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Factors Impacting Universal Health Care Implementation in Kenya: A Case Study of Bomet County

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Abstract

This study explored the challenges hindering the implementation of Universal Health Coverage (UHC) in Kenya, focusing specifically on Longisa County referral hospital in Bomet County. A descriptive cross-sectional analysis was conducted with a sample size of 59 individuals. Three objectives guided the study:(1) To assess how patient characteristics influenced UHC implementation, (2) To investigate the role of social health coverage in UHC implementation, and (3) To determine the effect of accessibility to health services on UHC implementation. Key variables such as Gender, Marital status, Age, Employment status, Levels of income, knowledge, and type of insurance, distance to health facilities, and barriers to UHC access were examined. Chi-square tests via SPSS version 20 revealed significant relationships among most variables, except religion and type of insurance cover. The study's findings emphasize the need for increased public awareness regarding UHC and basic health insurance. Additionally, the research recommended the deployment of innovative strategies like mobile clinics and ambulances to enhance healthcare accessibility. These insights provided a valuable contribution to the understanding of healthcare delivery in the region, presenting actionable guidance for both policymakers and healthcare practitioners.

Keywords: *Universal Health Coverage, Social health coverage, Healthcare accessibility, Healthcare delivery dynamics, Health insurance coverage, Health policy.*

1.0 Introduction

1.1. Background of the Study

Universal Health Care (UHC) stands as a beacon of modern healthcare systems, representing a commitment to universal accessibility and financial protection. The World Health Organization (WHO) defined UHC in 2006 as the assurance that "all people and communities can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship" (WHO, 2006).

1.1.1 Global Context

Worldwide, a stark disparity in access to necessary health services exists. The urgency of implementing UHC is highlighted by the alarming fact that at least half of the world's population lacks access to necessary health services, and 100 million individuals are annually thrust into extreme poverty due to out-of-pocket (OOP) spending on healthcare (Kutzin, 2008; WHO, 2006). Encouraging countries to transition towards UHC became a global initiative following the 58th World Health Assembly of 2005 (Bump, 2010). Developed nations such as Canada, Australia, Israel, Japan, and New Zealand have made significant strides in UHC implementation since the mid-20th century, adopting various models of coverage and access.

For example, Japan's legal mandate for universal insurance coverage contrasts sharply with New Zealand's tax-based system (Kwon, 1995; Lee, Huang, Tsai, 2010). Sri Lanka's universal healthcare provision since the 1930s has yielded the lowest maternal mortality ratio in the South Asian region (WHO, 2006), setting an example for neighboring nations.

1.1.2 African Context

In Africa, the journey towards UHC is marked by both challenges and successes. Rwanda stands as a commendable example, achieving coverage for approximately 95% of the total population through a mandatory Community-Based Health Insurance (CBHI) scheme (Kalisa et al., 2015). The Rwandan model, rooted in community collaboration, has inspired other nations and offers a valuable blueprint for achieving UHC within the constraints of emerging economies.

1.1.3 The Kenyan Context

In Kenya, UHC has become a central theme in strategies to enhance healthcare financing, increase coverage for quality services, and diminish the burden of OOP payments (Mwaura et al., 2015). The country's UHC initiative, aligned with the national Vision 2030 and the "Big Four Agenda," pledges strategic investment in healthcare, aiming for universal access by 2022. The launch of pilot UHC services in four diverse counties (Kisumu, Nyeri, Machakos, and Isiolo) in 2018 paved the way for a broader rollout. Under this initiative, free access to services was provided upon registration in the pilot counties.

1.1.4 The Case for Bomet County

In Bomet County, the UHC program was introduced in February 2019 with an allocation of Kshs.60 million for the health insurance coverage of 10,000 households. Additional funds were raised through a half-marathon, culminating in a total of Kshs. 87 million. The beneficiaries, selected based on poverty and vulnerability, exemplified the collaboration between social service and health departments in program management.

1.1.5 Implications

The diverse efforts to implement UHC across nations underscore the complexity and critical importance of this issue. As the subsequent chapters will elucidate, various factors impact the successful realization of UHC, and the study of Bomet County in Kenya offers valuable insights into the challenges and triumphs of actualizing universal healthcare in a developing nation.

