EdinBurg Peer Reviewed Journals and Books Publishers
Journal of Medicine, Nursing and Public Health
Vol. 4||Issue 2||pp 38-51||August||2024
Email: info@edinburgjournals.org

# Implementation of User Fee Policy in Psychiatric Hospitals in Kenya: A Case of Mathari Hospital, Nairobi

**[1]Winnie Kanana Munene, [2]Wanja Mwaura-Tenambergen, [3]Lillian Muiruri**
**[1,2,3]Department of Health Systems Management and Medical Education, Kenya Methodist University**
**Corresponding Email: kananawinnie@gmail.com**

**How to cite this article:** Munene, W. K., Tenambergen, W. M., & Muiruri, L. (2024). Implementation of User Fee Policy in Psychiatric Hospitals in Kenya: A Case of Mathari Hospital, Nairobi. *Journal of Medicine, Nursing and Public Health, 4*(2), 38-51.

## Abstract

In Kenya, user fees were implemented as a form of cost-sharing to lessen the financial burden of health financing on Kenyan patients. This occurred in 2004. The Kenyan Ministry of Health offers a financing mechanism through risk pooling to the greatest extent possible to achieve universal coverage for mental health care. The use of services is based solely on need for care, with no additional tax funding or required health insurance; contributions are determined by ability to pay. Diseases such as mental health have been on the rise in Kenya due to a change in lifestyle and as a result of other emerging diseases. In Kenya, the high expense of healthcare continues to be a major obstacle to receiving timely, high-quality medical care. Despite the increase in prevalence of diseases related to mental health, the government's user fee policy has not been able to keep up with inflation. The purpose of this study was to assess the implementation of user fee policy in psychiatric hospitals in Kenya: A Case of Mathari Hospital, Nairobi. The study was guided by objectives that were seeking to determine the utilization of user fee policy at Mathari Hospital and to establish how hospital policies influence user fee policy implementation at Mathari Hospital. A cross-sectional study design was used. Findings from this study established that utilization of the user fee policy at Mathari Hospital was aligned with the existing hospital policies. The management of Mathari Hospital should streamline user fee collection by constantly providing on the job training to the employees.

**Keywords:** *User fee policy, hospital policies, user fee policy implementation, Mathari Hospital*

## 1.0 Introduction

The absence of sickness and overall physical, mental, and social well-being are the broad definitions of health (WHO, 1948). For the provision of health care to be sustained, there must be sufficient resources. The Kenya Policy Framework (KPF) of 1994 recognized several approaches as significant means of supporting health care in the nation, including donor monies, user fees, taxes, and health insurance. These procedures were primarily designed to take into account the expenses associated with providing services and the population's capacity to pay for those services. The Kenyan government's Vision 2030 seeks to deliver egalitarian and high-quality health services by, among other things, lowering patient financial burdens.

For primary health facilities, exorbitant and variable user fees were eliminated in 2004 and replaced with flat rate costs of KES 10 for dispensaries and KES 20 for hospitals (MOH, 2004).

The Kenya user fee policy states that money collected from user fees should be used to maintain and grow health facilities, as well as to supplement the government's declining spending on health care services. It also aims to ensure that drugs and medical equipment are supplied. Kenya's 2004 health sector reforms resulted in the implementation of a 10/20 user fee policy, which was designed to fulfill the country's health sector policy objective of offering all Kenyans efficient, cost-effective, and accessible healthcare. The Kenyan government allayed widespread concerns that the health reforms would prevent the poor and vulnerable from receiving healthcare by introducing a system of waivers into the user fee policy before the implementation of the 10/20 user fee policy. Certain patient types were automatically exempt from user fees under waivers. These included individuals in need of family planning, kids under five, people with STDs, and those afflicted with HIV/AIDS.

According to the Kenya Health Policy 2012–2030, one of the leading causes of Disability Adjusted Life Years (DALYs), or time lost because of disability resulting from illness, is unipolar depressive disorder. This is because it is widely accepted that "Living with Schizophrenia and Unipolar Depressive Disorders" sheds light on a serious category of mental illnesses for which sufferers are frequently disregarded by friends, family, and the general public because of the stigma associated with the condition. The Kenyan cabinet secretary for health stated during his remarks on World Mental Health Day that schizophrenia is a chronic illness that frequently has relapses and begins early in life, generally in adolescence. This frequently causes problems for the patient in their social and professional lives, which results in poverty (Macharia, 2022).

