

HOSPITAL GOVERNANCE FOR THE COUNTIES IN KENYA, ‘EPHESIS ON GOVERNMENT-RUN INSTITUTIONS’.

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INTRODUCTION

Sound institutions and good governance go hand in hand, Kaufman and Kraay (2003) defines good governance as “the traditions and institutions by which authority in a country is exercised”.it encompasses:- the capacity of the government to formulate and implement sound policies, manage resources and provide services efficiently; and the process that allows citizens to select, hold accountable, monitor and replace government; and, the institutions that govern economic and social interaction.

Governance in health is regarded as a salient theme on the development agenda. The increased interest in governance has been driven by the need for greater accountability arising from both increased funding and a growing demand to demonstrate results, the UK government’s report on the commission of Africa places a premium on governance and institutions as complementary to other actions in bolstering development prospects in the region, and the US government’s millennium challenge corporation expects to spend billions of dollars on countries that demonstrate good governance:- thus both theory and empirical evidence is accumulating to place governance at the centre of development thinking, spending and action.(IMF &World Bank,2005).

Systems function so that services can be delivered and health professionals become accountable to the public, government and donors, an intrinsic aspect of governance therefore is accountability, which concerns the management of relationships between various stakeholders in health, including individuals, households, communities, governments and other entities which have the responsibility to finance, monitor; deliver and use health services. Accountability involves delegation, financing, performance, relevant information and enforcement (World Bank, 2004),

Governance takes place in three levels i.e family, corporate and societal. At all this levels governance addresses the leadership role. Its aim is to enhance efficient, effective and sustainable leadership that promotes the welfare of families, co-operations and societies.

Bad governance in Kenya just like in other developing countries results from Constitutional limitations, failure to implement national policies, lethargy in civil service, corruption, tribalism and impunity (Murray, 2015).

Governance therefore is an integral part of health systems components i.e health information systems, healthcare financing, human resources for health and health service delivery. Despite consensus on the importance of governance in improving health outcomes, it remains inadequately monitored and evaluated (WHO, 2000).

This paper therefore examines health systems and in particular hospitals from the perspective of governance in the wake of the new counties in Kenya with an emphasis on the government run-institutions and describes the role of the Chief Executive Officer in the commissioning.

Health system decisions in Kenya have traditionally been taken at the central level of government, through top down decision making and resource allocation. Efforts have been made to take development planning to the district level. Centralized health systems have been criticized for regional and provincial disparities in resource allocations and inequitable access to quality health services. Over the past decade, Kenya has committed to reforms to decentralize the country’s health management system, to increase decision making power for resource allocation and service delivery at the district and facility levels and to allow for greater community involvement in health management through gradual reforms outlined in the two health sector strategic plans. District health management boards and district health management teams have taken on responsibilities for facility level operations within their districts (Ndavi et al, 2009).

Despite these efforts majority of Kenyans still do not have access to affordable healthcare, nearly half (46 percent) of the population live below the poverty line (KDHS, 2009).

Health sector organization and investments prior to the new constitution in kenya Leadership and governance

Two ministries provided leadership and health. The ministry of medical services and the ministry of public health and sanitation. Their functions were defined by the government and co-ordination of service delivery was done through a sector wide approach. Challenges that were evident included; - key health related sectors were not fully engaged by the health ministries, harmonization of laws around an updated health act were not complete.

Health care financing

Mainly from Public, private, donors and households. Households remained the largest contributor at 35.9%. The high out of pocket household expenditures and the dependency on donors, especially for priority interventions, raised issues of sustaining the investment in the health sector for improved health outcomes.

Health workforce

The country had a relatively large number of health workers as compared to other countries in sub-Saharan Africa region (1.69 health workers, per 1,000 population). There was an acute shortage of critical health workers for some

staff cadres, unequal distribution of workers by urban/rural areas, by regions, and by level of care, and brain drain problems. Health workers existed at higher levels of service delivery due to better incentives.

The economic stimulus package and targeted donor support supported absorption of many health workers, particularly nurses across the country to reduce distribution inequalities. Weak health workforce management practices led to various training programs for inservice staff. Improved co-ordination and management of these training programs was a sector priority at the time.

Medical products, vaccines and technologies

There were endeavors to strengthen management of medical products and technologies to ensure that they were accessible and affordable, met the defined standards for quality efficacy and safety and for proper utilization. Regulation was a challenge due to various competing interests in the field, institutional weaknesses, low financing.

Health information

Efforts were made, in defining a comprehensive health information system that places emphasis on information generation, analysis and use. Information from health related sources, was increasingly being used. ICT solutions were applied and a district health information system was introduced. Information analysis and communication was further strengthened through implementation of a knowledge management framework. However, poor resourcing of health information function and development, and use of parallel information generation systems particularly from projects duplicated efforts which further constrained the already weak information capacity.

