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Effect of Devolved Health Sector in Kenya on Accessible Good Medical Care

(A Case Study of Kiambu County)

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Abstract: **Devolution, as other types of decentralization, profoundly changes governance relations in the health system. Devolution is meant to affect performance of the health system by transferring responsibilities and authority to locally elected governments. This study aimed to establish the effect of devolved health on the performance of the health sector in Kenya. The guiding objectives included: To establish the influence of devolved procurement on the performance of the health sector; to determine the effect of devolved leadership on the performance of the health sector; to evaluate the effect of devolved resources on the performance of the health sector; and to establish the effect of devolved policy and regulatory framework on the performance of the health sector in Kenya. The study adopted the descriptive survey research design. The target population was 572 patients and health care providers from Kiambu County. Stratified sampling method was adopted at the rate of 10% to come up with a sample size of 57 respondents. Primary data was collected using questionnaires from all the respondents. Secondary data was sourced from health sector reports in Kenya from the year 2015 to 2016. The collected data was then analyzed through frequencies and percentages to enable the research come up with conclusions and recommendations for the study. The research employed the assistance of some computer tools, including the Statistical Programs for Social Sciences (SPSS) and excel version 16 to analyze the data quantitatively. The analyzed data was presented in the form of graphs tables and charts. The Study established that devolution process has not been fully implemented and its effect has not been fully experienced in the health sector. The sector performance was averagely rated in the study and its contribution to GDP reduced by 0.5 percent by the end of the year 2016. The devolved procurement process, organizational leadership, resources allocation and availability as well as policy and regulatory framework had a significant influence on the performance of the level four hospitals and the overall health sector. It was recommended that the health sector players should improve in financing of critical health investment areas, particularly those relating to improving quality of care.**

Keywords: **Statistical Programs for Social Sciences (SPSS), GDP, GOOD MEDICAL CARE.**

1. BACKGROUND INFORMATION

This study sought to establish the influence of devolved health sector in Kenya on accessible good medical care. Decentralization of health system structure and management has been and continues to be a key issue for many countries in the achievement of health for all, and development of primary health care. According to WHO (1990), decentralization can be defined in general terms as the transfer of authority, or dispersal of power, in public planning , management and decision making from national to sub national levels. “Decentralization is therefore, not only an important theme in health management but also a confused one”, (Luoma et al, 2010). According to El-Saharty (2009), globally, there has been a

trend in the devolution of authority in healthcare. One can say that authority that was often sitting with one central Ministry or Department of Health has devolved over time. Ethiopia for example has moved from centrally-organized authority to a situation where block grants are redistributed from regional governments to districts. The districts, in turn, can set their own priorities and are free to further allocate this budget to health facilities, (El-Saharty, 2009).

Health Sector:

The Health sector has the overall goal of providing equitable and affordable health care to Kenyans at the highest affordable standards. The Health Sector comprises of Ministries of Medical Services, Public Health and Sanitation, Research and Development sub-Sectors, namely Kenya Medical Research Institute (KEMRI). The goal of Kenya's Vision 2030 for the Health Sector is to "provide equitable and affordable health care at the highest affordable standards to her citizens", (Atieno, Nancy and Spitzer, 2014). Good health is a prerequisite for enhanced economic growth, poverty reduction and a precursor to realization of the Vision's Social Goals. Further, the Constitution under the Bill of Rights states that access to healthcare is a right to every Kenyan. It is against this background that the Health Sector is re-positioning itself to fulfil the expectations of Kenyans through various strategic interventions through improved health systems such as infrastructure and service delivery, (MOH, 2013b). Following the general elections in March 2013, each county has the task of establishing a "blueprint for change" for its health system, (Barker, 2 0 1 4).

Performance of Health Sector:

Performance measurement has considerable potential in health service management in enabling national priorities for health reform to be translated into organizational and individual objectives, to provide a focus on results, and to enhance accountability, (Baines, 2009). Devolution is proposed within a framework that provides adequate and accurate information to inform decisions and enables decision-makers, managers, and staff to be held accountable. For effective devolution in health, performance measurement systems are required that enable health boards and providers to demonstrate that they are fulfilling devolved functions and for the department to monitor the performance of the system against agreed objectives, (Omondi,et al., 2012). The Comptroller and Auditor General (Amendment) Act, 1993 requires the Comptroller and Auditor General to audit the accounts of health boards, to include a review of whether the health board applied expenditure for the purpose for which it was intended, if transactions conformed to the correct authority, and if income and expenditure are supported by substantiating documentation. The Act also provides for the review of whether and to what extent resources were used, acquired or disposed of economically and efficiently and if disposals effected 'the most favorable terms reasonably obtainable'. It gives the Comptroller and Auditor General the right to access documents and information, to examine systems, procedures and practices, and to make comparisons as considered appropriate, (MOH, 2014).

Successive governments in Kenya have sought to address the problems of health system by adopting a variety of ways. As long ago as 1994, the Government of Kenya (GOK) approved the Kenya Health Policy Framework (KHPF) as a blueprint for developing and managing health services. According to (Kpmg, 2013), central to the creation of a health care system is the devolved authorities' ability to use these governance tools to rationalize, integrate and coordinate previously autonomous and sometimes competing services. Such rationalization can occur vertically (between institutional and community-based services) and horizontally (among institutional service) such as hospital mergers or among community- based services. Kenya Health Policy 2012 – 2030 provides guidance for the achievement of the highest standard of health. It aims to achieve this by "supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans" by focusing on primary care. Devolution of healthcare to the counties provides an enabling environment for this approach as the county governments are responsible for the provision of primary care. Bringing primary care services closer to the people allows for ownership and participation, (MOH, 2014).

Like most countries in Africa, the shortage of healthcare workers is not unique to Kenya. Indeed, Kenya is one of the countries identified by the WHO as having a "critical shortage" of healthcare workers. The WHO has set a minimum threshold of 23 doctors, nurses and midwives per population of 10 000 as necessary for the delivery of essential child and maternal health services. Kenya's most recent ratio stands at 13 per 10 000, (WHO, 2010). This shortage is markedly worse in the rural areas where, as noted in a recent study by Transparency International, under-staffing levels of between 50 and 80 percent were documented at provincial and rural health facilities. As a signatory to the 2001 Abuja Declaration, Kenya committed to allocating at least 15 percent of its national budget to health, (WHO, 2010). Not only is

Kenya spending a relatively low amount as a percentage of GDP on healthcare, but the allocation of funds to public facilities has been uneven. According to a 2011 Healthy Action report, secondary and tertiary facilities have historically been allocated 70 percent of the health budget. The same report notes that allocation of funds to primary care facilities has been "poor" − this despite the significant role these facilities play as the first point of contact in the provision of healthcare services, (Bashaasha, Najjingo and Nkonya, 2011).

Resource allocation formulas can help countries to redress inequities in access to healthcare by systematically and objectively incorporating needs-based criteria into allocation decisions. However imperfect the underlying data or their weighting may be, such efforts can help nations make progress toward achieving equitable access to healthcare, (Briscombe, Suneeta, and Margaret, 2010). Other African nations that face the same health challenges as Kenya have implemented effective approaches to ensure the equitable allocation of resources, including the introduction of needs-based criteria into their budgetary processes. Most of these nations face inequalities of access to healthcare, poor data collection and availability, and severe budgetary constraints similar to those of Kenya, (Briscomb, 2010). Another notable weakness in many health resource allocation formulas is their failure to address equity in human resource and drug allocations. Often these two resources prove more difficult to quantify in monetary terms because their costs are difficult to calculate or estimate, (Briscomb, 2010). Decentralization implies an increase in sub-national responsibilities for planning, implementing, and monitoring health services, yet sub-national entities currently lack the capacity to shoulder these responsibilities. Sub-national authorities also lack corresponding authority to secure resources and hold national-level policymakers accountable for promised funding and representation. The WHO has conducted some training on the preparation of budgets, but broader efforts are needed to build capacity to collect and use data, plan collaboratively, and manage resource allocation processes and formulas, (Atieno, Nancy and Spitzer, 2014).

