

**INVESTIGATION OF PUBLIC-PRIVATE
PARTNERSHIPS IN HEALTH CARE DELIVERY IN
NAKURU DISTRICT, KENYA.**

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BY

KARIUKI JAMES NGUMO

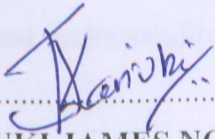
A MANAGEMENT RESEARCH PROJECT SUBMITTED IN
PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE
DEGREE OF MASTERS OF BUSINESS ADMINISTRATION
(MBA),
FACULTY OF COMMERCE,
UNIVERSITY OF NAIROBI.

NOVEMBER, 2003.

DECLARATION.

This research project is my original work and has not been submitted for a degree in any other university.

Signed:

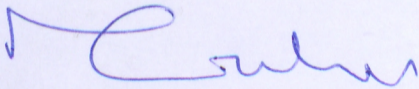


KARIUKI JAMES NGUMO

Date: 14th Nov. 2003

This research project has been submitted for examination with my approval as the University Supervisor.

Signed:



KIRUTHU Z. N.

Lecturer, Department of Management Science

Date: 14/11/2003

14/11/2003

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DEDICATION.

I would like to express my profound gratitude to my supervisor, Ms. Zipporah Karanja, for her continued support during the course research period. More specifically her ideas and their patience and understanding which have been instrumental in completing this thesis.

also extends to the Director, KEMRI, for permission to undertake this course and also for

time-off during working hours to travel for field work. Last but not the least, I wish to

Express my deep felt gratitude to Dr. David Mwangi, Director, CTRK for his invaluable

whose guidance and encouragement has inspired me throughout my pursue of education,

even when the odds appeared so insurmountable, kept assuring me that I can always make it.

Similarly, I would like to express my profound appreciations to my field assistants, namely,

Dad and Mum, I am truly indebted to you!

Mr. Peter Ngunjiri and Mrs. Carol Karanja for their assistance during my field work. On the

same note, I would like to thank all those health workers and patients who participated in the

research. This research would not have taken off without their responses and comments.

The course work and research were made possible with financial support from the Kenya

Danish Health Research Collaboration Project- KEDAHK (DANIDA funded) and I am

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Thank you all and God bless you

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Similarly, I would like to express my profound appreciations to my field assistants, namely, Mr. Peter Ngari and Ms. Carol Karanja for their assistance during my field work. On the same note, I would like to thank all those health workers and patients who participated in the research. This research would not have taken off without their responses and comments.

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Thank you all and God bless you.

ABSTRACT.

Over the past decade some of the best enterprises in the world have adopted the practice of continuous improvement. Partnership sourcing has been attributed as one of the success factors of such ventures which builds on previous innovations. Global health problems require global solutions: partnerships and to some extent mergers have been formed to provide solutions to the growing list of problems. Partnership sourcing has now taken center stage in the fight of the world's biggest killer diseases, namely, tuberculosis (TB), malaria and HIV/AIDS which require joint efforts from the government and the private health service providers. Kenya has experienced sub-optimal economic performance coupled with the rising cases of TB, malaria and HIV/AIDS epidemics. Poverty levels especially among the rural population have been on the rise. This has necessitated the government to explore the potential of partnering with the private sector so as to tackle some of the national health problems. One contrasting observation is the congestion levels at government health facilities by patients waiting for health care while in the private sector, the waiting rooms are almost empty.

The findings of this study demonstrates clearly that partnerships exist between the public and private health care providers in Kenya. However, the levels of partnerships are low and characterized by mutual awareness, without much cross functional relationships. On the other hand, available data is indicative that the government can enter into partnership with private health providers by contracting out facilities and earn rental incomes. Private providers on the other hand can source diagnostic services and

drugs from the government. This would translate into significant shifts of patients from government health facilities to private health care providers.

In conclusion, there is foundation of awareness of the potential benefits that would accrue from partnerships between the public and private health institutions. This awareness now needs to be translated into practice-al functional relationships, under mutually agreed upon terms, so as to yield the necessary results in the strengthening of the national health care delivery system.

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CHAPTER I: INTRODUCTION LIST OF ABBREVIATIONS.

1.1 Background.

AIDS	-	Acquired Immune Deficiency Syndrome
CPHR	-	Centre for Public Health Research
GoK	-	Government of Kenya
HIV	-	Human Immuno Deficiency Virus
JIT	-	Just-in-Time
KEMRI	-	Kenya Medical Research Institute
KEDADR	-	Kenya Danish Health Research Project
KNH	-	Kenyatta National Hospital
KShs.	-	Kenya Shillings
MBA	-	Masters of Business Administration
MoH	-	Ministry of Health
NGO	-	Non-Governmental Organizations
PGH	-	Provincial General Hospital (Nakuru)
QA	-	Quality Assurance
TB	-	Tuberculosis
TQM	-	Total Quality Management
USD	-	United States Dollar
UJSE	-	Union of Japanese Scientists and Engineers
UoN	-	University of Nairobi
WHO	-	World Health Organization

CHAPTER 1: INTRODUCTION.

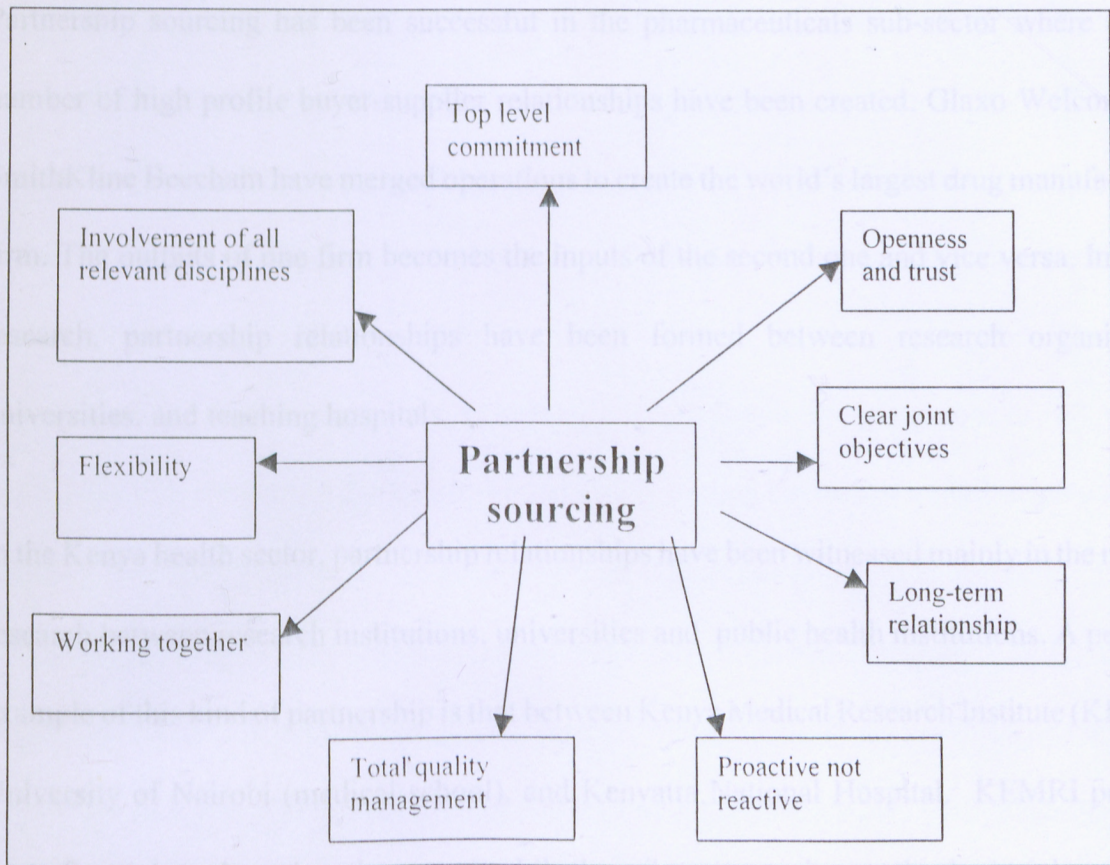
1.1 Background.

Over the past decade some of the best enterprises in the world have adopted the practice of continuous improvement. Partnership sourcing has been the success of such ventures where it builds on previous innovations such as total quality management (TQM), just-in-time (JIT) and electronic data interchange which have helped businesses to become more competitive in global markets. The concept of partnership sourcing is a simple strategy in that the customers and suppliers work together as a team. The benefits accrued include lower production costs, improved quality of products and services and quick delivery of outputs [Baily P *et al*; 1999].

Unlike mergers which are characterized by managerial take-overs and buy-outs of weak firms by superior firms, partnership relationships tend to be focused on delivery of services and products where one partner maintains their own managerial independence and complements the other's inputs.

The success in world markets of Japanese manufactured goods have led many Western countries to adopt Japanese style of management. One strategy of particular concern was that of manufacturers working closely with their suppliers so as to attempt to remove conflicts and tensions. These ideas have come to be known as "partnership sourcing" [Saunders M, 1997]. Figure 1 shows the principle characteristic of partnership sourcing noting that the whole process starts with commitment by the top-level management.

Figure 1: The principal characteristics of partnership sourcing



Source: Adopted from Baily P et al; *Purchasing Principles & Management*

Global health problems require global solutions: partnerships and to some extent mergers are formed to provide solutions to the growing list of problems [Birmingham, 2002]. Partnership sourcing has now taken center stage in the fight of the world's biggest killer diseases namely, tuberculosis (TB), malaria and HIV/AIDS which require joint efforts from the government and the private health service providers. Illness such as tuberculosis can be treated! However, it causes more mortality among adults than any other single infectious disease [Reich, 2000]. Recognition that a patient (client) comes first has been cited as one of the condition for effective management of the illness [Reich, 2000].

Partnership sourcing has been successful in the pharmaceuticals sub-sector where a large number of high profile buyer-supplier relationships have been created. Glaxo Wellcome and SmithKline Beecham have merged operations to create the world's largest drug manufacturing firm. The outputs of one firm becomes the inputs of the second one and vice versa. In health research, partnership relationships have been formed between research organization, universities, and teaching hospitals.

