A SURVEY OF THE BUSINESS CHALLENGES OF PRIVATE HOSPITALS IN NAIROBI TO THE HIV/AIDS PANDEMIC

BY

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DECLARATION

This management project report is my original work and has not been presented for a degree in any other University.

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To, my supervisor, family, friends and all who accompanied me on this journey to its very destination, you were all a source of valuable inspiration. I could not have come this far without you.

Thank you and God bless you all boundlessly.

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ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
ARVs:	Anti-Retroviral Drugs
HMO:	Health Maintenance Organization
GDP:	Gross Domestic Product
NHIF:	National Hospital Insurance Fund
MoH:	Ministry of Health of the Republic of Kenya
NHSSP:	National Health Strategic Sector Plan
GOK:	Government of Kenya
BMJ:	British Medical Journal
RMO:	Resident Medical Officer
RN:	Resident Nurse
SS:	Subordinate Staff
HIV:	Human Immunodeficiency Syndrome

ABSTRACT

The 20-year onslaught of HIV/AIDS has radically changed the economics of patient care, and its effects are still being felt throughout the health care system. The private hospitals are faced by many business challenges when dealing with HIV/AIDS patients now than before but still have the social responsibility of providing quality healthcare to all including HIV/AIDS patients. This report presents the findings of a survey of the business challenges of private hospitals in Nairobi, Kenya to the HIV/AIDS pandemic and how they have responded to it. The research was conducted among 55 private hospitals based in Nairobi, Kenya. The information sought in the study was collected using a structured questionnaire and personal interviews.

The study revealed that HIV/AIDS pandemic posed many business challenges to private hospitals. Average percent bed occupancy by HIV/ AIDS patients was 32.6%. There was a general upward trend in the total number of general patients attended to (33.5% increase) but this was not the case with HIV/AIDS patients. Of the respondents, 66.7% considered HIV/AIDS as a business opportunity of moderate to very high extent. However, 84.4% respondents considered HIV/AIDS as a business risk of moderate to very high extent. These findings indicate that HIV/AIDS is both a business opportunity and risk that co-exist together in a hospital. This was compounded by the finding that few HIV/AIDS patients (21.2%) fully paid their hospital bills.

The study further examined the responses of the hospitals to these challenges. Most hospitals (73.3%) involved themselves in a kind of program related to HIV/AIDS, with HIV management programs being most popular (84.4%). Awareness and prevention

programs are also both common with 67.7% each. These two programs have the same frequency because the programs in most hospitals are run concurrently. The study revealed that a majority of hospitals did not stock the ARV'S (82.4%) and a just a few did stock the drugs (17.6%). Very few hospitals 12.1% adopted advanced technology in radiology investigations for HIV/AIDS patients. On the other hand, when it came to adopting advanced technology for laboratory investigations for specific HIV/AIDS related cases, majority of the hospitals 56.3% had adopted it, and a few (43.7%) did not.

This study demonstrates that HIV/AIDS has actually caused a change in the business environment of private hospitals and these hospitals have responded with various measures to fit in a precarious environment. The study recommends further research like the strategy behind the responses made by the hospitals and to what extent does strategy play in dealing with the hospitals' business in HIV/AIDS and how effective these strategies are. These studies would expound on the current understanding of strategic issues in this poorly researched industry. The results of this study will assist managers of private hospitals in strategic management of hospitals in relation to HIV/AIDS.

CHAPTER ONE: INTRODUCTION

1.1 Background

The recent emergence of a new sexually transmitted pathogen, the Human Immuno-deficiency Virus (HIV) and its association with the fatal Acquired Immuno Deficiency Syndrome (AIDS), has generated renewed interest in the prevention and control of sexually transmitted infections (STIs) in general. While this new virus has presented many unique challenges to health programmers and providers, it has also revealed many of the old issues of inequality, power and stigmatization that have long frustrated attempts to develop an effective public response to STIs (Elias, 1991).

The World Health Organization (WHO) reported that a team of independent researchers discovered ten years after the virus; 16 million adults and 1 million children had been infected with HIV. The WHO (1994) estimated that 70% of all AIDS cases have occurred in Africa. Since the first AIDS case was diagnosed in Kenya in 1984, the epidemic has continued to grow at a rapid rate. Over 700,000 people had already developed AIDS with about 1.9 million adults aged between 15 and 49 years as well as 100,000 children were living with HIV by the end of 1998 (NASCOP, 1999). The average national HIV prevalence rate that was estimated at 9.9% in 1994 was estimated at 13.9% in 1998 with very low prospects of recording lower rates in the near future unless very effective intervention programmes are implemented (CBS, 2000). The social and economic impacts of society cannot be overstated.

Globally nearly 34 million people are living with HIV/AIDS. The pandemic continues to grow as 16,000 people worldwide become infected with HIV each day. While the

pandemic has spread nearly everywhere, the speed of its spread and its extent varies between countries and within countries. More than 90% of all adult HIV infections are situated in developing countries: two thirds, 14 million, in sub-Saharan Africa, 5.2 million in Asia and 1.3 million in Latin America. (Fransen, L. 1998, pp 1-6). Clearly nowhere in the world has the impact of HIVAIDS been more severe than in sub-Saharan Africa.

In 1989, the National AIDS Control Programme was set up to respond to this emerging threat. The initial focus was to create awareness on HIV/AIDS through IEC campaigns aimed at the reduction of HIV transmission. The major mode of transmission of HIV in Kenya on the basis of epidemiological evidence is heterosexual contact and perinatal transmission. About 75% of most economically productive group of the population-the deaths therefore constitutes an important economic burden. The close attention given to this devastating epidemic has gone beyond the study of sexuality to bringing in arguments on the social responsiveness of other industries.

Social responsiveness of industries is a leading area of concern in the business world and their public. Business that seek growth, survival and good reputation, must recognize the public's attitude and emphasis towards the sanctity of the human values, individual worth and general qualitative aspects of life in the society. Being a health issue, the relationship between the industry and HIV/AIDS pandemic is very close. The industry plays multiple roles in the control and managing the disease-including medical research. It is tasked with providing treatment, counseling and testing. It disseminates epidemiological findings to the government and other organizations, yet it must stay in the business of medicine-the primary objective being to make profit and serve the interest of the owners.

The health industry is in many ways run by the dictates of the modern managerial postulation that sees a positive relationship existing between social and economic performance. A lot of literature point at studies and investigations on the supposed correlation between social responsibility and quantitative measures of profitability. This research is concerned with the same issue, how HIV/AIDS challenges the business of the privately run hospitals.

The Ministry of Health (MOH) records show that Kenya has 4207 health facilities. This includes 3146 dispensaries, 579 health centres and 420 hospitals. The average bed ratio is 1.76 beds per 1000 Kenyans from a population of 521,186 beds. Government and mission health facilities are distributed throughout the country while private establishments are mainly concentrated in urban areas. (NHSSP 1999-2000).

Nairobi has 12% of the hospitals nationally, with 51 hospitals (MOH-1998), making it the urban centre with the highest concentration of hospitals. It is also estimated that 80% of the registered medical practitioners practice in urban centres with Nairobi taking a big chunk of 50% (MOH). This illustrates the fact that Nairobi has the highest population within Kenya of health skills and facilities hence justifying the study in Nairobi. Research effort will concentrate on the private hospitals in Nairobi; that play a big role in the management of HIV/AIDS; i.e. medical treatment, care and support, medical education, palliative treatment and research.

1.2 Statement of the Problem.

Business response in the light of social responsiveness to HIV/AIDS pandemic has been a leading concern to the needs assessment studies related to HIV infection. In

Kenya, the rising human cost of AIDS has become increasingly visible. Policy makers are giving more attention to the impact of the pandemic on socioeconomic development. Foreman et al (2000) investigating on the cost of treating HIV/AIDS which range from emotional support that comes from the care through the provision of painkillers and treatment for opportunistic infections, to the antiretroviral drugs which suppress the virus and restore the immune system. This study is therefore a complement to this concern, against a background that there are increasing demands on scarce resources to manage HIV/AIDS. Developing countries are heavily burdened by huge social economic challenges; AIDS threatens human welfare, development progress and social stability on unprecedented scale. But how do private hospitals respond to the challenge of HIV/AIDS being in the business of healthcare provision themselves?

The gap in research, which this study is focusing on, is to establish the responsiveness of private hospitals in Nairobi to the HIV/AIDS pandemic. Ceteris paribus, hospitals are concerned mainly with the health matters including those that surround HIV infection and HIV treatment, alongside creating awareness, guidance and counseling and advising policy makers. Lately in Kenya, the health sector has embarked on research for HIV vaccine in collaboration with international bodies.

It is against this function of the hospitals that the research attempts to establish whether the pandemic has been a challenge to the private hospitals or a big business opportunity. Is HIV/AIDS pandemic a big business opportunity or a financial risk to private hospitals? How do the private hospitals respond to this challenge or opportunity?

1.3 Research objectives

The main objective of this research study was to establish the implications of the HIV/AIDS pandemic to private hospitals and their responses to it.

More specific, the objectives included:

1. To establish if the HIV/AIDS pandemic is a business opportunity and a business risk to private hospitals.
2. To identify the business responses by private hospitals to the HIV/AIDS pandemic.

1.4 Importance of the study

The HIV/AIDS scourge is not confined to the health sector only, but touches all sectors of the nation, the study will hopefully awaken people to the reality of HIV/AIDS. This study is expected to be of benefit to various groups:

1. To the hospital community, it will hopefully contribute to increasing their awareness of the importance taking HIV/AIDS as a business opportunity.
2. The study will be of significance to managers of hospitals to know the strategic responses available to them when dealing with issues related to HIV/AIDS.
3. To the academicians, the study will be important as an addition to knowledge. It is hoped that it will stimulate study of other aspects of business and HIV/AIDS.
4. To the society, the study will hopefully shed light on their understanding of business dealings of hospitals with the society.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The initial common strategy adopted in reducing HIV/AIDS transmission, was awareness creation through campaigns. A lot of literature targeted this. With time, scientific works have covered the rich study areas of HIV transmission and spread with particular attention to the risk factors, the impacts of the pandemic in various circles, the trends and prevalence of the scourge, complementing the efforts with a look at the differentials. In this study, literature reviewed covered facts about HIV/AIDS against creation, socioeconomic and demographic impacts, and a brief on business responses to HIV/AIDS.

The global HIV/AIDS pandemic consists of many separate individual epidemics, each with its own distinct characteristics that depends on geography, the population affected, the prevalence of risk behavior and practices and the timing of the introduction of the virus. Medical science has it that a complex interaction among several variables determines how and where HIV spreads in a population. Biological factors do influence the spread of the epidemic by increasing or decreasing the infectiousness of those with HIV and hastening the progression of infection to disease and death. These include the presence of classical STDs, male circumcision and the viral characteristics and genetic strains of the HIV variables.