At the heart of an assessment of how best to deliver services efficiently and effectively is the issue of how to serve the public interest and generate 'public value', (English et al, 2011). The concept of public value has been advanced as a way of thinking about and evaluating the goals and performance of public policy and as providing a yardstick for assessing activities produced or supported by government. 'Public value provides a broader measure than is conventionally used within the new public management literature, covering outcomes, the means used to deliver them as well as trust and legitimacy, (Bashaasha, 2011). It addresses issues such as equity, ethos and accountability

Statement of the Problem:

Devolved government invariably involves a shift of power and control, and thus challenges accountability and performance management frameworks built around more traditional hierarchical authority structures. According to Kpmg (2013), a key challenge is to find new ways to support accountability, performance and public confidence while allowing for innovation and locally designed solutions to meet citizens' needs. In the devolved government, the Kenya Health Policy 2012 – 2030 provides guidance to the health sector in terms of identifying and outlining the requisite activities in achieving the government's health goals. The policy is aligned to Kenya's Vision 2030 (Kenya's national development agenda), the Constitution of Kenya and global health commitments such as the Millennium Development Goals, (MDGs). Kenya devolved its healthcare system since the time the county government came in power in March 4th 2013, however, very little has been done to establish the implications it has had in Kenya, (Atieno, Nancy and Spitzer, 2014)

Health staff unrest has been witnessed since the advent of county governance; affecting service delivery thus posing health risks to thousands of county residents and scaring away potential investors. Both the national and county government together with the various development stakeholders have paid little attention to such a situation despite the fact that if it remains unchecked could jeopardize service delivery, (Mwatsuma, Mwamuye, and Nyamu, 2014). Further, the case of stock outs on essential drugs has promoted health risks in the hospitals as well as affecting the economic status of households as they seek drugs from private pharmacies. This has a negative social effect especially to the poor who depend on subsidized government supplies. Poor treatment for emergencies as well as unserviced equipment, vehicles and facilities pose a challenge in the effective delivery of health services in the hospitals in Kenya. The problem of underfunding and poor control of resources, embezzlement and pilferage at the hospitals have significantly influence the above problems in Kenya, (Kpmg, 2013).

Dealing with rapid, complex, and often discontinuous change requires leadership. Ministry of Health and Medical services (2010) suggests that for county governments to have successful health care system the leaders must understand the nature and implications of change, have the ability to develop effective strategies that account for change, and the will as well as

the ability to actively manage the momentum of the devolution. It is against this backdrop that this study is conceived so as to fill the knowledge gap**.**

General Objective:

The general objective of the study was to establish the influence of devolved health sector on the accessibility of good medical care in Kenya.

2. THEORETICAL REVIEW

The Health Sector in Kenya:

A 2010 review of the health situation in Kenya, performed by the Ministry of Medical Services and the Ministry of Public Health and Sanitation, reveals that improvements in health status have been marginal in the past few decades and certain indicators have worsened. The review notes that, "geographical and gender differences in age-specific health indicators persist." According to Republic of Kenya (2010), approximately 78 percent of Kenyans live in rural areas, yet a disproportionate share of healthcare facilities are located in urban areas. Those in rural areas often have to travel long distances, often on foot, to seek care. According to the World Bank, the index of access to health services (measuring the share of new-borns delivered at a health facility) in Kenya, speaks volumes to this disparity. For example, over eight in ten children born in Kiambu County, which is located in the central part of the country, are delivered in a health facility. In Wajir, which is located in one of the most remote and marginalized regions of the country, one child in twenty is born in a health facility, (World Bank, 2010).

Atieno, Nancy and Spitzer (2014) inform that the health sector has achieved considerable outcomes as per its mandate: reduction of Under Five Mortality from 115 per 1,000 live births in 2003 to 51 per 1,000 live births in 2015/16 and Infant Mortality from 77 per 1000 live births to 52 per 1000 live births in the same period. The sector has also seen increased immunization coverage for under 1 year olds from 71% in 2010 to 77% in 2016. However, the sector still experiences some challenges especially regarding the high disease burden. Maternal Mortality Ratio has deteriorated from 414 in 2010 to 488 deaths per 100,000 live births in 2010-11; Births attended by skilled health personnel declined from 51 percent in 2009 to 43 percent in 2010, despite considerable funding flowing to the programs. Even with the increasing allocation to the sector, Public Per Capita spending currently stands at $19.2 and in general, Per capita health spending still remains low at $42 compared to the WHO recommendation of $54 per capita, (Atieno, 2014)

Devolved Governance in the Health Sector in Kenya:

Nzinga (2009) accord that in the devolved system, healthcare is organized in a four-tiered system: Community health services. This level is comprised of all community-based demand creation activities, that is, the identification of cases that need to be managed at higher levels of care, as defined by the health sector; Primary care services:- This level is comprised of all dispensaries, health centers and maternity homes for both public and private providers; County referral services- These are hospitals operating in, and managed by a given county and are comprised of the former level four and district hospitals in the county and include public and private facilities; National referral services- This level is comprised of facilities that provide highly specialized services and includes all tertiary referral facilities. The counties are responsible for three levels of care: community health services, primary care services and county referral services. The national government has responsibility for national referral services

The fourth schedule (article 185 (2), 186 (1) and 187 (2)) establishes the distribution of functions between the national government and the county governments where the government handles National referral health facilities and Health policy, while county government handles County health services, including, county health facilities and pharmacies; ambulance services; promotion of primary health care; licensing and control of undertakings that sell food to the public; However county governments were supposed to apply for the functions, (Chuma, 2009). In a special issue1795 of the Kenya Gazette Supplement No. 116 Legislative Supplement No. 51) legal notice no. 137 health services were transferred to the counties. County health services including, County health facilities and pharmacies and county health facilities including county and sub county hospitals, rural health centres, dispensaries, rural health training and demonstration Centre's, rehabilitation and maintenance of county health facilities including maintenance of vehicles, medical equipment and machinery. The success of devolution of health care will require strategic approach in order to realize the benefit of new governance dispensation, (Sihanya, 2013).

Devolved Procurement and the Performance of the Health Sector:

The following, according to C.I.P.S (2010) are some of the potential sources of risks in the in the supply chain: sources of risks from buyers; Clarity of definition of requirements, Presentation and approach to market, internal relationships and barriers to use particular suppliers. Other Sources of risks are from Suppliers, Production process capacity & supply chains, Competing demands from different buyers, Commercial and financial capability. Risks from existing buyer supplier Relationships; includes Contractual allocation of risks, Cultural fit and associated skill sets on both sides to manage the relationship Performance management arrangements. According to the findings of Bloom (2011)), there are five different sources of supply chain risks. These are based on, technological risks, political risks, market risks, turbulence risks, financial risks and organizational and societal risks. These risks affect the performance of the supply to varied levels depending with the existing circumstances.

Devolved Organizational Leadership and the Performance of the Health Sector:

In China, the government's capacity to shape the sector is further undermined by the role of the Communist Party. Hospital managers are often prominent party officials, or are closely connected to those who are prominent, which affords them opportunities to shape government priorities. When the government adopts measures controlling hospitals' behaviour in response to popular angst, the managers' party affiliations help to dilute their content and implementation (Chen 2011). The weakening of government control over providers has influenced the performance of the health sector. Another effect resulted from the gradual demise of health insurance during the 1980s. While previous health insurance programmes were a mechanism for mobilizing resources from the population rather than modern insurance pools with active purchasing functions, they did provide some supervision and control over providers. Once they had disappeared amidst transition to market economy, virtually no mechanisms remained to monitor providers and hold them accountable, (Tam 2008, 2010).

