



cutting through complexity

# Devolution of Healthcare Services in Kenya

Lessons learnt from  
other countries

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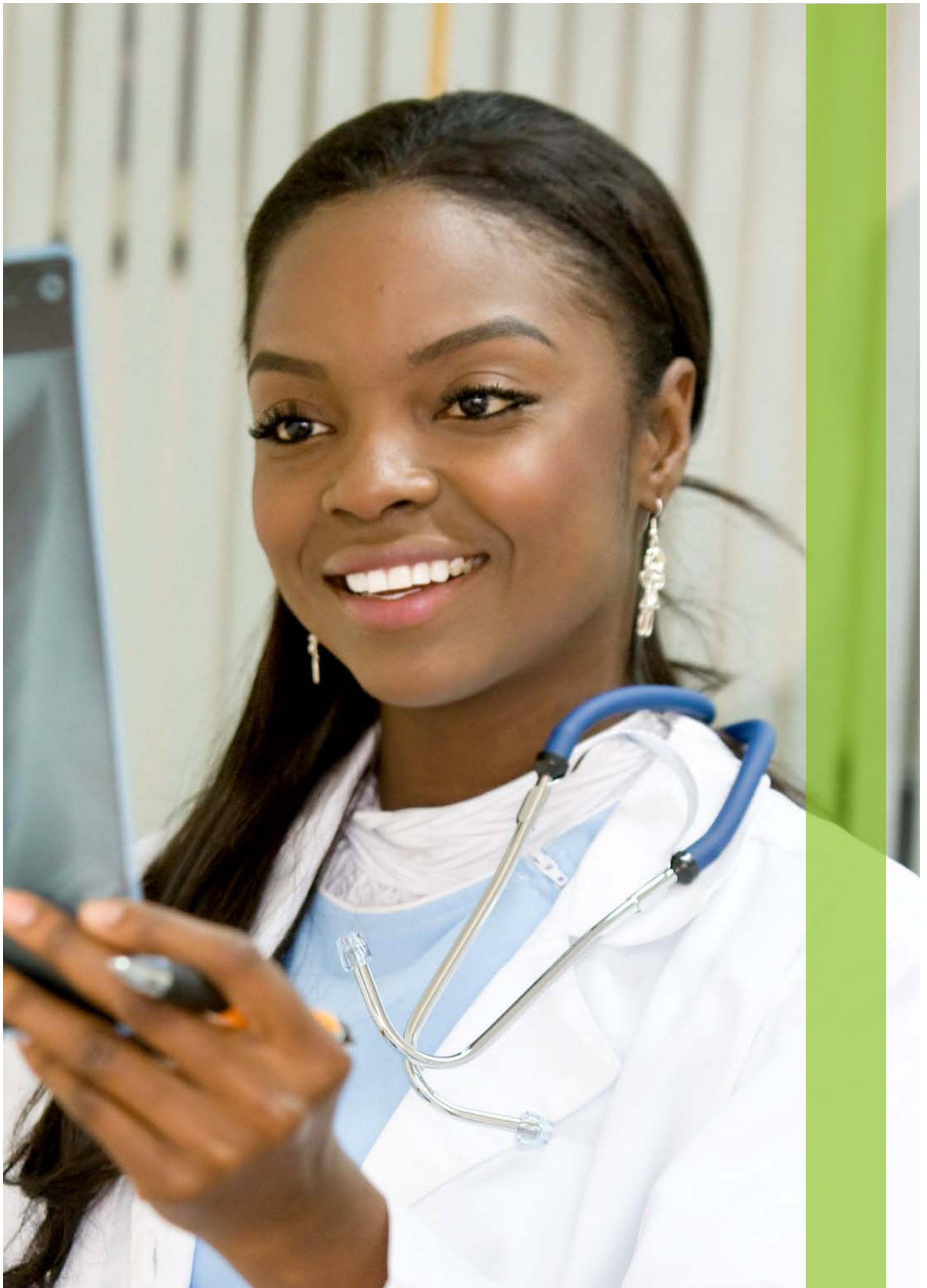
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# Introduction

On 4 August 2010, 67 percent of Kenyan voters approved a new Constitution in a constitutional referendum, and it was signed into law on 27 August 2010. The new constitution ushered in the “second Republic”, the manifestation of the people’s desire for change, government accountability, and democracy. At the heart of this change is the concept of devolution of political and economic power to 47 newly-created counties.

According to the World Bank:

*When governments devolve functions, they transfer authority for decision-making, finance, and management to quasi-autonomous units of local government with corporate status. Devolution usually transfers responsibilities for services to municipalities that elect their own mayors and councils, raise their own revenues, and have independent authority to make investment decisions. In a devolved system, local governments have clear and legally recognised geographical boundaries over which they exercise authority and within which they perform public functions. <sup>(1)</sup>*

Kenya’s devolution has been described by the World Bank as “one of the most ambitious implemented globally” because, besides the creation of 47 new counties, the process has also involved the creation of new systems of administration that have absorbed some or all of three prior systems of administration.

This report explores what lessons can be learnt from other countries that have devolved their health service delivery responsibilities to sub-national government levels. As such, it presents the building blocks that need to be in place for devolution to be successful in achieving its goals. We have evaluated other countries’ successes in light of Kenya’s objectives of devolution.

## The counties

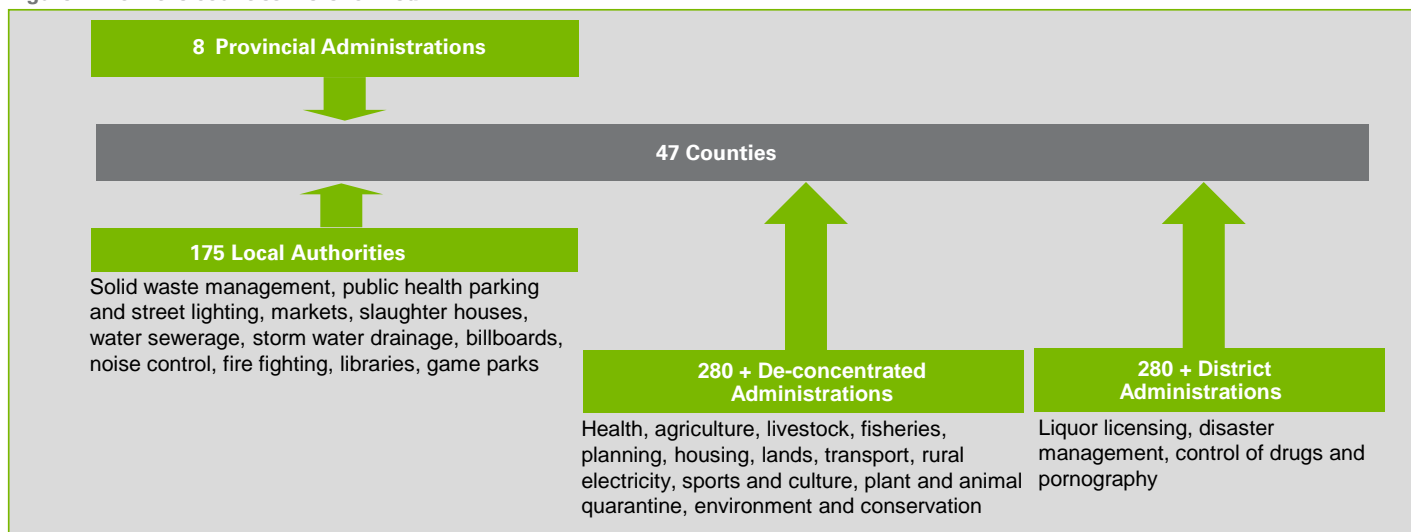
The county governments replace the provincial, district and local government administration governments that were created at independence. Figure 1 below shows the restructuring that resulted in the 47 counties. It depicts the former functions of the local, district and provincial administrations that have now been devolved to the counties. Population per county ranges from just over 100 000 (Lamu) to over three million (Nairobi).