Since the main mode of transmission of HIV in Kenya is through hetero-sexual relations and that about 75% of AIDS cases occur to adults in the reproductive age groups, research has shown that risk behavior are associated with age. To cope with the risk, a number of strategies have been recommended, including Abstinence, Being

faithful to one partner and condom use (ABC), suggesting that the spread has targeted sex (Jarabi, 2000). According to Cavael (1995), over half of all those aged 15-19 are already sexually experienced in Kenya, and other sub-Saharan Countries, the level of sexual experience is close to 99% among most of the populations studied in the WHO/GPA surveys.

Brown and Xenus (1994) state that increase in the number of single youths has been accompanied by decrease in the average age at first intercourse and the rising levels of premarital sex. Magadi (1996) shows the mean age for first sexual intercourse in Kenya at 13 and 14 for girls and boys respectively and by the age of 19 more of teenagers have initiated sex.

Fronck et.al (2000), in study on validity of the vaginal discharge flowchart in 3 clinics in Nairobi, found several risk markers (being single, younger than 20 years and having had more than one sex partner in the last 3 months) were associated with Cervicitis and HIV infection. Forsythe (1994), claims that about one out of twenty girls in Africa is HIV positive and infection occur in the youth aged 24 years and younger. Since the early 1990s, it has been clear that HIV/AIDS would aid in undermining development in countries badly affected by the scourge.

Literature on HIV/AIDS as related to socio-economic factors largely speak on the consequences or impacts felt in the various sectors of the economy, thus education, agriculture, commerce, transport, labour etc. Njue (2000) is of the perception that the current economic situation has created very many economic difficulties and hardships for many Kenyans, seen at its best in the dependency ratio. According to Bwana (1995) unemployment rates have tremendously worsened the situation of hopelessness among

the school and college graduates in Kenya. The magnitude of the pandemic makes it imperative that all sectors of the society i.e. the public, the private, government and local communities be involved in managing the crisis.

Nidbe (1987) pointed out that money is considered the fuel that keeps the engine of discriminate sexual relations running. The economic status of and individual or have a community has significant influence on the situation where HIV may be transmitted. Economic consequences of sexual behavior resulting in HIV/AIDS are mainly interrupted or limited education and career opportunities. These trigger many problems that include a higher degree of dependency and low socio-economic status. Kivumbi (1993) in study in Rakai, Uganda, shows a linear rise with education and occupational status for both sexes with exception of female and hotel workers.

Type of occupation has been found to play a big role in the transmission of HIV/AIDS in Kenya. Persons in the transport industry, entertainment industry and other attendant's personnel are particularly expected to situations for casual sex, many of who may be away from their regular partners for long periods (Ocholle-Ayayo and Muganzi, 1987). The heavy concentration of young people in the urban areas is due to increase in rural-urban migration triggered by massive poverty and pathetic situation in the rural areas. Most of these young people are not economically in apposition to have commitments like marriage-casual sex is therefore a common habit (Tuju, 1996). Caldwell et. al (1993) states that economic hardship has increased the need for and with commercial sex workers was cited as a probable source of infection by 90% of male patients with gonococcal gonorrhea.

Households hit by HIV/AIDS suffer a dramatic decrease in income (UN, 2000). Decreased income inevitably means fewer purchases and diminished savings. Families make great sacrifices to provide treatment, relief and comfort for a sick breadwinner. HIV is not fundamentally a disease of poverty. In many countries, HIV prevalence during the early stages of the epidemic has been greatest among people with relatively high incomes or educational levels, such as managers and technical workers (Ryder 1990; Melbye 1986). The World Bank estimates that AIDS could shrink some African economies by up to 25% over the next 15 years (Time Magazine pp32).

Managers at one sugar estate in Kenya said that they could count the cost of HIV infections in a number of ways: absenteeism (8000 days of labour lost due to sickness between 1995 and 1997); lower productivity (a 50% drop in the ratio of processed sugar recovered from raw cane between 1993 and 1997) and higher overtime costs for workers obliged to work longer hours to fill in for sick colleagues. Direct cash costs related to HIV infection have risen dramatically: spending on funerals rose five-fold between 1989 and 1997 whilst health costs rocketed by more than tenfold, reaching 19.4 million Ksh in 1997. Kenya, which has more than doubled the United States HIV cases, has to handle the enormous challenge with a gross domestic percentage that is more than seven hundred times smaller and a health budget percentage that is about ten thousand times smaller.

Meanwhile, the epidemic is claiming huge numbers of teachers, doctors, extension workers and other human resources. Some countries health care systems are losing up to a quarter of their personnel to the epidemic. According to the ministry of health, for example, five to six fold increases in health worker. Illnesses and death rates have

reduced personnel increasing stress levels and workload for the remaining employees (Wafula, 1997).

Essential services are being depleted at the same time as state institutions and resources come under greater strain and traditional safety nets disintegrated.

Replacing skilled professionals is a top priority especially in low-income countries where governments depend heavily in a small number of policy makers and managers for public management and core social seizes. The UNAIDS 2001 report, established that losing such personnel reduces capacity, while rising the cost of recruitment, training, benefits and replacement. It advises that a successful response to HIV/AIDS requires that essential public services such as education, health, security, justice and institutions of democratic governance be maintained. Each sector has to take account of HIV/AIDS in its own development plans and introduce measures to sustain public sector functions.

Muganzi (2000) maintained that sectors that explore innovative ways maintaining and rebuilding capacity in the work place would be better equipped to contain the epidemic. Thus labour and social legislation changes be made to boost peoples rights, as well as hang more effective and equitable ways of delivering social services and more extensive programmes that benefit those worst hit by the epidemic.

The ministry of health in its annual report in 1999 observed that an equal access to affordable treatment and adequate health services is new of the main factors accounting for drastically different survival rates among those living with HIV/AIDS. Public pressure and civil societies' engagement with pharmaceuticals corporations (through the accelerating Access initiative), along with competition from generic drug

manufacturers, has helped drive antiretroviral drug prices down. Mwaniki (2000) avers that prices remain too high for public sector budgets in Kenya and this is again compounded by a frail health infrastructure, which cannot bring life prolonging treatment to the millions who need it.

Roberts et al (1994) carried a needs assessment study on business responses to HIV/AIDS and the African formal sector work place. Companies that will struggle most as a result of HIV/AIDS are those that are highly labour-intensive, employ highly skilled workers, or offer comprehensive benefits to employees. These companies were also the ones identified as benefiting most of the HIV/AIDS prevention programmes.

One of the greatest fears about the HIV/AIDS pandemic has been that, because young adults suffer the highest death rates, countries that were already short of skilled workers would face enormous, even catastrophic deficiencies in the future. Iyimba et al (1991) returned a surprising finding from three sub-Saharan Africa countries based on empirical observation and economic models to refute this claims. According to them economic growth is likely to be healthy in a country with enormous skilled personnel, and the absorption of rapidly increasing number of people with at least some secondary education into the labour in a productive way will be a challenged to even in the era of HIV/AIDS.

Calderon (1997) developed a multidimensional model to the approach on combating the pandemic. To him HIV/AIDS is not a solely a medical or public health problem. The complexity of the pandemic requires innovative strategies that draw from the state-of –the-art bio-medical and public health interventions but that must, in addition, include broad-based socioeconomic development initiatives and policies.

Foreman et al (2000) wrote widely on the cost of treating HIV/AIDS in the developing world. He observed that only in a few countries, do most people with HIV/AIDS have access to all levels of treatment. The vast majority receives either no medical treatment or any palliative care to reduce pain and suffering. According to them expensive private facilities may offer standards of care on a level with the best in developed countries, whereas the quality of a country's public health service depends to a large extent on the money spent on it. Widespread treatment to AIDS is hampered by inadequate health services, poor infrastructure, lack of drugs, poor training of doctors on matters to do with treatment to patients.

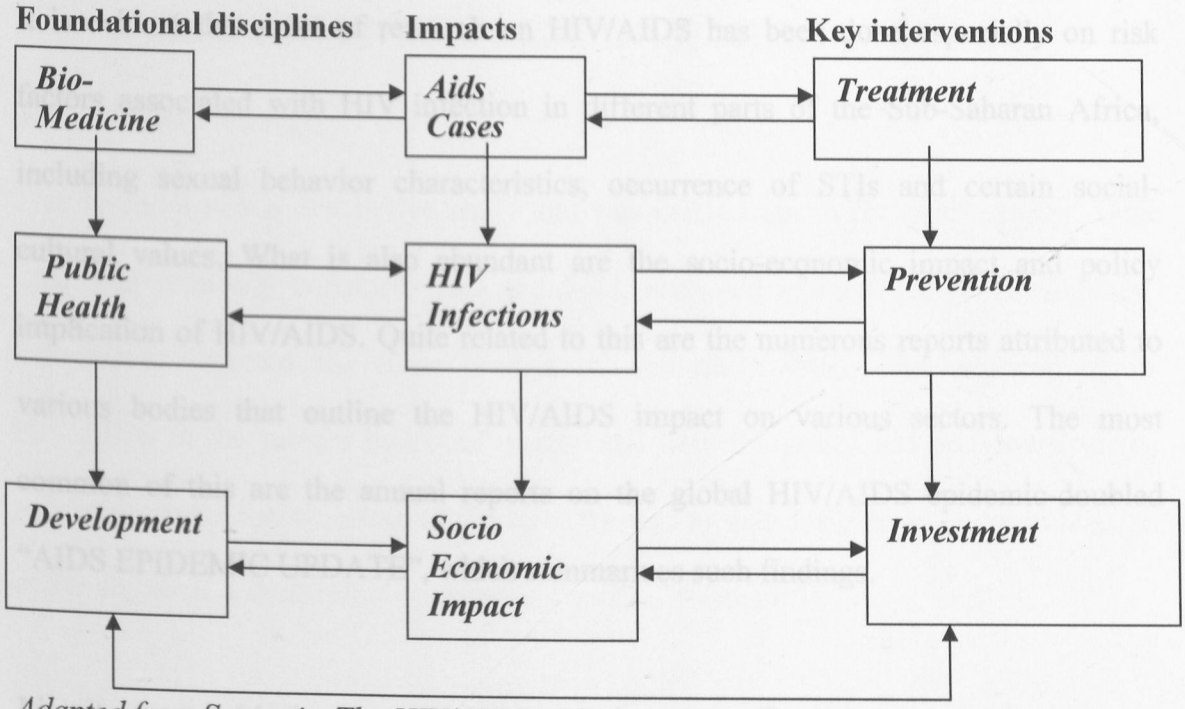
Further, in 1998 using 1994 statistics, WHO and UNAIDS compared estimates of the cost of providing antiretroviral drugs to all those with HIV in fifteen developing countries with the same countries' health budgets costs ranged from less than 1% of the health expenditure in China (a large country with few cases) to 81 times the health expenditure in Uganda (a relatively small country with a high proportion of cases). Indeed, the $13 billion dollars that would have been required each year was equivalent to more than three times Uganda's gross national product the total wealth produced in year.