Devolved Resources and the Performance of the Health Sector:

A study by (Muula, 2007) showed that shortages of essential drugs including vital anti- malarial or antibiotics pervade all levels of care as had been documented previously in Malawi, even in the vicinity of the capital. This excludes anti-retroviral drugs, which followed, up until this study, a different and independent mode of procurement and delivery. The reasons for inadequacies in drug procurement, storage and delivery were manifold. They documented deficiencies of finances, physical infrastructure (warehousing), staffing and drug quantification. Kutzin, Cashin and Jakab (2010) assert that possibly a structural challenge to reform is that procurement process embedded in central government structures. This means that it is highly dependent on direct funding from the Ministry of Finance and has a lack of discretion over recruitment of staff (including their qualification) and inadequate means of responsibility to perform duties independent of central government.

Vaillancourt (2009) accords that the devolution of purchasing power to Counties is providing more discretion to districts but this measure will remain unsuccessful until the procurement process has the means to manage drugs adequately at national level, including quantification of need and keeping an adequate buffer stock. Many donors and others have therefore called for procurement process to be changed into a (semi-) independent trust. Discussions regarding the institutional change are under way, but many complain about the long process and express doubt that procurement process can ever become independent of political interference, (Pavignani and Colombo 2009).

Devolved Policy and Regulatory Framework and the Performance of the Health Sector:

Globally, providers increasingly realize that delivering top quality care gives them the competitive edge they need in order to safeguard their growth – or more simply, their existence, (Bolton and Haulihan, 2007). Operational costs have to be brought down, while the safety, effectiveness, patient- centeredness, and timeliness of care have to be improved. Kenyan providers are no different. Indeed, the Joint Commission International (JCI) which provides healthcare accreditation to hospitals globally, and is a mark of quality, has made it to the Kenyan market. As is observed in the Ghanaian devolution process, different role players impact on the (performance of) the local health systems. Since there is no overarching strategy, policies, or regulations, many stakeholders have a limited understanding of government's plans and process objectives in terms of decentralization, deconcentration and devolution of responsibilities to sub-national levels, (Bennett , 2012). Kenya's evolving health policy context has much in common with that in many Anglophone African countries. The late 1980s saw the adoption of measures inspired mainly by the New Public Management rhetoric, (Noorein and

Pam, 2010), such as the introduction of performance management and advocacy for the "empowerment" of managers. Mbua and Ole Sarisar (2013) assert that devolving responsibilities does not only impact on those organisations or regions where responsibilities are devolved to, it also impacts on the organisation – typically a Ministry of Health – that is devolving its authority. Good governance should clearly spell out what (policies) the Ministry of Health would still be responsible for in a devolved health system. Examples of these are quality regulations and education and training of doctors. The role of a Ministry is therefore likely to be one of 'stewardship' and 'guidance' instead of 'own and control' in a devolved system.

Study Gaps:

Although adequate funding is crucial for any health system to be effective, it is not only funding that impact on health outcomes and service delivery. In all of the examples above, having the right governance and accountability structures as well as managerial capacity are believed to have a stronger impact on performance and outcomes than funding does. Further study is crucial to enlighten on the significant factors influencing the performance of the health sector under devolved governance system. It is clear that managerial capacity is a prerequisite for devolution to achieve its goals. It is often assumed that local capacity required managing a local health system and/or health facility is available, but in practice this turns out differently. It is clear that Kenyan referral hospitals fall under the responsibility of the Ministry of Health. Yet, it is less clear how patient referral mechanisms will impact on this and what (financial) incentives enforce these mechanisms. For example – is it profitable for hospitals, falling under the counties' responsibility, to treat as many patients as possible or will their budgets put pressure on them to refer patients to national referral hospitals in order to save costs and prevent losses? What mechanisms are put in place to prevent fraud and corruption? Will county offices be subject to annual national audits? Will the national department offer support in terms of setting up professional procurement departments at the county level? Have decisions been made in terms of the above on what thresholds approval from national departments is required? These aspects, if not addressed, pose potential risks to the success of devolution. This study sought to establish the reality of this phenomenon under the devolved system of government.

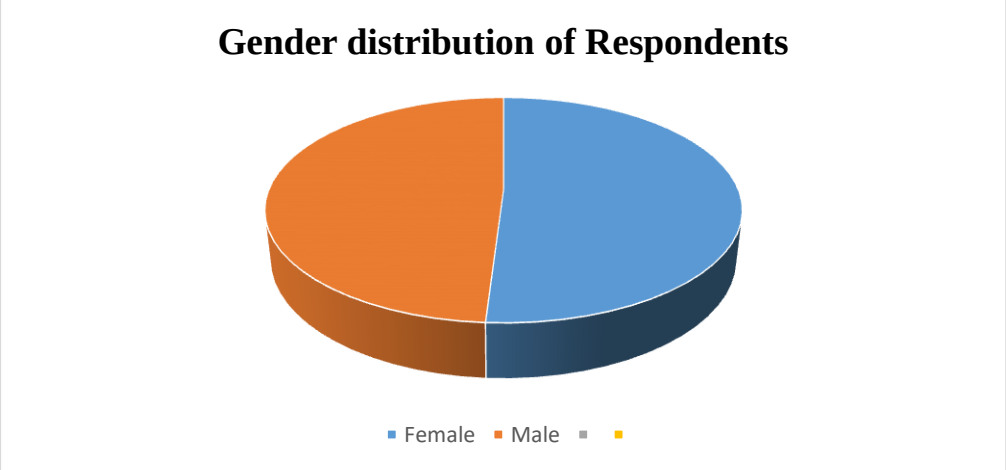
3. DATA ANALYSIS AND PRESENTATION

Response Rate:

The response rate was commendable since fifty five out of the fifty seven questionnaires administered were returned fully answered. Two patients did not return the instruments. This showed a response rate of 96%, and thus making the data reliable for inference.

Gender distribution of respondents:

The gender distribution of the respondents was 51% female and 49% male. As such there was an equitable distribution of the respondents and this reduced the effects of biased responses based on gender, an important ethical consideration in social sciences.



Gender Distribution of Respondents

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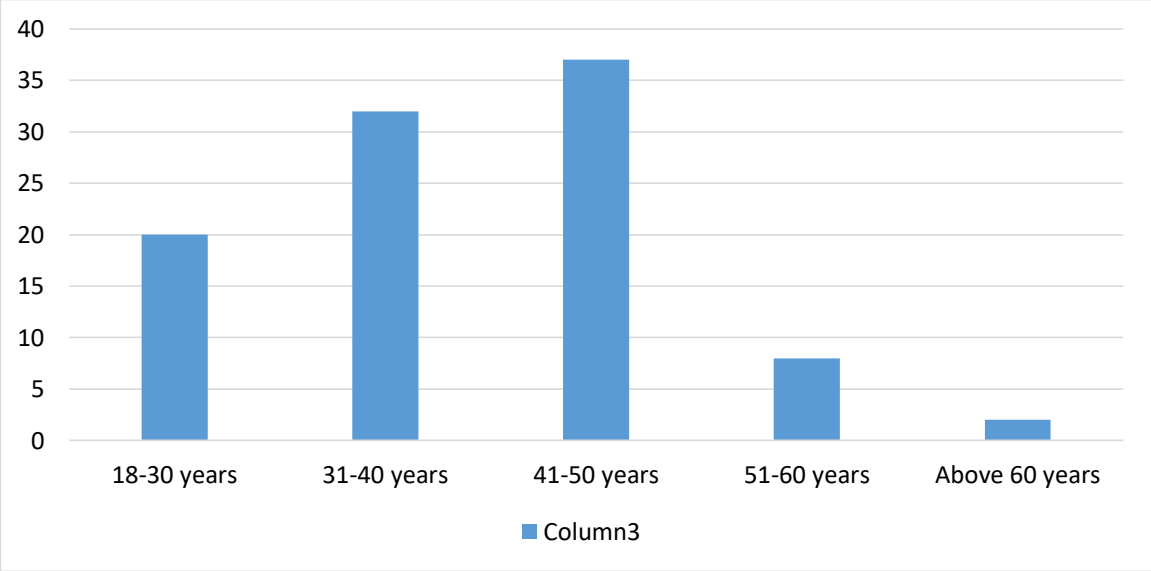
Age Distribution of Respondents

