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Challenges of the Devolved Health Sector in Kenya: Teething Problems or Systemic Contradictions?

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Abstract

The promulgation of the new constitution in Kenya in August 2010 effectively ushered in devolution as the latest and highest form of decentralization in Kenya. The health sector was the largest service sector to be devolved under this new governance arrangement. The rationale for devolving the sector was to allow the county governments to design innovative models and interventions that suited the unique health needs in their contexts, encourage effective citizen participation and make autonomous and quick decisions on resource mobilization and management possible issues. However, the sector in nearly all counties is currently bedevilled with monumental challenges ranging from capacity gaps, human resource deficiency, lack of critical legal and institutional infrastructure, rampant corruption and a conflictual relationship with the national government. The net effect of these challenges is the stagnation of healthcare and even a reversal of some gains according to health indicators. No doubt what is needed to guarantee an all-inclusive rights-based approach to health service delivery is its proper institutionalization to ensure good governance and effective community participation. This must however be accompanied by wider governance reforms as envisaged in the new constitution for the sustainability of Healthcare Reforms.

Key Words: Devolution, Healthcare Delivery, Healthcare Financing, Health Workforce, health governance.

Résumé

Au Kenya, la promulgation de la nouvelle constitution en août 2010 a véritablement introduit la dévolution en tant que forme de décentralisation la plus récente et la plus élevée. Le secteur de la santé était le plus important

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secteur des services à compétences dévolues dans ce nouveau système de gouvernance. La logique de cette dévolution était de permettre aux gouvernements de comtés de concevoir des modèles et des interventions novateurs adaptés aux besoins uniques en matière de santé dans leurs contextes, d'encourager la participation efficace des citoyens et de prendre des décisions autonomes et rapides concernant la mobilisation des ressources et la gestion des questions qui se posent. Cependant, dans presque tous les comtés, le secteur est actuellement miné par des défis colossaux qui sont notamment les lacunes en matière de capacité, l'insuffisance des ressources humaines, le manque d'infrastructures légales et institutionnelles cruciales, la corruption rampante et une relation conflictuelle avec le gouvernement national. Le résultat final de ces défis est la stagnation des soins de santé, voire un renversement de certains gains d'après les indicateurs de santé. Il ne fait aucun doute que ce qu'il faut pour garantir une approche des prestations de services de santé inclusive et fondée sur les droits, c'est qu'elle soit elle-même institutionnalisée pour assurer une bonne gouvernance et une participation communautaire efficace. Toutefois, cela doit s'accompagner de plus vastes réformes de la gouvernance, tel que prévu dans la nouvelle constitution pour la durabilité des réformes des systèmes de santé.

Mots clés : Dévolution, prestations de services de santé, financement des soins de santé, personnels de santé, gouvernance de la santé.

Devolution in Kenya

Decentralization has a long history in Kenya. Following independence in 1963, the British colonial government proposed a system of regional governments based on ethnic considerations. While this arrangement was never implemented with the newly independent state opting instead for a highly centralized state, it nonetheless formed a basis for ongoing debate with regards to decentralization of service provision. Between the 1970s and 1990s, a number of decentralization structures (without decision making authority) were created and variously funded including by the World Bank and International Monetary Fund (IMF) as part of structural adjustment programmes (Esidene 2011:2). These reforms continued to promote deconcentration, as the new structures took on more responsibility for service provision, but created no new decision-making powers. Other challenges accompanying this form of decentralization included: the poor legal basis for decentralization; limited decision space for local governments; weak citizen participation; capacity gaps within local governments; continued civil servant dominance; and a focus on outcome over process. By most accounts, these efforts at decentralization were not successful and Kenya remained highly centralized.

After a long period of agitation for a new constitutional dispensation by Kenyans, central to which was contestation of the over-centralization of powers around the presidency, in August 2010, 67 per cent of voters approved a new constitution in a referendum commencing devolution as the latest round of decentralization in Kenya. The new constitution introduced a devolved system of government where many national government services were delegated to the designated forty-seven county governments. These newly created counties were based on Kenya's 1992 district framework (KPMG Africa 2014:5). According to the constitution, the two levels of governments are interdependent and undertake their relations through consultation and cooperation.

The key distinguishing factor between the 2010 constitution and its predecessor, the 1962 Lancaster House constitution, is the level of people's participation. The 2010 constitution envisages a robust participation of citizens, right from the grassroots in decision making processes. This is guaranteed through devolution and platforms provided for this purpose. According to Article 174, the main objectives of devolution are: to promote democratic and accountable exercise of power; to foster national unity by recognizing diversity; and to give powers of self-governance to the people and enhance the participation of the people in the exercise of the powers of the state and in making decisions affecting them.