Eliminating payments at the point of service for health services gradually promotes equity and access to care for mentally ill individuals who do not have the financial means to pay for their care, particularly for underprivileged and marginalized communities. Mathari Hospital is a government hospital and can be referred to as a state psychiatric hospital. According to Chitty (2020), these types of state psychiatric hospitals have considerably decreased in numbers the world over because of policies that deinstitutionalize mentally ill patients and the unavailability of psychotropic medication. The requirements to pay before service provision could lead to barriers in quality health care services and preventive health therefore greatly affecting the quality of care given to psychiatric patients. Despite the government’s efforts to ensure health care for all, it is important to establish whether the user fee policy in Kenya is adhered to as stipulated. Studies conducted in countries like Armenia show that protection mechanisms do not always work well with the poor. It would therefore be important to establish whether this is the case for the mentally ill, who due to their health condition cannot engage themselves in reasonable employment or entrepreneurial activity (Zeng, 2021).

### 1.1 Problem Statement

The user fee policy is not adequately utilized in African Countries (Marangu *et al.*, 2020). This is because of the complexity of the diseases. In his findings on mental health care (McDaid *et al.*, 2008) states that most of the psychiatry departments in Africa usually work as standalone offices, often with little government support. According to Marangu et al. (2020), there is not enough time for psychiatric hospital staff in Kenya to meet with representatives from the national social welfare, education, employment, police, prisons, courts, and non-governmental organizations to make sure that mental health issues are properly incorporated into hospital policies and plans.

The Kenya National Commission on Human Rights (KNCHR, 2011) reported that 10 million of the 30 million Kenyan citizens suffer from mental disorders. Of the 10 million mentally ill citizens, 8.5 million do not receive treatment. Only 1.5 million receive treatment. These statistics depict that mental illness is a major public health concern. Therefore, mental illness makes it more difficult to fulfill other goals related to health and development, increases poverty and vulnerability, and imposes enormous financial and social costs on the individual, their family, the community, and society as a whole.

People who are mentally ill may not have the financial capability to seek health care (Kiima and Jenkins 2019). The hospital is therefore prone to enormous waivers on user fees. Therefore, it's critical to determine how the Mathari Hospital grants exemptions and how patient charge collection affects how the user fee policy is applied. The user fee policy was created to address issues with the delivery of health care, including declining spending in the health sector, inefficient use of resources, rising rates of sickness, and deepening poverty. There is a gap in the user fee policy's implementation in Kenya, though, as studies to determine the difficulties encountered in its implementation have not been conducted, at least not in Kenya (Kiima and Jenkins, 2019). In addition, Chuma and Maina (2019) state that there is a need for research incorporating impact analyses into the methodologies and process of user fee systems implementation. Russell and Gilson (2018) point out in their study that there aren't many studies that try to figure out what influences the user fee policy's ability to function as a policy that directs the finance system. Mathari Hospital is a psychiatric hospital located in Nairobi Kenya. It houses over 675 patients and has faced numerous challenges in management of psychiatric patients since it is the only National psychiatric referral hospital in Kenya.

### 1.2 Objective of the Study

i. To determine the utilization of user fee policy at Mathari Hospital, Nairobi.

ii. To establish how hospital policies influence user fee policy implementation at Mathari Hospital, Nairobi.

## 2.0 Literature Review

### 2.1 Theoretical Review

This research is guided by Social protection theory (Chisholm, 2005). Social protection theory is an endeavor by both public and private actors that provides money to the impoverished for consumption or income, shields the weak from threats to their livelihood, and improves the rights and social standing of any marginalized group. Mentally ill patients suffer socio-economic inequalities due to their inability to participate in paid and non-paid income roles (Kinyanda *et al.*, 2019). According to studies conducted in Uganda and Ethiopia, there was a direct link of poverty to widening income inequalities and a major risk for depression (Shakya et al., 2021). Socio-protection would enhance the economic outcomes of mentally ill persons, according to the United Nations' assessment of the progress made toward setting the Millennium Development Goals on ending the cycle of poverty and debt around them (United Nations, 2007). This can be done by lowering the cost of accessing mental health as stipulated in user fee policy. The flat rate fees are provided to the community to enhance access and thus their social protection.

Hailemichael et al. (2021) state that while mental illness does not exclusively cause poverty, it does have more detrimental effects than the majority of acute and chronic illnesses. These negative effects raise the possibility of poverty for mentally ill people, who experience a high burden of illness despite having poor social and economic outcomes. Social protection requires

care to be decentralized to the primary healthcare level and be made more cost-effective (Aceituno et al., 2019). In addition to Direct Facility Funding from the Central Government in Kenya, User fee remains a major mechanism through which hospitals raise supplementary funding in Kenya.

This theory is based on the fact that individuals or organizations optimize their goals such as health by reducing risks. According to this view, user fees are therefore borne by the patient as well as the healthcare provider because upfront expenses for providing services and potential losses could exceed operating capital and necessitate funding from both public and private sources (Kim et al., 2019). The variables in this theory include the cash and medical aid transfers which are monies and drugs that are directly paid by the state to the hospital to cater to the well-being of mentally ill patients. The other variable in this theory is the socioeconomic status of the patients which is their ability to pay the required user fees to access care. The social economic status of the patients is used as a main determinant according to waivers to the patients.