1.2. Statement of the Problem

The Government of Kenya is committed to providing universal health coverage to its citizens. Under this initiative, the Government committed to making strategic investments in health to ensure that all residents of Kenya access essential health services without incurring financial hardships. Universal Health Care (UHC) in Bomet County, Kenya, represents a vital endeavor to ensure quality healthcare without financial strain, a goal underscored by an allocation of Kshs. 87 million in February 2019 to insure ten thousand households. Despite these efforts, the realization of UHC faced significant obstacles, such as the disparity between limited coverage and a total population of 875,689, coupled with a 26.6% reliance on out-of-pocket payments for health expenditure. Further barriers like distance to healthcare centers and social status illuminated the gap between planning and execution. Conducting an incisive study to investigate the specific hindrances, including the examination of social health coverage, accessibility to health services, and patient characteristics, this research has surfaced essential insights. These findings present an invaluable compass for shaping future policy decisions and

sculpting strategies that promise a more equitable and accessible healthcare framework in Bomet County and potentially broader regions.

1.3. Objectives of the Study

1.3.1. General objective

The general objective of the study was to determine the factors affecting the implementation of UHC in Bomet County.

1.3.2. Specific Objectives

The study attempted to achieve the following specific objectives

i. To establish the extent to which patient characteristics affect the implementation of UHC in Bomet County
ii. To establish the extent to which social health coverage affects the implementation of UHC in Bomet County.
iii. To determine how accessibility to health services affects the implementation of UHC in Bomet County.

1.4. Research Questions

To attain the objectives, the research project attempted to answer the following research questions;

i. To what extent do patient characteristics affect the implementation of UHC in Bomet County?
ii. To what extent does social health coverage affect the implementation of UHC in Bomet County?
iii. How does accessibility to health services affect the implementation of UHC in Bomet County

2.1. Theoretical Literature

2.2.1. Universal Health Coverage

Universal Health Coverage (UHC) is a key focus in global health, supported by organizations like the WHO and the United Nations to reduce the burden of out-of-pocket (OOP) medical expenses. Various terms are used interchangeably to describe UHC, with distinctions based on the economic context: "universal healthcare" often refers to affluent nations, while "universal health coverage" pertains to low- and middle-income countries (Reddy K.S., et al., 2011). This highlights the global goal to achieve health equity and financial protection, adapting to different socioeconomic landscapes.

2.2.2. Health Care Financing in Kenya

Kenya's health system, reliant on out-of-pocket (OOP) payments, epitomizes the financial challenges common in low-income countries. These payments, which constituted significant portions of total health expenditures over the years (MoH, 2011), suppress healthcare demand and exacerbate poverty and inequities (GoK, 2010). This situation has spurred global shifts towards alternative financing models that protect populations from catastrophic costs. Unfortunately, Kenya's continued dependence on OOP payments, coupled with limited health insurance coverage, has led to stark disparities in healthcare access across regions and economic statuses. This underscores the urgent necessity to reform the country's health financing to enhance accessibility and reduce harmful disparities.

2.2.3. Challenges in the Provision of Universal Health Care

Universal Health Care (UHC) in Kenya has become a priority, aiming to ensure quality healthcare access without financial distress (HERU, 2019). However, the path to UHC is obstructed by complex challenges: recurring medical workers' strikes due to poor human resource management and infrastructure, delays in salary payments, and a lack of coherence in service schemes push citizens towards private health facilities. The National Hospital Insurance Fund's (NHIF) inability to timely honor payments, coupled with high medical costs in private facilities, further threatens impoverished households with financial catastrophe, emphasizing the intricate challenges of implementing UHC within the nation's health system.

2.3 Theoretical Framework

The theoretical framework of this study is anchored in theories that illuminate the prediction of health-related behaviors based on individual principles, social surroundings, and available resources (Becker& Maiman, 1975). Specifically, this section will discuss two pertinent theories: the Social Cognitive Theory (SCT) and the Theory of Reasoned Action/Planned Behaviour.

2.3.1. The Social Cognitive Theory (SCT)

The Social Cognitive Theory (SCT), developed by Albert Bandura in the 1960s, provides a comprehensive framework for understanding the complex interplay between social environment, individual practices, and others' practices on health decisions and behavior. Key components of SCT include self-efficacy (confidence in executing behavior), behavioral capability (possession of necessary skills and knowledge), expectations (anticipated consequences influencing behavior), observational learning (influence from others' successful behaviors), and reinforcements (responses affecting the continuation or cessation of behaviors). SCT goes beyond many health theories by also considering the sustainability of behaviors (Bandura, 1997). When applied to UHC, especially in challenging rural contexts like Bomet, SCT provides vital insights into social change in health practices and aids in the development of tailored solutions for community well-being improvement.

2.3.2. Theory of Reasoned Action/Planned Behavior

Developed by Martin Fishbein and Icek Ajzen, the theory asserts that health-related behavior stems from an individual's intention to perform that behavior, which is in turn shaped by attitudes and personal beliefs, often mirroring social and environmental influences (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975). This theory has been practically applied, such as in a Kentucky cervical cancer prevention program, where it served as a vital framework. In this context, the Theory of Planned Behavior guided strategies aimed at enhancing knowledge, altering attitudes, and promoting preventive behavior regarding cervical cancer (Robin, 2014), showcasing its utility in understanding and shaping health-related actions.