Devolution of the Health Sector

The 2010 constitution provides a legal framework that guarantees an all-inclusive rights-based approach to health service delivery to Kenyans. It provides that Kenyans are entitled to the highest attainable standards of health, which includes the right to healthcare services including reproductive health care (Article 43). Article 53 provides for the right of every child to basic nutrition, shelter and healthcare. In Article 56, the constitution provides that the state shall put in place affirmative action designed to ensure that minorities and marginalized groups have reasonable access to water, health services and infrastructure.

To actualize these rights, the constitution has divided the healthcare responsibilities between the county and national governments. The Fourth Schedule of the constitution provides specific guidance on which services the county or national governments are to provide. In the health sector, essential health service delivery is assigned to county governments, while the national government retains health policy, technical assistance to counties, and management of national referral health facilities.

For health services to be all inclusive and rights-based, as envisaged in the constitution, four important inputs are required. First, there has to be the availability of a network of healthcare facilities; second, the facilities must be functional with competent and motivated staff; third, there needs to be supplies of essential medicines, and, finally, funds for the operation and maintenance of health facilities must reach the facilities on time. These four factors are primary to delivering the healthcare promise to the 62 per cent of Kenyans who primarily rely on the public healthcare system (Mwangi 2013:13).

Availability of Health Care Facilities and Personnel

Health facilities must be physically available for the population to access healthcare services. Just 63 per cent of Kenyans have access to government health services located within an hour of their homes (International Rescue Committee 2015:12) and greater distance to a facility is a significant factor in decreased demand for healthcare in the country. Health facilities are unequally distributed across the forty-seven counties. In Turkana County for example, some residents in the far flung corners of the county have to travel for two days to access a health facility. As a result, health indicators are much below average, compared to other counties. In addition, there are only sixty-five public health facilities out of a total 4,929 in the country and twenty-one private facilities out of a total 3,794 in the country (Ministry of Health 2014). Further, only 18 per cent of births are delivered at a health facility against the national average of 61.2 per cent and an average of 23.9 per cent of persons experience stunted growth against the national average of 2.6 per cent.

Generally, half of the counties in Kenya have fewer than two health facilities per 10,000 people and fewer than 4.2 facilities per 100 square kilometres. Densely populated Mombasa and Nairobi have 134 and 124 health facilities per 100 square kilometres respectively, but far fewer facilities per 10,000 people (2.9 and 2.4 respectively). Marsabit, Tana River and Isiolo have the fewest health facilities per 100 square kilometres, but above-average numbers of health facilities per 10,000 people (Ministry of Health 2013:67). While these counties may have a sufficient number of facilities for the population, patients must travel long distances to reach them (Muoko and Baker 2014:16).

Beyond the number of health facilities, there are also great discrepancies between the numbers of health personnel per county offering services in these facilities. Overall, the ratio of healthcare workers to the population falls below the WHO recommended 230 per 100,000 people, and at the time

of writing stood at 169 per 100,000, but this compares favourably to other countries in the region like Uganda, Malawi, Tanzania and Mozambique (Government of Kenya 2010:54). However, this ratio masks the regional disparities across counties. Counties such as Nairobi and those of central Kenya are better resourced and therefore enjoy a higher ratio than those in the rural and marginalized sections of the country. As outlined in the Constitution of Kenya, recruitment and hiring of staff for devolved functions are the counties' responsibilities. Each county has a public service which is tasked with appointing its public servants within a 'framework of uniform national standards prescribed by an Act of Parliament' (Government of Kenya 2010, Constitution of Kenya, Article 235). In addition to appointing public servants, public service responsibilities include the establishment and abolishment of offices in its public service, disciplinary control and removal of persons acting in these offices.

The population densities of doctors and nurses are important indicators of a county's capacity to provide adequate primary healthcare coverage. The proportion of doctors per 10,000 people in the forty-seven counties ranges from zero (Mandera) to two (Nairobi). These rates are below the national benchmark of three medical officers per 10,000 people (Ministry of Health 2013). Counties generally have higher population density rates for nurses, ranging from 0.9 per 10,000 people in Mandera to 11.8 per 10,000 people in Isiolo. However, just four counties in Kenya currently meet the country's benchmark of 8.7 nurses per 10,000 people (Ministry of Health 2013). In general, counties with higher population densities of doctors tend to have higher population densities of nurses.

The lack of adequate personnel in most counties has been one of the biggest contributing factors to the current unrest in the health sector in several counties. Between January and August of 2015, more thantwenty-two counties experienced strikes by health personnel, who cited understaffing as one of the critical causes (Kariuki 2014). The main reasons contributing to the critical staff shortage include high rates of desertion by medical personnel, lack of proper structures to determine the health personnel requirements and place them accordingly, high corruption rates at the counties and lack of adequate funds to employ health personnel, among other reasons.