The health care provider or the patient may not know or may have misjudged the cost of providing or receiving the services stipulated in the contract, or they may occasionally be unable to handle the demands of multi-plan operations. As a result, the healthcare professionals or the patient may feel morally betrayed and may have to pay unexpected expenses that the patient has postponed. In this theory, the user fee policy determines the waiver process, the efficiency, professional/organizational performance of the healthcare provider by influencing the specific innovations implemented (Alshreef, 2019).

Targeted payments have the potential to encourage additional behaviors, including following the user fee policy. However, the service fee can also influence the number of waivers. Prospective systems that lead to reimbursement have put waiver process under the user fee policy. This can be achieved by using less expensive and ineffective treatments, as well as by decreasing the volume of healthcare provided, such as through hospital admissions of low-risk patients (Kintu, Kivumbi, 2002). Strategies such as pay for performance have been employed to counteract the impact of incentives that can promote noncompliance with the user fee policy. This is because targeted payments are used to encourage hospitals to adhere to policy and thus improve health care (Creese, 1990).

## 2.2 Empirical Review

### 2.1 Utilization of the User Fee Policy

Financing health systems in developing countries is usually a challenge because of the heavy disease burden (Chernew, 2008). Growing numbers of people in developing nations have created additional challenges because those who are most in need of medical assistance frequently lack the means to pay for it or to assess the quality of care they receive. The three primary components of health system financing are money collecting, money pooling, and the acquisition of quality medical treatment. Frequently, all three components fall short (Cleverley & Cameron 2007). The ability to collect taxes is not completely utilized in certain countries, while in others, tax payment and other contributions are practically optional due to inadequate infrastructure and enforcement mechanisms. The majority of medical expenses are covered by a combination of private out-of-pocket payments and outside funding, usually designated for particular ailments (Chernew, 2008). This has created difficulties for governments in deciding on how to adequately finance health care and as such mental health. Due to inadequate funds, the healthcare provider is left to grapple with challenges that result from a lack of resources (Molyneux, 2020). Another reason why adherence to user fee policy can be deemed to have a

role in failed health systems in developing countries is because of its autocratic nature (Chaudhury & Hammer 2003). The existence of these foreign funding sources, which are frequently unrelated to regional income-generating projects like user fees and community-based health insurance (Molyneux, 2020). Pooling resources is impractical due to several financing arrangements and purchasing services from providers strategically is not possible due to the numerous separate transactions resulting from out-of-pocket payments. Limited local resources fall short of covering gaps left by sponsors outside the region. This then poses a great challenge in the management of a health system in a country (Pagiwa et al., 2022).

Mental illness is highly disabling and has contributed to poverty and vulnerability of the populace. Massive financial and social costs have also been imposed on the affected person, their relatives, and society as a whole. On 10th October 2014, during World Mental Health Day, the Mental Health Atlas (2014) projected that one out of four individuals would suffer a mental disorder in their lifetime. Inability of healthcare users to pay for their health has caused fragmentation in financing the healthcare sector. In addition, presence of the 10/20 policy in hospitals created an avenue to protect the consumer of health care services and such efforts like out-of-pocket payment and insurance coverage of patients caused the fragmentation of funding mechanisms when not carried out as stipulated in the 10/20 user fee policy. The total healthcare system's potential for income and risk cross-subsidies is diminished when care is fragmented. Therefore, this study looked at whether Kenyans are adhering to the user fee policy and whether it serves as a mechanism for guaranteeing equity and access to mental health services in Kenya. A person with a mental disease has the right to be shielded from exploitation, abuse, and dehumanizing treatment in all contexts, including physical, economic, social, and sexual (Mental Health Policy, 2015).

### 2.2 Hospital policies and influence on the user fee policy

According to Masood et al. (2020), the health policy triangle describes the content, actors, process, and context of the policy as the main factors that influence formation and implementation of the policies. The user fee policy like other policies is an interrelationship of the actors who comprise the medical practitioners, patients and donor/funders, government, and health care institutions. The policy triangle's methodology and substance were the main topics of this study. This is what the policy states: the goals of the user fee policy are to provide justice in the provision of healthcare and to lessen the enormous expenditures incurred by patients in need of care. The policy by the Ministry of Health, Kenya also stipulates the process in which the user fee policy should be implemented and waivers accorded. The process entails the secondment by a local chief for persons requiring a waiver to the hospital superintendent who then authorizes treatment. (Chuma *et al.*, 2019). Generally, patients are required to pay Kshs. 20 for them to receive medical assistance and be registered in the hospital outpatient logbook. Patients pay for the full costs of their in-patient treatment unless they are accorded a waiver (MoH, 2004).

