Designing Kenya's Ideal Health System.

Mugambi Derrick Mbaya

R1910D9539154

Health System and Evaluation of Health Systems, Services and Public Health Programs

Marianna Charalambo

November 30, 2020

Table of Contents

Abbreviations

KMPDB	Kenya Medical Practitioners and Dentists Board
NHS	National Health Service
NCK	Nursing Council of Kenya
PHCS	Primary Healthcare Services
PPB	Pharmacy and Poisons Board
UHC	Universal Health Coverage
WHO	World Health Organization

Introduction

In Kenya, the healthcare system has a well-defined structure consisting of six (6) levels that are defined as follows (Francis W, Irene K, Ezra O, 2017):

Level 1 – Community Health Services,

Level 2 – Dispensaries and Clinics,

Level 3 – Health Centers, Maternity and Nursing Homes,

Level 4 – Sub-county Hospitals and Medium-sized Private Hospitals,

Level 5 - County Referral Hospitals and Large Private Hospitals

Level 6 - National Teaching and Referral Hospitals and Large Private Teaching and Referral Hospitals.

The system works in a hierarchical order or rather referral system whereby complicated medical cases are referred up the tier where the patient can have access to more sophisticated and specialized healthcare services. The healthcare system also comprises of various healthcare regulatory boards and councils such as the Pharmacy and Poisons Board (PPB), Kenya Medical Practitioners and Dentists Board (KMPDB), Nursing Council of Kenya (NCK) among others that are responsible for the training, registration, licensing, monitoring and evaluation of their designated cadres (Kenya Medical Practitioners and Dentist council, 2020). According to recent reports it is stated that the regulatory bodies due to their weak structures and the liberalization of the health market has contributed to the increase in counterfeits and substandard healthcare products and services which is now a major challenge in the country (Ministry of Health, 2014). The Ministry of Health has the mandate to regulate and create the policy framework for Health as well as manage national health facilities and offer capacity building and technical assistance to counties (Ministry of Health, 2014). You have to take note that Kenya is a devolved country divided into county governments that are responsible for delivering health services to their populations with the national government only responsible for the creation of health policies, managing national health facilities and financing the county governments. Because of this system we can all speculate that there will be differences in the level of care observed in different areas of the country and this will depend on the leadership in those particular areas, division of resources both at the national and county level, geographical factors, and level of education among other factors. In order to achieve the stipulated goal of Universal Health Coverage (UHC) as aligned to vision 2030, it is in my opinion that mandate of health service provision should be reverted to national government.

This paper aims at creating or rather designing an ideal health system for Kenya taking into consideration our cultural background as well as the resources at our disposal. The design will not take into consideration the current health system.

Discussion

As it stands, it is important to note that Kenya's health system is not a total wreck and has some components that are functional and effective. The healthcare structure for example is well defined and offers a clear path in which health services should be obtained by an individual and what to expect along the way. It is however of vital significance to note that most of the people in Kenya pay out of pocket for essential health services and products. With that said let us discuss the type of health system that would suite the country.

Health system type – Basically, as stipulated by (Mimi Chung, 2017), there are four major health systems models i.e. the Beveridge model, Bismarck model, the national health insurance model and the out-of-pocket model. It is reasonable to understand how each of the models work and borrow some ideologies that would fit Kenya. For example the Beveridge model with the introduction of the National Health Service (NHS) after World War II in the UK has been very effective and efficient in achieving UHC. Kenya has a long history of a policy, Harambee policy, which means "pulling together" introduced by the late first president of Kenya Mzee Jomo Kenyatta which saw people come together in communities and contribute funds for development (A.V. Noreh, 1988). The policy saw the establishment of dispensaries and health centers that are still in use to this date. This shows spirit of togetherness embedded within the Kenyan culture which supports that the Beveridge health system model could actually work in Kenya. However, with the recent scandals of embezzlement of health insurance funds in the government as reported by (Cyrus. O. and Roselyne. O., 2019) There is doubt of whether the government can be trusted not to misappropriate the taxpayer's funds. Privatizing Kenya's health care system is also not a very viable option considering the rise of cost of healthcare services as observed in countries such as the United States of America (USA) (Roosa T, Robin O, Elias M, Ana D, and George A. W., 2020). From where I stand, the best possible option for Kenya is to adopt a more decentralized health system with a clear structure and well-defined functions of each department along the structure for accountability purpose. The government could also adopt a mandated health insurance system to each and every citizen, as well as strengthen health facilities that provide Primary Health Care Services (PHCS). According to Dr. Got George in an interview (Dr.George, 2018) about what ails Kenya's health sector, he

states that about 70% of the Kenyan population healthcare needs can be met at the Level 1 to Level 4 health care facilities but we have to define what he refers to as the "service level package" which basically means the services, quality and standards to be expected in the facilities and what not to expect. The mandated insurance should be able to cover for most of the services stated in the service level package which should be all of the PHCS. The government could also create a system for contracting the private health sector to offer higher level services that would be very expensive thus saving on costs. The private health sector should also be allowed the freedom to operate on their own with the government only acting on a regulatory capacity. Most of the non-governmental organization should consider partnering with the government in delivering quality and affordable health services in order to improve the perception of the care delivered at government facilities. I believe partnerships with the private sector will also have the same effect.