In the Kenya health sector, partnership relationships have been witnessed mainly in the medical research between research institutions, universities and public health institutions. A pertinent example of this kind of partnership is that between Kenya Medical Research Institute (KEMRI), University of Nairobi (medical school), and Kenyatta National Hospital. KEMRI provides drugs for trials to the university at cost, while the university carries out the drug trials and KNH provides the curative services for the patients. In Kenya, health related partnerships between public and private health services providers commonly referred to as public-private partnerships, have always existed but the benefits that are accrued from such collaborations are either limited or lacking. There is no documentation of the strengths, weaknesses, opportunities and threats of such partnerships. Yet, in other sectors such as financial and agricultural sectors these partnerships have been successful. Evaluation of the partnerships between public and private health care providers entails examination of the inputs, processes and outcomes in relation to health service delivery and outcomes.

According to the Kenya Health Policy Framework Paper Number 2 [Ministry of Health,1999], the health care service delivery system in Kenya is based on a network of health services provided by both government and non-governmental organizations. For over twenty five years, provision of public health services by the Ministry of Health (MoH) has been centrally managed and essentially free. The government has over the periods been financing all aspects of the health service delivery in the public sector. However, in the recent years, Kenya has experienced sub-optimal economic performance coupled with the rising cases of TB, malaria and HIV/AIDS epidemics. Poverty levels especially among the rural population have been on the rise. This has necessitated the government to explore the potential of partnering with the private sector so as to tackle some of the national health problems. The current health services provision indicates that 43 percent of health services in the country are provided by the private health care providers [Wang'ombe *et al* 1998]. A notable observation is the mushrooming of private clinics at major market and urban centres. These clinics are managed by health professionals who are essentially employed by the government but due to the low wages, among other issues, they opt to set-up individual clinics next to residential areas. A number of studies indicate that nearly sixty per cent of Kenya households will first consult a private health care provider who will refer them to a government facility for further management. Only about a third of the patients are retained and management at a private health care facility [Mwabu *et al*, 1986].

1.2 Statement of the problem.

Public health facilities such as district hospitals and dispensaries in the country are congested and cannot cope with the service demand. This has created a situation of inelasticity of demand. Services at these government health facilities are either free-of-charge or cost-shared. Other problems experienced in relation to health services provision include inadequate medical supplies, lack of essential drugs, and high staff turnover.

On the other hand, as indicated above, private medical providers have established a number of clinics located at residential areas in the case of urban areas and near market centres in the rural areas. However, although patients first consult them whenever an episode of illness sets in, they do refer patients to government health facilities for further management. There are mission hospitals and established private hospitals offering health services but their numbers are so few and only found in certain localities which at times are too far for patients. This increases the burden of illness that patients have to bear with.

1.3.2 Quality.

This research study aimed at investigating whether there exists any partnership between the government and the private health care providers (especially among those operating solo clinics) and if there is any linkages, what is the magnitude of such partnerships. This study attempted to carry out a situation analysis of the private health care providers targeting those clinics operated and owned by individual persons and have a physical characteristic of one-to-three rooms at most. For the purpose of getting a deeper understanding of the attitude and practices of health care managers, TB was used as a reference illness because it requires referrals between various

category of providers and takes longer patient-doctor contact period than most other illnesses. It is hoped that this will help to fill up the knowledge gap in this areas as although much is talked about the benefits of partnerships, little is documented.

1.3 Definition Of Terms.

1.3.1 Capacity.

Heizer [1996] defines capacity from an operations management point of view as the key resources that any organization deploys and defines the maximum output or limits of that organization. For the purpose of this study, capacity will be defined as the maximum possible threshold which can be attained given a set resources. A theoretical example is where given a clinic with two doctors working three hours per day are able to attend to a maximum of forty TB patients per day. That is the capacity of that facility in relation to management and care of TB patients.

1.3.2 Quality.

There are a number of overlapping ideas about quality. Different authors and scholars have defined quality in different ways.

- i. Oakland defines quality as meeting the customer requirements.
- ii. Juran defines quality as fitness for purpose.
- iii. ISO (8402, 1986) defines quality as the totality of features and characteristics of a product or services that bear on its ability to satisfy stated or implied needs.
- iv. Deming defines quality attributes as the needs of the consumer (both present and future).

v. Feigenbaum defines quality as the total composite product and service characteristics of marketing, engineering, manufacture and maintenance through which the product and service in use will meet the expectation by the customer.

vi. Crosby defines quality as the conformance to requirement.

For the purpose of this study, quality will be defined as the totality of features and characteristics of a service and products that bear on its ability to satisfy stated or implied needs.

1.3.2 Partnerships Sourcing

1.3.3 Inputs. defines partnership sourcing as a commitment by both customers and suppliers.

Heizer [1996] defines inputs are those basic ingredients such as raw materials which are used to manufacture goods or facilitate creation of services. For this study inputs are defined as the resources used to provide health care and include fixed assets such as clinics and hospital buildings, durable capital equipments like ambulances, x-ray machines, among others.

customers and suppliers or between the public and private health service providers, having

1.3.4 Public health facility: the provision of health services in both short term and long term.

This term refers to government owned health institutions or facilities such hospitals, dispensaries and clinics.

1.3.5 Public-Private Partnerships

1.3.5 Private health facility: definition where he defines partnership as having at least two

This term refers to health facilities operated and managed by non-governmental institutions like religious organizations as well as those owned by individuals. They include nursing homes, hospitals, clinics, or mobile dispensaries.

linkage between the government on one hand and private health care providers on the other hand.

1.3.6 Strategy.

Heizer *et. al* [1996] defines a strategy as a set of plans and policies by which an organization aims at gaining advantage over its competitors. It is a plan to achieve a mission. An example of a health strategy is the formation of partnership between the government and private health care providers to offer health services.

1.3.7 Partnerships Sourcing

Bailey P [1999] defines partnership sourcing as a commitment by both customers and suppliers, regardless of size, to a long-term relationship based on clear, mutually-agreed objectives to strive for world-class capability and competitiveness.

For the purpose of this study, partnership sourcing will be defined as a linkage between customers and suppliers or between the public and private health service providers, having mutually-agreed objectives in the provision of health services in both short term and long term.

1.3.8 Public- Private Partnerships

Reich [2000] provides a working definition where he defines partnerships as having at least two components requesting (seeking) party and an accepting party who are bound by common understanding and want to achieve certain goals and objectives together. In this study, a public and private partnership is an established linkage between the government on one hand and private health care providers on the other hand.

1.3.9 Consumer.

A consumer is defined as a person who consumes services or products which are outputs of a firm [Terner *e.t. al* 2001]. Customer satisfaction is now of paramount importance to any manufacturing or service organization. The objective of implementing this disciplined approach of determining outputs, identifying customers, and requirements is to enhance the supplier's ability to meet the customers' needs and expectations and, consequently, increasing customer satisfaction.

1.3.10 Total Quality Management [TQM].

Oakland [1993] defines TQM as a comprehensive approach to improving competitiveness, effectiveness and flexibility through planning, organizing and understanding each activity, and involving each individual at each level.

Arygris [1992] defined TQM as interrelationship between the organization's culture, its relationship with its customers (both external and internal) the use of organization teams and cross-functional teams., an emphasis in problem solving using teams, recognition of the need for continuous improvement; and the use of measurements to evaluate systems and practices, and to indicate effectiveness of improvement efforts. TQM thus advocates for quality as a strategy of organizational management.

The three elements of TQM as applied in this study are: "Total" which suggests wholehearted commitment. "Quality" defined by Juran and Crosby as continuously meeting customers' requirements and "Management" which implies an active process facilitated from the top.

1.3.11 Quality Assurance (Q.A) as applied in Health Service Delivery.

Oakland [1993] defines Quality Assurance (Q.A) as the broad objectives taken in the prevention of quality problems through planned and systematic activities (including documentation). These include establishment of a good quality management system and the assessment of its adequacy, the audit of the operation of the system, and the review of the system itself. For the purpose of this study, Q.A can be defined as all the activities taken to make services better. These activities build on the principles of quality management which is a systematic managerial transformation designed to address the needs and opportunities of all organizations as they try to cope with increasing change, complexity and tension within their environment.

Q.A in health care is an important issue which is seen as continuous improvement of health care delivery. One aspect of Q.A is the growing recognition that consumers of health services come first. As an advocacy channel, partnerships among health providers are encouraged.

1.4 Research Hypothesis:

The null hypothesis is listed as follows:-

H₀: Involvement of the private health care providers does not significantly reduce shifting of patients from private health clinics to government health facilities (that is they cause congestion at public health facilities).

1.5 Objectives.

1. To investigate whether there exists any partnership between public and private health care providers.
2. To determine the extent of partnership between public and private health care providers.
3. To carry out a situation analysis of quality of health care provided by health care providers.

1.6 Justification.

Over time, MoH has experienced an inadequate management information system rendering the central planning, budgeting, and control functions to grow apart from the country's needs. Furthermore, disparities between demand and availability of services due to a large population, changing diseases patterns and emergence of new ones, and a chronically poorly-performing economy has plagued the health sector.

Another issue facing the health sector is inadequate and poor distribution of health professionals. According to Central Bureau of Statistics Report [2000], there is a key

concentration of professional staff in major urban centres especially in Nairobi, Mombasa, Kisumu, Nyeri, Eldoret, and Nakuru with only 16 percent of the total population and more than 50 percent of the health sector personnel work in these urban centers. In addition, majority of specialists and sub-specialists are based here. The rural communities have to incur extra costs while seeking specialized treatment.

Communicable diseases dominate the disease burden in the poor countries [Uplekar *et. al* 2001]. TB is a public health problem and the National Leprosy and Tuberculosis Programme (NLTP) is the government department within the Ministry of Health charged with its management and control. However, there are rising number of TB cases and the government cannot cope with the growing numbers. It is because of this problem that NLTP started reaching out to private health care providers to participate in the diagnosis, management and care of TB patients. This scenario offers a conducive stage of carrying out a situation analysis in the formation of partnerships between the government and private health care providers.