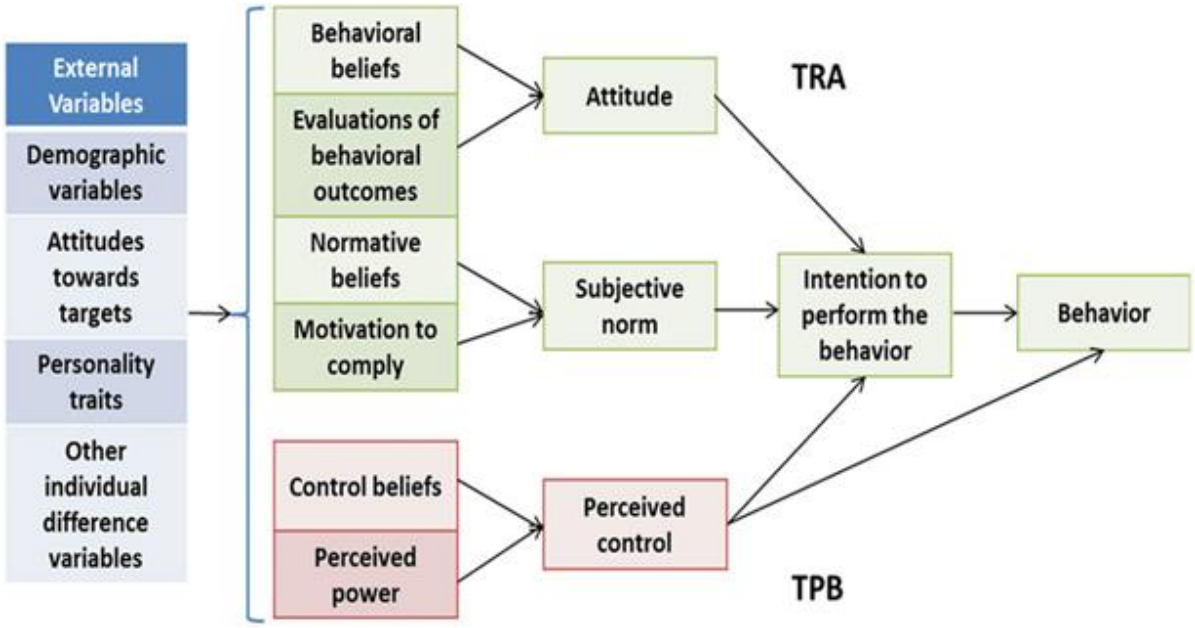

Figure 1: Sample Theory of Reasoned Action/Planned Behavior diagram

2.4. Empirical Literature

Healthcare delivery in Kenya is mediated through both public and private sectors, predominantly led by the National government through the Ministry of Health, and primarily financed by taxation (Muyia and Kamau, 2013; Kimalu et al, 2004). The evolution of Kenya's healthcare system is marked by three major phases: (1) Emphasizing free access to primary care; (2) Introducing user fees and focusing on integration within district-based structures; (3) Aligning healthcare with broader development initiatives, such as the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) (Audibert, Mathonnat, & De Roodenbeke, 2004).

Challenges confronted by this health financing system include controversial user fees that negatively impacted healthcare provision and inadequate governmental funding that led to reliance on out-of-pocket spending, limiting healthcare accessibility (Muyia and Kamau, 2013; Deloitte, 2011). Furthermore, nearly half of Kenyans live on less than a dollar per day, a circumstance that creates significant financial barriers to healthcare access and illustrates the interwoven nature of poverty and health (Deloitte, 2011). Government commitments to enhance healthcare include the Kenya Health Sector Strategic Plans, Vision 2030, the medium-term expenditure framework (MTEF) of 2008-2012, and the Health Bill of 2015. These articulate the pursuit of high-quality life as central to Kenya's global standing and prosperity, with legal provisions promoting user-driven delivery and reduced geographical disparities (GoK, 2008; GoK, 2010). Notably, the Health Bill of 2015 recognizes fundamental rights such as access to reproductive health, marking progress toward Universal Health Coverage (UHC). This synthesis shows the complex dynamics in Kenyan healthcare, including its evolution, inherent challenges, and targeted governmental interventions. The data underscore the multifarious relationship between healthcare and poverty and highlight the resolute efforts to align health services with overarching national development aims.