Per the Constitution of Kenya, 2010, transfer of functions from national to county government is expected to take no longer than three years. The county governments are responsible for

- County legislation
- Executive functions
- Functions transferred from the national government
- Functions agreed upon with other counties
- Establishment and staffing of a public service .

The two levels of government are distinct and interdependent and will conduct business on the basis of “consultation and cooperation” (The Constitution of Kenya, 2010, Chapter 2, Article 6(2)).

Figure 1: How the counties were formed



Source: World Bank <sup>(2)</sup>

1) The World Bank Group. (n.d.). Decentralisation and Sub-National Regional Economics.  
 2) Retrieved from <http://www1.worldbank.org/publicsector/decentralisation/admin.htm>



## Health Sector Context

Since independence in 1963, centralisation has been at the core of Kenyan governance, with power concentrated in the capital. As a result, Kenya has been marked by spatial inequalities during this period of time.<sup>(3)</sup> It is against this backdrop that healthcare devolution is taking place. Article 174 of the Kenya Constitution clearly articulates the rationale behind devolution as, among other reasons, self-governance, economic development and equitable sharing of national and local resources.

Firstly, we look at the frameworks, governance and strategy that have been proposed to facilitate a smooth healthcare devolution process. Secondly, we evaluate current areas of inequality in healthcare – financing, performance, access to health services and healthcare workforce – inequalities that many hope devolution will help narrow if not eradicate.

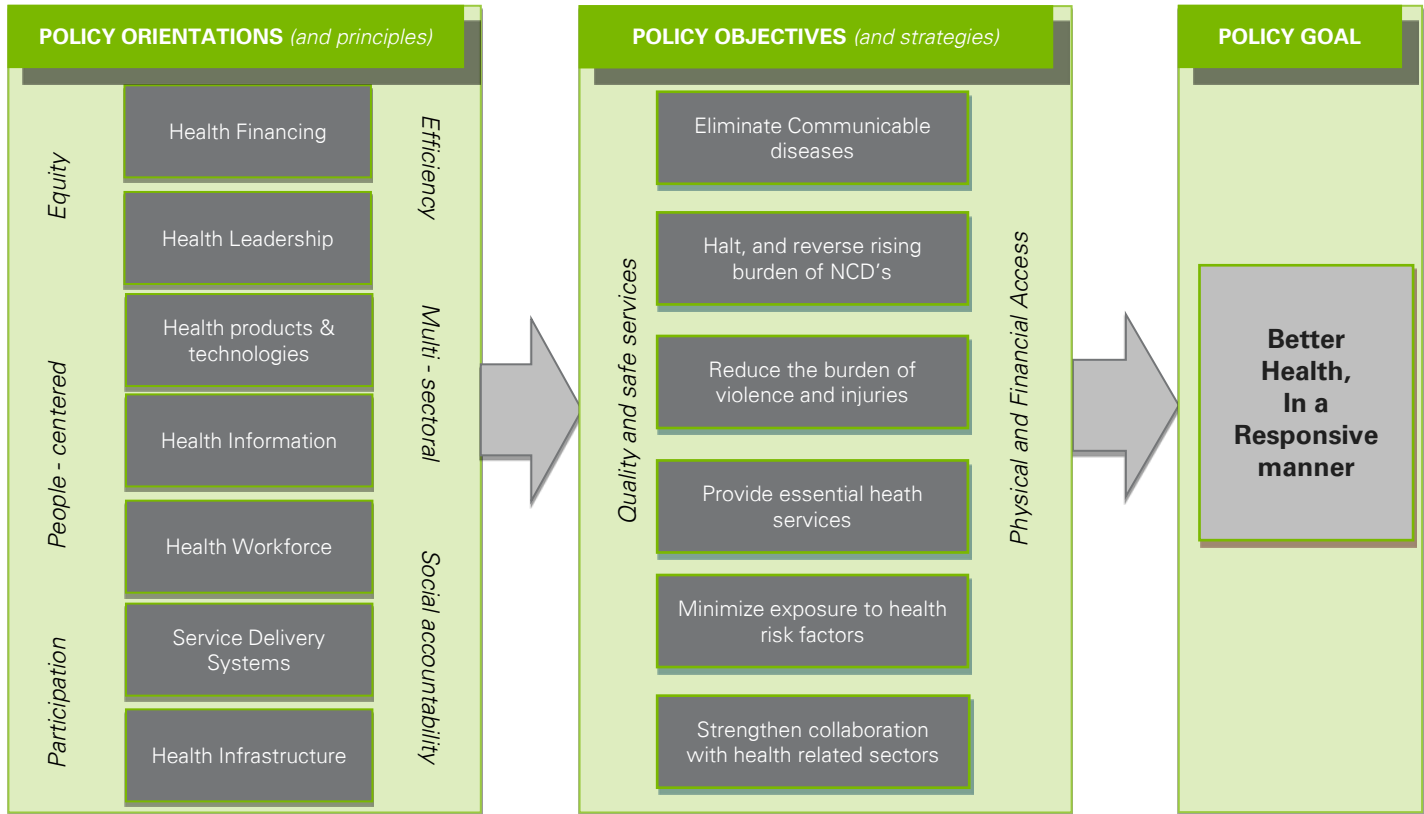
### Strategy <sup>(4)</sup>

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 (e.g. the Millennium Development Goals), and uses a three-pronged framework (comprehensive, balanced and coherent) to define policy direction as shown in Figure 2 below. It outlines the six objectives and seven orientations that the government should focus on to achieve its health goals. Implementation of the policy will be done through five-year medium-term strategic plans.



3) The World Bank. World Bank Fiscal Decentralisation Knowledge ProgrammeTeam. (November, 2012). Devolution Without Disruption: Pathways to a Successful New Kenya.  
4) Kenya Health Policy 2012 – 2030. Ministry of Medical Services and Ministry of Public Health and Sanitation.

Figure 2: Framework for Policy Directions



Source: Kenya Health Policy 2012 – 2030. Ministry of Medical Services and Ministry of Public Health and Sanitation

### Governance <sup>(5)</sup>

Kenya Health Policy 2012 – 2030 also provides an institutional framework structure that specifies the new institutional and management arrangements required under the devolved system. The policy acknowledges the need for new governance and management arrangements at both levels of government and outlines governance objectives as presented below.