In addition, the health-care sector is in itself realizing the need to adopt a patient's orientation process where patients are seen as customers and the centre of focus. This has prompted health care managers to start thinking in terms of quality of care, with a shift from a service provision "seller-oriented" to a "buyer-oriented" approach.

1.7 Importance of this study.

1. The research findings will be useful to health care policy makers and donors as it will document the challenges currently being experienced by public health care providers which hinder them from effectively participating in health care service delivery.
2. It will be useful to all health stakeholders as it will bridge the “knowledge gap” currently existing in the in the health care service delivery concerning partnership.
3. It will demonstrate the potential in the development of public-private health care service partnerships.

1.8 Dissemination of the Results.

The findings of the study will be disseminated to the university academia and policy makers at the Ministry of Health. Short versions of the findings and lessons learnt will be disseminated to communities during bazaars for their information as they continue to form linkages with various development partners in an attempt to minimizing some of the health problems facing them.

CHAPTER 2: LITERATURE REVIEW.

2.1 Public –Private Partnerships.

What is a public-private partnership? Although views differ, Reich [2000] highlights three key-points. Firstly, partnerships involve at least one private-for-profit organization and at least one not-for-profit organization. Secondly, the core partners provide a sharing of efforts and benefits. Finally, partnerships in public health are committed to the creation of social value (improved health), especially for disadvantaged population. Porter [1998] advocates that combining different but related businesses could create value through synergy which has been successful in small firms that would like to maximize their returns and also overcome their problems. In the health care industry, health institutions globally are forming partnerships so as to create synergy that work to their advantage thus reducing industrial competition in an ever “shrinking” global market.

2.2 The search for quality.

As many countries began to build their economies after the 2nd World War, one issue that became the focus of manufacturing firms was production management. This evolved to become operation management. Operation management is defined as the total of management activities that an organization uses to transform resources into products and services. Operation decisions encompass virtually all aspects of the operations management system namely production, marketing, human resources and technology issues.

Quality era started around 1940s with pioneering works of Deming, Juran, Crosby, Taguchi, and Ishikawa. During this period, mass production of goods was the norm. Little attention was paid to attributes of the product and customers' requirements.

The earliest work on quality could be associated with the works of Edwards Deming. In the late 1930s, Deming was responsible for mathematics and sampling at the United States Bureau of Census. His methods of statistical control achieved great improvement in the productivity and quality of the 1940 census. His work led to invitations to train industrialists and military personnel to quality improvement. Deming based his work on advanced statistical methods. He helped the Japanese business community adopt the concepts of quality.

Deming's main argument against traditional quality control was that it focused on the product rather than the process. Keeping down the number of defective products delivered typically meant high expenditure on inspection and rework. He advocated the use of statistics to measure process variability which was the major cause of poor quality. Thus he argued for continual investigation and fine-tuning to incrementally improve production system. He is accredited with the development of the Plan-Do-Check-Act (PDCA) cycle. Participation of everyone in the process was, at the time, a revolutionary notion.

Kaoru Ishikawa was a professor at the University of Tokyo who advocated ideas on quality before the Second World War. He founded the Union of Japanese Scientists and Engineers (UJSE) which became the focus of Japan's quality developments as its economy recovered.

Ishikawa advocated that the notion of customers being both internal and external was important to the organization. He also popularized the fish-bone analysis diagram as a problem investigation tool as well as other techniques.

Ishikawa observed that western management practices could not be grafted on to Japanese habits. He was a pioneer of quality circles which emphasized the role of the group in working and learning. His first quality circle was at Nippon Telegraph and Cable (NT&C) in 1962. By 1978, there were more than one million quality circles in Japanese manufacturing industry.

The background of Joseph M. Juran was in statistics. He also had a strong influence on Japanese managers, being linked to Ishikawa's UJSE. At that time many Japanese workers were illiterate and posed a hindrance to the introduction of quality processes.

Juran founded a training consultancy, the Juran Institute, and through this, spread his ideas about partnerships and teamwork, internal customers, problem solving techniques and application of Pareto analysis to quality issues. He was concerned about fitting quality improvement programmes into a company's current strategies and plans to minimize the risk of their being rejected. In this approach he differed from Deming's more conservative adherence to the idea of matching specifications.

Taguchi Genichi contributed to the development of industrial standards in Japan. His strength was in application of statistical methods, not in quality control where they had already found wide application, but in improving products and processes. Criticism was leveled at his work on use of statistics as being inefficient and cumbersome.

Philip B. Crosby authored a book entitled "Quality is Free" at the pinnacle of his career. He developed TQM programmes when he was a manager at International Telephone and Telegram (ITT) company. With credibility founded on his experience and well-documented examples of uncovering the costs of waste, scrap and re-works, Crosby became well known in the field of quality management.

His zero-defect strategy became important because the costs of poor quality were at that time seriously under-estimated. The zero-defect strategy became a part of quality management and had "*four essentials*" namely:-

1. Quality as conformance to requirements. Crosby advocated that a product either conforms or it does not. There was no such concept as "good" quality and quality had nothing to do with notions such as elegance.
2. Prevention is the route to achieve conformance, not appraisal.
3. Zero defects is the only acceptable performance standard.
4. Quality is assessed by the cost of non-conformance.

Crosby's contributions to TQM was more behavioral which stressed on management and organizational processes rather than the application of statistical methods.

2.3 Adversarial versus partnership approaches. (buyer relationships)

Saunders [1999] argues that partnership sourcing involves much more than simply picking a supplier or a contractor for each requirement in isolation. It involves continuing relationships, both with preferred sources which are actually supplying goods and services, and with potential sources which may have been passed over for the customers.

David Ford [Saunders 1999] developed five stages in the development of buyer-seller

The partnership model for buyer-supplier relationships is often contrasted with that of the adversarial model. The latter is characterized as being of an “arm’s length nature”, which relies on formal paperwork communications rather than personal contact. It is seen essentially as a short-term, competitive sourcing approach, which can lead to frequent changes of suppliers. Outcomes of adversarial or competitive behaviour are perceived in terms of “win-lose” results. Partnership model is held up as possessing the possibility of a “win-win” outcomes – both sides winning simultaneously, through the adoption of problem-solving approaches, for example, to resolve any difficulties.

As firms develop a strategic role for purchasing and supply management, so the implementation of that role is likely to lead to closer working relationships between buyers’ and suppliers’ organization and their representatives. The way in which these relationships are managed on an interpersonal basis can be expected to have a material effect on the results obtained. Co-operation between the parties within a partnership model, it is suggested, will produce greater benefits than with the traditional adversarial model.

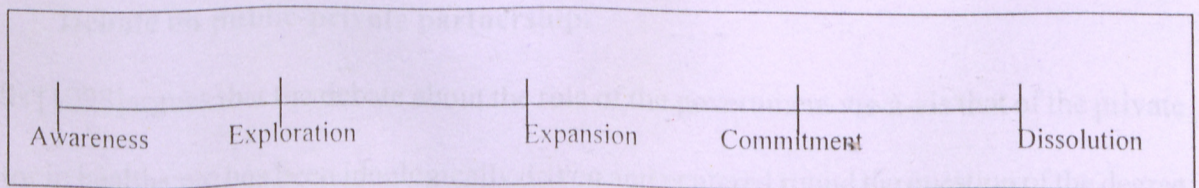
2.4 Life Cycle of Partnership sourcing (buyer-supplier relationships).

A life cycle perspective of buyer-supplier relationships recognized that they develop and change over time. Accepting this premise, then management of the relationships may also be varied at different stages in the life cycle.

David Ford [Saunders, 1999] developed five stages in the development of buyer-seller relationships. As the relationship progresses, so experiences of each other's performance help to reduce uncertainty and social exchanges increase trust between the parties. Also norms, values and working methods are brought together, closer in line with each other as time passes and as each makes adaptations to the other. Figure 2 shows the relationship life cycle. He identified the stages as:-

1. Pre-relationship stage (awareness)
2. Early stage (exploration)
3. Development stage (expansion)
4. Long-term stage (commitment)
5. Final stage (dissolution)

Figure 2: Relationship (partnership) life cycle.



Source: Saunders et. al: Strategic Purchasing of Supply Chain Management.

Cox suggests that relationship strategies need to be based upon a 'portfolio' approach, with different approaches being selected for different situations [Saunders, 1997]. He justifies this in considerations of competences or capabilities, ideas reminiscent of discussions regarding business strategies, as a whole, and 'make or buy' studies, in particular.

He further suggest that partnerships should be tailor-made for each partner and/or commodity or service purchased. The progress in the development of a particular partnership needs to be regularly monitored by those involved, often a multi-functional buying team in the customer company.

Despite the advantages that mergers and 'take-overs' presented to managers, they did not solve leadership crisis experienced at that time and instead companies opted to come into partnership. Partnership does not involve full acquisition of the franchise as is the case of mergers but involved limited participation in joint ventures for the benefit of the stakeholders and its customers. As at the end of the 20th century, partnerships became a norm instead of creating business rivals which cut down on stiff competition. The focus turned to the consumers of the product and service, and not the product or service characteristics.

2.5 Debate on public-private partnership.

Mills [1998] argues that the debate about the role of the government vis-à-vis that of the private sector in health care has been ideologically driven and centered round the question of the degree

to which health care is like any other physical product. However, it is increasingly acknowledged that there is no single "correct" mix of the public and private roles.

In the literature on the role of the private sector in provision of health care, a number of alternative scenarios are presented for the way in which the public sector might work with the private sector. For example, sometimes public and private sectors are seen as competitors and it is suggested that efficiency will be enhanced by promoting competition between providers, be they publicly or privately owned. However, much of the public health literature emphasizes on the role private providers play as collaborators in the endeavor to improve coverage by the public health services [Swan and Zwi, 1997].

The World Development Report [1993] placed considerable emphasis on the idea of the public and private sectors offering complementary services; while the public sector provides the core cost-effective services, provision of less cost-effective service could be left to the private sector.