Evidence regarding community health-seeking behavior and patient attendance in Africa is inconsistent (Mubyazi et al., 2015). Many developing nations have struggled financially in recent years to keep up with the rising demand for modern health care brought on by fast-expanding populations and shifting epidemiological patterns. In response, a few governments have started working on health financing reform initiatives with the goals of increasing funding, enhancing service quality and efficiency, and empowering citizens to take greater ownership of their health care. The National Hospital Insurance Fund (NHIF), a mandatory government social insurance program that covers inpatient services for nearly one-fifth of Kenya's population, is one of the programs that will use the revenue generated by raising the

nominal fees that are already in place, introducing new fees, and recovering the full cost of inpatient services for beneficiaries (GOK, 1993).

The National Health Insurance Fund (NHIF) and employment-based health insurance are the two concurrent subsystems that makeup Kenya's health insurance system. When specific conditions are met, employees of businesses, organizations, and companies as well as their dependents are covered by employment-based health insurance. On the other hand, the National Health Insurance Fund is a residential system that covers everyone else, including retirees, self-employed individuals, those without private insurance, and employees of small businesses. Two salient characteristics that serve as the foundation for this study are the distinctiveness of the Kenyan medical system, which may allow mentally ill patients to be isolated from their demands for care, and the lack of responsiveness on the part of insurers and healthcare providers (Molyneux et al., 2020).

First, with universal coverage, patients in Kenya receive therapy and managed care that is frequently suggested by healthcare professionals, giving them unlimited options when it comes to psychiatric medical providers. Second, private patients in Kenya have direct access to specialist treatment without passing through a gatekeeper or referral system, giving the specialist the authority to determine how much care will cost. Additionally, a patient is not restricted in the amount of visits they may have. In contrast to the United States, where people without insurance use hospitals for primary care, patients in this country can visit either hospitals or clinics for outpatient visits and hospitals for admissions (Molyneux et al., 2020).

The user fee policy also stipulates that healthcare providers get paid according to the national fee schedule, which is based on the patient's condition and the treatment being administered. This is possibly even more significant. Physicians therefore as actors in the policy have many incentives to influence patients' demand and quality of psychiatric health care and overly affect the utilization of the user fee policy. From the standpoint of the physician, for instance, there are several reasons to postpone surgery until the patient has cleared the hospital or paid for their costs. This is because hospital reimbursements and user fees vary with nature of condition being treated and the ability of patients to cater to the costs. The study's uniform fee schedule in the psychiatric hospital raises concerns about how waivers are granted to defaulters because it suggests that cost-shifting—a well-known cost-management practice in which healthcare providers charge private insurers higher rates to make up for losses from public health insurance beneficiaries—is unlikely to occur (Liu et al., 2021).

The first national health sector strategic plan (1999–2004) lists several difficulties facing the Kenyan health care system, including the absence of a well-defined, costed, and prioritized strategic plan. Additionally, the industry is lagging in terms of evaluating the standard of care provided to mental patients due to a lack of funding and a low degree of responsibility. (Capitman, J2019). For many years, the Kenyan government has set aside a certain portion of its overall budget for health care. The Abuja Declaration states that the Ministry of Health should receive fifteen percent of the overall budget. This hasn't been feasible, though, as the Kenyan government uses budgetary monies that come from tax collections to support the Ministry of Health. However, given the current macroeconomic circumstances in Kenya, which include a high national debt, inflation, and slow economic growth, tax revenues are an unreliable source of funding for healthcare. This has led to health budget shortfalls with a widespread lack of adequate pharmaceuticals, poor maintenance of equipment and facilities, and staff shortages amongst others. Prevalent shortfalls have been reduced by the presence of the user fee policy.

To close the funding gap between the actual budget and the amount of resources required to support activities in the public health sector, the user fee policy was created. However, because of increased poverty situations in most developing countries, cost-sharing policy often not been well implemented.

## 3.0 Methodology

The cross-sectional descriptive survey design used in this study aims to identify the elements impacting the user charge policy's implementation in Nairobi's Mathari Hospital. This study was carried out at the Mathari Hospital. The target population was 364 members of staff. The sample size was 191 respondents. The researcher used a questionnaire to gather information from the respondents. Data was analyzed using SPSS. Descriptive statistics were computed to generate a general understanding of the hospital and respondents' characteristics. Inferential statistics were computed as stage two of the analysis. The purpose was to ensure the generalizations of the findings were appropriate. Statistical techniques used were simple and multiple regressions. The data was then presented in tables and charts.

## 4.0 Results and Discussion

### 4.1 Utilization of the user fee policy

The first objective was to establish the utilization of the user fee policy at Mathari Hospital. The questionnaire had various indicators to establish this. Findings from the study revealed that the respondents had a general knowledge of the existence of the user fee policy. They explained that they had heard about its existence.