The human resource challenge becomes more apparent when broken down by specialization. The sector faces a critical brain drain which was exacerbated by devolution and the arising conditions at the county level. Currently between 30 to 40 per cent of the estimated 600 doctors who graduate in Kenya annually move to other countries in search of greener pastures after completing internships (Magokha 2015). According to 'The

Kenya Five Year Health Sector Human Resource Strategy Paper 2013–2018', there is currently not a single general cancer doctor in government hospitals. This is alarming considering that an estimated 112 Kenyans are diagnosed with cancer everyday (Ministry of Health 2013:15). Other greatly understaffed but critical areas include 169 medical engineering technologists against a critical requirement of 1,187 personnel; 73 gynaecologists in the public sector against a requirement of 300; and only one kidney doctor for children and two kidney physicians in the public sector. Most of these critical personnel are concentrated either in the national referral hospitals or in the counties' highest ranking level 5 hospitals, leaving the other health facilities without critical personnel; yet 68 per cent of Kenyans using the public health system use these lesser facilities (*ibid.*).

Healthcare Financing

Kenya is a signatory to the Abuja Declaration according to which African countries are committed to invest 14 per cent of the national budget in health. Paradoxically, the Government of Kenya over the past four years has drastically, and even dangerously, cut the financing of the health sector. In 2010, Kenya spent Sh7.20 out of every Sh100 on healthcare. This fell to Sh6.10 in 2011 and was further cut to Sh5.9 in 2013. In 2014, the national and county governments planned to spend Sh5.70 per Sh100 on the sector, translating to 5.7 per cent of the Sh1.6 trillion budget, a far cry from the 14 per cent pledged. These drastic cuts in healthcare provision have led to poor services, lack of drugs and frequent strikes as well as increased mortality and morbidity rates. Funding for county level functions is primarily from the national government. The four financing sources (three national governments and one county government) are: generation of revenues by the counties from property taxes, business licences and entertainment taxes; an equitable share with the counties assured of receiving no less than 15 per cent of national revenue; an equalization fund set aside for marginalized communities and representing an additional 0.5 per cent of national revenue; and conditional and unconditional grants from the national government. The revenue allocation formula, as presented by the Commission on Revenue Allocation (CRA), takes into account the following parameters: county population, poverty level, land area, basic equal share and fiscal responsibility (Commission on Revenue Allocation 2014).

Therefore, primary funding for healthcare comes from three sources: public, private (consumers) and donors. Consumers are the largest contributors, representing approximately 35.9 per cent, followed by the Government of Kenya and donors at around 30 per cent each (KPMG Africa

2014:7). Over the past few years, government financing as a percentage of GDP has been consistent at slightly above 4 per cent. A regional comparison of the total health budget as a percentage of GDP shows that Kenya ranks last, behind Rwanda, Tanzania and Uganda (*ibid.*).

While consumers are the largest contributors to the healthcare budget, the paradox is that the majority of those who opt for public health care are the poorest who cannot afford private care. This bracket of the population spends more than 40 per cent of non-food expenditure on healthcare (Government of Kenya 2014:34). Healthcare is thus a major source of financial distress for Kenyans.

As a devolved function, the major health financing at the county level comes through the county government, and beyond that is provided by consumers through cost-share. In the 2014/15 budget, counties received about 25 per cent of the total budget (Olugo 2015:26). However, at the level of individual county allocation, most counties allocated less than 5 per cent of the budget to health. A lot of this allocation went into remuneration of personnel, purchase and improvement of hospital equipment and infrastructure, and purchase of drugs. Because of the low allocation, however, the money is not enough, directly impacting on the quality of care.

With the adoption of the 2010 constitution, the government also introduced a new health financing system to supplement user fees and the county allocations. The Health Sector Services Fund (HSSF), launched in 2010, aims to expand the supply of healthcare and strengthen primary healthcare. This is through the improvement of delivery of quality essential health services in an equitable and efficient manner as envisaged by Kenya Vision 2030. It is also a response to the gaps identified in the Kenya Health Policy Framework1994-2010, and the Ministry of Public Health and Sanitation Strategic Plan 2008-2012. The HSSF is a revolving fund that provides direct cash transfers to primary health care facilities that include dispensaries and health centres. The local communities represented by the Health Facility Management Committee (HFMC) manage the funds received and prioritize their use according to health needs.

The HSSF mobilizes additional resources from the government and its development partners to improve service delivery. It ensures expeditious and direct cash transfers to primary health facilities run by the government and faith-based organizations, and supports an equitable distribution of resources. More importantly, the HSSF empowers local communities to take charge of their health by actively involving them through the HFMCs in the identification of their health priorities, and in the planning and implementation of initiatives responsive to the identified priorities (Muoko

and Baker 2014:67). Unfortunately, while the HSSF has been critical, especially in improving the physical infrastructure of health facilities in far flung counties, the allocation is minimal as it is based on the number of clients and the level of the facility. As a result, level 4 and 5 facilities get more money while levels 1 to 3, which are closest to the people, get very little allocation.