2.1 Multidimensional Model of HIV/AIDS

This study will borrow from Calderon (1997), who initiated an approach that looks at the multidimensional model (MM) for the prevention and control of HIV/AIDS. Admittedly, in this approach, HIV/AIDS is not solely a medical or public health problem. It is a complex socio-economic development issue, as such, threatens the sustainable development of societies as well as challenging the ethical foundations of

industries. The multidimensional model (MM) is conceptualized in this study as a strategy that when viewed horizontally it consists of three HIV/AIDS control and prevention approaches; biomedical, public health, and development.

The top portion of the MM illustrates the Bio-Medical approach and includes the foundational discipline, which is Bio-Medical Science, the impact, in this case the number of AIDS cases, and the key intervention which is the Treatment of AIDS cases. The middle portion of the MM represents the Public Health Approach, with its foundational discipline being Public Health, its impact shown as the number of HIV infections, and its key intervention of Prevention. The base of the MM reflects the Development Approach, which illustrates its underlying approach as Development, the effect exerted by HIV/AIDS as Socioeconomic Impact and its key intervention as investment.



Adapted from Synopsis, The HIV/AIDS multidimensional model, Calderon, 1997

The model is multidimensional as shown above, each approach and each individual dimension is intertwined with others. It is as a whole, that these approaches are truly effective. It is the development approach that directly implies to this study. The study will look at the possible investments the private hospitals can engage in the prevention and control of HIV/AIDS both for the benefit of humanity and for business.

2.2 Summary

HIV/AIDS is a terrible disease that is causing untold suffering. Its spread in Africa was much more rapid than most experts expected. Nevertheless, there is hope for the future. Economies will not collapse. There will be no exacerbated shortage of skilled workers or even a shortage of primary school teachers. HIV/AIDS medication is affordable and it is extremely important for policy makers to design intelligent programs for its distribution.

It is evident that a lot of research on HIV/AIDS has been done especially on risk factors associated with HIV infection in different parts of the Sub-Saharan Africa, including sexual behavior characteristics, occurrence of STIs and certain social-cultural values. What is also abundant are the socio-economic impact and policy implication of HIV/AIDS. Quite related to this are the numerous reports attributed to various bodies that outline the HIV/AIDS impact on various sectors. The most common of this are the annual reports on the global HIV/AIDS epidemic-doubled "AIDS EPIDEMIC UPDATE", which summarizes such findings.

Literature available in the challenges of HIV/AIDS on the business sector, point at what firms are purportedly doing to respond to the pandemics as it affects them. These includes awareness creation, prevention strategies, education programmes etc. in the light of what it costs the respective firms to have within its precincts, persons infected with HIV/AIDS. The fear is borne out of employee absenteeism, cost of medical cover, loss of expertise and others.

Study on the privately run health sector is therefore a rich area for research. The recognition that HIV/AIDS is not only a medical problem on other areas, at the behest of the implications in the business angle of the health industry. A fertile area of study is in the responsiveness of various sectors in HIV/AIDS. This study is challenged to bring out the issues surrounding the health sector as regard playing its role in the health implications of HIV infection and being in the business of health care provisions.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Study Design

This research was a descriptive study and was carried out in the health sector. Data used was primarily collected from the field, analyzed and used to draw findings. Information targeted the main themes of the study, being the implications of HIV/AIDS in the private hospitals' sector and how the sector has responded to the pandemic. Since the objective of the research was to gain insights and comprehension of the situation, a descriptive study would suffice. (Naresh, 1996)

3.2 Population

The population of interest in this survey constituted all private hospitals in Nairobi. In essence privately run hospitals are relatively better equipped in terms of hospital infrastructure, medication and personnel than public ones. Their role in the multidimensional approach that has been conceptualized in this study goes beyond bio-medical and public health issues to investment development issues. In this regard they make a rich study in establishing their business responsiveness to the HIV/AIDS pandemic.

The list of hospitals to be used included all the 55 private hospitals in Nairobi according to the MOH records and the Official Kenya Medical Directory 2003-2004 edition. The working definition of a hospital adopted for this study was any health care facility that provides both inpatient and outpatient care to patients. The population size was small and hence a census study was done.

3.3 Sample Design

Records from the Ministry of Health and the Kenya medical directory year 2003-2004 edition outline 55 institutions as being private hospitals with complete inpatient and outpatient facilities. The study included all these hospitals with an expected response rate of 76.5% as achieved in other similar studies (Gakombe 2002). The responses formed the sample.

3.4 Data Collection

Data was collected through interviews and by means of a structured questionnaire. The survey targeted persons in the management of hospitals such as the chief executive officer, financial director and clinical directors. The questionnaire was dispatched by drop and pick later method. Face to face interviews were conducted with the respondent, while empirical observation and review of economic data proffered supplementary information.

3.5 Data Analysis

The primary data collected was analyzed by means of statistical measures; the use of statistical package for social science (SPSS) was handy in analysis. Data from questionnaires was therefore edited, coded and entered in the package. Descriptive analysis then followed to generate non-parametric measures such as frequencies, percentiles, percentages, proportions, tables and charts. Information drawn from the interviews, empirical observations and records was adopted for qualitative analysis, meant to supplement and complement the research findings.

CHAPTER FOUR: FINDINGS AND DISCUSSION

4.1 Response rate

There were 55 hospitals in the population frame. However three hospitals had closed down at the time the study. Four did not fit into the definition of the study units because they operated as outpatient clinics only. The responses were 34 out of the possible 47 hospitals giving a response rate of 72.34%.

The respondents were the Chief Executives (34.4%), Clinical Director (12.5%) and others (53.1%). The others include the doctors or matrons in-charge. This was satisfactory because the responses were given with the overall guidance of the Chief Executives of the hospitals and therefore represented the strategic management views.

4.2 Industry characteristics

This part deals with analysis of the characteristics of the private hospitals.

4.2.1 Ownership of private hospitals

It was necessary to find out the ownership of the private hospitals because this gives on overall direction of their profit motives. The private hospitals were found to be owned by a majority of association of members with a percentage of 32.4%, followed closely by Individuals with 29.4%, Private company 14.7%, Religious organization 11.8%, and lastly by trust fund and NGO with 5.9% each.

4.2.2 Financial objective

Being private hospitals, it was of value to assess their financial objective on their existence. The respondents were asked to state the financial objective of the hospital.

Majority of the hospitals operate with the financial objective being for profit 64.7% while a minority of 35.3% are for non-profit making objective.

4.2.3 Size of the Hospitals

The Hospitals were asked to state their bed capacity by number. The number of beds was used as a way to classify hospitals by size. This is the generally accepted criterion globally that is most widely used including by MOH in Kenya. Using the number of beds, the hospitals were classified by size into four classes namely; very small hospitals as those with under 25 beds, small hospitals as those with 26-50 beds, medium hospitals as those with 51-75 beds and large Hospitals as those with over 75 beds. The results are as shown in the table below.

Table 1: Size of respondent hospitals

Class	No. Of beds	Frequency	%	Cumulative %
Very small	0-25	12	35.2	35.2
Small	26-50	13	38.3	73.5
Medium	51-75	2	5.9	79.4
Large	Over 75	7	20.6	100.0
TOTAL		**34**	**100.0**	

The bed capacity was widely distributed with a range of 8 to 250 beds. The most popular class was formed to be the very small and small categories with 38.3% and 35.2% respectively. The least common were the medium sized with 2 Hospitals (5.9%) of the respondents. The large sized hospitals comprised of 20.6% of the total. This group is more heterogeneous due to its wider range of respondents.

4.2.4 Staff capacity of the hospitals

Hospital capacity to provide services to patients can be measured by the staff capacity the hospital has. The main categories of hospital staff that are directly involved in patient care are the medical officers (doctors), Nurses and the subordinate staff. The

hospitals were asked to state their staff capacity in three categories namely, resident medical officers (RMO'S), resident nurses (RN'S), and subordinate staff (SS). These three categories are the main classes of staff found in any hospital and reflect on the total human resource capacity of any hospital to provide patient services.

The RMO'S were minimally distributed with a range of 1 to 30, with a total sum of 181, a mean of 6. This shows a low number of RMO'S available for the private hospitals. This contrasts strongly to the high numbers of RN'S and SS. The RN'S ranged widely from 4 to 490; sum was 1718 with a mean of 58 per hospital. Similarly, SS were also widely distributed from 2 to 500 with a mean of 50 per hospital. Hence for each RMO in a hospital, there are 10 RN'S and a subordinate. The roles of the RN'S and SS in a hospital were therefore not only supportive to RMO'S but also an integral part for the normal operations of the institution.

4.2.5 Bed occupancy of the hospitals

The study sought to know the bed occupancy by patients in the hospitals. It then categorized all patients as general patients, and in this, a subcategory of HIV/ AIDS patients on which the study was focused on. This was generally to find out the impact of HIV/AIDS on bed occupancy and hence the workload generated by HIV/AIDS patients.

a) Bed occupancy by general patients

Bed occupancy by general patients ranged from 2 to 120 patients with a mean of 29. The total beds occupied at the time of the study were 812 beds out of a total bed capacity of 1898, reflecting a 42.8% bed occupancy rate. The bed occupancy hence

ranges very widely with all the hospitals having some inpatients all the time but the bed occupancy changes with many other variables like seasonal changes.

b) Bed occupancy by HIV/ AIDS patients

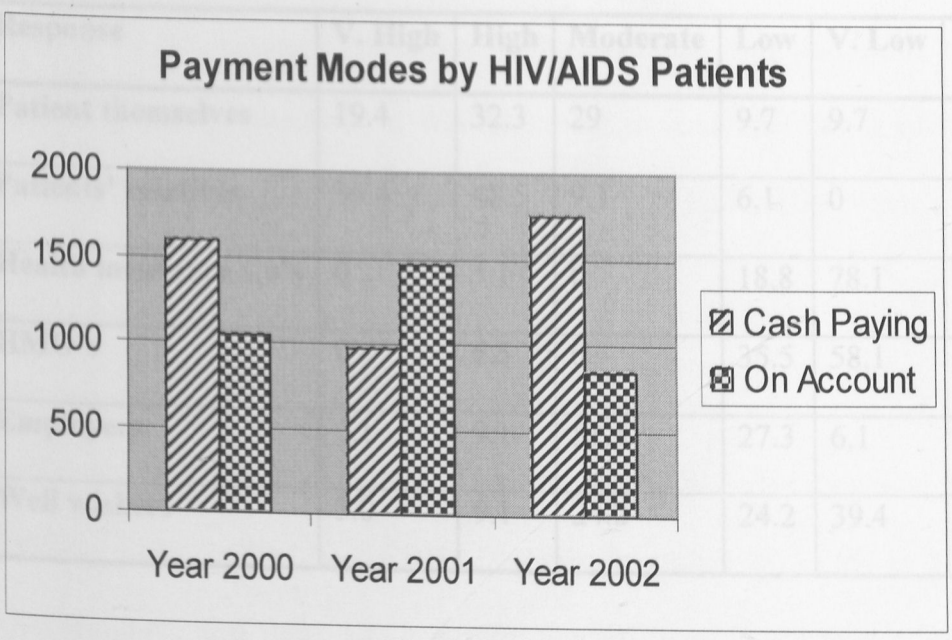
The hospitals were asked to state their average percent bed occupancy by HIV/AIDS patients. The responses ranged from 6% to 100% average percent bed occupancy by HIV/ AIDS patients, with mean of 32.6%. This indicates that irrespective of hospital size or any other factor, every hospital had some percentage of their beds being occupied by HIV/AIDS patients.