#### Objectives of Governance / Management Structure

- 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 current to proposed devolved arrangements
- Complementarity of efforts and interventions

5) Kenya Health Policy 2012 – 2030. Ministry of Medical Services and Ministry of Public Health and Sanitation.

### National Level

At national level, health leadership is provided by the Ministry of Health (MOH). The new MOH is the result of a merger between the Ministry of Medical Services and the Ministry of Public Health and Sanitation that, until early 2013, were responsible for the health sector.

Key mandates of the MOH are:

- Development of national policy
- Provision of technical support at all levels
- Monitoring quality and standards in health services provision
- Provision of guidelines on tariffs for health services
- Conducting studies required for administrative or management purposes

### County Government Level

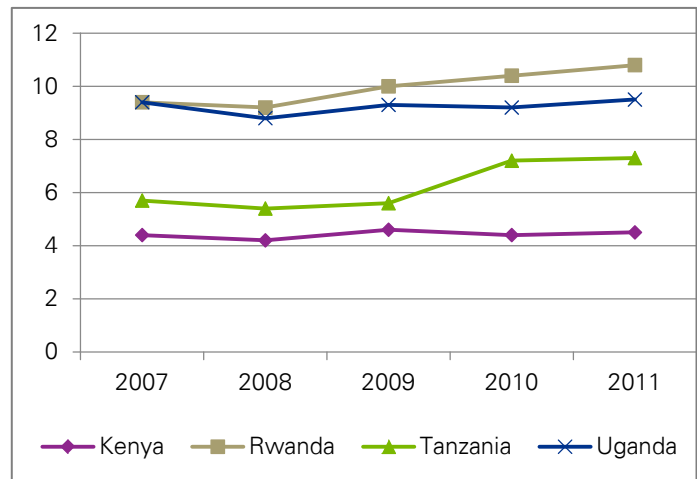
At county level, the Kenya Health Policy 2012 – 2030 proposes the formation of county health departments whose role will be to create and provide an enabling institutional and management structure responsible for “coordinating and managing the delivery of healthcare mandates and services at the county level.”

In addition to the county health departments, the policy calls for the formation of county health management teams. These will provide “professional and technical management structures” in each county to coordinate the delivery of health services through health facilities available in each county.

### Financing

Primary funding for healthcare comes from three sources: public, private (consumers) and donors. Consumers are the largest contributors, representing approximately 35.9 percent, followed by the government of Kenya and donors at 30 percent each.<sup>(6)</sup> Over the past few years, government financing as a percentage of GDP has been consistent at slightly above four percent. A regional comparison of the total health budget as a percentage of GDP shows that Kenya ranks last, behind Rwanda, Tanzania and Uganda (Figure 3). Government of Kenya, 2011. National Health Accounts, 2009/2010. Ministry of Medical Services and Ministry of Public Health and Sanitation.

Figure 3: Regional Comparison of Total Health Budget as a Percentage of GDP



Source: World Bank <sup>(7)</sup>

As a signatory to the 2001 Abuja Declaration, Kenya committed to allocating at least 15 percent of its national budget to health. 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,<sup>(8)</sup> 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.

### Performance and Outcomes

A 2010 review<sup>(9)</sup> 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 (Figure 4). The review notes that, “geographical and gender differences in age-specific health indicators persist.”

6) Government of Kenya, 2011. National Health Accounts, 2009/2010. Ministry of Medical Services and Ministry of Public Health and Sanitation.

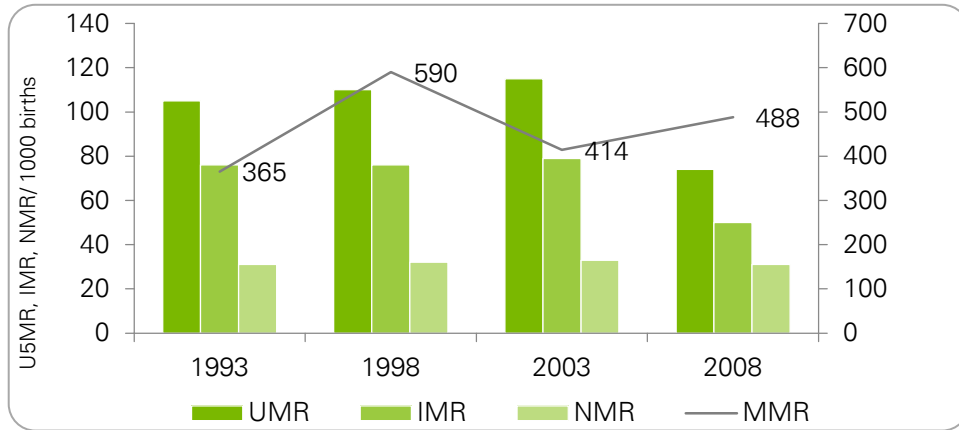
7) The World Bank. (n.d.). Health Expenditure, Total ( percent of GDP). Retrieved from <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

8) Healthy Action. (June, 2011). Health Financing in Kenya: The Case for RH/FP.

9) National Coordinating Agency for Population and Development (NCAPD), Ministry of Medical Services, Ministry of Public Health and Sanitation, Kenya National Bureau of Statistics (KNBS) and ICF Macro. (2011). Kenya Service Provision Assessment Survey 2010.



Figure 4: Trends in health impact indicators



Source: Kenya Service Provision Assessment, 2010

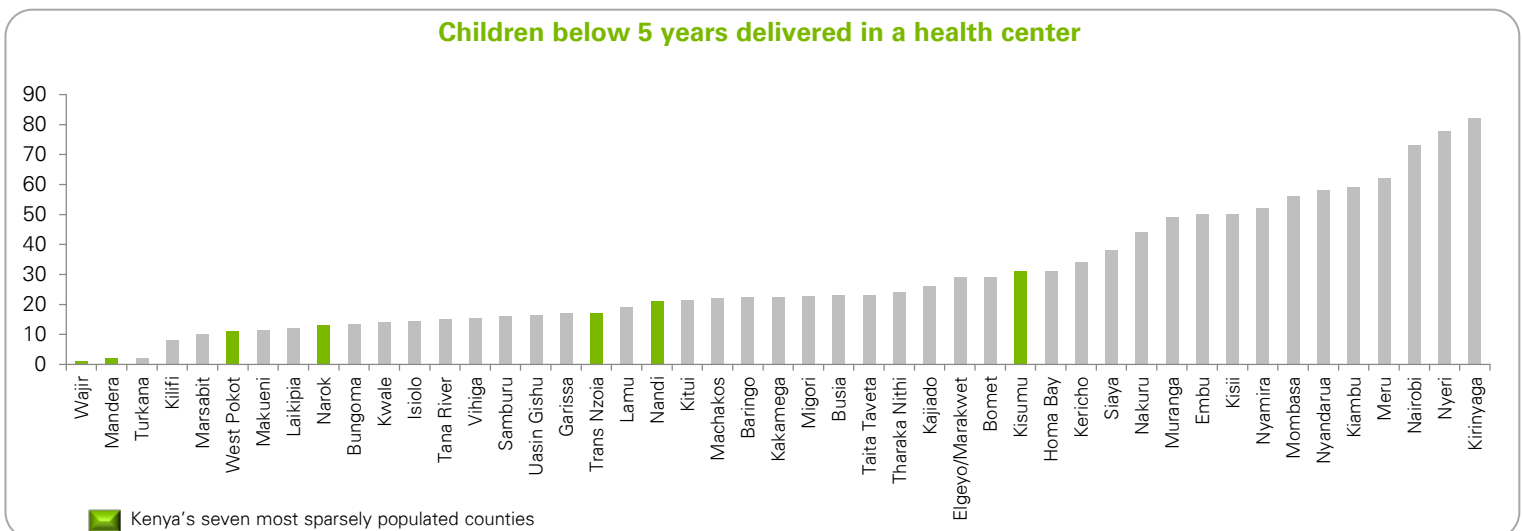
As can be seen from the figure above, Maternal Mortality Rate (MMR) and Neonatal Mortality Rate (NMR) have worsened over the past few decades, while Infant Mortality Rate (IMR) has only marginally improved.