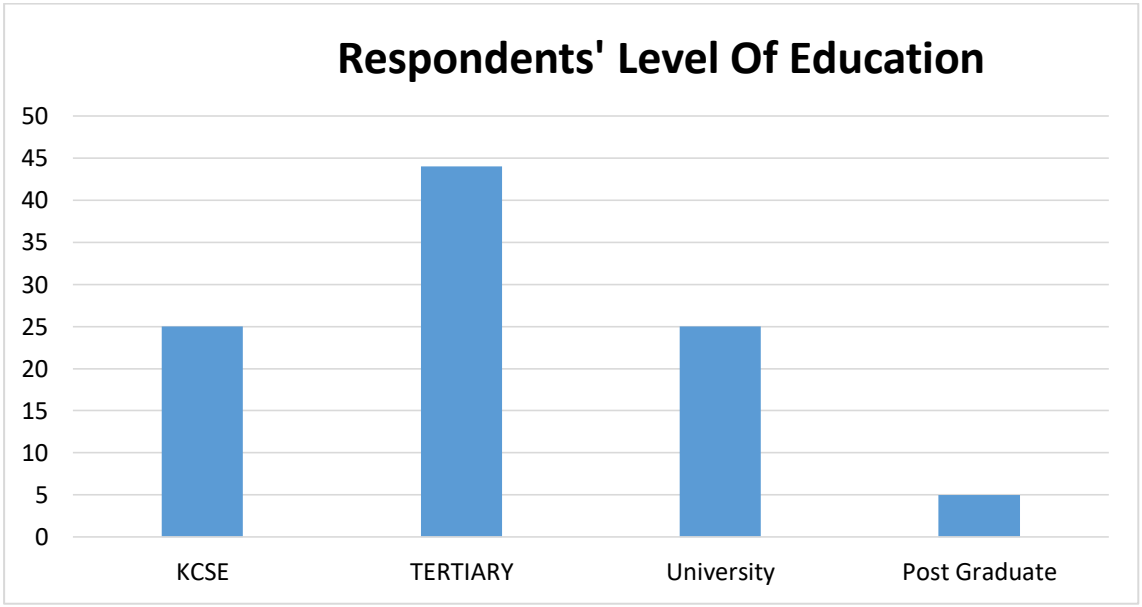
The age of the respondents was distributed as 41-50 years 36.3%, 31-40 years 32.7%, 18-30 years 20%, 51-60 years 9% and above 60 years 2%. Thus respondents were mainly young adults who could objectively contribute to the study.



Age distribution of the respondents

Respondents level of education:

The education levels of the respondents were cited to be tertiary by 43.6% of the respondents, university and KCSE by 25.5 % respectively and post graduate by 5.4% of the respondents. This should commendable academic standing that enabled the respondents to comprehend and provide reliable information for the study.



Respondents level of education:

Experience in the health sector:

The experience in the health sector was sought from the hospital attendants. Accordingly, 50% had 10-15 years' experience, 25% 5-10 years' experience, 10% below 5 years and 15-20 years respectively and 5% over 20 years. Thus the respondents from the hospital had experience in the health sector and could thus provide credible information befitting the study.

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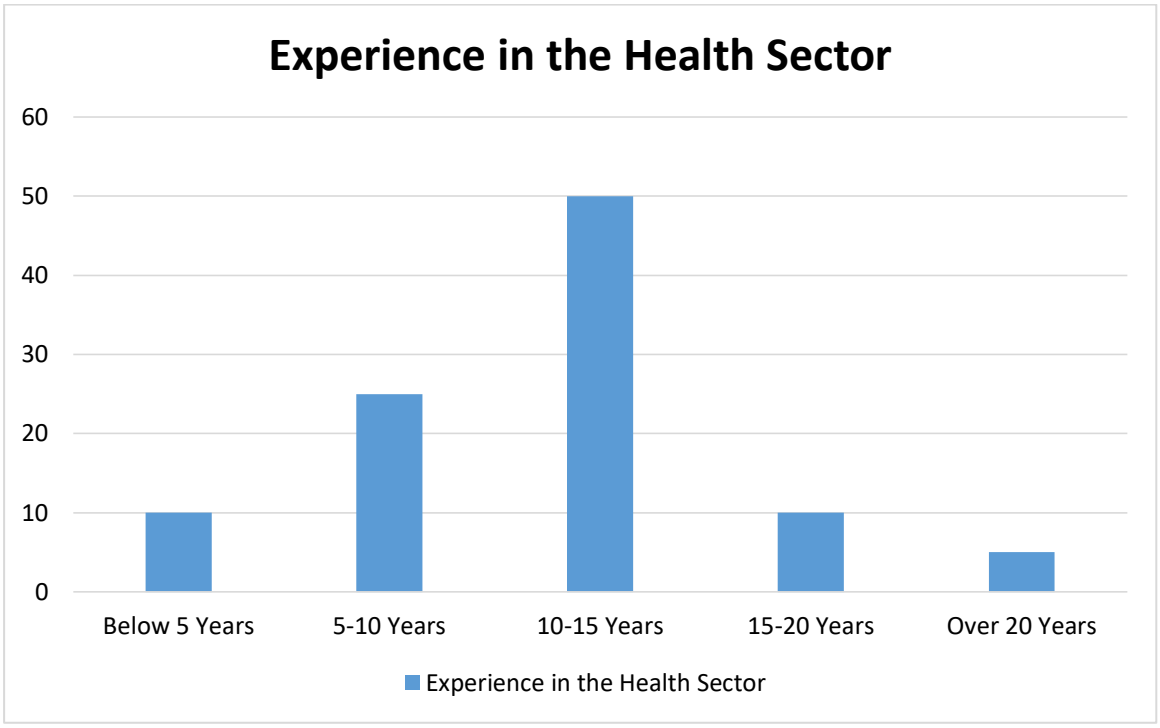
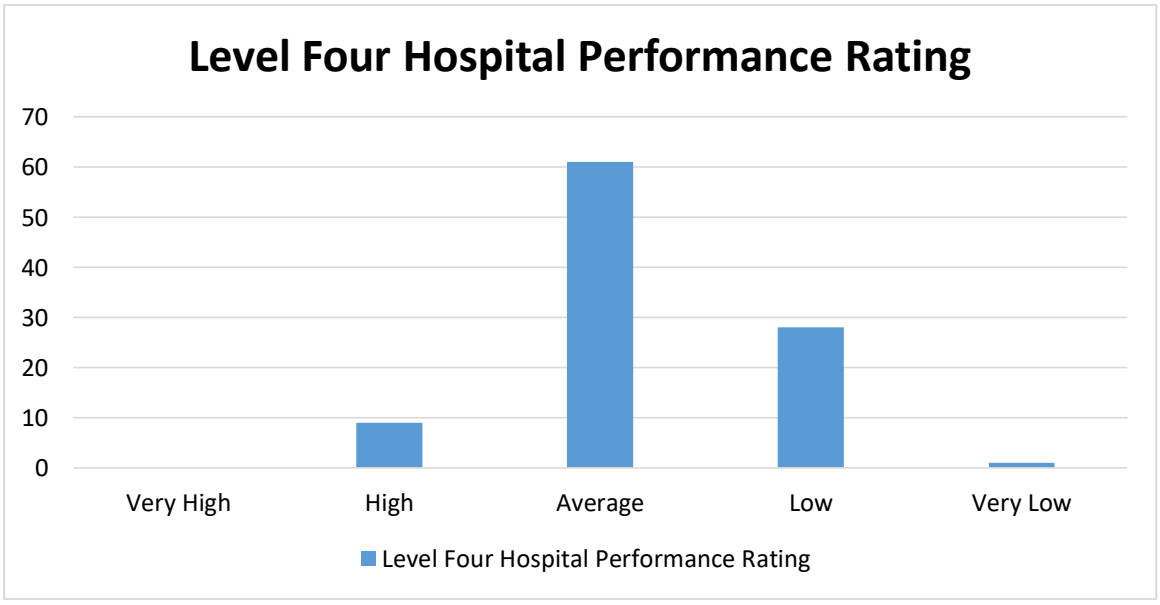


Experience in the health sector

Rating of the performance of the level four hospitals in respondent's area

The rating of the performance of the level four hospitals in respondents' area was average by 61.8%, low by 27.2%, high by 9% and very low by 2%. As such, the level four hospitals did not have high performance, a factor influencing the performance level of the overall health sector in Kenya.