The findings in (a) and (b) above indicate that in every hospital, there are some beds occupied by HIV/ AIDS patients regardless of the size or location of the hospital. Some hospitals are enjoying a 100% of their beds occupied being by HIV/ AIDS patients. In such hospitals, their inpatients revenue comes from the HIV/ AIDS patients and this could be an important source of revenue for these hospitals. The question that followed then was whether these patients actually paid their hospital bills and if so how?

4.2.6 Mode of payment of hospital bills by HIV/ AIDS patients

With some hospitals having 100% bed occupancy by HIV/AIDS patients as seen above it was of value to find out the mode of payment of the hospital bills. This question sought to establish the proportion of HIV/ AIDS patients who pay their hospital bills by cash and those who pay on account (credit). The responses are shown in the bar graph below.

Graph 1: Mode of payment



Cash paying patients initially decreased then increased, while on account patients initially increased then decreased. All in all, cash paying patients constitute a total of 4324 patients representing a 56.3% of all patients; while on account patients constitute a total of 3351 patients (43.7%). Hence slightly more patients paid their bills in cash than on account.

4.2.7 Payers of medical bills for the HIV/ AIDS patients

It was necessary to find out who the payers of the hospital bills for the respondents were so as to explore the reasons why the hospital bills were on credit and the possible reasons for bad debts. Respondents were asked to state the level of significance of various payers of medical bills of HIV/ AIDS patients ranging from very high to high, moderate, low and very low. The results are shown in the table below;

Table 2: Payers of hospital bills

Response	V. High	High	Moderate	Low	V. Low	Cumm. %
Patient themselves	19.4	32.3	29	9.7	9.7	100
Patients' relatives	36.4	48.5	9.1	6.1	0	100
Health insurance Co's	0	3.1	0	18.8	78.1	100
HMO's	0	6.5	0	35.5	58.1	100
Employers	6.1	9.1	51.5	27.3	6.1	100
Well wishers	3.0	9.1	24.2	24.2	39.4	100

The most popular response was patients' relatives with 84.8% of responses showing very high and high level of significance. This was followed by patients themselves (51.6%), then employers (15.2%), then well wishers (12.1%), Health management organizations (HMO'S) (6.6%) and lastly, health insurance companies with 3.1%.

These findings indicate that HIV/ AIDS patients themselves and their relatives are the most important payers of hospital bills and should be handled with an appropriate level of importance as stakeholders. The other payers, i.e. health insurance companies, HMO's, employers and well wishers are regarded as of comparatively low importance in paying the hospital bills for HIV/ AIDS patients. The trend here is that most employers and health insurance companies do not cater for HIV/ AIDS related patients.

4.3 Trends of patients in the hospitals

Patients are the principal customers of the hospitals. This part deals with trends of patients in private hospitals. It was important to study the trends of the patients in general followed by a closer look at the trends of the HIV/AIDS patients.

4.3.1 General patients trend

This question sought to establish the trend of the number of general patients. The study established that the total number of general patients attended increased from 18,054 in 2000 by 39.1% to 25,120 in 2001. This then increased by 33.5% to 33,523 in 2002. This illustrates that there was a general upward trend in the total number of general patients attended to.

4.3.2 HIV/ AIDS patients trend

The study established the total number of HIV/ AIDS patients attended to in the hospitals are 3 in the past years and found that 4,588 patients were attended to in 2000. This increased by 15.5% to 5,299 in 2001, which 10 then decreased by 24.6% to 3,998 patients in 2002. The decrease in the last year may be attributed to by the decrease in national HIV/ AIDS prevalence in Kenya from 13 to 10% as recorded by NASCOP 2002.

4.4 Business risk and opportunity in HIV/ AIDS

The respondents were asked to state to what extent they consider HIV/ AIDS pandemic as a business opportunity and a risk. The results are shown in the tables below;

Of the responses, 66.7% considered HIV/ AIDS as an opportunity of moderate to very high extent. However, 84.4% responses considered HIV/ AIDS as a business risk of moderate to very high extent.

Overall, these findings indicate that HIV/ AIDS is both a business opportunity and risk that co-exist together in a hospital. There are various factors that would favor it as an opportunity rather than a risk and vice versa, and the study further explored these factors below.

4.4.1 Factors contributing to HIV/AIDS as a business opportunity

There are many factors that were identified in the study to be contributing to HIV/AIDS as business opportunity as explained below.

a) New HIV/ AIDS patients

The question sought to know the average number of new HIV/AIDS patients reported in every hospital studied. Respondents were asked to state the average number of new HIV/AIDS patients that they saw every week. The results were that the average number of HIV/AIDS patients seen every week ranged from a minimum of 1 to a maximum of 5, with a mean of 2.61.

This shows that most hospitals were seeing at least one new HIV/AIDS patient every week. Some were seeing up to five patients in only one week. HIV/AIDS is a chronic illness that requires clinical follow-up. Hence the hospitals can take this as an opportunity to have these patients continually go back to the hospitals for follow-up. On average the hospitals have an average of 2.61 (S.D of 1.75) new patients every week, and potentially 10 patients in a month (four weeks). They can utilize this opportunity to have at least 10 new patients every month and this is a cumulative number that keeps on growing. Hence by the fact that the private hospitals got new

HIV patients every week or month illustrated the fact that there was a business opportunity that the hospitals could capitalize on.

b) Frequency of Hospital visits by HIV/AIDS patients

HIV/AIDS is a chronic illness that requires frequent follow up and monitoring of treatment in hospitals. The study sought to know whether the HIV patients visit the hospitals frequently hence creating an opportunity for hospitals to generate revenues every time the patients visited the hospital in fees. Respondents were asked to state the frequency of hospital visits in a month by HIV/AIDS patients after they have been diagnosed. The results are shown in the table below.

Table 3: Frequency of hospital visits by HIV/AIDS patients

Frequency of visits	Frequency	Percent	Cumulative percent
Below 5 times	20	74.1	74.1
6-9 times	4	14.8	88.9
10 and more times	3	11.1	100.0
Total	27	100.0	

The results show that most HIV/AIDS patients (74.5%) visit the hospital below 5 times in a month. However, most respondents clarified that the number of hospital visits depended largely on the clinical status of the HIV/AIDS patients, and hence if one is in a very bad health condition, their visits would increase to even more than 10 times in a month especially so if the patient has full blown AIDS.

The more the number of visits by a patient to the hospital the more the number of times the patient pays consultation and other fees to the hospital and hence a higher revenue for the hospital. Therefore due to high frequency of hospital visits by HIV/AIDS

patients, there is a real opportunity for hospitals to generate more revenue from these patients.

c) HIV/AIDS programs in Hospitals

HIV/AIDS is a disease that requires multidimensional approach in tackling it. The general approaches available in hospitals which are run as programs in the HIV/AIDS areas of awareness, prevention and management. The hospitals are not only involved in the clinical management of HIV/AIDS patients, but also in HIV/AIDS awareness and prevention. The study sought to establish the frequencies of hospitals that run these programs. The respondents were asked to state which HIV/AIDS programs their hospitals ran and the results are shown in the table below.

Table 4: Types of HIV/AIDS programs

HIV/AIDS program	Percent yes	Percent no	Cumulative percent
Awareness	67.7	32.3	100.0
Prevention	67.7	32.3	100.0
Management	84.4	15.6	100.0
Average percent	73.3	26.7	100.0

Most hospitals (73.3%) involved themselves in a kind of program related to HIV/AIDS, with management programs being most popular (84.4%). Awareness and prevention programs are also common with 67.7% each. These two programs have the same frequency because the programs in most hospitals run concurrently.

These programs were run both internally and by external partners (64.7%), while those run only internally were 11.8%, and those run only by external partners being 8.8%. This indicates that the war against HIV/AIDS requires a multi-sectoral approach. On

interviews, the external partners in these programs were found to be NGO'S, volunteers, the government and social groups.

It was necessary to establish exactly which programs were actually run in the hospital premises, and how popular they were in private hospitals. The respondents were asked to state whether or not their hospitals run the following programs. The results are shown in the table below.

Table 5: HIV/AIDS programs run by hospitals

Program	Percent yes	Percent no	Cumulative percent
Health education	72.7	27.3	100
Counseling on behavior change	78.8	21.2	100
VCT	55.9	44.1	100
PMTCT	60.6	39.4	100
Accidental exposure prevention program	67.6	32.4	100

The table illustrates that majority of the hospitals run the programs. Counseling on behavior change (78.8%) was the most popular followed by Health education (72.7%). VCT was least popular (55.9%).

d) Adoption of Advanced Technology

Technology can enable a hospital to create and sustain a competitive advantage. The study sought to explore whether the private hospitals had indeed realized a business opportunity in adopting advanced technology in providing services to HIV/AIDS patients. Therefore respondents were asked whether they have adopted technology on investigations on patients for specific HIV/AIDS related cases. The results are as follows:-

Table 6: Adoption of radiology advanced technology

Response	Frequency	Percent	Cumulative percent
Yes	4	12.1	12.1
No	29	87.9	100
Total	33	100	

Table 7: Adoption of laboratory advanced technology

Response	Frequency	Percent	Cumulative percent
Yes	18	56.3	56.3
No	14	43.7	100
Total	32	100	

Very few hospitals 12.1% adopted advanced technology in radiology investigations for HIV/AIDS patients. This was seen to be the case due to high capital investment while most of the clients as seen before may not be able to pay medical bills related to expensive highly advanced radiology investigations like magnetic resonance imaging (MRI).

On the other hand, when it came to adopting advanced technology for laboratory investigations for specific HIV/AIDS related cases, majority of the hospitals 56.3% had adopted it, and only 43.7% of the hospitals had not. This was seen to be the case due to relatively low capital investment for the laboratory advanced technology but highly demanded services by HIV/AIDS patients.