Availability of essential drugs is another key component of the health system and is closely related to financing. In Kenya, the government introduced the 'pull system' in 2010 to facilitate supply of relevant essential drugs to facilities throughout the country. The 'pull system' is a demand-based approach for ensuring the reliable availability of health commodities at all service delivery points within a health system. Under the National Health Sector Strategic Plan II (2005–2012) the government (Ministry of Health) established virtual 'drawing rights' for health facilities to move toward the 'pull' system of supply in which facilities order their required supplies and commodities based on actual need rather than receiving centrally determined numbers of medicine kits (referred to as the 'push' system of supply).

While this system was in place in most of the health facilities by 2013, the introduction of devolution has greatly disrupted it. This is because where it was previously facilitated by facilities drawing medicine from the Kenya Medical Supplies Authority (KEMSA), counties are no longer obliged to source from the government-run KEMSA and can source from other areas they deem better. This has opened an avenue for corruption, mismanagement and perennial scarcity of drugs at health facilities. This is because since procurement systems are still largely young and sub-optimal, unscrupulous personnel within the county governments are procuring drugs from unknown sources at great expense. This compromises not just the list of essential medicines, as provided by the Ministry of Health, but also the quality of the medication procured. Effective monitoring systems are urgently needed at county levels to address the question of drug supply and redress mechanisms put in place to curb the rampant corruption that is currently ongoing in relation to drugs.

Health Governance

In the devolved system, healthcare governance occurs at two levels: national and county. At the national level, the Ministry of Health (MoH) is responsible for providing stewardship and guidance. At the county level, county departments of health are responsible for coordinating and managing the delivery of health services. The roles of the MoH and those of the county departments of health are outlined in the Fourth Schedule of the constitution of Kenya. The two levels of government, while independent, will cooperate to achieve the

governance and management objectives as outlined in Kenya Health Policy 2012-2030. The health policy identifies seven policy orientations, that is areas earmarked for investment to enable the achievement of the policy's objectives. These are: healthcare financing, health leadership, health products and technologies, health information, health workforce, service delivery systems and health infrastructure (Ministry of Health 2014).

While new governance structures have been defined and the process of implementing them has begun, getting them right will be imperative. This is because governance entails more than having building blocks in place. It is important that roles, responsibilities/accountabilities and the chain of command for all structures and players in the sector are clearly defined and understood by all. This is currently critically lacking among the actors in the health sector in Kenya.

The Kenya Health Policy 2012-2030, provides an institutional framework that specifies the institutional and management frameworks required under the devolved system. The policy sets out the objectives of the new governance structure as:

- delivery of efficient, cost effective and equitable health services;
- devolution of health service delivery, administration and management to the community level;
- stakeholder participation and accountability in health service delivery, administration and management;
- operational autonomy;
- efficient and cost effective monitoring, evaluation, reviewing and reporting systems;
- smooth transition from old to devolved structures; and
- complementarity of efforts and interventions.

In the devolved system, healthcare is organized in a four-tiered system:

i. *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.
ii. *Primary care services*: This level is comprised of all dispensaries, health centres and maternity homes for both public and private providers.
iii. *County referral services*: These are hospitals operating in, and managed by a given county and are comprised of the former level 4 and district hospitals in the county and include public and private facilities.

iv. *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 (Government of Kenya 2013:7).

The transition process from centrally managed health care services to devolution at county levels was envisaged to be a gradual one as power and functions increasingly shifted from the national to county governments. This would allow for the creation of requisite capacities at the county level. In practice, however, this did not happen and devolution was almost achieved overnight. The newly formed county structures were in a rush to consolidate their power and hold over the lucrative health sector. As a result, transition from the national to county government has been marred by inconsistency, poor staffing of the system, management challenges and lack of coordination between the national and county governments. At the national level, poor management and inefficiencies in resource distribution have largely contributed to poor working conditions at the county level including delays in salary payments (Ministry of Devolution and National Planning 2015:37).

In spite of this confusion, counties are at varying levels of instituting structures and frameworks to help realize healthcare delivery to their citizens. Generally, health services at the county level are run by Ministry of Health services with various departments, depending on the specific needs of the county. Community participation is a top priority within these new structures. Community participation has been a mainstay of Kenya's healthcare system since the implementation of the Community Health Strategy (Ministry of Health 2006:34). The strategy is defined as, 'the mechanism through which households and communities take an active role in health and health-related issues' and its objectives are: community empowerment, to bring healthcare closer to the people, the establishment of community health units and the enhancement of community-health facility linkages. This aspect of community participation has been carried on to the devolved system. Organization of healthcare delivery in the new system is four-tiered and includes a community health services level whose objective is to promote community participation serving as the first point of contact.

At the facility level and in the spirit of effective public participation, provided for under devolution, health facilities are run by locally elected Health Facility Management Committees (HFMCs). According to World Bank research carried out in 2014, over 80 per cent of the health facilities

in Kenya have functioning HFMCs that meet regularly, at least twice a year, and that are responsible for general management of the facility (World Bank 2014:54). They work hand in hand with the county health management teams, representing citizens in health management at the county level.