Mills further argues that despite the heterogeneity in the private sector services there are potential incompatibilities between the roles of competitor, collaborator and complementary service provider which need to be thought through.

2.6 Global trends.

Recent trends in public health have shown an increasing partnership with private-sector organizations. This is also evident in international development relating to health issues,

particularly in efforts to expand access to drugs and vaccines in poor countries. The World Health Organization-W.H.O [2000] recognized that successful tuberculosis (TB) control depends on a partnership and not just between private and public health professionals, but it necessitates a high quality medical and public health practice, good politics, social and economic engagement and community involvement.

The trend is clear and widespread. But why has the issue of public-private partnerships become so prominent on the international policy agenda at this time? One reason is that new public health problems are being pushed on to the international policy agenda by non-governmental organizations that have gained influence in the past two decades. Subsequent problems often include less equity in health care access and an increasing gap between those with and those without adequate means [Paul *et. al*, 2000].

Traditional public health groups are confronted by limited financial resources, complex social and behavioral problems, rapid disease transmission across national boundaries and reduced state responsibilities. At the same time, private-for-profit organizations have come to recognize the importance of public health goals for their immediate and long-term objectives, and to accept a broader view of social responsibility as part of the corporate mandate. Pharmaceutical companies, for example, have become involved in a number of high-visibility drug donation programs based on partnerships and mergers. In short, both public and private participants are being driven towards each other, with some amount of uneasiness, to accomplish core objectives [Smith R, 2000].

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2.7 The health sector stakeholders.

Establishing partnerships involves carrying out a stakeholder analysis which is the process of identifying key industry players and movers. The purpose is to assess and document their interests, conflicts, and identify relations between them that may enable coalitions or mergers. [Quality Assurance Project Manual, 2000]. The term “stakeholder” refers to any persons, groups, or institutions with an interest in a project or programme.

In the context of this study, stakeholders in the health industry will mainly comprise of public health sector - these are government facilities comprising of provincial, district, sub-district hospitals, and dispensaries (offering preventive and curative services) and the formal Non-Governmental Organizations (NGOs) consisting of the private-for-profit facilities and private-not-for-profit facilities. The private-not-for-profit consist of mission hospitals and dispensaries. The private-for-profit entail the privately owned clinics, dispensaries, nursing homes, maternity and private hospitals. Their charges are slightly higher than either the private-not-for-profit institutions. Other categories of the non-governmental health care providers include the community based types such as chemists/pharmacies, shops, community initiatives and the indigenous sector. This category of providers is included in the private-for-profit facilities.

2.8 Situation of private health sector in Kenya.

The private health sector has a significant presence in Kenya. According to the Kenya's Health Policy Framework Paper Number 3 of 1994, twenty nine per cent (29%) of all health facilities

are private for-profit. The Government expenditure on health has increased seven folds in 17 years but in real terms the per capita expenditure on health declined three folds, from USD 9 to USD 3.

Wang'ombe *et. al* [1998] argues as a point of concern that increased demand/utilization may outstrip their capacity on non-governmental facilities at least in the short run. Financial sustainability is another problem faced by this category especially for private clinics and nursing homes. In summary, the issues revolving around non-governmental health care sub-sector are affordability, acceptability, availability, quality, efficiency and cost effectiveness, equity, sustainability, and the balance between support and control.

2.9 The Community.

Communities have always preferred public health facilities. Two studies done by Wang'ombe *et. al* [1998] and Mwaniki *et. al* [1997] found that between 60 to 80 percent of households usually sought care from government health facilities while between 20 to 40 percent sought care from non-governmental facilities. About three percent sought care from traditional healers and herbalists. Muthami *et. al* [1998] found that community participation is a key issue, which has proven to support programmes that benefit the community. Results from a community participation in malaria control survey indicated that community members do realize their common health problems and take part actively to overcome constraining factors. The principle factor that influence households' choice of health care sources are pricing of services and quality issues. Findings also show that government health facilities were chosen by same households

for these reasons; relatively lower fees, nearness to the facility, availability of qualified personnel, and availability of specialized care. For those households that sought health care from non-governmental facilities, the principle factors were drug availability, shorter waiting time, availability of specialized care, and courteous reception by staff.

However, a small-scale study by Litvack and Bodart [1993] found that when user-fees were accompanied by improvement of quality at public facilities, utilization by the poor increased, suggesting that there was a positive effect on quality. For the purpose of this study, the patients seeking treatment for TB illness will represent the views of the community so as to get insight into their health seeking behavior patterns, preferred choice of provider, and quality of the health care services.

CHAPTER 3: METHODOLOGY.

3.1 Study area and population

Nakuru has a variety of health institutions including four hospitals, five dispensaries, two nursing homes and over one hundred private health clinics. The main providers of health services include the government (Provincial General Hospital), Municipal Council of Nakuru (which runs two health centres and four dispensaries), religious and non-governmental organizations as well as private practitioners' clinics. These health facilities are generally well distributed within the Central Business District and in residential areas. However, services are scarce in pre-urban areas.

Using a purposive sampling approach, all the health care providers were divided into distinctively four categories based on their ownership or formation. Group 1 consisted of private health hospitals and nursing homes (*abbreviated as PH in the analysis section*). The second category consisted of religious and non-governmental organizations (*abbreviated as MISSIONs in the analysis section*). The third group was the government health facility (*abbreviated as PGH in the analysis section*). This group consisted of one facility that is the Provincial General Hospital. The final category consisted of private practitioners (solo ownership of facilities). This group was further sub-divided into two sub-groups namely degree holders (*abbreviated as MDs*) and diploma holders/community nurses (*abbreviated as COs*).

3.2 Study design

3.2.1 Cross-sectional survey:

This survey was carried out by interviewing health care providers on pertinent issues relating to health services delivery. Issues discussed included costing of services, quality issues, linkages and collaboration within and across various provider categories. This was essential to establish whether there exists any linkages and to what extent with reference to TB health service delivery.

Patients were also interviewed concerning their perception of the quality of services offered. Specific information was sought concerning why they were referred, what they thought about the staff, status of equipment, and cost of service rendered to them given their social-economic status.

3.3 Sampling frame.

From previous studies by Wang'ombe *et. al* and Muthami *et. al*, about 50% of patients first attend a private health facility to seek treatment for their illness. Sample size of patients was determined using the formula given below.

$$n = z^2_{1-\alpha/2} / [P(1 - P)] d^2$$

where

n= sample size

$z^2_{1-\alpha/2}$ = standard error for the mean (value = 1.92)

P = proportion of patients attending any health care facility (value = 50%).

d^2 = absolute precision level (set at 5% significant level).

Using 95% confidence level, this sample size yields 395 patients which was rounded up to give 400 patients. Thus each category of facility was to have 100 patients participate in the research.

3.3.1 Public health facilities:

The Rift Valley Provincial Hospital was considered sufficient for the study and was considered reference point for the other health facilities. The respondents to the interview were the hospital administrator and the clinical officer who attends to patients at the chest clinic. Specific information obtained included their perception about partnering with private health care providers, how to ease congestion at public health facilities and also their perceived strengths, weaknesses, opportunities and challenges they face in providing health care.

3.3.2 Private health providers:

All the 106 private health facilities were visited. Interviews were conducted by trained field workers with pre-tested questionnaires. However, only 49 providers participated in the interview. Majority of other health care providers were either specialists or refused to participate in the interview.

3.3.3 Patient interview:

Due to the constraints of time, financial resources, and limited TB patients attending private health facilities only 75 patients participated in the interview as they prepared to leave various clinics after collecting their drugs or prescriptions. The researcher had to interview additional

patients at the Provincial General Hospital for only those patients who had been referred from the private health facilities. This was to cater for low number of TB patients interviewed at the private facilities.

3.3.4 Focus Group Discussions.

A total of 5 key informants participated in the study. They included the Nakuru district health coordinator, a private pharmacist, an insurance agent, the Nakuru Provincial General Hospital administrator, and a consultant chest physician. Issues discussed included whether the government can contract out services to the private sector and what law(s) need to be in place for effective participation of all health stakeholders.

Also eight prominent private health service providers were selected at random depending on their years of experience. This provided extra information upon probing for additional information relating to subject matter.

CHAPTER 4: DATA MANAGEMENT

4.1 Data collection and management

Data was collected from a pre-tested questionnaire for a period of 3 months. Between the period of October through to December 2002 with the assistance of 2 field assistants who had initially been trained in questionnaire administration. The information was validated for consistency. Open-ended questionnaires were coded (that is assigning numeric digits to statements based on key words) and subsequent entry into the computer using MS ACCESS software. Validation and descriptive statistics were carried out using Statistical Package for Social Sciences (SPSS/PC+)TM software.

4.2 Data Analysis.

Data was analyzed using SPSSTM software. Analysis of data was carried out by category of providers to establish factors attributable to existence of linkages between the provider category using a weighted proportion of averaged for selected variables. Descriptive statistics were used to describe characteristics of the sample population while Chi-square test was used to establish whether there was a significant difference observed and expected outputs in the provider category.

A scoring system was also constructed with the help of a counting system. Each count corresponded to the attributes defined as indicative of a process as outlined in Figure 2. The counts were then summed up to give overall totals and percentages which reflect the magnitude of linkages between the public and private health care providers.

4.3 Data Limitation.

Due to the constraints of time, the targeted 100 patients per category was not attained. This resulted to the research team interviewing close to 250 patients at the Provincial General Hospital which is a government facility so as to make up for the significantly low number of respondents interviewed at private health care facilities. However, these patients must have been referred to the facility from a private health provider. In addition, not all the medical doctors who were approached and were given questionnaires responded. The research team had to revisit some of the facilities at least 6 times before a questionnaire was declared lost to follow. About 75% of all the questionnaires were returned to the research team.

Facility Type	Number of Patients	Number of Doctors
Private Hospitals & Nursing Homes (PH)	6	12
Private Clinics	17	26
General Practitioners (GPs)	23	48
Provincial General Hospital (PGH)	149	109

CHAPTER 5: RESULTS.