#### 4.1.1 Knowledge of its existence

The respondents explained that they had heard about the user fee policy at (142) 80% while (35) 7% of the respondents had not heard of the policy. This shows that most of the respondents were aware of the policy and could provide an explanation for how it was put into practice. Of the respondents explained (174) 98% that the hospital administration would also offer the patients letters that enabled them to go around the health care facility and points of care. These letters of introduction enabled the healthcare workers to offer care in the absence of payment receipts.

Findings from this study concur with similar findings from Chuma *et al* (2019). In her study, Chuma explains that many policies are on paper and not in practice especially if the provider is expected to act in the best interest of the patients. Provision of knowledge also helps patients to prioritize their care options.

#### 4.1.2 Skills of the health care workers

The respondents explained that they were skilled in their lines of service and were not skilled in administration of various policies of the hospital. They explained that relevant policies and guidelines reached them through government communication, official emails, and social media. The respondents explained that although they were well-skilled in their lines of operation, they did not receive additional skills to enable them to manage the dynamic nature of their patients. The respondents often called the hospital chief administrator to guide them in execution of their duties when such cases came up. There is a need for staff rotation, especially for medical staff stationed in the patient reception, wards, and finance departments. Cross-learning amongst the departments would enable the hospital staff to transfer skills and share experiences. Findings from the study are similar to findings by Pagiwa *et al*., 2021 who stated that the skills of the health workers are vital in implementation of revenue collection and user

fee policy implementation. It is imperative for enterprises to consistently enhance the competencies of their workforce to ensure the smooth execution of the user fee policy.

### 4.1.3 Perceived Utilization of the User Fee Policy

This study sought to establish the utilization of the user fee policy using various aspects in a 5-point Likert scale, indicating to what extent the respondents agree with the statement, where 1= Strongly disagree, 2= Disagree, 3= Neutral, 4= Agree, 5= Strongly agree. Explain how the analysis was done and what the means mean (the interpretation of the means).

**Table 1: Descriptive statistics on perceived of the user fee policy**

| Attribute | Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Mean | Standard Deviation |
|---|---|---|---|---|---|---|---|
| Refer to the user fee policy when carrying out your duties | 7 (9.6%) | 40 (22.6%) | 100 (56.5%) | 10 (5.6%) | 10 (5.6%) | 2.80 | 0.89 |
| Believe they are well versed with the user fee policy | 0 | 20 (11.3%) | 15 (8.5%) | 122 (68.9%) | 20 (11.3%) | 3.77 | 0.76 |
| Patients are well-versed with the user fee policy | 20 (11.3%) | 57 (32%) | 50 (28%) | 30 (17%) | 20 (11.3%) | 3.19 | 0.79 |
| Adequate wall charts and flow diagrams with information on how to access care for the patients | 0 | 10 (5.6%) | 12 (6.8%) | 102 (57.6%) | 53 (29.9%) | 4.20 | 0.57 |
| Hospital management adheres to the implementation of the user fee policy | 5 (2.8%). | 12 (6.8%) | 90 (50.8%) | 40 (22.6%) | 30 (16.9%) | 3.12 | 0.90 |

The participants disagreed that they have referred to the user fee policy while implementing their duties (Mean =2.80) and that the hospital management adheres to the implementation of the user fee policy (M=3.12).). The respondents agreed that they were well versed with the user fee policy (Mean =3.77) and that the wall charts and flow diagrams in the hospital were adequate (Mean=4.20).

Majority of the respondents noted that the major challenge facing utilization of the user fee policy was the “inability to pay by the patients. 80% of the respondents cited that abandoned patients at the hospital presented the largest challenge to utilization of the user fee policy. The respondents noted that the patients could not pay for services and needed medication.

The respondents noted that the user fee policy can be optimized through continuous on the job training of staff. The key informants explained that they were well aware of the existence of the Kenya Mental Health Policy 2015-2030 but did not have the resources to sensitize the members of staff on its utilization. The respondents also noted that they had heard of the existence of a new mental health policy but had not seen it. They said that they did not look out for it because they believed that it was almost similar to their day-to-day routine work and

that hospital management had not notified them of any required changes in rollout of their duties.

### 4.2 Hospital policies and implementation of the user fee policy

The second objective of this study sought to establish how hospital policies influence user fee policy implementation at Mathari Hospital, Nairobi.

#### 4.2.1 Presence of Practice Guidelines

The respondents stated there were hospital operational and patient care guidelines that refer to payment of the user fees. (159)90% of the respondents noted that they were aware of standard operating procedures and guidelines that are related to the user fee policy. Some of the respondents said that they did not know any other policy related to the user fee policy at (18)10%.