Challenges Facing the Devolved Health Sector in Kenya

A number of challenges continue to be experienced within the health sector at county level, threatening quality service delivery and gains made in the sector over the last thirteen years, with the coming to power of the opposition-led National Rainbow Coalition (NARC) government that prioritized education and healthcare in Kenya. These challenges are wide and far reaching spanning capacity issues, human resources, infrastructure, legal framework, resources and the relationships between county and national government (Mwangi 2013:2; Kibui et al. 2015:133; Ministry of Health 2014:27).

Transition from national to county governments has been marred by inconsistency, poor understanding of the system, management issues and lack of coordination between the two levels of government. At the national level, challenges of devolution as depicted in the media have emerged in the form of poor management, resource distribution, ethnicity fears, poor working conditions and delayed salaries, among other factors. Reports of health workers resigning due to these issues have been rampantand so are strikes and strike threats. In Turkana West Sub-county for example, a survey conducted by the International Rescue Committee among twelve health facilities in the sub-county in 2015 indicated that over 92 per cent of the health officers (nurses and levels above) were occupied by members of the local Turkana community, yet in 2013 May, the local community held 56 per cent of the positions. This disparity can be explained by the massive exodus of staff from other communities from the area since devolution. This out-migration was partly supported by ethnic fears, general desertion of the health sector by professions due to frustrations experienced since devolution as well as subtle political statements made by leaders in the area to the effect that they were discouraging outsiders from employment in the county. As a result, almost all the new employees hail from the local community as leaders justify this as affirmative action due to their historical marginalization (International Rescue Committee 2015:86).

There is a general fear among healthcare workers about their job security (Mwamuye and Nyamu 2014:266). A majority believe that devolution will create job insecurity and reports indicate that many have resigned orsought alternative employment in anticipation of this impact. Some have experienced delayed salaries since devolution tookeffect and they feel this is

unfavourable to their job security. Furthermore, employees transitioned to county governments are yet to get official letters of appointment.

Challenges in resource distribution have been witnessed whereby the allocation of funds to counties is inconsistent. This leads to stalling of functions at the county level, further creating inefficiencies. For example, the HSSF allocation is expected to be disbursed every quarter from the national government directly to health facilities countrywide. However, it is not unusual for certain facilities to receive only one or two disbursements in a year. This greatly disrupts the running of the facility as these funds are the ones used to primarily run the facility and cater for any arising emergencies. The lack of strong institutions at the county level means that there is no effective communication and follow-up between the two levels of government to speed up the disbursements, and therefore facilities are left on their own to follow up with the national government, which is a rather challenging task, given their physical, social and capacity distances from the national Ministry of Health in Nairobi. The delay in funds disbursement is also experienced at the county level where allocations from the national Ministry of Finance are often delayed leading to delays downstream with such results as frequent strikes over salaries by health personnel, lack of drugs and other basic necessities at health facilities and, ultimately, desertion of the health sector by qualified staff due to the arising frustrations. The delay in allocations has been so rampant that counties see it as a political strategy to sabotage their health delivery so that citizens can push for the function to revert back to the national government (Kariuki 2014).

Overall, there is limited knowledge about devolution, which is proving detrimental to achieving the desired impact and the realization of the highest possible standards of health for all. In a survey conducted on knowledge of devolution in health in Kenya, only 11 per cent of respondents indicated that they had full understanding of devolution in health; 78 per cent indicated partial understanding; while 9 per cent did not understand it at all (Center for Health Solutions in Kenya 2013:26).

Management of health facilities at county level is another big challenge. The county government, facing serious capacity challenges, has left the management of facilities in the hands of health personnel. While they have a lot of technical and professional expertise, the majority lack adequate strategic management skills to access and make proper use of resources and mitigate against new devolution challenges. Furthermore, the procurement of goods and services at county level has been centralized at county headquarters. That has led to confusion and procurement challenges which affect quality of procured products and service delivery (Mamuye and Nyamu 2014:18).

This over-centralization of procurement at the county level introduces the same hurdles that were experienced with the former system of centralization at the national level, and which necessitated devolution.

Currently, most county governments have no clear procurement plans in place for the purchase of medical supplies (*ibid.*). The county governments are under no obligation to procure from the Kenyan agency fordrugs supply (KEMSA) which has been procuring in bulk and thus enhancing economies of scale while also monitoring the efficacy of the drugs for purposes of continuous improvement. This has also introduced an opportunity for corruption in supplies procurement where suppliers are acting in cahoots with corrupt county officials to supply medical supplies of questionable quality at inflated prices. This not only leads to wastage but also endangers the lives of the population. In Isiolo County in January 2015 for example, an audit report showed that Kshs. 1.2 billion had been earmarked for the purchase of drugs and other medical supplies, yet a spot check in hospitals showed a lack of the said drugs in health facilities, and yet government records indicated that they had been delivered in December 2014. The audit report also revealed that there were no proper procurement systems that led to the identification of the supplier and the firm was hardly known by the people in the office. Nor had the tender been advertised as is required by law (Mutai 2015).