5.1 Situation analysis.

A total of 49 providers responded to the interview. Except for clinical officers (CO) who had 58.3% of them having been operational for less than 5 years, the other health facilities (over 50%) had been in operation for more than 10 years.

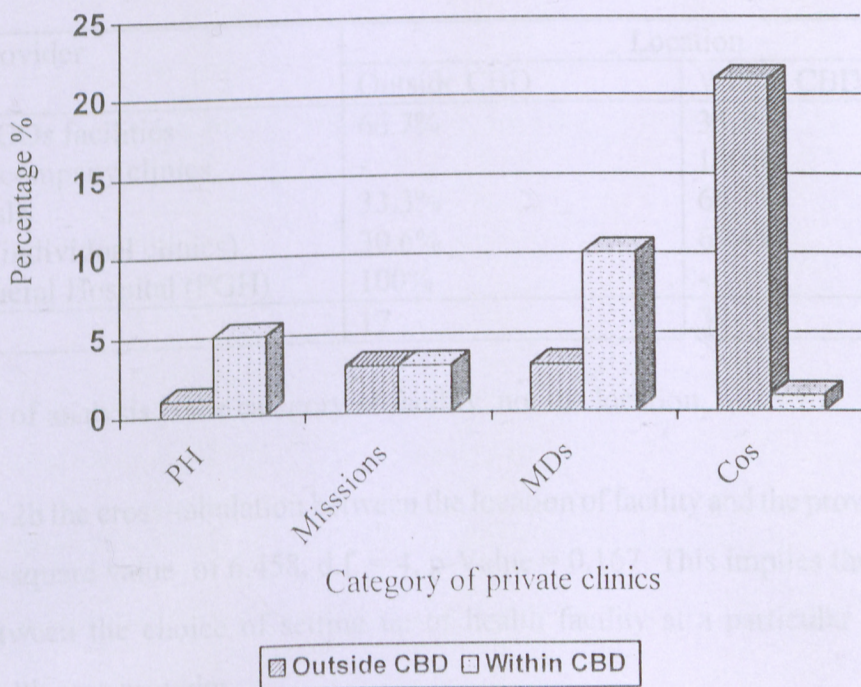
Table 1: Distribution of health care providers by category.

Provider category	Frequency	Percentage (%)
NGOs & Mission facilities (Missions)	6	12.2
Private Hospitals & nursing homes (PH)	6	12.2
Solo practices		
1. Degree holders (MD)	13	26.5
2. Clinical officers & community nurse (COs)	23	46.9
Provincial General Hospital (PHG)	1	2.0
Total	49	100

Distribution of facilities indicated that most of the facilities were located around commercial areas and congested residential areas. This acted as catchments for the health seeking clients who visit the nearest health facility. Figure 3 shows the location of health facilities.

The location of MDs against that of COs was found to be statistically significant ($p < 0.02$, Chi-square 13.5, d.f. = 2). A significant proportion of the MDs were located within the CBD (implying they are specialists / consultants) from lower level facilities while COs are predominately located at residential areas implying they are the first line of consultations. They presumably refer patients upwards (i.e. they can act as filter clinics).

Figure 3: Distribution of locations of various private health facilities.



Range of services

- All the PHs and Missions offer primary health care services (PHCs) i.e. preventive and promotive health services.
- The solo practices offer limited services and often refer patients upwards (i.e. to the next higher level facilities). Table 2a shows the range of services offered while table 2b shows the physical location of providers.

Table 2a: Range of services offered by solo practices.

Service types	Solo practices	
	MDs	Cos
Integrated health services	100%	98%
Lab and Diagnostics	23.1%	12.5%
Specialized clinics	23.1%	25.0%
FP/MCH	15.4%	41.7%
Counselling	15.4%	4.2%
Minor surgery	7.7%	8.3%
Promotive & Pharmacy	15.4%	4.2%
Total*	26	52

Total * - allow for multiple responses.

Table 2b: Distribution of providers by location.

Category of provider	Location	
	Outside CBD	Within CBD
Missions & NGOs facilities	66.7%	33.3%
Institutions & company clinics	-	100%
Private hospitals	33.3%	66.7%
Solo practice (individual clinics)	30.6%	69.4%
Provincial General Hospital (PGH)	100%	-
Total	17	32

Note: The unit of analysis is the category of facility not the location.

From the table 2b the cross-tabulation between the location of facility and the provider category returned a Chi-square value of 6.458, d.f. = 4, p-Value = 0.167. This implies that there was no correlation between the choice of setting up of health facility at a particular location and category of health care provider.

The number of patients were found to be evenly distributed across the various category of providers thus demonstrating that choice of facility by a patient is based on other factors and not popularity or nearness to the facility. Table 3 shows the number of patients attending clinic in a given typical week.

Table 3: Number of patients attending clinic in a given week by provider

Number of patients attended to per week		PHs	Missions	Solo practice	
				MDs	COs
New cases	Mean (s.d)	39.8 (s.d. 31)	91 (s.d. 106)	26 (s.d. 27)	26 (s.d. 43)
	Median	36	49	20	10
	Min – max	3 – 85	13 – 300	5 – 100	2 – 200
Old cases – revisits/re-attendances	Mean (s.d)	46 (s.d. 32.4)	64 (s.d. 75)	37 (s.d. 56)	36 (s.d. 52)
	Median	56	32	20	11
	Min – max	3 – 80	5 – 200	2 – 200	3-200
Total		6	6	11	23

Figure 4: Knowledge of existence of partnerships

Clinic operating hours: In a typical day, the MD group of clinics operate for an average of 10 hours per day (s.d. 1.7, min 8, max 15, n= 13) while the CO group operate for 11 hours per day (s.d. 1.6, min 8, max 15, n = 23).

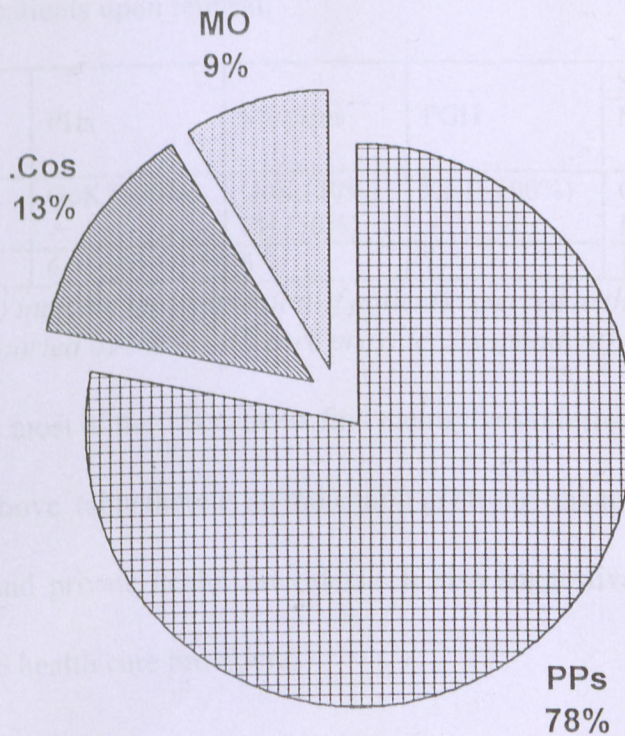
Availability of clinicians: The MD group are usually available in their clinics for a mean of 6.5 hours per day (s.d. 2.4, min, 3, max 10, n= 13). The CO group are available for a mean 9 hours per day (s.d. 2.4, min 4, max 12, n= 23). The Chi-square value = 0.925, d.f. = 5, p-Value=0.89. This implies there was no statistical significance between the availability of the clinicians and workload (that is the number of patients attending the clinic per any given week).

5.3 Objective 1: Existence of linkages between public and private health care providers.

A total of 18 out of 24 health providers have heard about partnership. In the solo category, 3 of 12 medical doctors reported that there were some form of partnership between the private health service providers and public health service providers. All the other category reported that there was no formal existing partnership. Figure 4 show the proportion of providers who reported that they have heard and participated in a partnership programme with the government in providing TB health service care.

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Figure 4: Knowledge of existence of partnerships



Of the 6 private hospital, 2 providers reported that they source drugs at the government stores. At the public health facility, the respondents reported that they sourced specialized x-ray services from private hospitals. None of the 2 facilities reported having a formal agreement with any government organization. Services were based on ability to pay.

On the issues of referrals and linkages between all categories of providers.

- The PHs category, all 6 respondents reported that they refer TB patients to other facilities.
- In Missions category, 4 out of 5 respondents refer TB patients to higher facilities.
- In the solo practices:- 12 out of 13 MDs and all 24 COs refer to higher facilities.

Table 4 shows the movement of patients from facility to facility.

Table 4: Destination of patients upon referral.

Rank	PHs	Missions	PGH	Solo practice	
				MDs	Cos
Most important referral point 2 nd referral facility	GoK (100%) -	GoK (50%) PH (50%)	KNH 100%) -	GoK (80%) PH (20%)	GoK (80%) PH (20%)
Total	6	6	1	13	23

Note: The parenthesis (%) indicate the proportion of patients referred to those higher facilities which are estimates as reported by the health care provider (respondent).

It is important to note that most of the TB patients find themselves referred to the government health facility. From the above table there is an indication of strong linkages existing between public health providers and private health providers. It also suggestive of weak linkages between private-to-private health care providers.

5.4 Objective 2: Association of partnership between public and private health care providers.

Table 5 shows the various attributes that were used to assess magnitude of partnership between public health facility and private health care providers.

Table 5: Attributes used for the partnership of magnitude of partnership between public and private health care providers.

Attributes	Category and elements assessed
Inputs	
Staff sharing	• Work part-time in public health facility
Equipment and laboratory facility	• Does the facility have x-ray and laboratory services? (no)
Training & seminars	• Has the provider attended any seminar in the past one year?