Disease burden as a result of malaria, tuberculosis and HIV/AIDS, which together account for almost 50 percent of all deaths in the country, have received the most attention<sup>(10)</sup>, with the government and donors focusing on prevention, treatment and eradication efforts. While infectious diseases continue to be a burden to the Kenyan healthcare system, the incidence of non-infectious diseases such as diabetes, cancer, cardiovascular disease and high blood pressure are on the rise. Government of Kenya. (2010). Kenya Health Situation Analysis, Trends and Distribution, 1994 – 2010 and Projections to 2030. Ministry of Medical Services and Ministry of Public Health and Sanitation.

### Access to Health Services

Approximately 78 percent of Kenyans live in rural areas, yet a disproportionate share of healthcare facilities are located in urban areas.<sup>(11)</sup> 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 newborns delivered at a health facility) in Kenya, speaks volumes to this disparity. For example, over eight in ten children born in Kirinyaga 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 marginalised regions of the country, one child in twenty is born in a health facility.<sup>(12)</sup>

Figure 5: Differences in access to healthcare between counties



Source: World Bank computations based on Kenya Integrated Household Budget Survey, 2005/06

10) Government of Kenya. (2010). Kenya Health Situation Analysis, Trends and Distribution, 1994 – 2010 and Projections to 2030. Ministry of Medical Services and Ministry of Public Health and Sanitation.  
 11) The World Health Organisation. (May, 2012) Country Health Profile. Retrieved from <http://www.who.int/countries/ken/en/>  
 12) The World Bank. World Bank Fiscal Decentralisation Knowledge Programme Team. (November, 2012). Devolution Without Disruption: Pathways to a Successful New Kenya.



### **Healthcare Work Force**

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.<sup>(13)</sup> 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.<sup>(14)</sup>



13) World Health Organisation. (August, 2010) Global Atlas of Health Work Force.  
14) Transparency International – Kenya. (2011). The Kenya Health Sector Integrity Study Report.

# Devolution of healthcare in Kenya

## What will be devolved?

The table below outlines the responsibilities that will continue to reside with the national government and those that have been devolved to the county governments.

Figure 5: Responsibilities of the National and County Governments

National ministry responsible for health	County department responsible for health
<ul style="list-style-type: none"> <li>■ Health policy</li> <li>■ Financing</li> <li>■ National referral hospitals</li> <li>■ Quality assurance and standards</li> <li>■ Health information, communication and technology</li> <li>■ National public health laboratories</li> <li>■ Public-private partnerships</li> <li>■ Monitoring and evaluation</li> <li>■ Planning and budgeting for national health services</li> <li>■ Services provided by Kenya Medical Supplies Agency (KEMSA), National Hospital Insurance Fund (NHIF), Kenya Medical Training College (KEMTC) and Kenya Medical Research Institute (KEMRI)</li> <li>■ Ports, borders and trans-boundary areas</li> <li>■ Major disease control (malaria, TB, leprosy)</li> </ul>	<ul style="list-style-type: none"> <li>■ County health facilities and pharmacies</li> <li>■ Ambulance services</li> <li>■ Promotion of primary health care</li> <li>■ Licensing and control of agencies that sell food to the public</li> <li>■ Disease surveillance and response</li> <li>■ Veterinary services (excluding regulation of veterinary professionals)</li> <li>■ Cemeteries, funeral homes, crematoria, refuse dumps, solid waste disposal</li> <li>■ Control of drugs of abuse and pornography</li> <li>■ Disaster management</li> <li>■ Public health and sanitation</li> </ul>

Source: Constitution of Kenya, 2010. Fourth Schedule.<sup>(15)</sup>

## Organisation of Healthcare in the Devolved System

In the devolved system, healthcare is organised in a four-tiered system: <sup>(16)</sup>

- **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 centres 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 specialised 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.

15) The Constitution of Kenya, 2010. Fourth Schedule.  
 16) Kenya Health Policy, 2012 -2030. Ministry of Medical Services and Ministry of Public Health and Sanitation.





## Lessons learnt from other countries

This section describes what lessons can be learnt from other countries that have used devolution as a means to strengthen their health service delivery. The countries discussed in this context are Ethiopia, Ghana and Thailand. For each of these countries, we briefly touch upon the background of devolution and how it has impacted on their health systems, but more importantly we elaborate on the strengths and weaknesses of the devolution mechanism(s) applied. These are the basis of our lessons learnt that informs the discussion in the next section of this document. In our evaluation, we have largely focused on how devolution impacts on primary healthcare because this is often the first, if not the only, level of health services subject to devolution in a country. We have also chosen this focus because the facilities that deliver these kinds of services will be subject to devolution in Kenya, as opposed to the larger acute healthcare facilities – the referral hospitals – that are under the responsibility of the Ministry of Health.

### **Ethiopia** <sup>(17)</sup>

The concept of devolution was introduced in 1996 and 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 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 regional government and they, in turn, were entitled to set their own priorities and determine further budget allocation to healthcare facilities based on local needs. As such, the district levels are responsible for human resource management, health facility construction and supply chain processes.

### **Ghana** <sup>(18)</sup>

Decentralisation 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 coordination of health service delivery on a district level.

### **Thailand** <sup>(19)</sup>

Through the implementation of the Local Administrative Organisations Act in 1999, a target was set for transferring a significant share of national budgets to Local Administrative Organisations (LAOs). The minimum share of budget to be transferred was 25 percent, with a target of 35 percent. 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 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 centres' staff involved need to be willing to transfer to LAO employment.

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, training and regulation of health professionals.

17) The content of this section is largely based on the following publication: "Ethiopia: Improving Health Service Delivery", Sameh El-Saharty, Sosena Kebede, Petros Olango Dubusho, Banafsheh Siadat, 2009. The International Bank for Reconstruction and Development, The World Bank, Washington.