Due to the insistence on the autonomy of individual counties to conduct their own affairs, they are missing out on the benefit of economies of scale. The fragmentation of procurement can increase costs and the risks of corruption. There are a number of supporting functions such as financial management and human resources management which may be more economically operated at a level above the counties to reduce costs and make use of scarce expertise. Another related challenge is conflict with vertical programmes. Programmes such as for HIV, TB and health promotion are often organized on a vertical basis, sometimes funded by external donors. In some situations, these donors are nervous about using the devolved structures and have developed confidence in their own vertical programmes. There is potential for unhelpful overlaps and conflict between the vertical programmes and the newly-devolved structures. The complete devolution of budgets also means that it is difficult to run large national programmes, and that less money may be earmarked for these.

Lessons from other Countries

This section of the article seeks to compare and draw lessons from other countries that have devolved healthcare as a means of strengthening service delivery. The lessons are drawn from some of the key pillars of health systems

including governance, service delivery, health financing and organization of the health workforce. The countries analysed include Ethiopia, Thailand, Uganda and Ghana.

Ethiopia

The concept of devolution was introduced in 1996 and was seen as the primary strategy to improve health service delivery in Ethiopia. It formed part of a broader devolution strategy across different sectors, of which healthcare was one. Devolution first took place at the regional level and was further extended to the district, or *Woreda*, level in 2002. Through devolution, a four-tiered system of care facilities was created – national referral hospitals, regional referral hospitals, district hospitals and, lastly, primary healthcare facilities. The devolution mechanism entailed districts receiving block grants from the regional government. They, in turn, were entitled to set their own priorities and determine further budget allocations to healthcare facilities based on local needs. As such, the district levels are responsible for human resources management, health facility construction and supply chain processes (Dubusho et al. 2009).El-Saharty et al. (2009) report that impressive improvements of service delivery were observed despite some challenges in the initial stages.

Ghana

Decentralization has played a pivotal role in government policy ever since Ghana became an independent country. Following the 1993 Local Government Act, the District Assemblies' responsibilities were limited to activities in the field of public health (e.g. health promotion and disease surveillance and control). The Ministry of Health has delegated the responsibility of managing its facilities to an autonomous entity created in 1996, the Ghana Health Service (GHS). The GHS is responsible for managing and operating most of the country's facilities and offices. The GHS subsequently evolved into a more deconcentrated structure with regional and district health offices. Although both structures are based on the principle of delegation and deconcentration at a district level, there is not one single authority for the coordination of health service delivery at a district level.

Thailand

Through the implementation of the Local Administrative Organizations Act in 1999, a target was set for transferring a significant share of national budgets to Local Administrative Organizations (LAOs). The minimum

share of budget to be transferred was 25 per cent, with a target of 35 per cent. The Act impacted on several sectors, including healthcare. Devolution of health services mainly focused on primary health centres and the transition of ownership from the Ministry of Health to the LAOs. Before devolution, health centres had little autonomy and, through the aforementioned Act and guidelines developed by the Ministry of Health, the health centres were given the option to either perform services under the flag of the Ministry of Health or to devolve them to the LAO-level. However, devolution of health centres only occurs if two conditions are met. First, the LAO must have received a good governance award demonstrating that it is capable of managing the health centre. Part of this also implies that sufficient funds are earmarked by the LAO for health-promoting initiatives. Second, at least half of the health centre's staff involved need to be willing to transfer to LAO employment (Pongpisut 2012).

Devolution in the Thai primary healthcare environment thus means that the LAO becomes responsible for primary health service delivery through health centres. This implies that day to day operational responsibility, including financial and human resource management, have become the responsibility of the LAO. The Ministry of Health continues to be responsible for technical, policy, supervision and training aspects, and regulation of health professionals (Hawkins 2009).

Uganda

Devolution was introduced in Uganda in 1997 under a local government Act. The main focus was on education, health and agricultural advisory services, as well as on the management of natural resources in Uganda. Studies show that there has been no improvement in health services with many health status indicators either stagnating or worsening. In general, decentralization of education and health services has not resulted in greater participation of ordinary people or accountability of service providers to the community. The lack of community participation, inadequate financial and human resources, a narrow local tax base and a weak civil society all underscored the need for improvements if devolution was to attain the anticipated results. The case study from Uganda cautions against the tendency to romanticize devolution as the new-found solution for past and current institutional and socio-economic distortions. It shows that devolution can make state institutions more responsive to the needs of the communities, but only if it allows local people to hold public servants accountable and ensures their participation in the development process (Patrick 2013:43).

Lessons for Kenya

Kenya can Learn a Number of Critical Lessons from these Countries

From all four countries, what is evident is that creating the right governance and accountability structure is critical to making devolution and, in the end, service delivery to the patient, successful.