Attributes	Category and elements assessed
	(yes) <ul style="list-style-type: none"> • Has the provider attended any post qualification training? (yes)
Processes	
Affordability	<ul style="list-style-type: none"> • Do provider refer patients on issues relating to unaffordability of services (yes)
Accessibility	<ul style="list-style-type: none"> • Is the private facility located within 3-5 kms radius to a public facility? (yes)
Acceptability	<ul style="list-style-type: none"> • Do you refer patients with clinical notes to a public health facility? (yes) • Are the same procedures repeated again at public health facility? (yes: patients to respond).
Utilizations	<ul style="list-style-type: none"> • Does the facility receive more than 5-10 TB patients per week (yes)
Efficiency	<ul style="list-style-type: none"> • Do patients queue for more than 30 minutes before being attended to? (yes) • Are there any missing components hindering patient management? (yes)
Outcomes	
Referrals	<ul style="list-style-type: none"> • Were patients referred to another facility for any service? (yes)
Deaths	<ul style="list-style-type: none"> • Were there any deaths reported in this facility relating to TB illness? (yes)
Unaccounted patients	<ul style="list-style-type: none"> • Were there any patients who started on treatment and later abscond treatment? (yes)

Note: The parenthesis() are indicative of the valid response for scoring purpose.

Source: research findings.

From Table 5, a total score and percentages were computed for each category of health provider with the exception of the PGH which was taken as a reference point. Table 6 shows that MDs (45.6%) and the COs (45.2%) categories have high degree of partnership with the public health facilities compared to PH (26.9%) and Missions (33.3%). The table is further suggestive that the MDs and COs facilities lack essential attributes in the process aspects which leads to their reliance on other facilities for further diagnosis and management of patients.

Table 6: Attributes of partnership between public and private health care providers.

Attributes	Number of positive responses (counts) within attributes			
	PH category	Missions category	MDs	C.Os
Inputs:				
<u>Staff sharing:</u> Do any staff work part time at a GOK facility?	0	1	10	15
<u>Equipment/Lab services:</u> Does facility have a functional x-ray facility/laboratory?	4	6	1	3
<u>Training/seminars:</u> Attended any seminar in last 1 year?	0	0	6	2
<u>Training/seminars:</u> Attended any post-qualification?	0	2	12	5
Processes:				
<u>Affordability:</u> Refer patients on cost issues?	3	2	9	19
<u>Accessibility:</u> Located within 3-5 kms radius to PGH?	6	4	10	8
<u>Acceptability:</u> Any procedures repeated again at PGH?	3	3	10	23
<u>Utilization:</u> Does facility receive > 5 TB patients per week?	1	4	3	6
<u>Efficiency:</u> Do patients queue > 30 minutes?	0	0	4	12
Any missing components thus hindering diagnosis?	1	0	6	20
Outcomes.				
<u>Referrals:</u> Are patients referred to PGH from here?	0	1	4	12
<u>Deaths:</u> Has there been any deaths due to TB in this facility?	1	0	2	1
<u>Unaccounted patients:</u> Any patients who absconded treatment under your care?	2	3	0	9
Total score (percentages)	31 (26.9%)	26 (33.3%)	72 (45.6%)	135 (45.2%)
Grand Total (total sample * total attributes 13).	78	78	169	299
Total sample size	6	6	13	23

5.5 Objective 3: Situation analysis of quality of care by category from patients perspective.

A total of 75 patients were interviewed as they prepared to leave the various category of clinics. A total of 52 patients were interviewed at PGH, 2 patients interviewed at Missions, 3 patients at PH, 4 patients interviewed at MDs clinics and 14 interviewed at COs clinics. From a selected facet that reflect on issues relating to quality, Missions category had the highest overall quality index of 76% (from a total of 25 points out of possible 55). The lowest quality index was observed with the MDs and COs categories that had an index of 45.5% and 38.6% (from total of 25/55 and 56/145) respectively. Table 7 shows the distribution and quality index score by category of provider.

Table 7: Quality index score by providers as reported by the patients.

Selected quality facets.	Valid count with the characteristic				
	PGH	PH	Missions	MDs	COs
Physical infrastructure:					
1. Water to wash hands (yes)	50	3	0	0	4
2. Toilets with water (yes)	50	2	1	0	2
3. Clean clinic floor	25	2	1	2	2
4. Reading materials available	0	3	1	3	4
5. Was TV on during waiting time? (yes)	0	3	1	2	3
Sub total (percentage)	125 (50%)	13 (86.7%)	4 (80%)	7 (35%)	15 (30%)
Total	250	15	5	20	50
No. of patients with valid responses	50	3	1	4	10
Drugs and physical examination:					
1. Were all anti-TB drugs available? (yes)	52	0	2	0	0
2. Was any x-ray/lab services available? (yes)	52	2	1	2	0
3. Was any medical history taken? (yes)	52	1	1	3	9

Selected quality facets.	Valid count with the characteristic				
	PGH	PH	Missions	MDs	COs
4. Was any physical examination done? (yes)	52	1	1	1	9
5. Did you take <30 minutes before seeing a doctor? (yes)	10	2	2	2	6
Sub total (percentage)	218 (83.8%)	6 (60%)	7 (70%)	8(53.3%)	24(48)
Total	260	10	10	15	50
No. of patients with valid responses	52	2	2	3	10
Health workers-patient interaction and health education:-					
1. Was discussion with doctor interesting? (yes)	32	2	2	4	9
2. Did the doctor explain all procedures he was carrying out? (yes)	12	0	2	3	5
3. Any education given to you about TB as an illness? (yes)	5	1	1	1	1
4. Any education relating to medication intake? (yes)	2	1	1	1	1
5. Any education relating to clinic return dates? (yes)	15	1	2	1	1
Sub total (percentage)	66 (41.3%)	5(50%)	8(80%)	10(50%)	17(37)
Total	160	10	10	20	45
No. of patients with valid responses	32	2	2	4	9
Overall total quality index score (percentage)	409 (61%)	24 (68.6%)	19(76%)	25(45.5%)	56(38)
Grand Total	670	35	25	55	145
Sample size (patients)	52	3	2	4	10

5.5.1 Cost of treatment.

Part of the large influx of patients to public health facilities is due to cost of service. Assuming that availability of anti-TB drugs is a constant factor (that is, drugs are available to all facilities), other costs such consultations and diagnostic services will still cause a significant shift of patients to the public health facility. Table 8 shows cost structure by health care providers.

Table 8: Cost structure by provider category.

Provider category	No. of respondents (N)	Mean (s.d.) Kshs.	Minimum Kshs	Maximum Kshs.	Median* Kshs	
PH	1 st consult	6	241.6	200	350	-
	fee	6	(66.5)	100	350	-
	2 nd consult	3	195 (92.5)	150	280	-
	fee	4	210 (65.6)	400	780	-
	Lab services	1	607.5	-	-	625
	X-ray Anti Tb drugs		(157.8) 6,000			
Missions	1 st consult	5	500	100	1950	150
	fee	3	(811.6)	100	1600	150
	2 nd consult	2	616	100	300	200
	fee	1	(851.9)	-	-	-
	Lab services X-ray		200 (141.4) 500			
PGH	Lab services	1	50	-	-	-
	X-ray	1	300	-	-	-
MDs	1 st consult	10	315	200	600	-
	fee	8	(137.5)	100	500	-
	2 nd consult	1	250	-	-	-
	fee X-ray		(146.4) 600			
COs	1 st consult	17	157.6	50	300	-
	fee	13	(72.4)	50	250	-
	2 nd consult	2	123.1	80	100	-
	fee	2	(56.3)	50	2,500	1,275
	Lab services		90 (14.1)			
	Anti Tb drugs		1,275 (1,732)			

Key: s.d. - standard deviation

Median* - this value is given to circumstances where s.d. equals or is greater than the mean value.

Most of the patients pay cash for services provided to them. This is consistent with previous study by Mwabu *et. al* [1999] whose findings indicated that choice of facility is largely a function of income levels. Table 9 shows the payment methods used by various patients.

Table 9: Method of payment for services offered by provider.

Payment method	PHs	Missions	PGH	Solo practices	
				MDs	COs
Cash	90%	80%	90%	80%	70%
Credit cards/cheques	5 %	5%	5%	15%	2.5%
Company schemes/insurance	2.5%	5%	5%	2.5%	2.5%
Waivers	-	10%	-	-	15%
Others (special arrangement)	2.5%	-	-	2.5%	10%
Total	6	5	1	11	24

The parenthesis indicates the proportion of patients who use that particular method of payment.

5.6 Focus Group Discussions: Partnership sourcing of health care in Kenya among service providers.

Four respondents from private nursing homes and one hospital administrator reported that they are having a working relationships although with no memorandum-of-understanding (MOU). They partner with private companies, and 3 government parastatals concerning offering of service to employees and family members in a pre-designed medical schemes.

The Nakuru District Medical Officer of Health cited that non-existence of laws covering formations of health teams makes partnership sourcing between the private and public very difficult. He noted that public facilities are funded by Exchequer and are essentially “free of charge” while those at private institutions are at a cost. He feared there would be exploitation of

the public since private health care providers would get say "the free TB drugs" from the government stores and sell them at a price.

Seven private consultants felt that with supervision and proper costing of services, the private sector can decongest the public health facilities by causing a significant shift of patients from the PGH. Two specialists at private clinics cited that the government health facilities had a lot of un-utilized physical facilities especially at local dispensaries which could be leased and earn rental revenue. This would cause services to be centralized at certain localities. Two politicians cited that the District Health Boards be expanded to accommodate more private physicians and personalities from the private sector. Currently, two private sector employees are co-opted in the hospital's management boards.

CHAPTER 6: DISCUSSIONS.

There is increasing evidence that partnerships exist in the private sector between the public and private health care providers. This is evident by the number of referrals of patients between various health facilities. Also, it should be noted that most of the medical assistants (clinical officers and nurses) as well as some of the first degree holders in medicine (general medical practitioners) work at government health facilities. However, from the focus group discussions and other respondents, there is lack of binding agreements such as memoranda of understanding (MoUs) or recognized referral documents. The implication of this is that patients are always re-examined again for the same illness previously diagnosed elsewhere.