2.5. Critical review of existing literature

The discourse on Universal Health Care (UHC) within existing literature reveals a diversity of perspectives, focusing on varied challenges, objectives, and proposed solutions. HERU (2019) emphasizes the critical challenges faced at both the local and global levels, such as delayed payments and inadequate infrastructure, which can result in substandard services. Maina (2006), on the other hand, turns attention to strategies like the Social Health Insurance scheme (SHI), aimed at enhancing healthcare accessibility for the impoverished, albeit with certain limitations in scope. Muyia and Kamau (2013) present an encompassing examination of Kenya's healthcare, underscoring the blend of public and private provisions, primarily funded by taxation. This examination resonates with the challenges cited by HERU (2019), especially regarding the inadequacy of funding leading to restrictive out-of-pocket spending. The "inverse care law" (J., 1971) adds a different dimension by focusing on the equitable distribution of resources, highlighting the paradox of unequal access. The existing body of literature, while providing valuable insights, appears oriented toward a broad national and global analysis of UHC. Most works generalize findings across the entire population of the country. This paper, by contrast, narrows the focus to a specific rural community, endeavoring to explore the distinct features and challenges of UHC in this context.

2.6. Conceptual Framework

The study's conceptual framework, designed to explore Universal Health Care (UHC) implementation in Bomet County, investigates three core dimensions: the characteristics of patients, including demographics, to uncover unique needs and barriers; the availability of Social Health Cover, assessing existing health insurance schemes and support systems; and challenges in accessing UHC services, focusing on regional obstacles such as distance, inadequate infrastructure, and staffing issues.

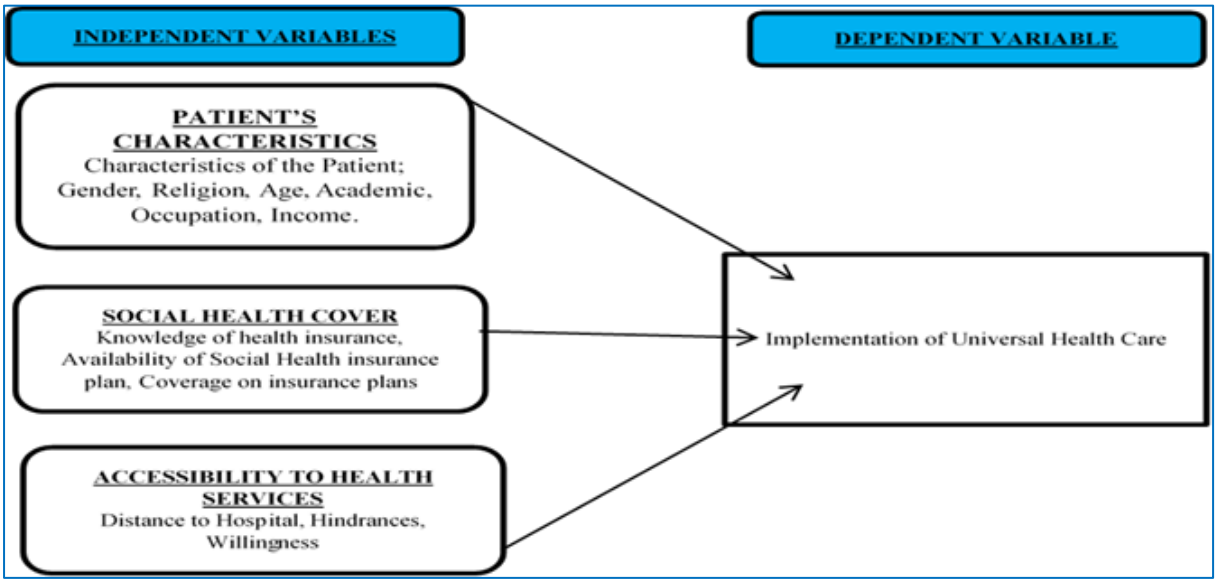

Figure 2: Conceptual framework

2.7. Research Gap

Kenya's government has collaborated with various partners to advance Universal Health Care (UHC) through policies and strategies such as the National Health Sector Strategic Plan and the Health Bill 2015, aiming for UHC by 2022. However, a research gap exists in evaluating

the effectiveness of these initiatives, indicating a need for further examination and policy refinement.

3.0 Methodology

3.1. Research Design

The research employed a descriptive cross-sectional study design to examine factors affecting the implementation of Universal Health Coverage (UHC) at a specific point in time. This method, emphasizing natural observation without variable manipulation, was chosen to answer the constituents of who, what, when, where, and how, providing rich data that could lead to meaningful recommendations (Rothman & Greenland, 1998; Carl, 1994.