On enabling communities to participate, in general, it is believed that local governments are more transparent than national governments. This is due to the proximity of local governments to their communities. One of the aims of devolution is to create more intense community involvement in order to adjust service delivery models to the communities' specific needs. As such, the local government must have the authority to involve communities. It was found in Ethiopia that communication channels with communities were not well established whereas the opposite is true in Ghana where mechanisms for local community participation have been established at different levels. In Thailand, there was an increased level of responsiveness to the community the health centre operated in and the patients it catered for. This, in turn, also impacted positively on community participation and, as a result, health centres found the number of patients visiting had increased.

On patronage and corruption, it was found 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. However, this assumes that there is an active local political system, news outlets which are themselves not part of these webs of influence and that people will be prepared to blow the whistle where they see problems and that they will be listened to. External audit and review and the opportunity for issues of this sort to be escalated may be required.

Devolving responsibilities does not only impact on those organizations or regions where responsibilities are devolved to, it also impacts on the organization – 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 'ownership and control' in a devolved system.

Another key lesson is the need to deal with cross-border flows of patients. For example, if one area runs poor services with long waiting times, there will be incentives for people to go elsewhere. The area gaining additional patients will not gain additional finances unless there is an adjustment

for these movements of patients. This sets up perverse incentives for all concerned. It is not desirable or very practical to limit people's ability to travel. Furthermore, although adequate funding is crucial for any health system to be effective, it is not only funding that impacts 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 (KPMG Africa 2014:37).

On process versus outcome objectives, in some systems it seems like devolution, or to this extent delegation or deconcentration, are goals in their own right rather than a means to achieve a broader objective like improved health levels for the population. It is therefore important to separate process and outcome objectives. It was found for example in Ethiopia, that health outcomes such aschild and maternal mortality rates have decreased, but it could be argued that this might also be a result of other health strategies being implemented at the same time. Besides this, Ethiopia was coming from a poor baseline in terms of health outcomes.

Making Devolution of Healthcare Workable in Kenya

From the foregoing arguments about how devolution is currently playing out in Kenya as well as lessons from other countries that are implementing devolution, a number of key lessons towards making devolution work can be drawn. First, it is evident that devolution is not an event but a process whose ultimate aim is better healthcare with more meaningful access for the majority of citizens in Kenya. It is also clear that healthcare will remain a devolved function and will not revert to the central government as some political actors are pushing for. This is because for this to be possible, a referendum is needed which is both very expensive to execute,and withunpredictable results. It is therefore not in the interest of the political elite to push for a referendum on the same. Therefore, while time has to be given to the instruments of devolution to be nurtured, it is important to ensure that the requisite frameworks and institutions are in place.Failure in this respectpresents the risk of making wrong investments in terms of time and resources.In the end some people will be more alienated from the system than before devolution. The changes envisaged should provide both immediate and long term gains; in the short term, they should foster trust in devolution as a system, and, in the long run,lead to institutional strengthening of the health system. Some of these changes include the following.

Make Existing Public Primary Healthcare Facilities Functional

Devolution provides a unique opportunity to strengthen primary healthcare service delivery. With counties now responsible for delivering primary healthcare services there is hope that some of the chronically persisting weaknesses to make the existing facilities operational will be addressed. By the end of the first year of devolution some of the initial gains made in improving delivery of primary healthcare services are clearly visible. For example, the Governor of Mandera has taken the initiative to make all fifty-two primary healthcare facilities in the county operational by recruiting staff. The Governor of Machakos is focusing on improving access to safe delivery of services by providing maternity units to all primary healthcare facilities and positioning ambulances in eachward. Kakamega is giving strategic focus to improving maternal and new-born health services. There are several ongoing initiatives in many counties, which are not yet systematically documented. Many counties have undertaken audits of human resources to weed out ghostworkers. It is also expected that with closer oversight, the absenteeism of health staff will reduce.

Build on Existing Partnerships with Faith-based Organizations (FBOs) and Partner with the Private Sector

There is already a strong partnership with FBOs, which complement public health facilities. Counties need to build on this well established relationship. Kenya has a vibrant private sector which is rapidly expanding to rural areas through franchised networks. It is important to effectively leverage such networks for public goods, especially for delivering reproductive maternal, new-born and child health services.

Adopt a Primary Healthcare Approach

Primary healthcare is defined as essential healthcare; based on practical, scientifically-sound and socially acceptable methods and technology; universally accessible to all in the community through their full participation; available at an affordable cost; and geared toward self-reliance and self-determination (World Health Organization 1990). The county government needs to shift the emphasis of healthcare to the people themselves and their needs, reinforcing and strengthening their own capacity to shape their lives.

Healthcare needs to be delivered close to the people; thus, should rely on a maximum use of both lay and professional healthcare practitioners. They should include the following essential components: education for

the identification and prevention of illnesses; control of prevailing health challenges, proper food supplies and nutrition; adequate supply of safe water and basic sanitation; maternal and child care, including family planning and immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases using appropriate technology; promotion of mental, emotional and spiritual health; and the provision of essential drugs. For this to be achievable, counties must strengthen networks, empower community healthcare workers and promote meaningful community participation in decision making and the oversight of health services.