Rating of the performance of the level four hospitals in respondent's area

Rating of the respondent's satisfaction level of quality services delivered in the level four hospitals:

The satisfaction level of the respondents on the quality of service delivery in the level four hospitals was rated average by 56.4% of the respondents, low by 36.4% and very low by 7.2% of the respondents. Thus, the hospitals were not providing services to meet the needs of the patients, a factor influencing low performance rating by the public.

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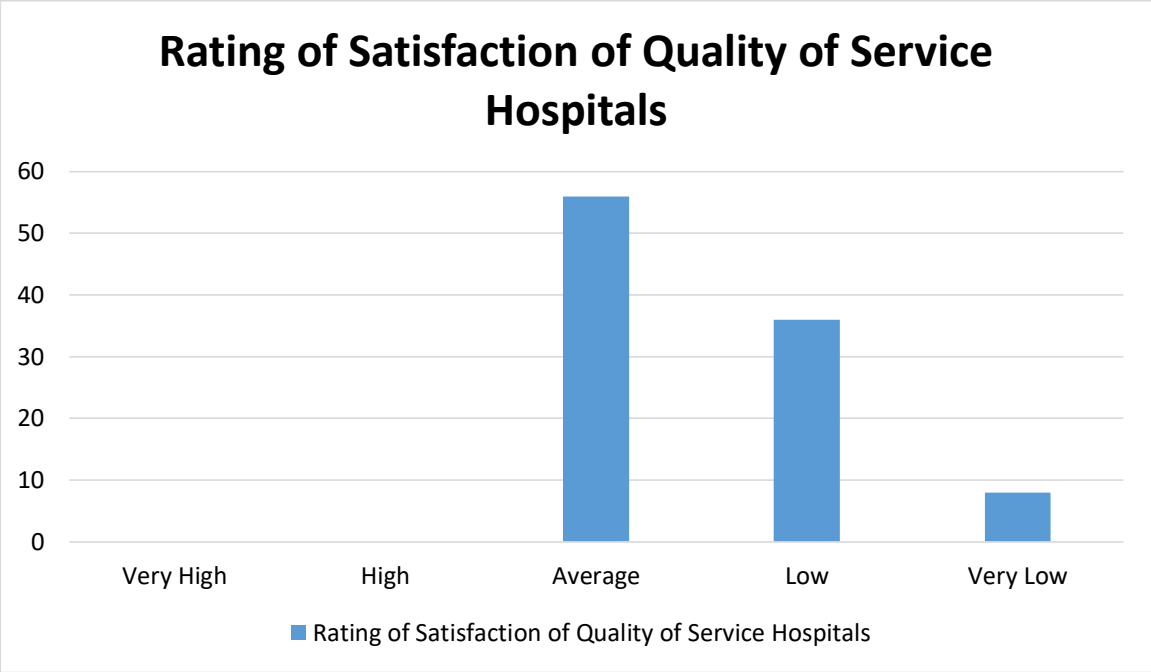
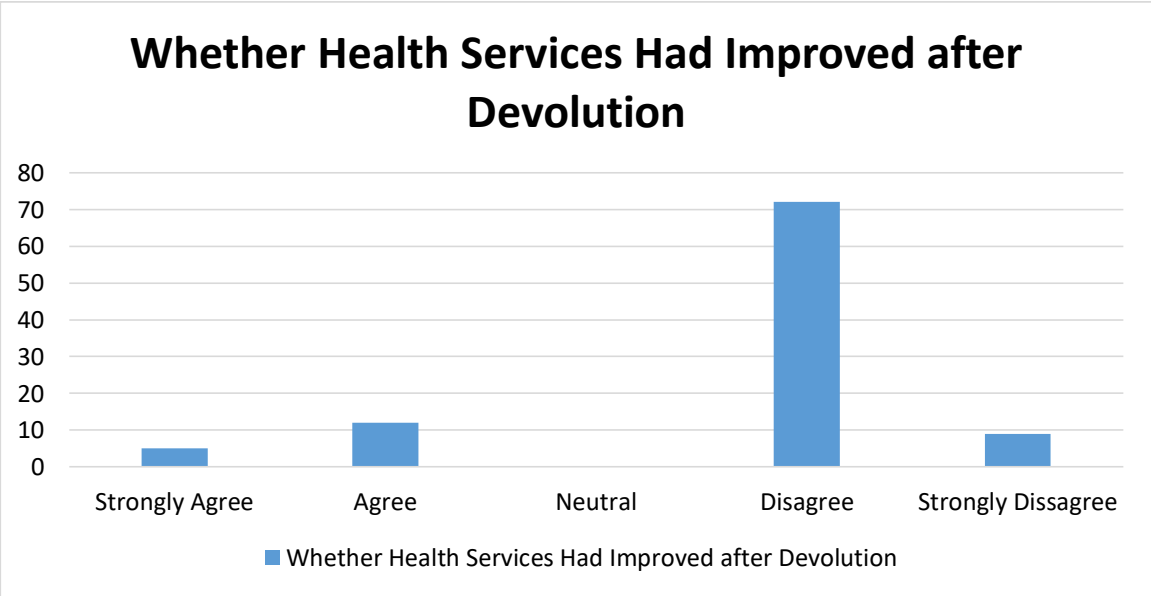


Rating of the respondent's satisfaction level of quality services delivered in the level four hospitals:

Whether Health services have improved since the implementation of devolved governance:

The study sought to establish whether health services had improved since the implementation of devolved governance. Accordingly, 73% of the respondents disagreed, 9% strongly disagreeing while 13% agreed and 5% strongly agreed. As such, there has not been a significant improvement of the health services after devolution.



Whether Health services have improved since the implementation of devolved governance

DEVOLVED PROCUREMENT AND HEALTH SECTOR PERFORMANCE:

Whether devolution of the procurement process has enhanced access to drugs, equipment and facilities at the level four hospitals:

As to whether devolution of the procurement process has enhanced access to drugs, equipment and facilities at the level four hospitals, 74.5% of the respondents disagreed, 20% agreed and 5.5 % strongly agreed. Thus access to drugs had not improved after implementation of devolved procurement.