3.2. Study Population

The study population consisted of patients seeking medical services in Bomet County, Kenya, which had a total population of 875,689 as of 2019, covering an area of 1,630.0 km^2. The population density was around 346 individuals per square kilometer, with a gender distribution of approximately 434,287 females, 441,379 males, and 23 intersex persons. The county is divided into five sub-county administrative units. Inclusion criteria for the study included patients above 18 years who consented to participate, while exclusion criteria omitted patients in critical condition or those showing COVID-19 symptoms. This approach aimed to encompass a diverse demographic representation in line with the research objectives.

3.3. Sample Frame

A stratified random sampling technique was employed, creating three strata based on age sets: adolescents (15-24 years), adults (25-59 years), and the elderly (60 years and above). This approach facilitated a representation of patients across various demographic lines, with a final sample size of 60.

3.4. Sample Size and Sampling Technique

The study utilized a sample size of 60, carefully selected to represent variability among variables. Through the application of stratified random sampling, it ensured equal representation across various subgroups, thereby providing an enhanced analysis of the population. The choice of this sample size was guided by practical considerations and statistical theories (Botev, Ridder, 2017).

3.5. Data Collection Procedures

The study obtained data from primary sources via structured interviews and secondary sources from governmental and international publications. Efforts were made to ensure data validity by crafting questions aligned with the research objectives.

3.6. Data Processing and Analysis

The study utilized content analysis for processing and examining qualitative data, including interviews and open-ended survey questions (WEBER, 1990). Specifically, it assessed relationships between categorical variables related to UHC, employing the Chi-Square statistical test to identify correlations or independence between these variables.

4.0 Research Findings and Discussion

4.1. Response Rate

The study achieved a response rate of 98% with 59 positive responses out of 60 targeted respondents. Such a rate surpasses the 70% threshold considered adequate for academic research (Mugenda & Mugenda, 1999), making it highly satisfactory for the ensuing data analysis.

4.2. Demographic Characteristics of the Respondents

Table 1 presents a summary of the demographic characteristics of the respondents.

Table 1: Demographic characteristics of respondents

Variable	Category	Frequency	Percentage
Gender	Male	34	58%
	Female	25	42%
Religion	Muslim	3	5%
	Christian	56	95%
Marital Status	Divorced	6	10%
	Married	31	53%
	Single	21	36%
	Widowed	1	2%
Age	15 – 24 years	11	19%
	25 – 59 years	43	73%
	60 Years and above	5	8%
Academic Level	Primary level	5	8%
	Secondary level	21	36%
	College level	17	29%
	University level	13	22%
	Postgraduate level	3	5%
Employment	Employed	29	49%
	Not Employed	30	51%
Income	Below 15,000	42	71%
	15,000- 50,000	14	24%