Health Financing – The purpose of health financing as stated by the World Health Organization (WHO) is to "make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care" (WHO, 2008). The best way to do this is by pooling together funds through a mandated insurance payment scheme. The scheme should consider the financial disparities that exist between individuals and bring forth a proposal that aims at minimizing the disparities in terms of contributions in relation to services to expect in the service level package. Taxation is also a way to finance the health system. The government should ensure that it allocates ample amount of taxpayers' funds to the health-sector for the purpose of developing standard infrastructure, strengthening health systems and encouraging innovativeness in healthcare delivery systems. As it stands, Kenya also receives external funding from donors and well-wishers but we cannot rely on this because the aim here is to create a self-sufficient health system. The question that remains is how do we manage these funds? The ministry of health should be allowed to manage most of the taxpayers funds through a regulatory body with members vetted and trusted not to misappropriate the funds. The ministry of health should then assess the health care needs of the Kenyan population and allocate funds equitably to cater for the needs. Push and pull systems of allocation of resources should be used interchangeably depending on the presenting circumstances. The mandated insurance scheme should also be allowed to manage its own funds. Basically, it should be given the responsibility of providing cover to each and every citizen in the scheme to obtain free healthcare services especially those not indicated on the service level package.

Leadership and Governance – This are two very different concepts that are very crucial in the development of any system. Governance as defined by (IBE-UNESCO, 2020) is the "structures and processes that are designed to ensure accountability, transparency, responsiveness, rule of law, stability, equity and inclusiveness, empowerment, and broad-based participation." Key emphasis should be placed on transparency, accountability and equity. Leadership on the other hand is having the people in positions of authority and influence. In order for the system to prosper leaders should be able to articulate the vision of the healthcare system to the people under their influence and create an atmosphere that allows new and innovative ideas to be debated and integrated into the system. The responsibility of ensuring quality, accessible and affordable health services should not only be left to the leaders and government but also to the individual citizen who should take up an active role of social responsibility in health. The government should also have strong regulatory bodies, and research teams that are constantly monitoring, evaluating and presenting the performance of the system basically because the system largely relies on the government's ability to create and formulate policies as well as implement them to ensure that it works effectively and efficiently. As indicated by (World Health Organisation, 2006) due to the failure of the market to meet the populations health demands the government is obliged to take up the responsibility of ensuring that the population health needs are met equitably and effectively without diminishing the quality of care.

Human resource in health – Statistics show that in 2018 the number of physician per 1000 people in Kenya stood at 0.157 whiles the number of nurses per 1000 people was 1.166 during the same year (World Health Organisation, 2018). This number is way below the WHO recommended standard of 1 physician for every 1000 people (Raman Kumar and Ranabir Pal, 2018). One of the reasons behind this appalling statistic is the inability of the country to retain its trained medical personnel due to poor working environment and conditions. There is a culture and belief that exists within the Kenya populations that moving or relocating to other countries especially developed countries presents you with a better opportunity to succeed and live the good life. What the majority of people do not understand is that no health system can prosper without adequate and competent personnel that are highly motivated to make a change and so we must embody ourselves in the spirit of patriotism and loyalty to ensure that we develop our health system for the betterment of our people. On that note, emphasis should not only be made on the technical personnel such as doctors and nurses but also on community health workers, health influencer's, management and support staff (World Health Organisation, 2010). These are the cadres that help link the community

to the health system and ensure there is cohesion in way of obtaining healthcare services, advocating for the communities health needs which helps in the better utilization of health care services (U.S. Department of Health & Human Services, 2007). Leaders and government should be tasked with the role of creating platforms and systems that are compassionate to the health work force like for example providing incentives and awards to people that provide exceptional service among other systems to ensure we retain as much competent personnel as possible. We should also invest a lot in the training of new medical personnel as well as offer continuous medical education to our existing health personnel through ideas like introducing short courses aimed at improving and educating the workers on current health care practices, new innovations as well as offering them an opportunity to specialize on their specific areas of interest. Specialization however should be done in moderation because as it is indicated in (Dr. Detsky, 2012) research, the cost of specialization might outweigh the benefits in some instances.