There were several practice guidelines in use by various departments in the hospital. All the respondents noted that they consulted their patient care and work guidelines regularly as advised by the hospital management. There were wall charts drawn on the hospital outpatient unit where all patients began their search for medication in the hospital. The charts showed the flow of care for the inpatient and outpatient services. The cost of care was also illustrated in the hospital wall charts and drawings. Pagiwa, *et al., (*2021) also note that the capacity to administer and manage the user fee collection has been a major hindrance to effective implementation of the user fee policy in Botswana.

#### 4.2.2 Guidelines related to implementation of the user fee policy

The responses were further rated on a five-point Likert scale indicating to what extent the respondents agree to the statements where 1= Strongly Disagree, 2= Disagree, 3= Neutral, 4=Agree, 5=Strongly Agree. See Table 2.

**Table 2: Descriptive statistics on hospital policies**

| Attribute | Strongly Disagree | Disagree | Neutral | Agree | Strongly disagree | Mean | Standard Deviation |
|---|---|---|---|---|---|---|---|
| Hospital guidelines are in line with the user fee policy | 5 (2.8%) | 80 (45%) | 12 (6.8%) | 60 (33.9%) | 10 (5.6%) | 2.38 | 1.53 |
| Guidelines that stipulate courses of action in collection of user fees | 30 (16.9%) | 60 (33.9%) | 48 (27.1%) | 12 (6.8%) | 27 (15.2%) | 2.67 | 1.26 |
| Presence of financial partners and donors who work closely with the hospital | 0 | 0 | 50 (28.2%) | 82 (46.3%) | 75 (42.4%) | 3.97 | 0.73 |
| Adherence to the user fee policy by members of staff | 20 (11.3%) | 50 (28.2%) | 57 (32.2%) | 20 (11.3%) | 30 (16.9%) | 2.93 | 1.23 |

According to the findings, most respondents disagreed that staff members adhere to the user fee policy (Mean = 2.93), that staff followed guidelines that stipulate courses of action in collection of user fees (Mean = 2.67), that the hospital guidelines were in line with the user fee

policy (Mean = 2.38). The respondents agreed that were financial partners and donors who work closely with the hospital (Mean =3.97).

Similar empirical studies show that hospital guidelines focus on care and not on management of patients who can barely afford the user fees (Maria, Charles, and Paul., 2011). Studies done in Africa indicate that user fees were well stipulated on where and when to be paid. The guidelines did not indicate the process flow for patients who were not able to raise the user fees. The patients depended on the goodwill of the clinicians to access psychiatric care. These findings relate well with studies done in Ethiopia that showed that adherence to the user fee policy was barely effective. Mathari Hospital worked with various financial partners to run various psychiatric care clinics.

The following were listed as the main guidelines in use that influenced the implementation of the user fee policy. These guidelines include the Kenya Mental Health Act of 2014 which provided free medical aid for all mentally ill patients regardless of whether they can afford care. Despite presence of this act, funds to foster its implementation and training on its contents have not been done. This was largely an aspect of the policy on paper and not yet implemented due to financial constraints.

The second care guideline used in the hospital that related to the user fee policy was the care given to patients covered by the National Health Insurance Fund. The respondents noted that all the active patients covered by the National Health Insurance Fund were not required to pay admission and treatment fees up to a maximum of 500,000 Kenya Shillings per patient per year while they were required to raise the outpatient consultation fee and the drug fee for the outpatients.

### 4.3 Regression analysis of hospital policies and implementation of user fee policy

The study sought to establish how hospital policies influence the implementation of the user fee policy in Mathari Hospital Nairobi. The adjusted R square coefficient was 0.621 implying that 62% of the variation in implementation of user fee policies was explained by the hospital policies.

**Table 3: Model summary for regression analysis of hospital policies and implementation of user fee policy**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Durbin-Watson |
|---|---|---|---|---|---|
| 1 | .790[a] | .624 | .621 | .65931 | .112 |

a. Predictors: (Constant), hospital policies
b. Dependent Variable: Implementation of user fee policy

The significance of the model was evaluated using the ANOVA. As indicated the fitted model was significant. (F = 289.886, p value < 0.05).

**Table 4: Anova table for regression analysis on hospital policies and implementation of user fee policy**

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 126.009 | 1 | 126.009 | 289.886 | .000[b] |
| | Residual | 76.070 | 175 | .435 | | |
| | Total | 202.079 | 176 | | | |

a. Dependent Variable: Implementation of user fee policy

b. Predictors: (Constant), hospital policies

**Table 5: Coefficient table for hospital policies and implementation of user fee policy**

| Model | | Unstandardized Coefficients | | Standardized Coefficients | t | Sig. |
|---|---|---|---|---|---|---|
| | | B | Std. Error | Beta | | |
| 1 | (Constant) | -2.389 | .261 | | -9.164 | .000 |
| | Hospital Policies | 1.458 | .086 | .790 | 17.026 | .000 |

Dependent Variable: implementation of user fee policy

Hospital policies have a substantial impact on the implementation of user fee policies. The p-value is less than 0.05 level of significance.