One point to note here is the levels of partnerships are lower and skewed in favour of the government health services. From Table 4, over 80% of all patients are referred to the government health facilities for further management. Only 3 out of 12 private health service providers have an official agreement with the government in acquisition of anti-TB drugs as well as admission of patients to government medical wards. Also the government health facilities do send patients to these private providers for specialized x-ray services. This is a strong indication that the government can contract out services to the private health care providers. This is consistent with the findings of Litvack J [1993] who observed that where the government supports the private sector, there is enhanced quality of health care to the local communities.

Partnership between public and private health care providers in Kenya is currently at the pre-relationship stage. This stage is characterized by awareness about the issue but the respondents cannot pin-point specific areas of partnership. Most of the health service providers reported knowing about partnerships but are not involved in any. The closest they came to, is that of referring patients to the next level for further management. However, key informants feel that partnerships can work in a defined environment which the health care providers have yet to define and implement. There is still a lot of uneasiness about the cost and benefits that accrue to each partner. Cox Saunders [1997] argues that partnership models can be held up as possessing the possibility of a “win-win” outcomes – with both sides winning simultaneously, through the adoption of problem-solving approaches, for example, to resolve any difficulties. This is yet to be realized in the Kenyan health sector. Most of the private providers view that they are willing to participate in organized private sector partnership with public sector if only such arrangement can translate to more patients and increased financial in-flow.

There are wide benefits that can emanate from joint partnership. From table 6 on issues of quality, the solo practitioners can benefit in terms of sourcing of diagnostic services from government health facilities as well as obtaining drugs. The only condition that should be put in place is that they should allow for government supervision. On the other hand, the government can subsidize the cost of health care inputs. Table 7 suggest that most of medical assistants and general practitioners have low consultation costs (mean of Kshs. 123, s.d. +/-56, minimum 50, maximum 250) which can attract more clients. This is consistent with previous study by Mwabu *et. al* [1999] which indicated that the choice of facility is largely a function of income

levels and cost of services rendered.

Other tangible benefits of partnerships would include convenience to the clients (patients) who would get all the required services at their initial location for procurement of the health services. Also some of the solo clinics can specialize in offering one-to-two types of services.

There is need to establish official documents such as memorandum of understanding (MoU), contracts or letters of agreement (LoA) to spell out the charges, scope and mode of operation of such partnership. Such documents would include items such as acceptable forms which patients can use if they move from one facility to another. This would significantly reduce the patient's financial and mental stress of being compelled to undergo repeated procedures for the same illnesses. There is need to explore possibilities of establishing specialized clinics which are recognized by both private and public health care providers, and their costs of services be regulated. These clinics should be located within residential areas where most of the patients first go for health services when an illness first sets in.

In conclusion, the study has demonstrated potential for development of viable private and public health service partnerships for their mutual benefits as well as to strengthen the national health care delivery capacity.

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS.

Partnership sourcing can work in the health service delivery. The data presented is suggestive of weakness on one provider which could be a strengthen for the other. However, certain issues have to be addressed. First there is need to carry out a stakeholders forum where all the private clinics and the government health providers can deliberate on issues affecting them. It is in such a forum that both the private and public health care providers would identify the individual strengths and weaknesses in their respective systems and devise modalities for development of sustainable partnership to supplement and strengthen their mutual capacities.

There is need to establish official documents such as memorandum of understanding (MoU), contracts or letters of agreement (LoA) to spell out the character, scope and mode of operation of such partnership. Such documents would include items such as acceptable forms which patients can use as they move from one facility to another. This would significantly reduce the patient's financial and mental stress of being compelled to undergo repeated procedures for the same illnesses. There is need to explore possibilities of establishing specialized clinics which are accredited by both private and public health care providers and their costs of service be regulated. These clinics should suitably be located within residential areas where most of the patients first go for health services whenever illness first sets in.

In conclusion, there is enormous potential for development of viable private and public health service partnerships for their mutual benefits so as to strengthen the national health care delivery capacity.

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ANNEX 1:

HEALTH CARE PROVIDERS
QUESTIONNAIRE

ANONYMOUS HEALTH SERVICE PROVIDERS QUESTIONNAIRE

Background information

Facility ID: _____

Date of interview (dd/mm/yy) _____

Category of clinic

- 1. Private health clinic (missions/NGOs)
- 2. Private health clinic (institutions / companies)
- 3. Private health clinic (hospitals)
- 4. Private clinic (solo practice)

Where is this clinic located?

- 1. Within the central business district (CBD)
- 2. Outside the CBD - residential area

Which residential area (high / moderate / low / tick)

Qualification of the physician / clinician responsible

When was the clinic established

ANNEX 1:

What range of services do you offer in this clinic?

HEALTH CARE PROVIDERS QUESTIONNAIRE.

Workload
No. cases

Patients

Please let me know your clinic routines in relation to

hours you are available at the clinic per day (hours of service)

number of days the clinic is open per week

time when the clinic opens

time when the clinic is closed

ANONYANOUS HEALTH SERVICE PROVIDERS QUESTIONNAIRE.

Background information.

Facility ID: _____

A. Date of interview (dd/mm/yy) _____

B. Category of clinic

1. Private health clinic (missions/NGOs)
2. Private health clinic (institutions / companies)
3. Private health clinic (hospitals)
4. Private clinic (solo practice).

C. Where is this clinic located?

1. Within the central business district (CBD)
2. Outside the CBD - residential area
Which residential area (high / moderate/ low) tick..

D. Qualification of the physician /clinician responsible _____

E. When was the clinic established / opened (year) _____

F. What range of service(s) do you offer in this clinic?

1. _____
2. _____
3. _____

G. What is the total number of patients (*all cases*) do you see in a typical week?

Workload	Week
New cases	
Re-visits	

F. Please let me know your clinic routines in relation to:-

Hours you are available in the clinic per day (hours of service)	
Number of days the clinic is open per week	
Time when the clinic opens	
Time when the clinic is closes.	

Existence & extent of partnership in TB health service delivery.

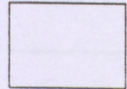
1. Have you ever heard about partnership? Yes No

1b. Who do you partner with and for what service? _____

1c. Are there any formal agreement(s) that you signed in the partnership you are involved in?
Yes No

2. Where do your TB patients mainly come from?

- 1. Within the town
- 2. Outside the town but within the district
- 3. Outside the district
- 4. Others (specify) _____



2b. What percentage would you allocate to occupations of TB patients who seek health care at your clinic?

Category	Percentage (%)
Business people/ traders	
Employed:- Formal	
Informal	
Unemployed	
Students	
Farmers	
Others	

Place referred to	Percentage of patients	Reason for referral
Govt health clinics (specify)		
Non-Govt health clinics (specify)		
Others (specify)		

2c. What percentage (%) on of your clients can be grouped into the following social economic strata

Strata		Percentage (%)
High income group		
Moderate	Upper income groups	
	Low income groups	
Low social economic group	High	
	Low	

3a. Are patients referred to this health clinic? 1. Yes 2. No

3b. If yes, where are they referred from

Source of patients	Estimate in percentage (%)
1. GoK health clinics/hospitals	
2. Non-GoK health clinics / hospitals	
3. Self referrals / relatives/ friends	
4. Others (specify)	

4a. Do you refer patients for treatment/services to other health clinics? 1. Yes 2. No

4b. If yes, where do you refer them to and why:-

Please tick	Place patients referred to	Percentage of patients, %	Reason for referral
1.	GoK health clinics (specify)		
2.	Non-GoK health clinics (specify)		
3.	Others (specify)		

4c. On average about how many TB patients do you refer to other health facilities in a week?

4d. Do you have any standard referral forms for patients? 1. Yes 2. No
(If yes, please let me have a copy of the forms).

5. How is diagnosis of TB arrived at in this facility
1. Most important method _____
2. 2nd method: _____
3. 3rd method: _____
4. Other methods : _____

6a. Please let me know your charges for the following services:-
1. Consultation: a. 1st visit: _____ b. Re-visits _____
2. Laboratory services _____
3. X-ray services (chest) _____
4. Drugs (anti-TB drugs) _____
5. Other charges _____

6b. How do patients pay for the services rendered to them:-

Methods of payment	Percentage of patients using this method (%)
1. Cash	
2. Credit cards/ cheques	
3. Company schemes	
4. Medical insurance covers (NHIF/AAR)	
5. Waivers	
6. Others (specify)	

7. Do you stock anti-TB drugs in this clinic? 1. Yes 2. No

8. If none, do you refer patients to particular a pharmacy for drugs and where?
1. Yes (name) _____
2. No

9. From your experience of handling TB patients, what is the lag time among your patients (days)? _____

10. What other information do you give to your patients? _____

11. How do you keep patient data?

1. Manual filing
2. Computerized database
3. No formal filing system
4. Others (specify) _____

11b. Do you produce any reports from your records?

1. Yes (how often in a year) _____
2. No

12. Do you notify any of the following cases to the local Medical Officer of Health (MOH) office?:-

	1. Yes	2. No
TB case (notification)		
Other public health conditions (specify)		

13. What issues would like to see addressed so as to encourage collaboration between GoK clinics and private sector clinics so as to reduce the TB burden in this country?

Issue / Recommendation	Reason(s)

PATIENTS QUESTIONNAIRE

Background information

Date of interview (dd/mm/yy)

Serial number

Category of clinic

- 1. Government health clinic/hospital
- 2. Private health clinic (missions/NGOs)
- 3. Private health clinic (special programme)
- 4. Private clinic

Existence & extent of partnership in TB health service delivery

1. Where do you reside?

- 1. Within the town
- 2. Outside the town but within the district
- 3. Outside the district
- 4. Others (specify)

ANNEX 2:

2a. Were you referred to this clinic for this particular illness?

- 1. Yes
- 2. No

2b. If yes, where were you referred to?

- 1. Government health clinic/hospital
- 2. Private health clinic (missions/NGOs)
- 3. Private health clinic (special programme)
- 4. Private clinic
- 5. Others (specify)

PATIENTS QUESTIONNAIRE.

2c. What was the reason for your referral to this clinic?

Critical success factors of partnership in TB health care delivery

3a. Please tick how many health care services you have sought for any of the following services.