50,000- 100,000	3	5%

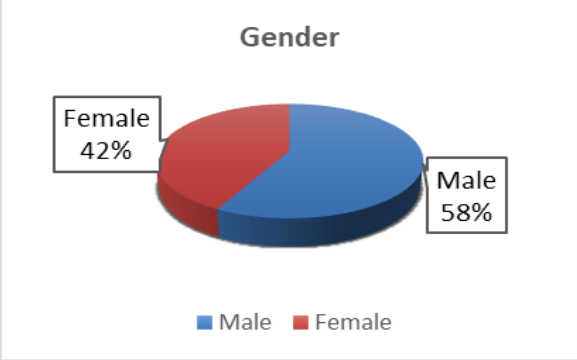

Figure 3. Gender

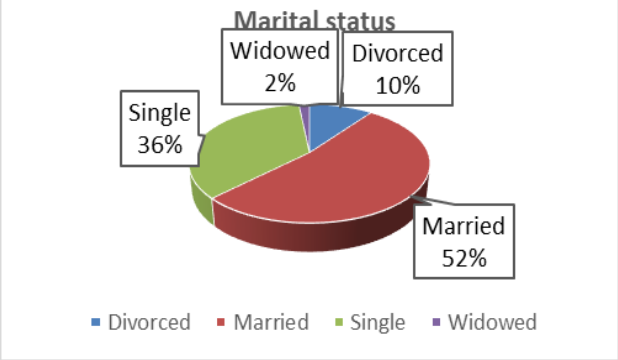

Figure 4. Marital status of the respondents

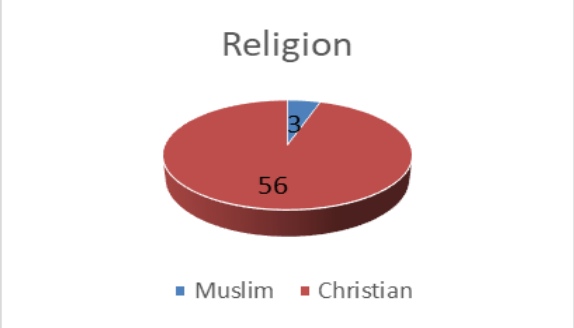

Figure 5. Respondents' religion

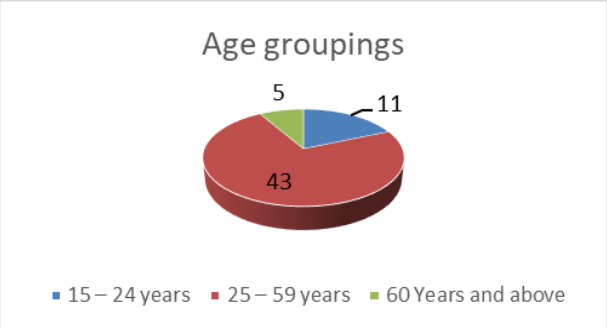

Figure 6. Age groupings of the respondents

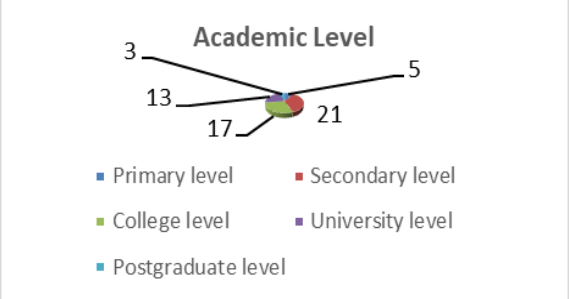

Figure 7. Academic level of the respondents

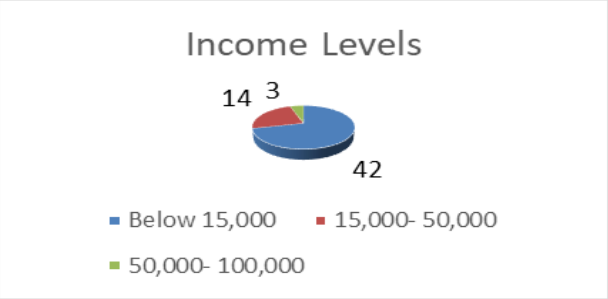

Figure 8. Income levels of the respondents

4.3. Gender, Marital status, Religion, Age Groupings, Academics and Income Level Statistics

The sampled population consisted of 58% males and 42% females, with the majority (53%) being married, reflecting a higher propensity to seek healthcare. The predominant age group was 25 – 59 years (73%), followed by 15 – 24 years (19%), and the vast majority identified as Christians (95%). These demographics provide a valuable understanding of the healthcare-seeking behavior in the studied community. The study's findings on academic and income levels disclosed that the largest portion of respondents (36%) completed Secondary education, trailed by college (29%), University (22%), Primary (8%), and Postgraduate levels (5%). Concerning employment, over half (51%) were not formally employed, and the income data revealed that 71% earned below Kshs. 15,000, 24% earned between Kshs. 15,000-50,000, and 5% earned between Kshs 50,000-100,000. The lack of respondents earning above Kshs

100,000 may signal a predilection for private hospitals or be indicative of the overall low income in the county

4.4. Extent to which patient's characteristics affect the implementation of UHC

4.4.1. Gender and UHC

While 88% of female respondents were aware of UHC, 57% of them have not benefited from it; in contrast, 83% of male respondents knew about UHC, with 79% having benefited. This apparent discrepancy led to a further statistical analysis. A chi-square test was conducted to assess the relationship between gender and UHC, yielding a χ^2 value of 24.396 and a P-value of 0.02. The study confirmed a significant relationship between gender and UHC. The results emphasize the influence of gender on the implementation and accessibility of UHC within the surveyed population.

4.4.2. Religion and UHC

Among the 56 Christian respondents, 86% were aware of UHC, with 54% having benefited from it; all three Muslim respondents knew about UHC and had benefited. A subsequent chi-square test assessing the relationship between religion and UHC yielded a χ^2 value of 7.452 and a P-value of 0.191 at the 0.05 significance level. The study concluded that there is no relationship between religion and UHC. These findings indicate that religion does not influence the awareness or accessibility of UHC within the sampled population.

4.4.3. Marital Status and UHC

Of the 31 married respondents, 84% were aware of UHC, with 77% having benefited; among 21 single respondents, 71% knew about UHC, with 40% having benefited; all six divorced respondents were aware of UHC, and 83% had benefited; the lone widowed respondent had heard of and benefited from UHC. A chi-square test was conducted to examine the relationship between marital status and UHC, resulting in a χ^2 value of 27.467 and a P-value of 0.001. The study concluded that there is a significant relationship between marital status and UHC, underscoring the impact of marital status on the implementation and accessibility of UHC within the surveyed population.