Health Information Systems – This building block is crucial in every health system mainly because it links all other building blocks together to kind of look at issues from a broader perspective. The main functions of a health information system being data generation, compilation, analysis and communication (World Health Organisation, 2010)

The health information system should be used to monitor, evaluate and help in the decision making process of the different parts that exist in a health system. For example, the creation of a workforce information system to provide critical information aimed at addressing the human resource needs will help leaders and decision makers to develop strategic plans and make well-informed decisions perhaps in the hiring, contracting and training of medical personnel. The idea here is to have several information systems in the different departments of health interlinked. It is therefore important that information and systems or structures used to manage information to be decentralized and accessible to virtually all of the decision makers and strategic planners.

Health Service Delivery – Having an effective and efficient health information system as well as adequate, competent and highly motivated health workforce will have a direct impact on how health care services are delivered. Service delivery system should be comprehensive in the sense that it offers a wide range of services that are accessible to most if not all of the population. In health, the services need to be focused on the patient, what we call patient-centered care and not the disease alone so as to manage the patient holistically. Good management will ensure that the quality services are offered to the patients consistently over time. Patients should be in a position to be

able to give feedback on their level of satisfaction and areas that need to be improved among many others. Health services delivery should be the end-goal. If the services delivered do not improve the quality of life of patients as well as improve the health of the population in general, it means that there are flaws in the system that need to be addressed (Health Partners international Global Health Company).

Conclusion

From my point of view, there is nothing like an ideal health system. There are prototypes that work better in certain areas or countries but would totally produce the opposite result in other countries. It is necessary that a country and its government understand its history, cultural beliefs and ethos while trying to design a health system. In my case, I chose to design a system that relies a lot on how the government and its leadership perform. The latter which is to privatize healthcare did not seem viable especially due to the high costs of healthcare services and in some instances the exploitation and underpayment of health workers. It is therefore important that the people take into consideration the people they chose in government and the policies they allow. The people should take up active responsibility to improve their health and demand the standard quality care from government facilities when they get ill. The system also goes on to address all the major building blocks of an effective and efficient health system systematically. With that said, this is just but a mere suggestion of what an ideal health system in Kenya should look like but I would be unwise to say that it addresses all issues that affect health. For example, in the cases of increased violence, crime rates, war, famine and many other risk factors to health, the system would need to adapt to the situation at hand.

References

A.V. Noreh. (1988). HARAMBEE IN KENYA: A BIBLIOGRAPHY. Nairobi: University of Nairobi library.

Cyrus. O. and Roselyne. O. (2019, February 25th). Over Sh10 billion feared lost in new NHIF pay scandal. *The Standard Media*. Nairobi.

Dr. Detsky. (2012). Specialization in Healthcare. *JAMA*.

Dr.George. (2018, April 3rd). What ails the health sector in Kenya. (NTV, Interviewer)

European Commision. (2019). State of Health in the EU. United Kingdom Country Health Profile 2019.

Francis W, Irene K, Ezra O. (2017). PRIMARY HEALTH CARE SYSTEMS. Case Study from Kenya, abridged version. *World Health Organisation*.

Health Partners international Global Health Company. (n.d.). Health Service Delivery. *Building Partnerships for Equitable Health Systems*.

IBE-UNESCO. (2020). Concept of Governance. *International Bureau of Education*.

Kenya Medical Practitioners and Dentist council. (2020). *Ensuring Quality Healthcare*. Retrieved 11 30, 2020, from medical board Kenya: https://medicalboard.co.ke/about-us/core-functions/

Kenya National Bureau of Statistics. (2019). 2019 Kenya Population and Housing Census Results. *KNBS*.

Mimi Chung. (2017). HEALTH CARE REFORM: LEARNING FROM OTHER MAJOR HEALTH CARE SYSTEMS. *Princeton: Public Health Review*.

Ministry of Health. (2014). *MINISTERIAL STRATEGIC & INVESTMENT PLAN: JULY 2014– JUNE 2018.* Nairobi: Ministry of Health.

Raman Kumar and Ranabir Pal. (2018). India achieves WHO recommended doctor population ratio: A call for paradigm shift in public health discourse. *Journal of Family Medicine and Primary Care*.

Roosa T, Robin O, Elias M, Ana D, and George A. W. (2020). INTERNATIONAL HEALTH CARE SYSTEM PROFILES. *The Common Wealth Fund*.

U.S. Department of Health & Human Services. (2007). *Community Health Worker Health Disparity initiative* . Retrieved from Health Resources & Services Administration; Health work force.

WHO. (2008, June). Health Systems Financing. *Toolkit on monitoring health systems strengthening*. World Health Organisarion.

World Health Organisation. (2006, July). The role of government in health development. *Technical Discussions*. WHO.

World Health Organisation. (2010). Health Workforce. In *MONITORING THE BUILDING BLOCKS OF HEALTH SYSTEMS: A HANDBOOK OF INDICATORS AND THEIR MEASUREMENT STRATEGIES* (pp. 37-40).

World Health Organisation. (2018). *The World Back*. Retrieved December 2, 2020, from https://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=KE