The medical director of one of the hospital, a clinician, stated that every HIV/AIDS patient requires a viral load to be done on them and this creates a demand for hospitals to adopt advanced technology to provide these services. Hence 56.3% of the hospitals

have invested in viral load testing machines with the hope that they will attract and keep more HIV/AIDS patients requiring the viral load tests at their facility.

d) Sales of Anti-retroviral drugs (ARVs)

HIV/AIDS patients can prolong their life by taking anti-retroviral drugs (ARVs). Businesses that can stock ARVs and sell them to patients at some profit margin can potentially increase access of the needed drugs to HIV patients and at the same time increase their revenue base. Private hospitals by nature of dealing with HIV patients can take up this opportunity and exploit it. The study sought to know whether private hospitals are stocking these vital drugs in the fight against HIV/AIDS, and if so, whether they make reasonable sales of them. Respondents were asked to first state whether they stock the ARV'S or not. The results are shown in the table below.

Table 8: Stocking of ARVs

Response	Frequency	Percent	Cumulative percent
Yes	6	17.6	17.6
No	28	82.4	100.0
Total	34	100.0	

The results indicate that a majority of hospitals do not stock the ARV'S (82.4%) and just a few did stock the drugs (17.6%).

It would have been expected that with the high proportion of patients seen in private hospitals being HIV/AIDS patients, then the hospitals would stock and sell the ARV'S. The reasons cited by some of the hospitals for not stocking the drugs include low profit margins; difficulty in access to the drugs and one doctor said that the patients do not have enough financial resources to regularly buy the drugs.

4.4.2 Factors contributing to HIV/AIDS as a business risk

HIV/AIDS was seen by respondents to be having factors contributing to it as both a business risk and a business opportunity. Various factors were identified as contributing to it as a business risk and these are discussed below.

a) Payment rates

It was necessary to find out whether the HIV/AIDS patients paid their bills or not because this could contribute to HIV/AIDS being a business risk to private hospitals. The respondents were asked to state whether these patients fully paid their hospital bills or not. The table below shows responses to whether the HIV/AIDS patients fully paid the hospital bills.

Table 9: Hospital bills payment rates

Response	Frequency	Percent	Cumulative percent
Yes	7	21.2	21.2
No	8	24.2	45.5
Sometimes	18	54.5	100
Total	33	100	

Few HIV/AIDS patients 21.2% fully paid their hospital bills compared to 24.2% who did not pay. A majority 54.5% sometimes paid their bills fully other times they did not. This in itself is a big risk to the hospitals because they could end up having huge bad debts arising from HIV/AIDS patients.

b) Reasons for failure of payments

With a reasonable proportion of HIV/AIDS patients failing to pay their hospital bills, then respondents were asked to rate the reasons why the patients did not pay the

hospital bills. The reasons given are rated as follows from the response rated as very high to low.

Table 10: Reason for failure of payments

Response	V. High	High	Moderate	Low	V. Low	Cumm. %
Lack of medical cover	72.7	12.1	9.1	6.1	0	100
Inadequate medical cover	72.7	21.2	3.0	3.0	0	100
Finances exhaustion	54.5	30.3	12.1	3.0	0	100
Neglect by relatives	17.6	11.8	38.2	29.4	2.9	100
Other reasons	55.6	11.1	22.2	11.1	0	100

The other responses included items like sheer poverty, stigma and perceived lack of hope to live by the patients.

Most HIV/AIDS patients do not have medical insurance cover, and the few who have it, it excludes HIV/AIDS related illness, hence most patients have to pay out-of-pocket and considering high poverty rates prevailing in the country then most of the patients hardly pay fully their hospital bills. There is little or no neglect from the guardians or relatives of the patients as most times the patients are brought into hospitals for care by their own relatives and friends.

4.4.3 Difficulties in dealing with HIV/AIDS patients

It was necessary to assess the level of difficulties faced by private hospitals in dealing with HIV/AIDS patients in various aspects of health service delivery. The respondents were asked to state the extent to which they have difficulties on a scale of 1-5, ranging from very low, to moderate, to very high in terms of quality of medical care, quality of

nursing care, quality of catering, quality of accommodation, range of services offered, prices of services, collecting payment, credit control and litigation risk.

The results are shown in the tables below, i.e., tables to show difficulties in dealing with HIV/AIDS patients.

a) Quality of medical care

Quality of medical care is an essential component of quality of services being offered to patients in hospitals. It was important to find out whether hospitals were having difficulties in handling HIV/AIDS patients in delivering high quality of medical care to internationally accepted standards.

Table 11: Quality of medical care

Response	Frequency	Percent	Cumulative
Very high	6	18.2	18.2
High	9	27.3	45.5
Moderate	9	27.3	72.7
Low	8	24.2	97.0
Very low	1	3.0	100
Total	33	100	

Most respondents 72.7% considered dealing with HIV/AIDS patients in terms of quality of medical care difficult.{Moderate to very high extent of difficulties}.On interviewing some respondents, one medical director stated that HIV/AIDS is a complex medical care which most hospitals are not capable to provide. He added that it's a condition with a medical cure, treatment is aimed to prolong life of the patient, and the HIV/AIDS medical subspecialty keeps on changing and this compound on to the social-cultural challenges of giving quality medical care to HIV/AIDS patients in developing countries like Kenya.

b) Quality of Nursing Care

HIV/AIDS patients demand high quality nursing care and hence it was necessary to find out whether private hospitals were finding this a challenge to them or not and to what extent they faced difficulties in this. The results are shown below.

Table 12: Quality of nursing care

Response	Frequency	Percent	Cumulative Percent
Very high	9	26.5	26.5
High	7	20.6	47.1
Moderate	6	17.6	64.7
Low	9	26.5	91.2
Very low	3	8.8	100
Total	34	100	

Majority of the respondents 64.7% rated the difficulties in dealing with HIV/AIDS patients in terms of quality of nursing care as moderate to very high. A small percent 35.3% considered this as low and very low extent. It was explained that most are admitted to hospitals require specialized nursing care and hence the difficulties arising in providing the required nursing care. Many of the patients need end of life nursing care and this complicates the hospitals can provide to these patients.

c) Catering

Hospitals do run a catering department to cater for meals for the inpatients. HIV/AIDS patients may occasionally require special meals as part of their treatment hence creating possible difficulties in catering for them. The results from this question are shown below.

Table 13: Catering

Response	Frequency	Percent	Cumulative Percent
Very high	3	9.1	9.1
High	6	18.2	27.3
Moderate	11	33.3	60.6
Low	8	24.2	84.8
Very low	5	15.2	100
Total	33	100	

The responses were well spread out among the various choices. Most respondents 33.3% rated the extent of difficulties in dealing with HIV/AIDS patients in terms of catering as moderate. Very high [9.1%}and high {18.2%} responses gave a cumulative total of 27.3% while low and very low responses totaled to 39.4%.This shows that there were few difficulties in terms of catering in dealing with HIV/AIDS patients.

d) Quality of Accommodation

It was also necessary to find out the extent of difficulties faced in dealing with the accommodation of HIV/AIDS patients. In special cases some of these patients would demand a special accommodation to be able to deal with their denial of unprecedented diagnoses. The results are shown below.

Table 14: Quality of accommodation

Response	Frequency	Percent	Cumulative Percent
Very high	3	9.1	9.1
High	6	8.2	27.3
Moderate	7	21.2	48.5
Low	8	24.2	72.7
Very low	9	27.3	100
Total	33	100	

The analysis for quality of accommodation compared very well to that of catering.

Very high and high responses both accounted for 27.3% while moderate was 21.5% and low and very low as 51.5%.This illustrates that the extent of difficulties in terms of quality of accommodation for HIV/AIDS patients are not high but generally low. Respondents explained that these patients do not necessarily require special accommodation and hence few difficulties if any.

e) Range of services offered

The range of services being offered to HIV/AIDS patients was explored to find out whether the hospitals are faced with difficulties to provide a wide range of services to these patients. This was because if more services are offered the revenue collection base can be widened and create an opportunity for business growth and vice versa. The results are shown below.

Table 15: Range of services offered

Response	Frequency	Percent	Cumulative Percent
Very high	7	21.9	21.9
High	5	15.6	37.5
Moderate	10	31.3	68.8
Low	6	18.8	87.5
Very low	4	12.5	100
Total	32	100	

Respondents were asked to rate the extent of difficulties they face in dealing with HIV/AIDS patients in terms of range of services offered. The table above shows that most respondents 68.8% responded very high, high and moderate. This was explained by some respondents that hospital are not able to offer a wide range of services because of high capital investments required to offer a wide range of services to these patients. A wide range of services to HIV/AIDS patients may be more of a risk than an opportunity because many patients are not eager to utilize all services provided

because the patients want to save their recourses for only those critical services that are a must for them to live like ARV drugs.

f) Price of services

The respondents were asked to state the extents of difficulties they faced in dealing with prices of services for HIV/AIDS patients. This was to assess whether they really considered this unique patient in setting their prices and to what extent this was of a difficulty to them. The results are shown below.

Table 16: Price of services

Response	Frequency	Percent	Cumulative percent
Very high	4	12.5	12.5
High	5	15.6	28.1
Moderate	9	28.1	56.3
Low	8	25.0	81.3
Very low	6	18.8	100
Total	32	100	

Respondents to this question were well spread out among the various responses. Most respondents (28.1%) rated the extent of difficulties in dealing with HIV/AIDS patients in terms of price of services as moderate. Very high (12.5%) and high (15.6%) gave a cumulative percent of 28.1% while low (25.0%) very low (18.8%) totaled to 43.8%.This shows that there were very few difficulties in setting the price of services for HIV/AIDS patients in hospitals.

4.5 Business risk factors encountered in dealing with HIV/AIDS patients

The study further went on to identify various business risk factors associated with dealing with HIV/AIDS patients and how they were rated. Respondents were asked to

rate several business risk factors likely to be encountered in dealing with HIV/AIDS patients.

a) Risk of bad debts

This was to determine whether bad debts were real in dealings with HIV/AIDS patients and to what extent was this risky. Most respondents (75.8%) rated this as very high (33.3%) and high (42.4%) risk. Therefore most respondents rated risk of bad debts as a relatively high risk when dealing with HIV/AIDS patients.

Respondents were also asked to state the level of difficulty in collection of payment from HIV/AIDS patients and the results from this are shown below.

Table 17: Collection of payment

Response	Frequency	Percent	Cumulative percent
Very high	8	24.2	23.5
High	5	15.2	38.2
Moderate	7	21.2	70.6
Low	9	27.3	91.2
Very low	4	12.1	100
Total	34	100	

The respondents were asked to rate the extent to which they have difficulties in dealing with HIV/AIDS patients in collecting payment. Majority of them 70.6% responded as very high, high and moderate, while 29.4% responded as low and very low. This shows that there are certain difficulties in dealing with HIV/AIDS patients in terms of collecting payment. The reasons for this were asked, evaluated and analyzed and the results are given further in this chapter.