4.4.4. Age and UHC

In the 15-24 years age bracket, 82% of the 11 respondents were aware of UHC, with 56% having benefited. Among those aged 25-59 years, 88% of the 43 respondents were aware of UHC, with 79% having benefited. In the 60 years and above category, 80% of the 5 respondents had heard about UHC, and all who responded positively had benefited from it. A chi-square test assessing the relationship between age and UHC yielded a χ^2 value of 14.892 and a P-value of 0.001. The study concluded that there is a significant relationship between age and UHC, emphasizing the influence of age on the awareness and utilization of UHC within the community.

4.4.5. Academic Level and UHC

Within various academic levels, the awareness and benefit from UHC varied: primary level (60% aware, 60% benefited), secondary education (90% aware, 79% benefited), college-level (76% aware, 54% benefited), university level (85% aware, 64% benefited), and post-graduate level (67% aware, 100% benefited). A chi-square test was conducted, yielding a χ^2 value of 17.421 and a P-value of 0.01. The study thus concluded that there was a significant relationship between the level of education and access to UHC, highlighting the influence of educational attainment on both knowledge and utilization of UHC.

4.4.6. Employment and UHC

Among the employed respondents (29), 93% were aware of UHC, with 63% having benefited. In contrast, of the 30 respondents who were not employed, 67% were aware of UHC, with 65% having benefited. A chi-square test assessing the relationship between employment status and access to UHC resulted in a χ^2 value of 12.549 and a P-value of 0.029. The study therefore established that there was a significant relationship between employment status and access to UHC. The findings illuminate the impact of employment on the understanding and accessibility of UHC within the surveyed population.

4.4.7. Income and UHC

The study explored the correlation between income levels and knowledge and access to UHC. Among those earning below Ksh. 15,000, 76% had heard of UHC, with 53% benefiting. In the income bracket of 15,000-50,000, 86% were aware of UHC, with 75% having benefited. All three respondents earning between 50,000-100,000 knew about UHC, with 67% benefiting. The income distribution revealed that 71% earned below Ksh. 15,000, 24% earned between Ksh. 15,000-50,000, and 5% earned between Ksh. 50,000-100,000. A chi-square test, yielding a χ^2 value of 20.729 and a P-value of 0.001, confirmed a significant relationship between income levels and access to UHC. The findings articulate the substantial influence of income on the implementation and accessibility of UHC within the county's population, drawing attention to economic considerations in healthcare provision.

4.5. Extent to which social health cover affects implementation of UHC

4.5.1. Knowledge of insurance and type of insurance

The study delved into the respondents' awareness of medical insurance's role in Universal Health Care (UHC) and their particular type of insurance. A remarkable 95% were informed about the importance of medical insurance concerning UHC, while a minority of 5% were not acquainted with this information in the given county. The data further highlighted the popularity of various insurance types, with the National Health Insurance Fund (NHIF) covering 90% of UHC in Bomet. Those covered by employer-based insurance were at 3%, private insurance at 5%, and other types of coverage at 2%. These results indicate that the government's emphasis on medical insurance has found resonance in this county.

The study established a significant relationship between knowledge of insurance and access to UHC, reflected by a χ^2 value of 17.503 and a P-value of 0.001. However, in relation to the type of insurance, the chi-square test (χ^2 = 28.510, P-value=0.300) led to the conclusion that no significant relationship exists between the type of insurance and access to UHC. In essence, the findings demonstrate that the nature of the insurance—whether basic or more comprehensive—does not substantially impact access to UHC. The implications underscore the broad accessibility of UHC, irrespective of the specific insurance coverage, within the surveyed population.

4.5.2. Coverage of insurance

The coverage of insurance was fairly balanced between Public and All other hospitals whereby 58% of the respondents were covered by all other hospitals and 42% were covered in Public hospitals.

4.6 How accessibility to health services affects implementation of UHC

4.6.1. Distance to Hospital

The majority of respondents lived within a distance of 1km-4km from a hospital facility, representing 63%, while 22% lived beyond 4km, and 15% lived within 1km. A chi-square test to determine the relationship between distance and access to UHC yielded a χ^2 value of 24.860 and a P-value of 0.001. The study, therefore, established a significant relationship between proximity to a hospital and access to UHC, highlighting that patients living closer to health facilities found it more accessible to avail themselves of UHC services.

4.6.2. Whether respondents consider hospitals easily accessible

The respondents were asked if they considered hospitals to be accessible easily and 33% of the respondents were affirmative however 67% were of the contrary opinion that it is not easily accessible.

