMENT (KES)**	**REASON FOR ELIGIBILITY**	**REIMBURSED? (Y/N)**

PART B: COST OF WAIVERS AND EXEMPTIONS

1. What is the average reimbursable cost of waiver per patient?
2. What is the average reimbursable rate of maternity exemption per patient?
3. What is the average total reimbursable rate of waivers and exemptions per month?
4. What is the average total reimbursable rate of waivers and exemptions per annum?

DATA ABSTRACTION TOOL FOR WAIVERS						
DATE	**AGE**	**SEX**	**DIAGNOSIS**	**COST OF TREATMENT (KES)**	**REASON FOR ELIGIBILITY**	**REIMBURSED? (Y/N)**

PART C: BUDGETARY IMPLICATIONS AND FACILITY COPING STRATEGIES.

1. Do you believe that the waivers and exemptions have some serious budget implications for your facility? 1. YES, / 2. NO
2. If YES, in total what percent of your budgets go into waivers and exemptions?
3. In cases of budget deficits, how does this impact on waivers and exemptions?
    a. _____
    b. _____
    c. _____
    d. _____
4. How do you cope with budget deficits in the era of waivers and exemptions?
    a. _____
    b. _____
    c. _____
    d. _____
    e. _____
5. In case of borrowing, what proportion of the budget is borrowed? _____%
6. What is the repayment period for money borrowed? _____
7. Do you BORROW every financial year? 1. YES / 2. NO (includes bank overdrafts)
8. Where do you get loans to plug budget deficits?
    a. Banks
    b. SMEs
    c. Government
    d. Development partners
    e. Other (specify_____)
9. Do you default in payment? 1. YES / 2. NO
10. What happens in case of default? _____

    _____

    _____
11. In case of CUTS IN SPENDING, what programs and services are affected?

a. _____

b. _____

c. _____

d. _____

e. _____

12. Why these particular programs and services?

a. _____

b. _____

c. _____

d. _____

e. _____

13. Does a coping mechanism also mean limiting waivers? 1. YES / 2. NO

14. Does a coping mechanism also mean limiting exemptions? 1. YES / 2. NO