Respondents were also asked to state the extent of difficulties in credit control when dealing with HIV/AIDS patients so as give a clearer picture of the risk of bad debts that the hospitals face. The results are shown below.

Table 18: Credit control

Response	Frequency	Percent	Cumulative percent
Very high	8	24.2	24.2
High	5	15.2	39.4
Moderate	7	21.2	60.6
Low	9	27.3	87.9
Very low	4	12.1	100
Total	33	100	

The analysis for credit control compared very well to that of collecting payment with very high response 24.2%, high response 15.2% and moderate response 21.2% all giving a cumulative total of 60.6%. Compared to a cumulative total of 39.4% for low (27.3%) and very low (12.1%) responses. This illustrates that majority of hospitals have difficulties in dealing with HIV/AIDS patients in terms of credit control.

Overall, the risk of bad debts is high and is compounded by the fact that hospitals are finding it increasingly difficult to deal with credit control and collecting payments from HIV/AIDS patients.

b) Risk of hospital stigmatization and bad publicity

Hospitals dealing with HIV/AIDS patients are perceived to be stigmatized and hence the need to find out whether this is real business risk and its extent. Only 6.1% of the respondents rated this as a very high risk. Majority of respondents 48.5% rated this as low and 15.2% rated this as very low risk. Hence the risk may exist but a very low risk.

If a hospital is stigmatized then it will generally have bad publicity. Hence respondents were also asked to rate the risk of bad publicity when dealing with HIV/AIDS patients. This was rated as a very low risk by majority of the respondents 37.5%. The society views hospitals as social amenities that provide vital care to the well being of

humanity, and therefore there is very low risk if any of publicity when a hospital is dealing with HIV/AIDS patients.

c) Risk of Government interference

The government can interfere with the operations of private hospitals as healthcare provision is a social duty of the government to the taxpayers and the society at large. Hence governments can interfere with private hospitals so that its duty is met through them. Hence the need to study whether this risk actually existed and if so to what extent.

The results showed that this was generally rated lowly, with 27.3% rating it as very low. The government has no direct control in the day running and management of private hospitals hence a very low risk of government interference.

d) Risk of litigation

Respondents were asked to rate the risk of litigation likely to be encountered in dealing with HIV/AIDS patients. This was generally rated lowly, with 37.5% of respondents rating it as low .The risk exists in a few selected cases of overt medical negligence as a medical officer stated. HIV/AIDS patients do not generally want to spend money on litigation instead of medical care, but by a hospital or its staff, the patients will definitely file a legal suit.

Litigation risk can seriously affect the operations of a hospital and in Kenya litigations against private hospitals are on the rise and hence it was also important to find out how

it is rated in terms of the difficulties it raises in dealing with HIV/AIDS patients. The results are shown below.

Table 19: Litigation risk

Response	Frequency	Percent	Cumulative Percent
Very high	4	12.1	12.1
High	8	6.1	18.2
Moderate	2	24.2	42.4
Low	11	33.3	75.8
Very low	8	24.2	100
Total	33	100	

The respondents were asked to rate the extent to which they have difficulties in dealing with HIV/AIDS patients in terms of litigation risk. Majority of respondents rated this as low risk (33.3%) and very low risk (24.2%) compared the few who rated this as very high (12.1%) and high (6.1%). A few (24.2%) of the respondents rated this as moderate. This illustrates that a small percent of hospitals considers litigation risk as a difficulty in dealing with HIV/AIDS patients. Hence most hospitals do not have difficulties in handling the litigation risk associated in dealing with HIV/AIDS patients.

e) Risk of patients rejecting special HIV treatment

HIV/AIDS treatment requires special drugs which are given to improve quality of life and to help the patients to live a longer and more productive life. However there is no cure for HIV/AIDS available today. This makes HIV/AIDS patients to reject the treatment since it will not cure them anyway, hence even if the hospital provides high quality of care, treatment and support to these patients, the hospitals still run the potential risk of patients rejecting the treatment and associated services.

From the responses analysis, this risk existed but to a low extent. Most respondents 42.4% rated this risk as low (21.4%) and very low (21.2%). Some patients reject the special HIV treatment because they believe in faith-healing and do not want to mix the faith-healing with HIV drugs. Other patients reject it due to stigma associated with HIV treatment.

f) Risk of HIV/AIDS unit affecting performance of other units

Some hospitals had started running a HIV/AIDS unit to specifically cater for these patients. This was because the needs of these patients are unique and hence constituting a special category of customers to the private hospitals. But questions arise as to whether the HIV/AIDS unit affects the performance of other hospital units or not and if so what extent of a risk does it constitute.

The results indicated that this was also rated generally as a low risk. Most respondents 35.7% rated this as low and 28.6% rated this as very low risk. This was due to the fact that a separate HIV/AIDS unit did not seem to affect other units of a hospital that had already been established. HIV/AIDS is developing as a specialty of hospital care hence since it's a separate specialty; it did not significantly the already established specialties. However whether this will change in the future or not waits to be seen as the HIV/AIDS clinical specialty picks momentum.

4.6 Responses by private hospitals to HIV/AIDS

Private hospitals in Nairobi found themselves in a challenging business environment with HIV/AIDS patients to cater for. These were difficult patients who had no medical insurance cover and few paid their medical bills. However, the hospitals had the

responsibility to cater for all kinds of patients whether HIV/AIDS patients or not. The study went on to find out how the private hospitals responded to these business challenges that they face.

4.6.1 Running of HIV/AIDS Programs

This was an option most hospitals took as explained in paragraph 4.4.1. (c), most hospitals (73.3%) started running HIV/AIDS programs, with the HIV/AIDS patient management program being the most popular. Most hospitals sought external partners like NGO'S to run these programs in their hospitals so as to act as strategic partners in dealing with their challenges

One CEO of the hospital stated that when hospitals are faced with the challenge of HIV/AIDS pandemic, they have the option of going into strategic alliances with partners who need the hospitals to be able to fight HIV/AIDS .These partners are likely to fund expensive capital investments associated with caring for HIV/AIDS patients like the viral load machines. Working with these partners puts a hospital at a competitive advantage ahead of the rest of the pack.

The hospitals adjust themselves to the changing business environment by running HIV/AIDS programs solely and with strategic partners. It was therefore necessary to find out whether the motive for these programs was for profit or not.

Table 20: Motives for running HIV/AIDS programs

Response	Frequency	Percent	Cumulative percent
For profit	7	21.2	21.2
Not profit	26	78.8	100
Total	33	100	

Majority of the respondents 78.8% stated that the motive was for non-profit. This was seen to be associated with the society perception of HIV/AIDS related illness without making a profit. Hence most hospitals run these programs for not profit while a few 21.2% run these for profit.

4.6.2 Charges to HIV/AIDS patients

The respondents were asked to state whether HIV/AIDS patients are charged relatively more than general patients. This was to assess whether the programs were based on higher charges or not and hence a profit motive. The results compared very well to the question on profit motive above.

Table 21: Charges to HIV/AIDS patients

Responses	Frequency	Percent	Cumulative percent
No	27	79.4	79.4
Sometimes	7	20.6	100
Total	34	100	

Most respondents, 79.4% stated that sometimes the HIV/AIDS patients are charged relatively more than other patients. A small percent, 20.6% stated that this is not the case. On interviewing respondents further it was established that very few hospitals approximately the 20.6% do not charge HIV/AIDS patients relatively more. They do not care much to HIV status of the patients when it comes to charges.

4.6.3 Stocking of HIV/AIDS drugs

The hospitals being faced with the HIV/AIDS as a business challenge could opt to take this as a business opportunity and stock the required HIV/AIDS drugs called antiretrovirals (ARVs). The ARVS however are expensive drugs requiring constant

supply to the HIV/AIDS patients who may not always have the finances to buy these drugs regularly from the hospitals.

The respondents were asked to state whether they stocked and sold ARVS to the HIV/AIDS patients. The results were as follows.

Table 22: Stocking of HIV/AIDS drugs

Response	Frequency	Percent	Cumulative percent
Yes	5	14.7	14.7
No	28	82.4	97.1
Sometimes	1	2.9	100
Total	34	100	

The results showed that majority of the Hospitals (82.4%) did not stock and sell ARVs. One of the Hospitals, representing 2.9 % sometimes stocked the drugs and sold on specific patient requests/orders. This illustrates that most hospitals did not want to venture into this part of dealing with HIV/AIDS. The World Health Organization (WHO) has been on the forefront of campaigns to ensure access to ARVs by patients but private hospitals in Nairobi have not heeded to this. This may be due to the low level of mark-up profits recommended by WHO and other global health bodies on ARVs. Hence hospitals do not find this a lucrative business despite the high demands, the situation being worsened by the high bad debts profile of HIV/AIDS patients. Some respondents lamented that why should they stock ARVS if the medical insurance companies do not cover for these essential drugs. The basic ARVS are in the list of essential drugs by WHO, but private hospitals still shy away from doing business in stocking and selling ARVS to patients.

4.6.4 Adopting advanced technology

In a changing environment of the business world of private hospitals, few have adapted advanced technology to create competitive advantage. Only 12.1% of the hospitals adopted advanced technology in radiology while 56.3% adopted advanced technology in laboratory investigations.

4.6.5 Running a specialized HIV/AIDS clinic/department in the hospital

Private hospitals in Nairobi have the option of running a specialized HIV/AIDS clinic to cater for the growing number of HIV/AIDS patients in hospitals and their special needs. Respondents were asked to state whether they run a specialized HIV/AIDS clinic/department in the hospital precincts. The results are shown below.

Table 23: Running a specialized HIV/AIDS clinic

Response	Frequency	Percent	Cumulative percent
Yes	8	24.2	24.2
No	25	75.8	100
Total	33	100	

Most hospitals 75.8% do not run specialized HIV/AIDS clinic. The medical officers interviewed stated that this was because of stigma associated with a specialized HIV/AIDS clinic because HIV/AIDS patients shy away from such a facility as they fear being branded HIV positive by merely being seen by others visiting the specialized HIV/AIDS clinic. Stigma therefore must be fought successfully for the hospitals to run the HIV/AIDS clinics successfully.

4.6.6 Running other related services

Hospitals could also respond to the business challenge of HIV/AIDS by running other services that are not unique to these patients but can increase business opportunity by venturing into them. These are provision of services like mortuary, autopsy and post-death counseling of the affected. Respondents were asked to state if in the light of AIDS related deaths they run autopsy, mortuary or post-death counseling of the affected services. The results are shown below for each of these services.

a) Autopsy services

Autopsy services are done to scientifically identify the cause of death after it has occurred. Relatives of the deceased are the ones who request for this service and it can be a revenue generating activity for the hospital. The study sough to find out whether the private hospitals are taking this as an option in tackling the business challenge posed by HIV/AIDS pandemic.