18) The content of this section is largely based on the following publication: "Decentralisation and Governance in the Ghana Health Sector", Bernard F. Couttolenc, 2012. The International Bank for Reconstruction and Development, The World Bank, Washington.

19) The content of this section is largely based on the following publication: "Devolution of Health Centers and Hospital Autonomy in Thailand: A Rapid Assessment", Loraine Hawkins, Jaruayporn Srisasalux, Sutayut Osornprasop, 2009. Report from HSRI and World Bank.



## Degree of devolution

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 has moved from centrally-organised 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. On the one hand, districts are relatively free to spend their budget on whatever health facility they want. On the other hand, it does mean that districts still rely on budgets that are allocated to them.

The situation in Ghana is a bit more complicated. On one side there is the GHS to which the responsibility of managing health facilities has been delegated. The GHS organised itself into regional and district offices. On the other side there is the District Assembly and, in future, potentially, the district Departments of health that will act as devolved entities.

Because the system of devolution in Thailand is based on a health facility level instead of a regional level, the country is now in a situation in which some facilities have devolved and some have not.

Kenya has chosen full devolution.

## Lessons learnt

We have evaluated the successes and challenges these countries had in implementing devolution in their health system. We have grouped these lessons into seven key categories.<sup>(20)</sup>

### Governance

#### Get the governance structures right

What is seen in all three countries is that creating the right governance and accountability structure is critical in making devolution and, in the end, service delivery to the patient, successful.

Ghana is an example where important building blocks are in place. They have established district health offices (as part of the GHS) and District Assemblies. These have responsibilities ranging from planning and budgeting to operational management of health facilities to prevention and health promotion. There is, however, no legal or policy framework that enforces a coordinated approach for these entities on a district level. Up until now, policies have been confusing, contradictory and inconsistent. Because of this, governance and accountability of health facilities has weakened due to overlap and duplication of reporting lines. Lastly, many stakeholders themselves have a limited understanding of government's plans and process objectives in terms of decentralisation, deconcentration and devolution of responsibilities to sub-national levels. Although the building blocks are in place in Ghana, the governance and accountability structures to let them 'talk' to each other are not fully developed yet.

In Thailand, it was found that health centres that devolved to Local Administrative Organisations (LAO) experienced more management flexibility and quicker decision making. This logically follows the shorter chain of accountability since staff experience management of LAO to be 'closer' to them compared to the (provincial) Department of Health. The downside of the Thai system is that there was limited change to existing governance structures, which created an additional line of accountability for those health centres that did devolve. In general, governance structures should balance the trade-off between transparency versus the administrative burden it puts on health facilities or regional government departments. There were no escalation mechanisms put in place for LAOs, which raises the question of what will happen and who will act upon unwanted events at health facilities residing under these LAOs.

In Thailand, there was a growth in political influence as health centres moved closer to the centre of political decision making – or so it was perceived by staff working in these devolved health centres. There seemed to be a relationship between those health centre heads that were closer to the LAOs' CEO and the funds these health centres received. This had a negative effect on those health staff still deciding on their vote to devolve their health centre, ie to transfer their employment contract from the Ministry of Health to the LAO level.

Lastly, the Thai system requires a good governance award to be achieved by the health centres that opt for devolution. When implementing devolution, this should be considered as one of the criteria before, eg, transferring national budgets to sub-national levels.

<sup>20)</sup> These lessons learnt are based on the studies referred to in footnotes 17, 18 and 19 and have been supplemented with additional desktop research, insights and experience of KPMG experts.

### **Enable communities to participate**

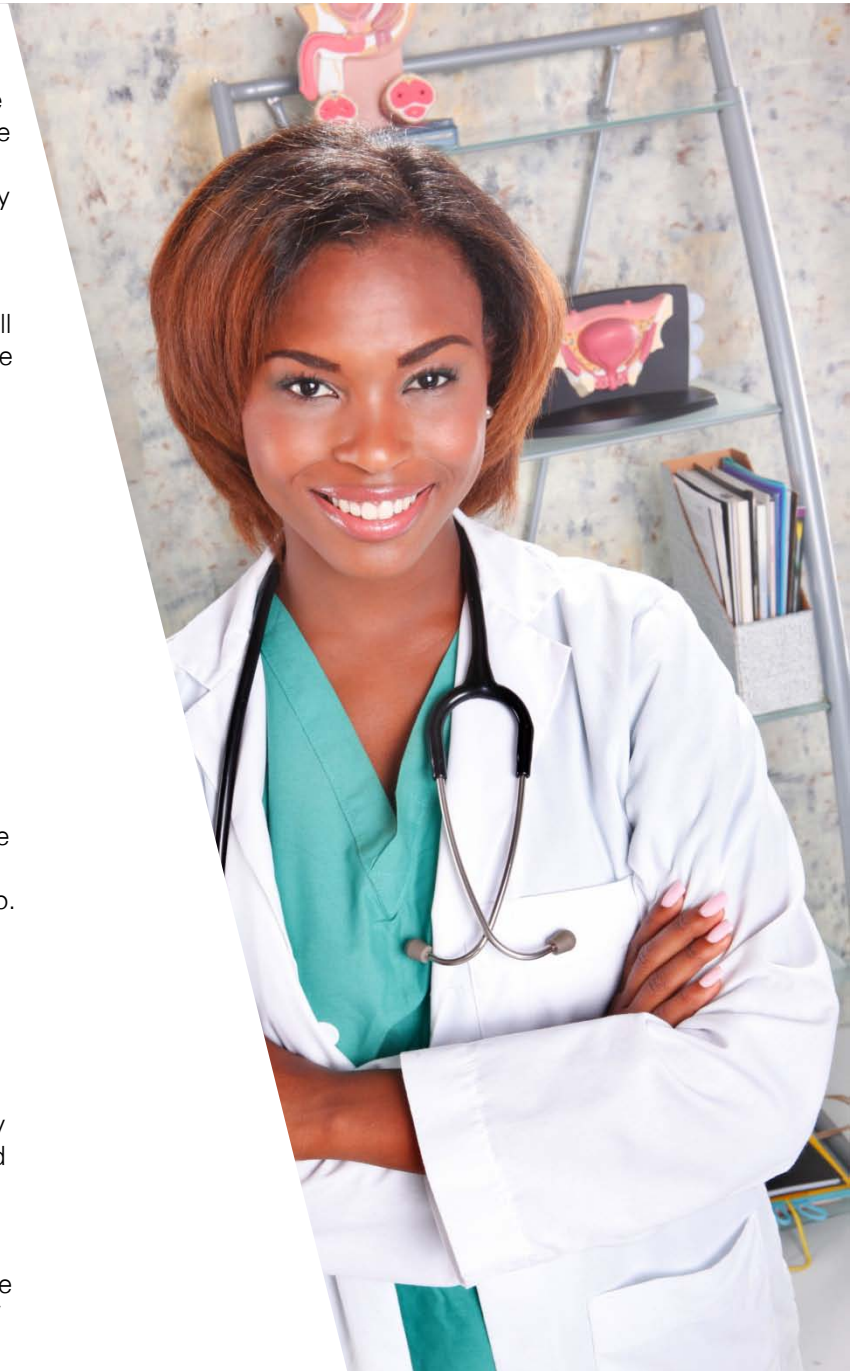
In general, it is believed that local governments are more transparent than national governments. This is due to the proximity of local governments to their communities. One of the aims of devolution is to create more intense community involvement in order to adjust service delivery models to the communities' 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 for 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 health centres had increased.