Service delivery systems

Health service delivery was organized in 6 levels of care, from community (level 1) to the national level (Level 6). Each level had both service delivery and management functions. Services offered at each level were defined according to the norms and standards. The management function was physically distinct from the service delivery function at level 4 (office of the District Medical Officer), level 5 (office of the Provincial Medical Officer), and level 6 (MOH headquarters). The management level expanded over time, and had increasing capacity for development of policies, guidelines and regulations, evaluations, analysis and studies. Service delivery function was rationalized, based on the need for efficiency, but effectively delivered the defined set of services in the Kenya essential package for health (KEPH). A referral system was also strengthened, to improve linkages across service levels and to ensure a more wholesome healthcare seeking effort by the population.

ORGANIZATION AND MANAGEMENT OF COUNTY HEALTH SERVICES

County health services will be organized around three levels of care:-

Community services will comprise of all community based demand creation activities, organized around comprehensive community strategy defined by the health sector.

Primary care services will comprise of dispensaries, health centers and nursing homes for public and non-public providers. Their capacity will be upgraded, to ensure they can provide appropriate demanded services.

Primary referral services will include all level 4 hospitals, which will be referred to as county referral hospitals.

The hospitals in the county will work as one unit to ensure comprehensive provision of specialized health services in line with current world health organization recommendations to countries, to focus on integrated service delivery models that emphasize efficiency, access and equity in resource use, and take into account the role of a strengthened referral system vis-a-vis construction of large facilities which while politically good, are an inefficient use of available health resources, strengthening of such hospitals should be prioritized by the health sector in the respective counties.

Management of health at the county

A new health management structure will be established at the county to co-ordinate and manage delivery of the defined health services through the network of health facilities in the county that will consist of the overall *county director*, *disease prevention unit*, *medical services unit*, *health promotion unit* and *planning and monitoring unit*. A management team will be required to co-ordinate the county level health management functions.

Role of the county Health Management Team

A minimum management capacity will be established for operational management of county health services. The county executive committee (CEC) member designated as responsible for health will provide political linkage to the County Executive Committee, and work with this minimum capacity to manage health. The role of the health management team will include:-

- **Overall county director** – co-ordination and responsibility for overall health in the county.
- **Disease prevention unit** – co-ordination of disease prevention activities in the county.

- **Medical services unit** - Monitoring of clinical care, emergency services, and referral system functioning.
- **Planning and monitoring unit:** - Co-ordination of strategic and operational planning and monitoring, including information generation, validation, analysis, dissemination and use.
- **Health promotion unit** – co-ordination of health promotion and monitoring of health related sector actions.

Additional capacities will be required based on the county priorities e.g malaria department in a malaria prone area.

Management of the sub county level

A sub-county structure will support co-ordination of primary care and community services for sub-county units within the county.

Human resource for health

The counties and public service commission will be responsible for recruitment, and management of schemes of services for public servants. The national government (health ministry through national legislation needs to provide norms, and standards as part of its policy function). The health work force is however dynamic and unique, lack of incentives especially on the hard to reach areas will be a key challenge.

Affirmative action programs will be needed to recruit, and sustain critical numbers of health work force across the country. Standardized staffing norms and job descriptions will ensure that counties are recruiting competent and appropriately skilled staff in numbers that ensure equity in distribution across the county. The current regulations and acts on human resource should be incorporated within the new health act to ensure it is harmonized with other provisions of health legislation.

Management of health commodities at the county

Centralized procurement mechanisms will be more efficient. Counties will receive their funds in the spirit of the constitution, but use centralized procurement systems in phases and use the *pull system* which is demand driven as opposed to the *push system*.

KEMSA Will be a point for medicines and medical supplies by both the national and county governments, single sourcing introduces monopoly inefficiencies, and hence placing an option of other accredited centralized suppliers will introduce competition to ensure efficiency and effectiveness.

A harmonized monitoring and evaluation framework will be required to enable the counties put in place needed corrective measures to address their health problems, and allow the country to provide information on international health reporting obligations.

The two ministries of health will be merged to bring together all the functions relating to stewardship of health at national level in line with the new constitution which places a limit on the total number of ministries in government.

Health sector dialogue and co-ordination frameworks with other relevant arms of government and other stakeholders around principles of Aid effectiveness will be required to ensure efficiency and effectiveness in health care delivery. The national legislation should define frameworks for this co-ordination to guide counties in applying them. This will limit duplication and enhance service delivery.

CONCLUSION

Returns to health investments may be very low where governance is not addressed, hence:-

- Funding with the necessary institutional strengthening will be necessary to achieve Results.
- Address inequities in provider distribution using the relevant legal and institutional frameworks while upholding transparency in distribution, hiring and placement, give way to a HRH planning process which will account for disease burden, population density and geographical challenges to access. Incentive schemes to motivate staff e.g formulating a clear and good staff training policy, recognition of superior performance etc.
- Health management information systems should be strengthened by ICT connectivity, systems redesigning and capacity building.
- Enhance KEMSA procurement system to avoid delays.
- Review the legal and institutional frameworks to facilitate implementation of projects i.e health infrastructure, service delivery, healthcare financing and public private partnerships.

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