### 4.4 Summary of Findings

#### 4.4.1 Utilization of user fee policy at Mathari Hospital, Nairobi.

According to the study, most respondents attested that Mathari Hospital was putting the user fee policy into effect and that most of its staff members were aware of it. Owing to the nature of their jobs and their areas of competence, medical professionals frequently sent patients who were looking for waivers or subsidies to the waiver committee and hospital administration. The hospital management did not encourage the patients to get waivers but instead purchased the National Health Insurance Fund which would cover all the cost of medication and admission at the hospital. Similar studies done in Africa show that the main barrier to treatment of mental illness is the cost of mental healthcare. This is compounded by the fact that most insurance companies do not cover specific mental health therapies, making them unaffordable for patients to pay for out of pocket. Sometimes people with mental illnesses need care for extended periods, which causes them to use up their insurance coverage limits. Other people do not have health insurance, which can further increase the expense of healthcare.

It can be explained that the reason why the hospital management did not publicize existence of the user fee policy amongst the general public was because of high cases of defaulters among families that could afford care. Studies that have been done show the same trend in provision of other primary health care services. Relying entirely on the reimbursement from the government and the user fee policy in provision of mental health care has not borne fruit. According to Saxena et al. (2003), there exists a disparity between policy and financing in developing nations, resulting in inadequate allocation and inefficient utilization of resources (Andrade *et al.*, 2008; Seedat *et al.*, 2008). This is because identification of the needy cases is a process and also requires finances to implement.

#### 4.4.2 Hospital Policies Influence User Fee Policy Implementation

There were various policies and standard operating procedures that influenced the implementation of the user fee policy. Financial and other structural obstacles were frequently mentioned in serious situations that were acknowledged. A sizeable section of the populace occasionally lacks health insurance, even in certain industrialized nations where it is necessary to pay for medical care (Mechanic, 2002). Community-based services remain inadequate, there is a lack of integration with primary care in some Latin American countries where mental health reform has been implemented, and the number of inpatient beds has been lowered to a level that may not be sufficient to meet the needs (Andreoli et al., 2007; Caldas de Almeida & Horvitz-Lennon, 2010; Romero-Gonzalez et al., 2003). Population density, lack of skilled

personnel, and physical remoteness from services in rural areas all contribute to service deficits in many middle-income and lower-income nations (Jacob et al., 2007).

## 5.0 Conclusion

Implementation of the user fee policy is influenced by other policies at the hospital. Information provided on the hospital wall charts and job training can foster the implementation of the user fee policy. Where user fees are levied amongst the mentally ill, it is important that the economic well-being of their families is considered and robust mechanisms for exemptions and waivers are accorded. This ensures that patients receive drugs and continued psychiatric care.

## 6.0 Recommendations

The management of Mathari Hospital should streamline user fee collection by constantly providing on the job training to the employees. The hospital user fee implementation process should include effective communication, enhancing staff participation in the process, and avenues for consultation and feedback during decision-making on user fee implementation.

## References

Aceituno, D., Vera, N., Prina, A. M., & McCrone, P. (2019). Cost-effectiveness of early intervention in psychosis: systematic review. *The British Journal of Psychiatry*, *215*(1), 388-394. https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/costeffectiveness-of-early-intervention-in-psychosis-systematic-review/F91B706D8861C86181AD8126CB3402AE

Alshreef, A. (2019). Provider payment mechanisms: effective policy tools for achieving universal and sustainable healthcare coverage. *Universal Health Coverage*, *9*, 1-9. https://books.google.com/books

Capitman, J. A. (2019). *Cancer and elders of color: Opportunities for reducing health disparities: Evidence review and recommendations for research and policy*. Routledge. https://www.taylorfrancis.com/books/mono/10.4324/9781351162128/cancer-elders-color-opportunities-reducing-health-disparities-john-capitman

Chaudhury, N., Hammer J. (2003). The effects of a fee Waiver Program on Health Care Utilization among the poor. World Bank Washington D.C

Chernew, M. E. (2008). "Impact of Decreasing Copayments on Medication Adherence within a Disease Management Environment." *Health Affairs*, 27(1): 103–12.

Chisholm, D. (2005). Choosing cost-effective interventions in psychiatry: results from the CHOICE programme of the World Health Organization. World Psychiatry 2005; 4:37–44

Chitty, E. G. (2020). *Trauma, attachment and inpatient perceptions of restrictive practice in forensic mental health services* (Doctoral dissertation, University of Surrey). https://openresearch.surrey.ac.uk/view/delivery/44SUR_INST/12139150210002346/13140696040002346

Chuma, J. & Maina, T. (2019). Catastrophic health care spending and impoverishment in Kenya, BMC Health Services. *Research. biomedcentral*.1472-6963/12/413.