### **Patronage and corruption**

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.

### **Changing roles for other key players**

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.



## Strategy

### Make devolution of healthcare part of multi-sector devolution policies

Ethiopia had the advantage of healthcare not being the only sector that was subject to devolution, as was the case for Ghana. Research has found that devolution is more successful if multiple sectors devolve responsibilities to a sub-national level, thus creating a spill-over and learning effect across sectors, which will in turn increase managerial capacities, which all sectors will benefit from.

### The impact (or lack thereof) of other national health strategies rolled out parallel with devolution

Other factors that are not necessarily connected to the devolution of health services impact on the perception populations have of the success of devolution. Ethiopia rolled out several other health improvement strategies parallel to devolution. Some of these strategies, eg health facility rehabilitation, did not progress as fast as was initially planned. Delays on other strategies can have a negative impact on health service delivery in general, resulting in a perception that devolution is at fault.

### Create a clear strategy that is understood by all players in the health system

As is seen in Ghana, 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 decentralisation, deconcentration and devolution of responsibilities to sub-national levels.

The lesson learnt from Thailand is that devolving responsibilities to health facility level might be less effective compared to devolving to a region or district. This will also prevent different health centres and LAOs developing in different directions.

### Implementation strategy

Ethiopia chose to gradually implement its devolution mechanism through first devolving responsibilities to regional level before further devolving it to district level. This approach created a platform for managerial capacities to evolve within these regions and districts.

International studies found that a national implementation strategy is often lacking and that process objectives are not always shared and communicated with stakeholders.<sup>(21)</sup> In some instances, the plans for devolution are there, but the actual implementation plan with interim milestones is absent. Having such a plan in place will help to identify what activities and policies are required at what point in time to achieve the objectives of devolution. It will furthermore help in explaining and operationalise a national strategy.

An undesirable scenario – which is occurring in Thailand and seems likely in Cambodia – is one in which the MOH retains its county offices under its hierarchy but this office loses most of its functions. The county then has to build capacity from a zero base while all the best available candidates at the MOH office stay in post. In Thailand, there has been a very modest amount of voluntary spontaneous moves of MOH staff into local government jobs – applying for vacancies as they are advertised.



21) "Decentralisation and Governance in the Ghana Health Sector", Bernard F. Couttolenc, 2012. The International Bank for Reconstruction and Development, The World Bank, Washington.

## Finance

### Budgets set the tone

In Ethiopia, districts are financed through block grants that regions receive. These block grants are based on the size of the population and not necessarily on the need of the population. In Thailand, the devolved LAOs contract with the local payers – this contributes towards achieving universal coverage in the country, as regional budgets are set based on population. Thailand has also set itself a target of transferring at least 25 percent of the national budget to LAOs. Ghana budgets for regions and districts that, in turn, can allocate budget to health facilities. A lesson learnt from all three countries is that national governments still have strong say into what budgets are allocated to what region or district, including what parameters underpin the size of the budget. This puts constraints on the levels of authority sub-national entities have to influence the budget, specifically if this is based on population numbers rather than need and demographic factors. The risk of using budgets per region is the insufficient ring-fencing of the budget for healthcare. Combined with a lack of managerial capacity, this can lead to underfunding of health service delivery.

### Creating opportunities to raise funds

What is seen in other countries is that devolution creates opportunities to generate additional income, usually by charging co-payments from patients using facilities. As such, devolution is also used to limit the burden on government's budget spent on healthcare. The downside of this is that it might further constrain access to healthcare for the poorer groups of the population.

### Cross-border flows

One 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 and poor service, 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.

### It's not just finance causing differences per region

Lastly, 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.

## Equity of access

### Urban versus rural access to healthcare

It should not come as a surprise that those living in urban areas normally have better access to healthcare than those living in rural areas because of the proximity of health facilities in urban areas. This effect might even be strengthened by devolution as the devolved sub-national authorities in urban areas are more likely to attract more resources with strong managerial capacities and capabilities. On the upside of devolution however, is the ideal of establishing responsiveness at entities that are believed to be closer to the communities they serve.

### Reaching out to communities

An alternative way of increasing access to primary healthcare is a policy currently applied by the South African government. Provincial departments of health are currently establishing health outreach teams, consisting of nurses and environmental health officers that are connected to a clinic or community health centre. These teams visit the rural communities and offer basic healthcare services and undertake prevention and promotion activities.

## Performance and outcomes

### Process versus outcome objectives

In some systems, it seems like devolution, or to that 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 like child and maternal mortality rates decreased, but it could be argued that this might as well 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.

### What indicators?

The latter raises the question of what key performance indicators (KPIs) measure the progress and success of devolution. Ideally, these KPIs should be measured as a baseline, in order to measure true progress on devolution. A lack of defined performance indicators proved to be an inhibiting factor in Ethiopia. There was no mechanism in place to align district level goals with national goals. In line with this, no indicators were agreed upon to measure the impact devolution of health services had, specifically on the poor population. Lastly, it should be clear what factors influence process and outcome KPIs and who is accountable to achieve these KPIs.



## Resourcing

### Managerial capacity

It is clear that managerial capacity is a prerequisite for devolution to achieve its goals. In all three countries included in the analysis above, it was found that those regions or districts with strong management capacity in general would lead to stronger performance results. Attracting capable staff is often more difficult in rural areas. Very close proximity to politicians can be a deterrent.