Continue HSSF but Shift Emphasis on Accountability to Results

Performance accountability remains a cornerstone for the devolved health system in Kenya. This now needs to trickle down from top management to sub-county health teams and the facilities in charge. The experiences of the Results Based Financing pilot in Samburu shows that objective assessment of performance through regular supportive supervision enhances motivation of providers as well as supervisors and improves retention (World Bank 2014).

Rationalize Hospital Infrastructure

Hospitals are expensive to build and maintain. Countries in Central Asia and Brazil realized the importance of rationalizing hospital infrastructure and created hospital networks that optimize efficiency. Clusters of counties now need to collectively work together to develop well networked hospitals which provide high quality referral back-up to primary care facilities.

Maintain Commodity Security

All counties have entered into a Memorandum of Understanding with KEMSA, or the Mission for Essential Drugs and Supplies (MEDS), an agency which does pooled procurement for FBOs. This will ensure better economies of scale and quality of essential medicines. KEMSA has now moved into a supermarket mode and entered into memoranda of understanding with all forty-sevencounties. An analysis of ordering patterns showed that twenty-seven out of forty-fourcounties which ordered from KEMSA in the first quarter of 2013/14 ordered 50 per cent or more of the supplies made to primary healthcare facilities. While this is a positive trend, more careful scrutiny is required by the MoH to track these trends and compliance with the essential drug list carefully.

Beyond the short term gains, mechanisms of how the two levels of governments interact should be explored and instituted especially since there are polices such as those covering HIV/AIDS that cut across both. This is not currently happening and the two levels either have an antagonistic relationship or at best ignore each other. Funds are either made available through national budgets or off-budget via international donors. Care therefore needs to be taken to ensure that the distribution of these funds in the country as a whole is not hampered by devolution.

Devolution signifies changing roles and magnitudes of responsibility between national and county government. Increased responsibility due to devolution typically lies with county offices, and the MoH would experience decreased responsibility. Although Kenyan policy is clear on what responsibilities belong to which entity, there should be no doubt as to how these policies will be rolled out from the MoH to the counties. One such example is education and training of doctors and, in line with this, continuously keeping the clinical workforce up-to-date with recent medical developments. While the constitution is not clear on whose mandate this is, ways should be worked out to allow the national government especially, as part of quality oversight, to also be responsible for continuous training of the workforce. Of course the counties are also expected to set aside resources for the same but national government is better placed to offer standardized training.

Another consideration is how to make funding to the counties more equal without destabilizing or disrupting the system. As the World Bank (2014) points out, the current CRA funding mechanism displays 'strong equalization bias' as it favours areas that have been historically underfunded. The risk posed for historically overfunded regions is that they will take on additional service delivery commitments that they will be unable to meet. On the other hand, historically underfunded areas will receive additional funding that they will be unable to spend effectively. To ensure the most equitable funding, and thus avoid disruption, county functions and needs should be accurately defined.

Good governance must also be effectively instituted and nurtured. Governance structure should at least contain costs and improve service integration. The county government should ensure accountability mechanisms and clearly defined degrees of authority and methods of funding, where people will not need to beg or patronize someone in order to receive funding for the project. The county government's expectations, the providers' interests and the local citizens' needs and preferences must all be taken into consideration wherever decisions are being made. Citizen input to experts will be crucial in matters that affect them. Health sector governance and participation at local

level are important elements for devolution because the influence held by various stakeholders over decision making processes could express priorities as a means of providing higher quality care.

There is also a need to address the critical concern of the workforce exiting the county health facilities, especially due to lack of faith in the new structures. For devolution to be effective, there needs to be faith in county governments and service providers, and players in the health sector should be willing to implement devolution with a common understanding and by putting the interests of the public first. To promote the process, health workers need to be assured of their job security which includes proper transitioning to county governments with institutions and frameworks that are clearly spelt out, based on the rule of law and sustainable in the long run.

Finally, when it comes to measuring progress, inevitably, the counties will be compared against each other using indicators that have been defined by the national government. However, the counties are coming from different baselines – some are, and have always been, better resourced both financially and in terms of human resources than others. It will therefore be important to recognize this legacy of disparities and address it when measuring inter-county progress. Other than the nationally defined progress indicators, counties also need to identify and measure their own county-specific progress indicators.

Conclusion

Healthcare in Kenya will remain a devolved function despite the many challenges the sector currently faces. These challenges are related to capacity gaps, lack of infrastructure and personnel, conflictual relationships with national government and a lack of understanding of devolution among citizens, which translates into little or no support from the same. To institutionalize devolution within the health sector, learning from other areas where devolution has worked and devising home grown solutions will help. Concerted efforts towards this from both governance institutions and ordinary citizens are needed to ensure that devolution delivers on its promises as enshrined in the constitution.

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