4.6.3 Whether respondents have ever been unable to access health service

The research found out that at some stage 33% of the respondents have been unable to access health services and 66% have never had hindrance to access to health services.

4.6.4 Hindrances to access to health services

The respondents in this research pointed out that the major hindrance to health services was the distance to hospitals which stood at 50% followed by the financial constraints at 33% whereas 17% had no hindrance at all.

4.6.5 Whether respondents would access health services if facilities were closer

A total of 93% of the respondents thought that they would access health services if the facilities were closer and only 7% would not access it even when closer. This confirms that distance is a major hindrance to access to health facilities as the findings show in section 4.6.4 above.

4.7 Discussion of the Results

4.7.1 The Extent to Which Patient's Characteristics Affect the Implementation of UHC

The study explored the extent to which various patient characteristics affect the implementation of Universal Health Coverage (UHC) in Bomet County. Factors including gender, religion, marital status, age, education level, employment status, and income were examined. The findings revealed disparities in knowledge and utilization of UHC across different demographic groups. For instance, males were more likely to have heard and benefited from UHC than females, and Muslims were found to benefit more than Christians. Singles showed the lowest utilization and knowledge of UHC, whereas widows benefitted more, potentially due to county-provided insurance coverage for this vulnerable group. A majority of respondents in the adult category (25-59 years) were aware of UHC, with postgraduate-educated individuals benefiting most. Employment and income level were also found to influence knowledge and benefit from UHC, with higher-income earners displaying greater awareness. The study highlights the complex interplay between various demographic factors and the implementation of UHC, indicating areas where targeted interventions may enhance understanding and accessibility.

4.7.2 Extent to which social health cover affects implementation of UHC

The study on the extent to which social health cover affects the implementation of Universal Health Coverage (UHC) in Bomet County revealed a high level of awareness regarding medical insurance, with 95% of respondents cognizant of it. The predominant insurance coverage was NHIF at 90%, with additional categories including corporate medical covers and private

insurance. Insurance coverage was fairly balanced between Public and All other hospitals (58% and 42%, respectively), and 88% of respondents had health insurance coverage. The findings indicate that the availability of health insurance, permitting respondents to seek care across various types of hospitals, positively impacts the implementation of UHC. This flexibility was especially critical during an industrial action at public health facilities, enabling those with social health insurance to access services at private and faith-based facilities.

4.7.3 How accessibility to health services affects implementation of UHC

The study concerning how accessibility to health services influences the implementation of Universal Health Coverage (UHC) reveals significant findings related to proximity and perceived accessibility. A majority of respondents (63%) resided within a distance of 1km-4km from a hospital facility, with 22% living beyond 4km, and 15% within 1km. While 33% of respondents found hospitals easily accessible, 67% opined the contrary. At some point, 33% of respondents were unable to access health services, with 66% reporting no hindrance. Distance to hospitals emerged as the primary obstacle to health service accessibility, represented by 50% of responses, followed by financial constraints at 33%, and 17% reporting no hindrance at all. These findings align with the World Health Organization's recommendation that health facilities be within 5 km for ease of accessibility.

5.0 Conclusions

The study sought to identify the challenges affecting the implementation of Universal Health Coverage in Kenya, a case of Long'isa County referral hospital in Bomet County. A review of the empirical studies was done and research methodology was conducted. This chapter contains a summary of the findings, conclusions, recommendations, and suggestions for further study.

The study provides an encompassing insight into the implementation of Universal Health Coverage (UHC), revealing that a majority of respondents had heard about UHC, with variations in accessibility and benefits across gender, religion, marital status, age, education, employment, and income levels; that 95% were aware of medical insurance regarding UHC, with NHIF being the prominent insurance covering UHC in Bomet; and that accessibility to health services largely depended on distance, with 63% living within 4km of a hospital, but 67% finding hospitals not easily accessible, with distance and financial constraints identified as the primary hindrances.

6.0 Recommendations

The study recommends several strategies to enhance the implementation of Universal Health Coverage (UHC). Addressing the knowledge gap by disseminating information about UHC and its benefits is essential to ensure wider access. The government should prioritize expanding insurance coverage, as any form of insurance promotes UHC access. To overcome geographical barriers, mobile clinics, and improved healthcare infrastructure could be implemented. Specific awareness campaigns should target women, adults, individuals with lower education, the unemployed, and those with lower incomes. Encouraging enrollment in health insurance, particularly for middle-aged individuals, could bolster UHC success. The County Government of Bomet is advised to increase its allocation to UHC to accommodate a growing population. Strengthening all pillars of UHC, including service delivery and governance, is vital for comprehensive implementation. Further research should delve into how each pillar influences UHC's execution.

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