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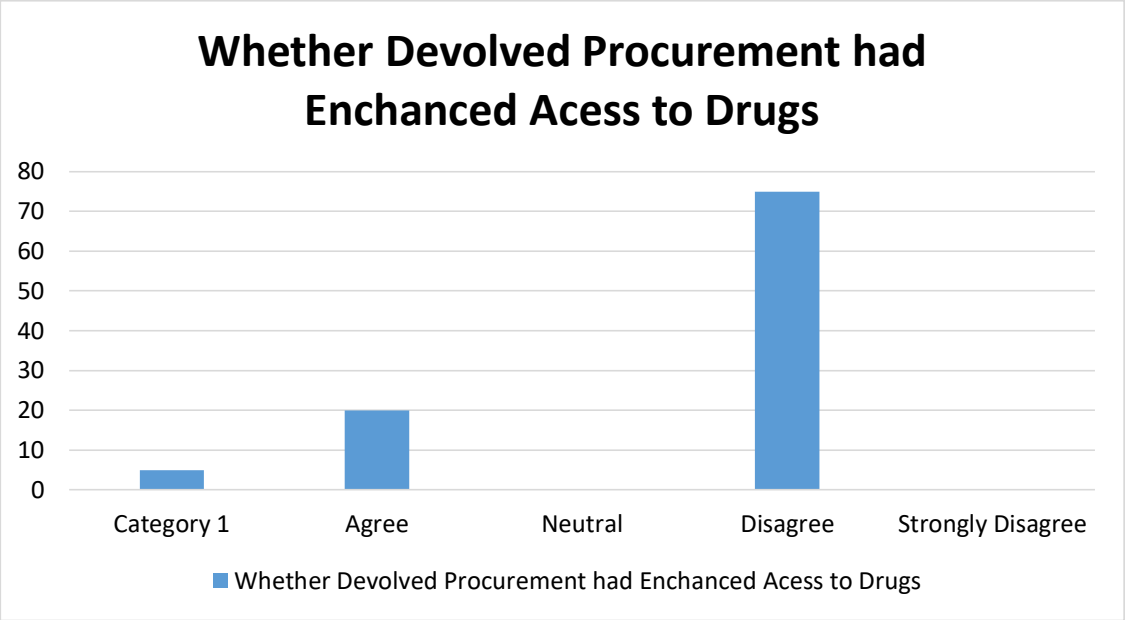
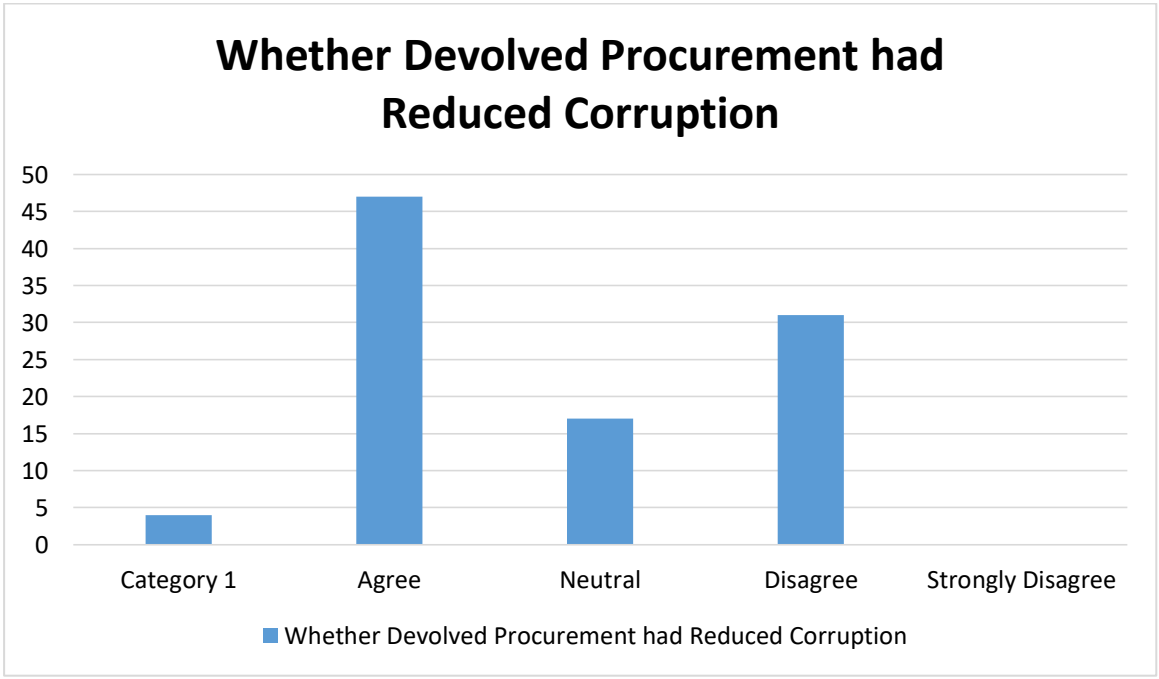


whether devolution of the procurement process has enhanced access to drugs, equipment and facilities at the level four hospitals

whether devolved procurement process has reduced the instances of corruption at the level four hospitals:

In response to whether devolved procurement process has reduced the instances of corruption at the level four hospitals, 47% of the respondents agreed, 31% disagreed, 18% were neutral while 4% strongly agreed. As such there was some significant improvement in curbing corruption in the procurement process, through devolution at the level four hospitals.



whether devolved procurement process has reduced the instances of corruption at the level four hospitals

Whether devolution has enabled public scrutiny of the procurement process at the level four hospitals:

Response as to whether devolution has enabled public scrutiny of the procurement process at the level four hospitals was provided. Accordingly, 53% agreed, 29% strongly agreed while 18% of the respondents disagreed. This showed that devolution has empowered the community to monitor the procurement process at the level four hospitals, a factor enhancing the health sector performance.

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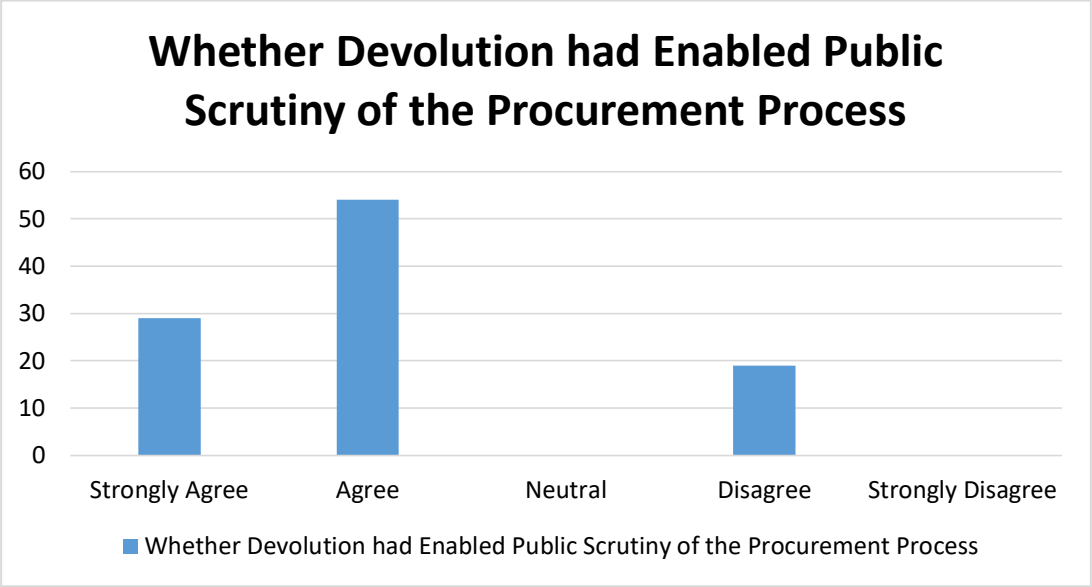


Whether devolution has enabled public scrutiny of the procurement process at the level four hospitals

DEVOLVED LEADERSHIP AND THE PERFORMANCE OF THE HEALTH SECTOR:

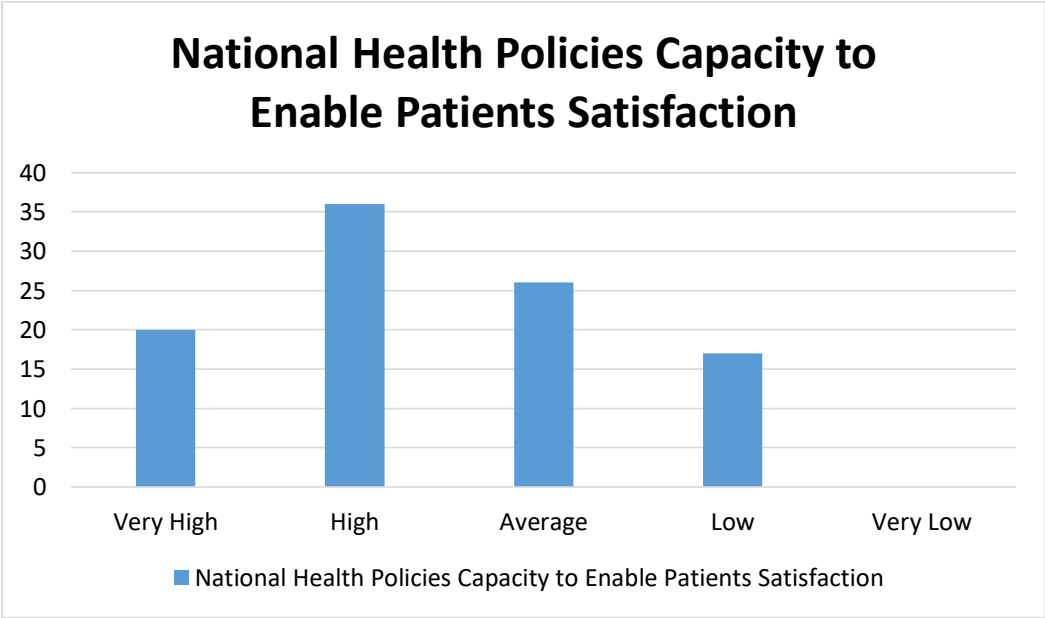
Extent to which the new management under devolution has enabled quicker decision making by the level four hospital leaders:

The extent to which the new management under devolution has enabled quicker decision making by the level four hospital leaders was cited to be much by 56% of the respondents, very much by 35% and moderate by 9%. Thus, quicker decision making has been enabled through devolution, an important factor for strategic change at the hospitals.

DEVOLVED POLICY AND REGULATORY FRAMEWORK:

Rating of the National Health Policies in enabling patients' satisfaction on services delivered at the hospital:

The capacity of the National health policies in enabling patients' satisfaction at the level four hospitals was rated high by 36% of the respondents, average by 26% and very high by 20%. Thus the health policies and regulations were well formulated to enable effective and efficient service delivery to the satisfaction of patients at the level four hospitals.



Rating of the National Health Policies in enabling patients' satisfaction on services delivered at the hospital

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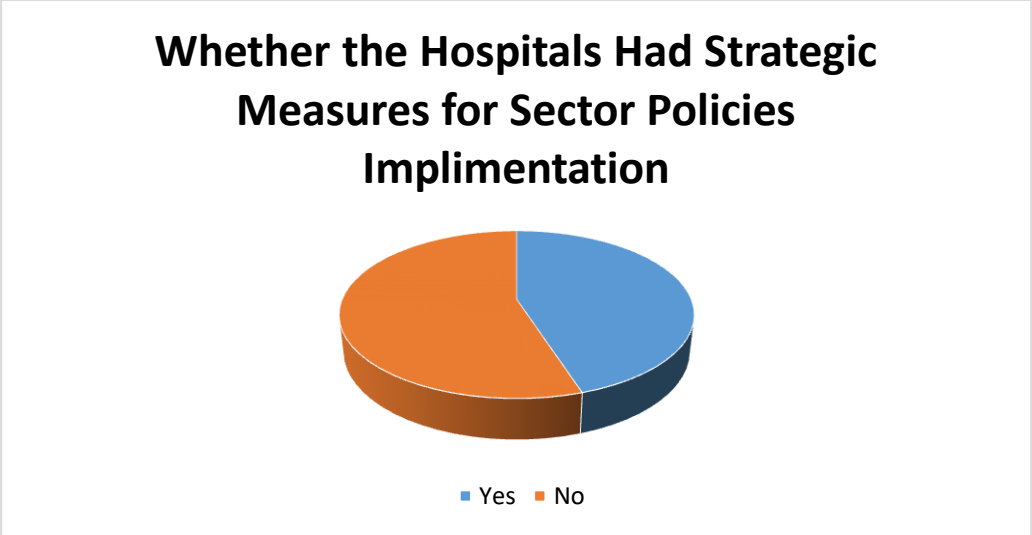
Whether there any strategic measures undertaken by the level for hospitals to effectively implement the health sector policies:

According to 55% of the respondents, there were no strategic measures undertaken by the level four hospitals to effectively implement the health sector policies. However, 45% said that they were there, and this showed low strategic planning by the hospital administration to ensure sector policies are followed for better performance.



SECONDARY DATA ANALYSIS:

The contribution of the health industry to the overall GDP is shown below. Contribution of health to GDP (Kshs)

	2012	2013	2014	2015
Overall GDP at market Prices	**2,570,334**	**3,047,392**	**3,403,534**	**3,797,988**
Total Health Industry	**64738**	**74237**	**81850**	**72914**
Private sector contribution	**34920**	**38805**	**42153**	**45112**
Government Contribution	**29818**	**35432**	**39697**	**27803**

The contribution of the health industry to the overall GDP has remained low, and showed a reduction to 1.9% from 2.4%. The trends in the annual production accounts for health in the country also show a reduction in the health output (expenditure), with the per capita health spending suggestive of a reduction from KES 3,046 (US$ 35.84) to KES 2,722 (US$ 32). The Service Availability and Readiness Assessment Mapping (SARAM) exercise provided the health sector with a comprehensive baseline regarding availability of services, and investments at the beginning of the reporting period. Further, Looking at the health workforce, useable information is difficult to come by, particularly as a result of the transition of the health workforce management to counties during the period. However, it can be inferred that the disruptions in personnel emoluments for health workers noted during the year reduced their productivity.

The effects on health services arising from reduced productivity would be most marked in the counties that witnessed severe disruptions in services and less so in those counties that managed to maintain personnel emoluments for their staff. Additionally, this effect should be blunted by the –as of now anecdotal evidence of –increased availability of lower level cadres recruited by counties to make functional their lower level facilities. It is however imperative that both levels of government must put in order mechanisms of monitoring and reporting on the health workforce delivering health services both at the county and at the National level.

Finally looking at leadership and governance, we see the general trend in most of the counties being that of calling for quick results in health outcomes. To facilitate these, the health management teams in counties were largely left intact, with changes primarily at the political and administrative levels where CECs and Chief Officers were appointed. These provide the required political and administrative oversight of health activities as required in the constitution. As a result, it

has been seen at least two trends in management structures emerging in the counties depending on how the technical health functions are managed.

1. A single, versus multiple Directors (public health, clinical / medical)

2. A single large county management team, versus a small county management team complemented by multiple sub county teams

It is expected that improvements in access, quality of care, and demand for services resulting from the various investments made in the sector. From this perspective, it is noted the sector primarily focused on improvements in access to services as opposed to quality of care, or demand for services. Such access improvements are most noted with physical access (more reported facilities / staff / commodities) and financial access (free maternity services, and free primary care services), though there is no clear evidence of improved socio-cultural access. The effects of this are quite varied across counties. Quality of care initiatives are mostly still at the drawing board, with very limited roll out across implementing units effected. The community based, and advocacy efforts to improve demand and use of available services were being scaled up in selected counties –with no clear evidence these were having significant impact by the end of the reporting period.

4. SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

Summary of Findings:

The performance of the level four hospitals in respondents' area was rated average by 61.8%, low by 27.2%, high by 9% and very low by 2%, while the satisfaction level of the respondents on the quality of service delivery in the level four hospitals was rated average by 56.4% of the respondents, low by 36.4% and very low by 7.2% of the respondents. As such, the level four hospitals did not have high performance. The study also sought to establish whether health services had improved since the implementation of devolved governance. Accordingly, 73% of the respondents disagreed, 9% strongly disagreeing while 13% agreed and 5% strongly agreed. As to whether devolution of the procurement process has enhanced access to drugs, equipment and facilities at the level four hospitals, 74.5% of the respondents disagreed, 20% agreed and 5.5 % strongly agreed.

In response to whether devolved procurement process has reduced the instances of corruption at the level four hospitals, 47% of the respondents agreed, 31% disagreed, 18% were neutral while 4% strongly agreed. Response as to whether devolution has enabled public scrutiny of the procurement process at the level four hospitals was provided. Accordingly, 53% agreed, 29% strongly agreed while 18% of the respondents disagreed.