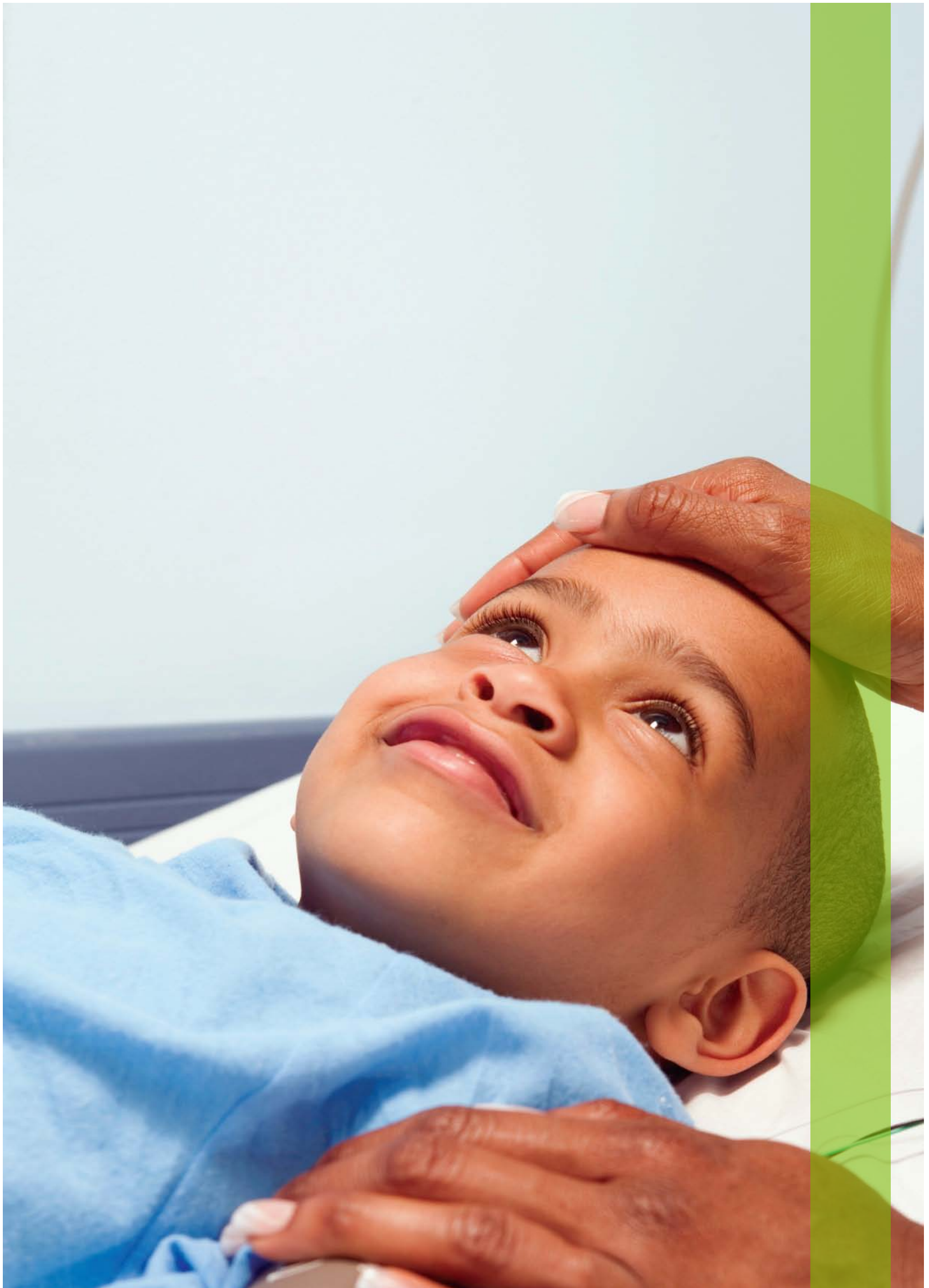
It is often assumed that local capacity required to manage a local health system and/or health facility is available, but in practice this turns out differently.

### The danger of unintended consequences

As with all policies there is always a danger that the change may produce some unexpected and unwelcome results. Experience in the countries listed above and elsewhere suggests some potential concerns:

- **Training.** This is often organised nationally and new techniques are cascaded down the system. Some training still needs to be nationally organised.
- **Career structures can suffer.** Small administrative areas have fewer layers and, while this is an advantage in terms of efficiency, it reduces the opportunities for talented people to rise up through promotion.
- **Planning the workforce becomes more difficult.** Workforce planning and the production of new staff – particularly where only small numbers are required – can become difficult as the system may be fragmented. Information can be difficult to acquire.
- **Conflict with vertical programmes.** Programmes such as HIV, TB and health promotion are often organised 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 a 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 less money can be earmarked.
- **The loss of expertise and 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, human resource management etc. which may be more economic to operate at a level above counties to reduce costs and make use of scarce expertise.





# Discussion

## Progress to Date: How has Kenya fared so far? <sup>(22)</sup>

As mentioned in Section 3.5, Degree of Devolution, Kenya has chosen full devolution with transfer of authority and accountability to the counties. As every country is unique in each approach to devolution, none of the case studies discussed in the previous section perfectly mirror the Kenya situation. They do, however, offer lessons that Kenya can learn from as it embarks on the devolution of healthcare to the counties. In this section, we look at the progress Kenya has made thus far with regards to governance, strategy, financing, equity of access, performance and outcomes and resourcing.

## Governance

### New governance structures and the changing role of earlier key players

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/management objectives as outlined in Kenya Health Policy 2012 – 2030.

While new governance structures have been defined and the process of implementing them has begun, getting them right will be imperative. As discussed in the previous section, 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.

### Community participation is a top priority

Community participation has been a mainstay of Kenya's healthcare system since the implementation of the Community Health Strategy.<sup>(23)</sup> 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. Organisation 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.

## Strategy

### Devolution of healthcare is part of a broader national policy

In Kenya, as was the case in Ethiopia, devolution of healthcare is part of a broader national policy. The only two sectors that will not be devolved are education and the police force.

### National health strategies are being rolled out in parallel with devolution

Kenya Health Policy 2012 – 2030 identifies seven policy orientations, that is, areas earmarked for investment to enable the achievement of policy's objectives. These are: healthcare financing, health leadership, health products and technologies, health information, health workforce, service delivery systems and health infrastructure. This is similar to the approach taken in Ethiopia that coupled decentralisation with seven strategies that were to be implemented at the sub-national level.

### There is a strategy for the health system

As previously noted, Kenya Health Policy 2012 - 20130 is the guiding policy document for the health sector. It outlines the orientations and objectives that are imperative in attaining the government's health goal of "Better Health in a Responsive Manner".

### There is an implementation strategy

In addition to providing the health sector strategy, Kenya Health Policy 2012 – 2030 also provides an implementation framework. Implementation will be through five-year medium-term strategic plans and will employ a multi-sectoral approach at both government levels and involve clients/consumers, non-state actors and state actors – including semi-autonomous government agencies.

22) The content in this section is largely based on the following document. Kenya Health Policy 2012 – 2030. Ministry of Medical Services and Ministry of Public Health and Sanitation.

23) Taking the Kenya Essential Package for Health to the Community. A Strategy for the Delivery of Level One Services. (April, 2006). Ministry of Health.



## Financing

### Budgets set the tone – revenue allocation and generation

As is the case with our case studies, 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 own revenues by the counties from, eg, property taxes, business licenses, entertainment taxes

Equitable share with the counties assured of receiving no less than 15 percent of national revenue

Equalisation fund set aside for marginalised communities and represents an additional 0.5 percent of national revenue.

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. <sup>(24)</sup>

## Equity of Access

### The focus is on primary care

As noted in the Lessons Learnt section, while the correlation between devolution and equity in access is unclear, that of devolution and community participation is clear. 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.