- 1. Direct TB drug
- 2. Consultation with TB staff
- 3. Laboratory services
- 4. Support services (e.g. transport)

PATIENTS QUESTIONNAIRE.

Background information.

Date of interview (dd/mm/yy) _____

Serial number: _____

Category of clinic

1. Government health clinic/hospital
2. Private health clinic (missions/NGOs)
3. Private health clinic (special programme)
4. Private clinic

Existence & extent of partnership in TB health service delivery.

1. Where do you reside?

1. Within the town
2. Outside the town but within the district
3. Outside the district
4. Others (specify) _____

2a. Were you referred to this clinic for this particular illness?

1. Yes
2. No

2b. If yes, where were you referred from:-

1. Government health clinic/hospital
2. Private health clinic (missions/NGOs)
3. Private health clinic (special programme)
4. Private clinic
5. Others (specify) _____

2c. What was the reason for your referral to this clinic? _____

Critical success factors of partnership in TB health care delivery.

3a. Please let know how much you have spent so far for any of the following services:

1. Drugs (TB drugs) _____
2. Consultancy: a. 1st visit: _____ b. Re-visits _____
3. Laboratory services _____
4. X-ray services (chest) _____
5. Others _____

3b. How did you for services you received in the course of seeking treatment:-

1. Cash
2. Credit cards
3. Company schemes
4. Medical insurance covers (NHIF/AAR)
5. Waivers
6. Others (specify) _____

4a. Did you get all the required drugs?

1. Yes
2. No

4b. If no, where were you told to buy (source) the drugs? _____

5. How would rate the following :-

- | | | | |
|----------------------------|-------------|----------------------------------|----------------|
| a. Staff (nurses/doctors): | 1. Friendly | 2. Unfriendly | 3. Rude |
| b. Equipments: | 1. Working | 2. Working but with difficulties | 3. Not working |
| c. Buildings: | 1. Clean | 2. Untidy | 3. Dirty |

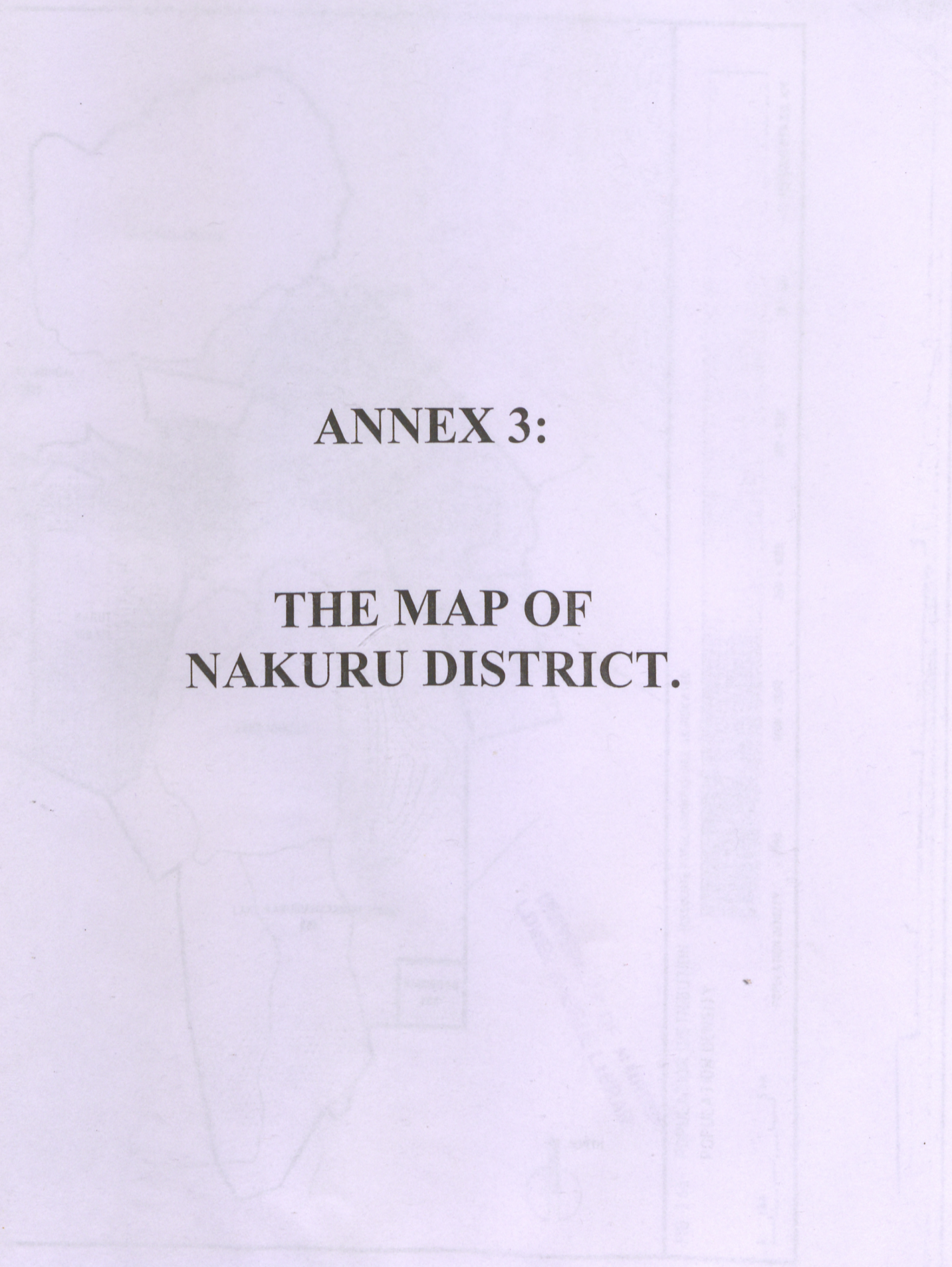
6. How long did you wait on the line before seeing a doctor (minutes) _____

7. What areas would you like to see improved/added in this clinic so as to offer better services? -----

THE MAP OF
NAKURU DISTRICT.

ANNEX 3:

**THE MAP OF
NAKURU DISTRICT.**



From: Nakuru Strategic Plan
(2000 - 2004)

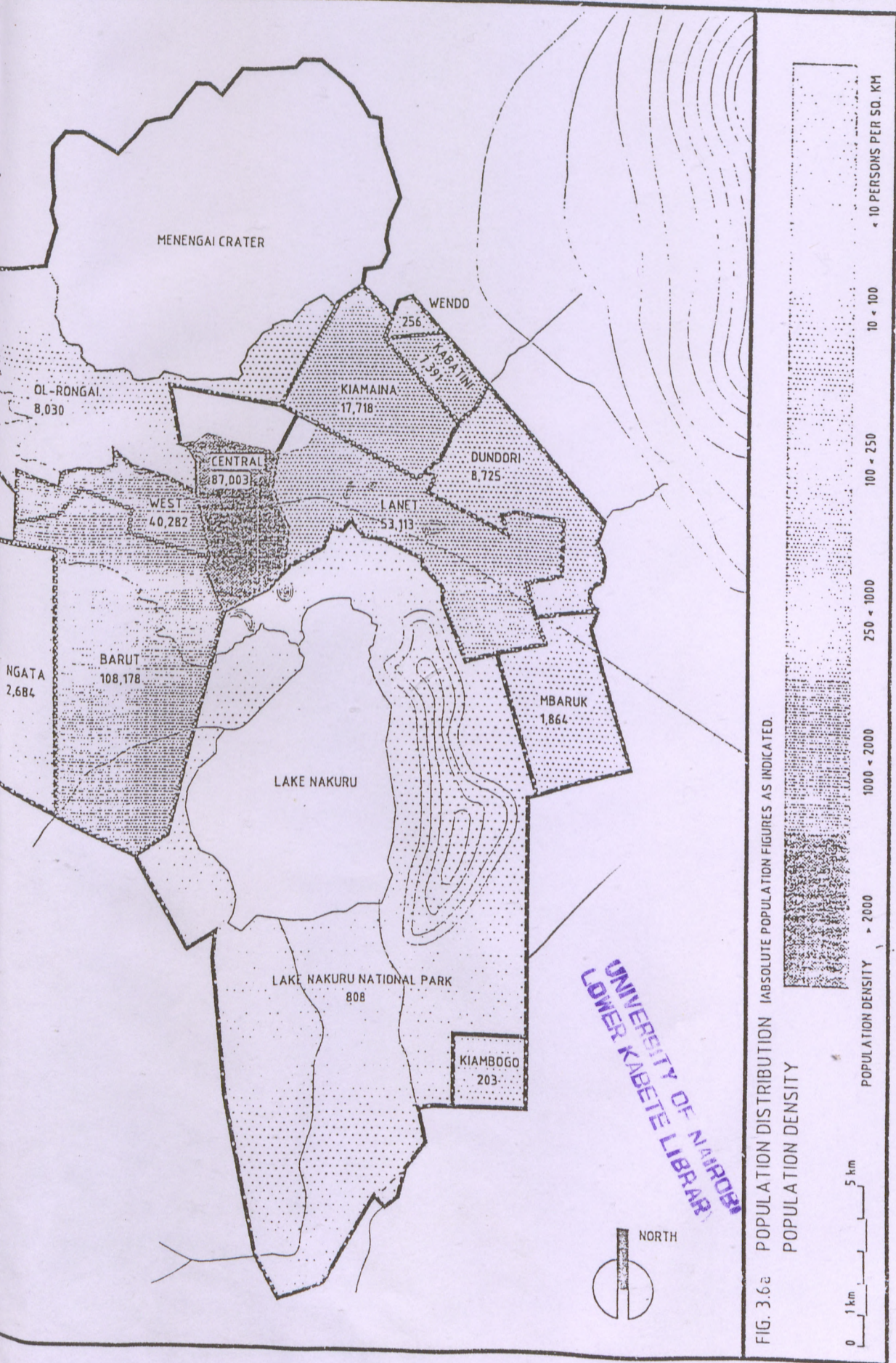


FIG. 3.6a POPULATION DISTRIBUTION (ABSOLUTE POPULATION FIGURES AS INDICATED)

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