The extent to which the new management under devolution has enabled quicker decision making by the level four hospital leaders was cited to be much by 56% of the respondents, very much by 35% and moderate by 9%. Thus, quicker decision making has been enabled through devolution, an important factor for strategic change at the hospitals. The influence of devolved leadership on hospital development planning was rated as very high by 73% and high by 27% of the respondents.

Public accessibility to leadership under devolution was cited to be very high by 55%, high by 29% and average by 16%. Access to medical drugs and facilities at the level four hospitals was cited as insufficient by 51% of the respondents, fairly sufficient by 29%, sufficient by 13% and highly insufficient by 7% of the respondents. In response as to whether devolved governance enabled human resource satisfaction at the level four hospitals, 96% of the respondents were of the contrary opinion, while 2% affirmed. The influence of devolved resources on rehabilitation and improvement of the level four hospitals was rated as high by 40% of the respondents, average by 38% very high by 13% and low by 9%. The performance level of the staff at the level four hospitals was rated low by 55% of the respondents, average by 22% and high by 14%. According to 67% of the respondents, the devolution of resources enabled effective allocation of adequate facilities at the hospitals. However, 33% cited that it did not agree. Capacity building of hospital managers' influence on the health sector performance was cited to be very high by 76% of the respondents and high by 24%.

The capacity of the National health policies in enabling patients' satisfaction at the level four hospitals was rated high by 36% of the respondents, average by 26% and very high by 20%. According to 55% of the respondents, there were no strategic measures undertaken by the level four hospitals to effectively implement the health sector policies. However, 45% said that they were there. As to whether respondents had ever been involved during the formulation of policies and

regulations in the level four hospitals, 80% cited that they had not while 20% had, showing low inclusivity during the policy formulation process. The extent to which public participation would enhance the performance of the level four hospitals was cited to be high by 55%, very high by 40% and average by 5% of the respondents.

The health sector performance report 2014 documents that the contribution of the health industry to the overall GDP has remained low, and showed a reduction to 1.9% from 2.4%. The trends in the annual production accounts for health in the country also show a reduction in the health output (expenditure), with the per capita health spending suggestive of a reduction from KES 3,046 (US$ 35.84) to KES 2,722 (US$ 32). Useable information was difficult to come by, particularly as a result of the transition of the health workforce management to counties during the period. However, it could be inferred that the disruptions in personnel emoluments for health workers noted during the year reduced their productivity. Looking at leadership and governance, the general trend in most of the counties was that of calling for quick results in health outcomes. To facilitate these, the health management teams in counties were largely left intact, with changes primarily at the political and administrative levels where CECs and Chief Officers were appointed. The report noted that the sector primarily focused on improvements in access to services as opposed to quality of care, or demand for services. Quality of care initiatives are mostly still at the drawing board, with very limited roll out across implementing units effected Finally, the community based, and advocacy efforts to improve demand and use of available services were being scaled up in selected counties –with no clear evidence these were having significant impact by the end of the reporting period.

Discussions:

Kenya Health Policy 2012 – 2030 provides guidance for the achievement of the highest standard of health. It aims to achieve this by "supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans" by focusing on primary care.

The performance of the level four hospitals in respondents' area was rated average by 61.8%, low by 27.2%, high by 9% and very low by 2%. This has an influence on the overall health sector performance. Actually the health sector performance report documents that the contribution of the health industry to the overall GDP has remained low, and showed a reduction to 1.9% from 2.4%. This performance influences the satisfaction levels of the patients and in this study, the satisfaction level of the respondents on the quality of service delivery in the level four hospitals was rated average by 56.4% of the respondents, low by 36.4% and very low by 7.2% of the respondents.

Bashaasha (2011) posited the concept of public value has been advanced as a way of thinking about and evaluating the goals and performance of public policy and as providing a yardstick for assessing activities produced or supported by government. 'Public value provides a broader measure than is conventionally used within the new public management literature, covering outcomes, the means used to deliver them as well as trust and legitimacy. This thus needs to be entrench in the health sector policies in all the 47 counties.

The study also sought to establish whether health services had improved since the implementation of devolved governance and accordingly, 73% of the respondents disagreed. Devolution was expected to enhance health sector performance in all health care facilities.

As suggested by Sihanya (2013), the success of devolution of health care will require strategic approach in order to realize the benefit of new governance dispensation. The study also found that devolved procurement process has reduced the instances of corruption at the level four hospitals since 51% of the respondents agreed to this. Sihanya (2013) posits that devolution can make the actions of local officials more transparent and provide a check on corruption, appointments based on family ties or other connections and other poor practices. Actually, devolution has enabled public scrutiny of the procurement process at the level four hospitals as agreed by 82% of the respondents, a factor that reduces corruption and resources mismanagement.

Access to medical drugs and facilities at the level four hospitals was cited as insufficient by 51% of the respondents, fairly sufficient by 29%, and as such patients were not satisfied at the hospitals. A tenet of the Constitution of Kenya, 2010 (COK, 2010), is the right to healthcare for every individual. To this end, the government is working towards achieving universal health coverage (UHC) for its citizens. As the government implements approaches to increase demand, it will be imperative to ensure that the supply side is able to adequately respond. According to the Kenya Medical Supplies Agency (KEMSA) procurement Review Report (2008) there was no comprehensive consolidated annual procurement plan

prepared by procurement unit for some tenders and contracts. Concerns were also raised over the inadequate pre-procurement planning that at times contributed to non-payment of suppliers. This influenced access to drugs at the hospitals.

In response as to whether devolved governance enabled human resource satisfaction at the level four hospitals, 96% of the respondents were of the contrary opinion. This finding concurs with those of Mwatsuma, Mwamuye, and Nyamu (2014) that health staff unrest had been witnessed since the advent of county governance; affecting service delivery thus posing health risks to thousands of county residents and scaring away potential investors. Both the national and county government together with the various development stakeholders have paid little attention to such a situation despite the fact that if it remains unchecked could jeopardize service delivery. However, public accessibility to leadership under devolution was cited to be y high by 84% of the respondents, a factor that enhances communication and feedback on health facilities issues. Health policy issues influenced the performance of the health sector. Their implementation process influenced successful service delivery and health care for all.

Conclusions:

It reduces cases of diseases and deaths among the citizens, and provides affordable health care for all. Devolution process has not been fully implemented and its effect has not been fully experienced in the health sector. The sector performance was averagely rated in the study and its contribution to GDP reduced by 0.5 percent by the end of the year 2013.

The sector appears to have no significant increases in investments during the period under review. It was however characterized by accelerated implementation of the constitution, particularly devolution which changed the characteristics of determining and financing sector priorities.

There were significant investments made across the different investment areas of the sector, though these were primarily focused in specific, visible areas relating to improving access to services (physical, financial access). There were minimal investments in other required output areas, particularly in quality of care. The devolved procurement process, organizational leadership, resources allocation and availability as well as policy and regulatory framework had a significant influence on the performance of the level four hospitals and the overall health sector. There are major efficiency gaps in the health sector, which if addressed can significantly increase available resources, and improve on the health outcomes for the people in Kenya. Further, Counties are utilizing health resources with levels of efficiency that are staggeringly different.

Recommendations for the Study:

1. The level four hospitals should formulate internal policy and regulatory frameworks and plans for effective implementation. This will enable provision of quality health for all.

2. The Hospital administration should adopt e- procurement that is more efficient and reduces instances of corruption and enhance access to medical drugs and facilities.

3. The County government of Kiambu should adopt effective remuneration systems that enhance staff motivation and better productivity.

4. The County government should also avail development resources for the level four hospitals in order to enhance service delivery.

5. Improvement in financing of critical health investment areas, particularly those relating to improving quality of care is needed

6. The sector should focus more keenly on improving efficiency in the utilization of available resources, focusing on the counties with the lowest relative efficiency values

Recommendations for Further Research

Studies should be undertaken to establish the impact of devolution on the productivity of the staff in the health sector. Further study should be undertaken to establish the effect of privatization of hospitals on quality of service delivered.

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