## Performance and Outcomes

### Performance objectives and measurement

Kenya Health Policy 2012 – 2030 also provides a monitoring and evaluation (M&E) framework that aligns national and county level goals. As previously mentioned, the policy will be implemented via five-year medium-term strategic plans that will detail objectives, investments and programme outcomes. In addition, programme business plans focusing on specific services/areas, eg, HIV, malaria, healthcare financing, or human resources for health, will be used to mobilise resources for respective focus services/areas. And finally, investment plans meant for “decision making units”, namely counties, referral facilities and semi-autonomous government agencies, will “provide information and guidance on annual targets and budgeting processes.”

The Kenya Health Policy 2012 – 2030, the medium-term strategic plans, the programme business plans and the investment plans will allow for the identification of priority areas and budgets that will allow for the creation of detailed annual work plans at programme, facility, county and national levels.

### Progress Indicators have been identified

As noted in our Lessons Learnt section, defining KPIs and measuring them before devolution is rolled out are imperative if true progress is to be measured. Kenya Health Policy 2012 – 2030 has identified progress indicators, their 2010 baselines and their 2030 targets. The targets are based on the WHO’s statistics of the average value of four middle income countries. The indicators chosen include, amongst others: life expectancy at birth, years lived with disability, neonatal mortality rate, infant mortality rate, maternal mortality rate, under five mortality rate and adult mortality rate.

## Resourcing

### Counties are responsible for staffing

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” (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 and disciplinary control and removal of persons acting in these offices.

24) Commission on Revenue Allocation. (n.d.). Revenue Allocation Formula. Retrieved from <http://www.crakenya.org/information/revenue-allocation-formula/>.





## The way forward

Having compared the lessons learnt with the current situation in Kenya, we would like to explore the following practical considerations, or next steps, that are worth unpacking on the route to full devolution. These next steps could also be interpreted as risks if not looked after carefully.

It should be clear how the two levels, national and sub-national, “talk to each other”, especially since there are polices such as those covering HIV/AIDS that cut across both. 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 are not be hampered by devolution.

In our Lessons Learnt section we have mentioned the changing roles of both national and sub-national entities. Increased responsibility due to devolution typically lies with district offices, and the Ministry of Health would experience decreased responsibility. Although Kenyan policy is clear on what responsibilities belong to what entity, there should be no doubt on how these policies will be rolled out from the Ministry of Health to 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. Would this, for example, imply that national government trains counties and counties train doctors? Will doctors themselves be responsible for ongoing training and schooling, the counties or the Ministry of Health?

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.

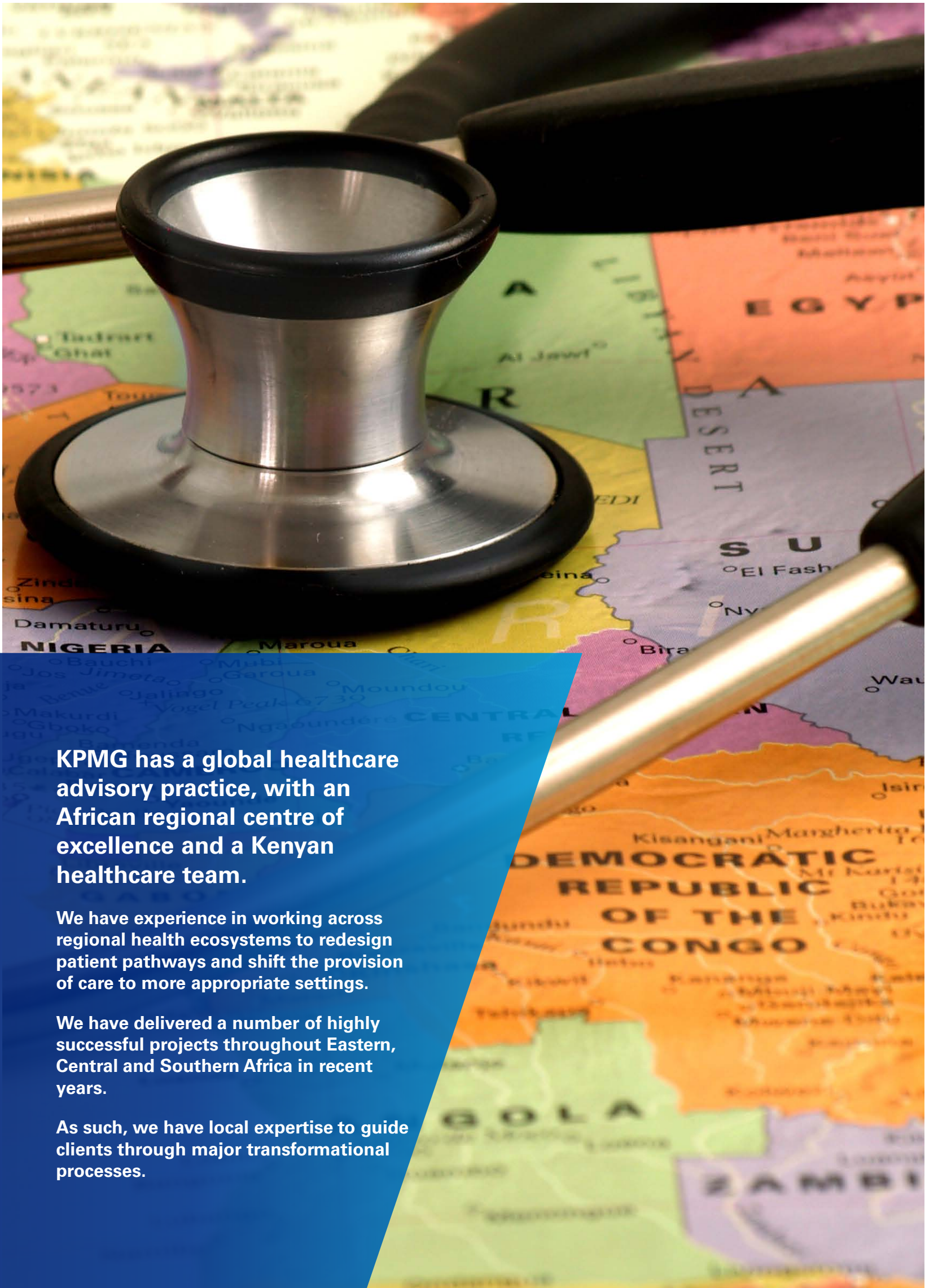
Another consideration is how to make funding to the counties more equal without destabilising or disrupting the system. As the World Bank points out, the proposed CRA funding mechanism displays “strong equalisation bias” as it favours areas that have been historically underfunded.<sup>(25)</sup> The 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, how will county functions and needs be accurately defined?

Finally, when it comes to measuring progress, inevitably, the counties will be compared against each other using KPIs that have been defined by the national government. Having said that, the counties are coming from a different baseline – some are, and have always been, better resourced both financially and in terms of human resources than others. How will this legacy of disparities be addressed when measuring inter-county progress? Other than the nationally defined progress indicators, how will county-specific progress indicators be identified and measured?



25) The World Bank. World Bank Fiscal Decentralisation Knowledge Programme Team. (November, 2012). Devolution Without Disruption: Pathways to a Successful New Kenya.





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