Table 24: Autopsy services

Response	Frequency	Percent	Cumulative percent
Yes	4	13.3	13.3
No	26	86.7	100
Total	30	100	

Most hospitals 86.7% did not run autopsy services, probably because it's presumed that the cause of death of HIV/AIDS patients is already known to be the HIV itself, hence services not generally provided due to low demand.

b) Mortuary services

Mortuary services are offered to preserve the body of the deceased until a time that the relatives are ready for the final disposition of the body usually the burial in most Kenyan communities. This service is perceived to be on the increase due to increased

number of deaths occurring from HIV/AIDS. Respondents were asked to state whether their hospitals provided this service or not.

Table 25: Mortuary services

Response	Frequency	Percent	Cumulative percent
Yes	12	40	40
No	18	60	100
Total	30	100	

Mortuary service was also not generally provided, only 40% of the hospitals provided it. This is associated with high investments required to maintain a good morgue, and respondents stated that this has little co-relation with the specific needs for HIV/AIDS patients. "You do not need a special morgue for HIV/AIDS patients", one hospital matron stated, hence hospitals do not generally find the need to always run a mortuary service.

c) Post-death counseling of the affected

This was a service provided by 65.6% of the hospitals. On interviewing respondents, they stated that this is a general service provided to the relatives of the deceased whether they died of a HIV/AIDS related illness or not. Hence it was more of a hospitals' social responsibility to the bereaved relatives rather than a business venture.

CHAPTER FIVE: SUMMARY, LIMITATIONS AND RECOMMENDATIONS

5.0 Introduction

The results of this study include how the environment of private hospitals' business has changed in the wake of the HIV/AIDS pandemic and how they have responded to these business challenges. This section of this paper summarizes these conclusions and highlights the applications of the results to hospital managers and by future researchers.

5.1 Summary

This study attempts to explore how the environment of private hospitals has changed in face of HIV/AIDS and hence whether hospitals take this as a business opportunity and risk. This was then explored to find out the responses to these challenges.

Business risk and opportunity

The study revealed that HIV/AIDS pandemic posed many business challenges to private hospitals. Average percent bed occupancy by HIV/ AIDS patients was 32.6%. There was a general upward trend in the total number of general patients attended to (33.5% increase) but this was not the case with HIV/AIDS patients where the trend was not stable because it went up by 15.5% 2001 and went down by 24.6% in 2002.

Of the respondents, 66.7% considered HIV/AIDS as a business opportunity of moderate to very high extent. However, 84.4% respondents considered HIV/AIDS as a business risk of moderate to very high extent. These findings indicate that HIV/AIDS

is both a business opportunity and risk that co-exist together in a hospital. Few HIV/AIDS patients 21.2% fully paid their hospital bills.

Business opportunities

Business opportunities assessed to determine why the hospitals viewed the pandemic more of an opportunity rather than a risk were several. HIV/AIDS made the patients visit the hospitals more than once in month for continued care and hence an opportunity for hospitals to generate revenue from this. 74.1% of these patients visited the hospital more than once in a month (but less than five times). Hospitals also identified an opportunity in running HIV/AIDS programs (73.3%) in the hospitals of one form or another. Another big opportunity the hospitals identified was in adopting advanced technology in the laboratory for HIV/AIDS patients. This mainly lay in the view that since HIV patients require monitoring their clinical progress then laboratory motoring was essential. 56.3% did adopt various technologies like CD4 count to monitor the patients on treatment and this was a good opportunity to generate revenue from the laboratory section of the hospital.

Business risks

The main risk why HIV/AIDS was viewed by the hospitals as a risk rather than an opportunity was bad debts. Only a mere 21.2% of the HIV/AIDS patients fully paid their hospital bills. The low payment rates were mainly due to lack of medical cover (72.7%). Hence the risk of bed debts was real and very high (75.8%). This subsequently made the hospitals to shy away from stocking the crucial ARVs; only 12.1% of the hospitals stocked these drugs and sold them.

Other risks were generally low. These were risk of hospital stigmatization (48.5%rated this as low risk), risk of government interference (27.3% rated as low), risk of litigation (37.5% rated as low), risk of rejection of special HIV treatment (42.4% rated as low), risk of HIV/AIDS unit affecting other units (37.5% rated as low) and risk of bad publicity (37.5% rated as low).

Responses by private hospitals to HIV/AIDS

The most popular response by private hospitals to the HIV/AIDS pandemic was running HIV/AIDS programs within the hospital (73.3%) This was seen to be strategic alliance with other partners like NGO's involved with HIV/AIDS work. The hospitals provide the facilities to treat the HIV/AIDS while the partners provide staff, patient educational materials and technical support. This way of working with other parties was seen to be successful and the alliances worked well. Most of these programs however are not for profit (78.8%).

The other strategic response was to ensure that HIV/AIDS patients were not charged higher than the general patients. This response had been adopted by 79.4% of the hospitals. This really helped in fighting the stigma towards these patients. The prices for services were uniform across the categories of patients.

Technology strategy can be used to create competitive advantage. Technology strategy was adopted in the laboratory department (56.3 %), but minimally adopted in the radiology department (12.1%). Stocking of ARVs was unexpectedly low (14.7%), mainly because of the low profit margins associated with ARVs and the fear of bad debts from the patients.

Other responses that the hospitals put in place were a special HIV clinic (24.2%), autopsy services (13.3%), mortuary services (40%) and post-death counseling of the affected (65.6%).

5.2 Limitations of the study

The study was limited to private hospitals. Inclusion of other facilities that provide health care to HIV/AIDS patients may have enriched the study and its findings.

It was not possible to include small outpatient health facilities that did not qualify as hospitals because this may have resulted in a different group of study units. This may have facilitated comparison of these other health facilities with the hospitals. Also the study was confined to Nairobi, an urban population and did not look at the rural hospitals. This too would have facilitated comparison between the two populations.

5.3 Recommendations for further research

The study should cover other parts of the country other than Nairobi only and areas which are hard hit by the pandemic. This can then be compared to the hospitals in Nairobi to see how different or similar the responses are.

Other sub sectors of this industry should also be studied for example pharmacies, doctors, clinics, public hospitals and NGO's to enrich the results. This would create a wider view of what's happening in the whole health sector in response to the HIV/AIDS pandemic.

The responses adopted by private hospitals to tackle the challenge of HIV/AIDS on their businesses are good but have not been observed for a long time to determine their success. Therefore more research can be done with time to measure the success of the responses adopted today by the hospitals to the pandemic.

The pandemic affects all sectors of the economy. This research focused on the private hospitals only and did not look into any other sector. The scourge requires a multifaceted approach to bring it under control. Further research can be conducted on other sectors to find out how the pandemic has affected their businesses and how they have responded to it as well as measure the success of these responses.

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Appendix II Questionnaire

A SURVEY OF THE BUSINESS CHALLENGES FACED BY PRIVATE HOSPITALS IN NAIROBI IN RELATION TO THE HIV/AIDS PANDEMIC

Questionnaire

Introduction:

This questionnaire is basically for academic research on hospitals. It is not in any way meant to assess any given institution but rather draw a generalized opinion on the business response of private hospitals to the HIV/AIDS pandemic. The cooperation of respondents is therefore imperative and will be truly appreciated by the researcher. The researcher has made a commitment not to divulge any information or conclusion on any institution or individuals covered in the survey.

Questionnaire Design (please tick where appropriate).

SECTION A: GENERAL INFORMATION

1. Name of hospital…….. ……(optional)
2. Designation of respondent

   CEO ( ).

   Clinical director ( ).

   Financial Director ( ).

   Other (specify) ----------
3. What is the hospital's bed Capacity by number? ----------
4. How many permanent Resident medical officers does the hospital have? -------
5. How many permanent Resident Nurses does the hospital have? --------

6. What is the hospital's number of subordinate staff? ----------

7. Who owns the hospital? Tick as appropriate

Religious organization ( )

Private company ( )

Association of members ( )

Public company ( )

Trust fund ( )

Non governmental Organization ( )

Individual ( )

Co-operative society ( )

Other (specify) ----------

8. How do you classify your hospital's financial objective?

For profit ( )

Non profit ( )

9. What is the average hospital's bed Occupancy by patients by number? ---------

10. a) How many patients did you attend to in 2000? ----------

2001? ----------

2002? ----------

b) How many HIV/AIDS related patients did you attend

to in 2000?----------

2001----------

2002----------

c) How many of the patients in (b) were

	2000	2001	2002
i) Cash paying	--------	----------	----------
ii) On account	---------	----------	----------

11. What is the average number of new HIV/AIDS patients are reported every week in this hospital? ----------

12. What is the hospital's average bed occupancy by HIV/AIDS patients?----------

SECTION B: HIV/AIDS PROGRAMMES

13. Does the hospital have any kind of the following HIV/AIDS programmes?

A} Awareness programme Yes ( ). NO ( ).

B) Prevention programme Yes ( ). NO ( ).

C) Management programme Yes ( ). NO ( ).

14. Are these programmes internal or external? (internal refers to those programmes concerned with the hospital's employees while external refers to those programmes concerned with your customers, i.e. patients)

Internal ( ).

External ( ).

Both ( ).

None ( ).

15. Does your hospital run any these programmes?

a. Health Education: Yes ( ).

No ( ).

b. Counseling on behavior change Yes ( ).

No ( ).

c. Voluntary Counseling and Testing (VCT).

Yes ( ).

No ( ).

d. Prevention of Mother to child HIV transmission (PMTCT) Yes ( ).

No ( ).

e. Accidental exposure prevention programme Yes ( ).

No ( ).

16. Who runs the HIV/AIDS programmes?

Internal staff ( )

External partners ( )

Both ( )

None ( )

17. What is the motive for running these HIV/AIDS programmes?

For profit ( )

Non Profit ( )

18. What is the average frequency of visits by HIV/AIDS patients in a month?

Below 5 times ( ).

6-9 times ( ).

10 and more times ( ).

19. Are HIV/AIDS patients charged relatively more than other patients?

Yes ( ).

No ( ).

Sometimes ( ).

20. Are the HIV/AIDS patients stigmatized by the handling of the hospital staff?

Yes ( ).

No ( ).

Sometimes ( ).

21. Do you stock and sell anti-retroviral drugs to your HIV/AIDS patients?

Yes ( ). No ( ).

22. What is the average monthly cost of anti-retroviral drugs to the patient in this hospital? KSH. ----------

23. What is the average number of HIV/AIDS patients on regularly on the monthly anti-retroviral drugs in this hospital? ----------

24. What is the average the average monthly sales of anti-retroviral drugs in this hospital? KSH. ----------

SECTION C: BUSINESS CHALLENGES

25. To what extent do you consider HIV/AIDS pandemic as a business opportunity and a business risk for the hospital?

	Very high	high	moderate	low	very low
Business opportunity	1	2	3	4	5
Business risk	1	2	3	4	5

26. How would you rate the extent to which you have difficulties in dealing with HIV/AIDS patients in terms of the following? Circle as appropriate number against each of the statements.