Cleverley, W.O. & Cameron, A.E. (2007).Essentials of Health Care Finance. Jones and Bartlett Publishers, Sandbury, Massachusetts

Creese, A. L. (1990). User charges for health care: a review of recent experience. *Health Policy Plann* 6:309–319

Hailemichael, Y., Hailemariam, D., Tirfessa, K., Docrat, S., Alem, A., Medhin, G., ... & Hanlon, C. (2021). The Effect of Expanded Access to Mental Health Care on Economic Status of Households with a Person with a Mental Disorder in Rural Ethiopia: A Controlled Before-After Study. https://www.researchsquare.com/article/rs-1006902/latest

Kenya National Commission on Human Rights (2011). Silenced Minds: the systemic neglect of mental health in Kenya. Mental Health Report.

Kiima, D. & Jenkins, R. (2019). Mental health policy in Kenya – an integrated approach to scaling up equitable care for poor populations. International Journal of Mental Health Systems 4(1):19.

Kim, N. H., & Look, K. A. (2019). The effect of reduced drug copayments on adherence to oral diabetes medications among childless adults in Wisconsin Medicaid. *Journal of Managed Care & Specialty Pharmacy*, *25*(12), 1432-1441. https://www.jmcp.org/doi/abs/10.18553/jmcp.2019.25.12.1432

Kinyanda, E., Woodburn, P., Tugumisirize, J. (2019). Poverty, life events and the risk for depression in Uganda. Social Psychiatry and Psychiatric Epidemiology 2009; 46:35–44

Liu, J. L., Levinson, Z. M., Qureshi, N. S., & Whaley, C. (2021). *Impact of policy options for reducing hospital prices paid by private health plans*. RAND. https://www.rand.org/content/dam/rand/pubs/research_reports/RRA800/RRA805-1/RAND_RRA805-1.pdf

Macharia, J. (2022). The World Mental Health Celebrations, Ministry of Health, Nairobi, Kenya.

Marangu, E., Sands, N., Rolley, J., Ndetei, D. & Mansouri, F. (2020) Mental Health Care in Kenya: Exploring optimal conditions for capacity building

Masood, S., Kothari, A., & Regan, S. (2020). The use of research in public health policy: a systematic review. *Evidence & Policy*, *16*(1), 7-43. https://bristoluniversitypressdigital.com/view/journals/evp/16/1/article-p7.xml?rskey=THxyOp&result=105&utm_source=TrendMD&utm_medium=cpc&utm_campaign=Evidence_%2526_Policy_TrendMD_1

Mental Health Atlas (2014). World Health Organization, ISBN 9799241564359 WHO Press, Geneva Switzerland

Molyneux, S., Toda, M., Opwora, A., Waweru, E., Edwards, T., Fegan, G., Noor, A., & Goodman, C. (2020). Adherence to user fee charges at primary care facilities and implications for quality of care.*The African Journal of Health Sciences*, Nairobi, Kenya

Mubyazi, G., Massaga, J., Kamugisha,M., Nyangoma, J. M., Magogo, C. G.,Mdira Yahya, K., Gesase, S., & Sukwa T. (2015). User Charges in public health facilities in Tanzania: effect on revenues, quality of services and people's health seeking behavior for malaria illnesses in Korogwe district. Nuffield Institute for Health, University of Leeds.

Pagiwa, V., Shiell, A., Barraclough, S., & Seitio-Kgokgwe, O. (2022). A review of the user fees policy for primary healthcare consultations in Botswana: problems with effective planning, implementation and evaluation. *International Journal of Health Policy and Management*, *11*(10), 2228. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9808281/

Shakya, A., Mahapatra, P., Behera, B. K., & Pathak, M. (2021). Life satisfaction and depression among women living in slum areas of Bhubaneswar. *International Archives of Integrated Medicine*, *8*(2), 69-76. https://www.iaimjournal.com/wp-content/uploads/2021/02/iaim_2021_0802_10.pdf

Shaw, R. & Ainsworth, M. (1996). Financing Health Services Through User Fees and Insurance: A Case Study from Sub-Saharan Africa. The Library of Congress Cataloguing-in-Publications Data. Washington, DC: World Bank Institute.

United Nations. (2007). The Millennium Development Goals Report New York, NY: United Nations.

Walt, G., & Gibson, L. (1994). Reforming the health sector in developing countries: The central role of policy analysis. Health Policy and Planning, 9: 353-70

World Health Organization. (1948). *International Health Conference,* New York, USA

Zeng, X. (2021). *Mining Claims Data Using Deep Learning Frameworks for Medical Risk Stratification and Management*. Ohio University. https://search.proquest.com/openview/0cf8f6879037b5c8d8113c04146cdc5d/1?pq-origsite=gscholar&cbl=18750&diss=y