EXECUTIVE SUMMARY

Context

Health care is a consumption good as well as an investment good. As a consumption good, health care improves welfare, while as an investment commodity it enhances the quality of human capital. In a system of government-provided health care services, a balance must be struck between these two views of expenditure.

The context of structural adjustment brought cost sharing to Kenya’s social sector to relieve the government of the financial burden of providing public services. In the health sector, cost sharing meant that the beneficiaries of public health services, who had received almost free medical care, would be required to contribute substantially to the financing of health care delivery. The fees were to bring in revenues to support the services.

What is the problem?

The introduction of cost sharing does not automatically mean that income will be derived from health services. Cost sharing not only changes the status of the clientele from dependents to consumers, it also creates expectations for better services. Consumers review their ranking of preferences to reflect both the cost and the quality of service across the spectrum of possible service providers. Policy makers need to know how consumers make these decisions. The purpose of this study was to look at the impact of cost sharing on preference order in the household and the implied pattern of health seeking behaviour.

The health sector in Kenya

The government of Kenya has long regarded expenditure in health care as an essential investment and the policy objective is to provide affordable, effective and accessible health services that promote well being and improve and sustain the health status of all Kenyans.

The sector expanded over the years to encompass a wide range of providers-government, private, sector and voluntary agencies (churches, missions, industrial health units, private Institutions, individuals and NGOs) - but government continued to dominate. By 1996, the government provided 43% of the total sector funding and 70% of the hospital beds (of which the Ministry of Health provides 62% and Kenyatta National Hospital 8%). The voluntary sector
provided 20% of hospital beds and the private sector 10%. MOH operated 71% of the health centres and dispensaries while church related NGOs ran 14%. The rest of the health facilities were shared among other government entities and private providers.

The expansion of the sector meant better coverage of the population. Kenya has an average of one health facility per 12,600 people. There are 950 persons per hospital bed, 10,000 people per doctor, and 950 people per nurse. Accessibility also improved, with 42% of the population living within 4km of a rural health facility and 75% within 8km. And with the expansion of the sector, substantial gains were made. The crude death rate declined from 20 per 1000 in 1963 to 13 in 1987 and 12 in 1991. Life expectancy increased from 40 to 58 years between 1960 and 1994. Infant mortality declined from 126 per 1000 in 1962 to 60 in 1994. Immunization coverage rose from 40% to 70% in the same period.

A number of constraints made it impossible for the government to continue financing the increased demands for service by Kenya’s exploding population growing at nearly 4% per year by the late 1970s) in the face of deteriorating economic growth. Of the total delivery system expenditure, about 80% went to recurrent expenditure (70% to staff remuneration alone) and only 30% for supplies, including drugs. Expenditures were biased toward urban areas and the rich. Other inefficiencies and inequities characterized the delivery system because of poor management and inappropriate pricing of services. This called for improvement in the health centres and dispensaries to enhance efficiency in service delivery.

Cost sharing was introduced in December 1989. Though the fee structures have changed somewhat, the system was expected to encourage patients to use less costly preventive and primary health care services and discourage the use of costly hospital services for common illnesses. Cost sharing was also expected to encourage people to take more responsibility for their own health care.

**Study methodology**

The study surveyed both households and formal health service facilities in a rural community. A random sample of 234 households in all the administrative units of Kirinyaga District were interviewed, as well as 94 outpatients and 59 inpatients at various private and public facilities. Data covered the period 1985-1995. Among other things, the study looked at the pattern of demand for health care services, the action taken with a health problem, costs of seeking medical services and behaviour pattern in the choice of facilities.

**Research findings**

Agriculture was the mainstay of the study areas, with average land size 1.53 hectares and farm income equaling 63% of total household income averaging Ksh3,598.65. Health problems in the area included malaria, bilharzia and typhoid, exacerbated by the floodwaters from rice irrigation and the lack of clean piped water. The health care system in the district is dominated by public facilities, with some 67% of facilities run by the government.

On the assumption that the imposition of user fees would cause shifts in the choice of facilities, the study looked at the month-on-month attendance data for the service facilities. The assumption was made that any such shifts would indicate differences in quality and cost of services. Attendance at public facilities showed an overall drop in attendance rates after
the fee was introduced. The health centre indicated a drop in new family planning and child welfare attendance, while old cases increased their attendance. The dispensary recorded increased growth of all family planning attendance, along with a drop in new cases for child welfare and increasing attendance of old cases.

Community members decide whether they needed medical care on the basis of their previous experience with the health problem. While there was no clear relationship between the action families took and the degree of seriousness of the disease, families did respond by seeking medical help. The mother played a key role in diagnosing illness in children; grandparents and teachers (for school-age children) also had a considerable role. The father had a lesser role, but he was supplied with information about the situation. The choice of non-public facilities to treat children was significant.

Use of over-the-counter medication was often a first action, usually because the condition was not perceived as serious buta1so for cost considerations. If the tablets did not work, help was sought from a health facility. Traditional remedies were sometimes sought if the cost of medication was an obstacle or if the patient did not respond to the medication. Shifts across facilities were not significant, but were more pronounced away from public facilities than vice versa. This was mainly because the service at the non-public facilities was regarded as high quality.

Direct costs for health care services are transport, treatment and consultation. Indirect costs are measured by days out of school for children and output or production lost by workers, including days lost nursing the sick. Of the total costs spent using a public facility, 85% covered consultation and medication and the rest transport. In the mission facility adults tended to pay significantly more than children because they reported in serious condition, implying more attention and more services that had higher cost implications.

It was found that patients were not fast in reporting their sickness. Some 57% of outpatients reported within two days of diagnosing the problem, while 40% of inpatients reported within five days. But 81% of patients at the mission facility reported within two days compared with 70% at the health centre and 67% at the public dispensary. Those who delayed reported in serious condition, especially adults. Patents with very serious cases were found to prefer facilities of higher quality, such as the mission hospital and the health centre.

Income significantly influenced the choice of facility: the higher the income, the higher the tendency to shift to non-public facilities. Similarly, the higher the prevalence of illness, the greater the tendency to use non-public facilities. This is because the more frequent demand for health care means a higher probability of facing periods of scarcity of health care services in public facilities. It also suggests the trade-off between time lost seeking medical care and the cost incurred for treatment and implied quality of service. It was more costly for households to wait long and pay a fee for poor service in the public facilities, so they opted to wait long and pay a fee for satisfactory service.

**Implications for policy makers**

Health care consumers are not passive recipients of government service. They prefer services that are comparable to the fees charged, particularly the availability of drugs and the quality of care. Patients --especially inpatients-- felt that they risked their lives visiting public
facilities because of the irregular drug supply and the poor quality of care. They thus opt to go to private sector / mission facilities and the government health service loses that revenue. The message to policy makers is that services in public facilities did not improve with the reform process. Clearly, user fees must be accompanied by improved services in order to make public facilities competitive. A second policy point that can be derived from the study concerns the delay in seeking medical treatment, which results in deteriorating status of the sick person and thus contributes to high costs to the consumer. This situation indicates the need for a public awareness campaign to inform patients of the importance of seeking medical care promptly when an illness is suspected.

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