	Very high	high	moderate	low	very low
Quality of medical care	1	2	3	4	5
Quality of nursing care	1	2	3	4	5
Catering	1	2	3	4	5
Quality of accommodation	1	2	3	4	5
Range of services offered	1	2	3	4	5
Price of services	1	2	3	4	5
Collecting payment	1	2	3	4	5
Credit control	1	2	3	4	5

Litigation risk	1	2	3	4	5

27. How would you rate the extent of change of the following within the last five years as regards your HIV/AIDS patients? Circle as appropriate number against each of the statements.

	Highly Decreased	Decreased	Not changed	Increased	Highly Increased
No. of admissions	1	2	3	4	5
No. of out-patients	1	2	3	4	5
No. of operations	1	2	3	4	5
Bed occupancy	1	2	3	4	5
Revenue	1	2	3	4	5
Staff costs	1	2	3	4	5
Outstanding debts	1	2	3	4	5
Bad debts	1	2	3	4	5

28. Do HIV/AIDS Patients fully pay hospitals bills?

Yes ( ).

No ( ).

Sometimes ( ).

Never ( )

29. Who pays the medical bills of the HIV/AIDS patients? Rate them according to their level of importance/significance.

	Very high	high	moderate	low	very low
Patients themselves	1	2	3	4	5

Patients' Relatives	1	2	3	4	5
Health Insurance co's	1	2	3	4	5
Health Mgt. Organisation	1	2	3	4	5
Employers	1	2	3	4	5
Well Wishers	1	2	3	4	5

30. How would you rate the following reasons why HIV/AIDS patients don't pay hospital bills?

	Very high	high	moderate	low	very low
a) Lack of medical cover	1	2	3	4	5
b) Medial cover excluding HIV/AIDS related cases	1	2	3	4	5
c) Financial resources exhaustion in prior medical bills	1	2	3	4	5
d) Neglect by relatives or guardians	1	2	3	4	5
e) Other (specify)----------	1	2	3	4	5

31. Does the hospital spend more resources managing HIV/AIDS cases at the expense of other cases? In terms of;

(a) Bed occupancy	Yes ( ).	No ( ).
(b) Laboratory investigations	Yes ( ).	No ( ).
(c) Radiology investigations	Yes ( ).	No ( ).
(d) Man-hour Consultancy rates	Yes ( ).	No ( ).

32. Are the staff members stigmatized in handling HIV/AIDS patients?

Yes ( ).

No ( ).

Sometimes ( ).

33. Do you have a specialized HIV/AIDS clinic/department in the hospital precincts?

Yes ( ).

No ( ).

34. Does your special HIV/Aids clinic run services of the following professionals?

HIV/AIDS specialist doctor	yes	( )	No	( )
Dietician	yes	( )	No	( )
Pharmacist	yes	( )	No	( )
Nurse educator	yes	( )	No	( )
Counselor	yes	( )	No	( )

35. Have you adopted advanced technology on investigations of specific HIV/AIDS related cases?

(a) Radiology investigation

E.g. MRI Yes ( ).

No ( ).

(b) Laboratory investigation

E.g. viral load count Yes ( ).

No ( ).

36. How would you rate the following business' risk factors likely to be encountered when dealing with HIV/AIDS patients?

	Very high	high	moderate	low	very low
a) Risk of bad debts	1	2	3	4	5
b) Risk of hospital					

Stigmatization	1	2	3	4	5
c) Risk of Government interference	1	2	3	4	5
d) Risk of litigation	1	2	3	4	5
e) Risk of patients rejecting special HIV treatment	1	2	3	4	5
f) Risk of HIV/AIDS unit affecting performance of other units	1	2	3	4	5
g) Risk of bad publicity	1	2	3	4	5

37. In the light of AIDS related death cases, do you run the following Services?

Autopsy service	yes	( )	No	( )
Mortuary service	yes	( )	No	( )
Post death counseling of the affected	yes	( )	No	( )

THANK YOU

Appendix III INTERVIEW QUESTIONS

1. Give a brief history of the hospital highlighting its key developments in dealing with the HIV/AIDS pandemic.

2. What is the role of private hospitals in the war against the HIV/AIDS pandemic?

3. How has the HIV/AIDS pandemic affected the operations and business of the hospital in the last five years?

4. What are the key business strategic responses the hospital has developed and implemented in view of the HIV/AIDS pandemic?

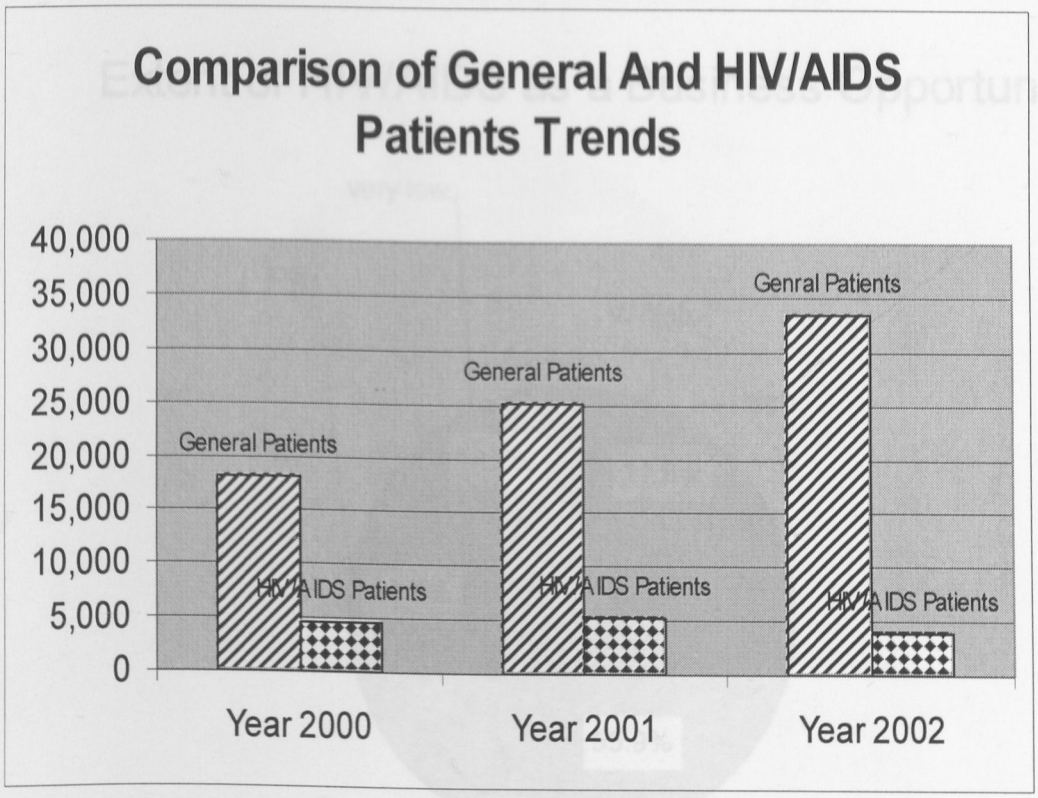
5. In your personal view, do you consider the HIV/AIDS pandemic a business opportunity or a risk? Explain your view.

6. What are the major business challenges you face when dealing with the HIV/AIDS clientele?

7. HIV/AIDS patients occupy currently over 50% of the country's hospital beds, (KMA 2003). Where does the future of private hospital business lie?

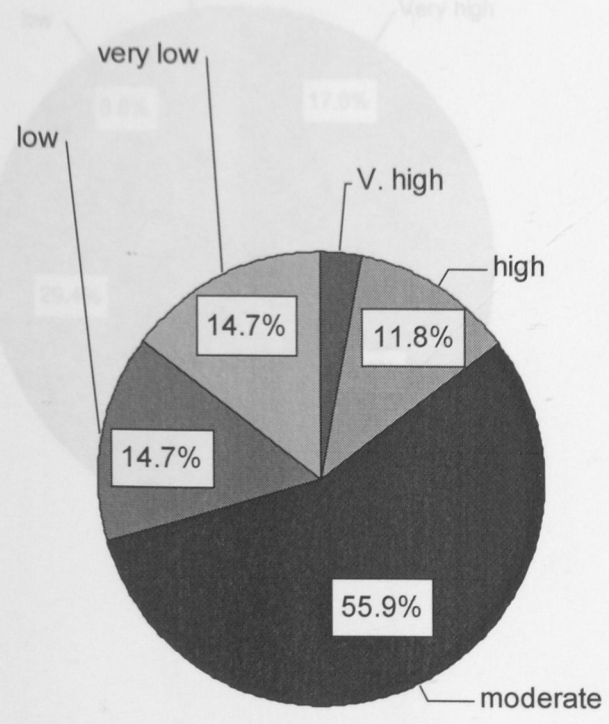
Appendix III Graphs and pie charts

Graph 2

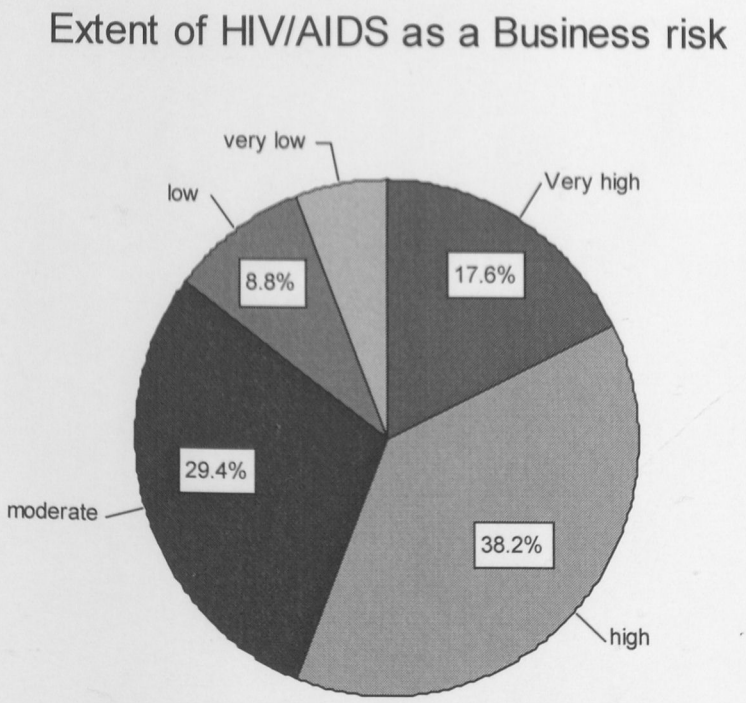


Pie chart 1

Extent of HIV/AIDS as a business opportunity



Pie chart 2


Extent of HIV/AIDS as a Business risk
very low
Very high
low
8.8%
17.6%
29.4%
moderate
38.2%
high