

***APHIA Financing and Sustainability Project***

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 **MSH Management Sciences for Health**

**Ministry of Health** 

# **Health Sector Decentralisation: A Kenyan Framework**

*Report of a Workshop  
held at the Mayfair Court Hotel, Thursday 3<sup>rd</sup> April 1997*

**John Fox**

**May 6, 1997**

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## Executive Summary

*Health Sector Decentralisation A Kenyan Framework* was a workshop sponsored by the recently launched APHIA Financing and Sustainability (AFS) project. It was held at the Mayfair Court Hotel on Thursday 3<sup>rd</sup> April, 1997, and attended by departmental and divisional heads of the Ministry of Health, some Provincial Medical Officers, and Health Board members - drawn from all those departments and groups which are particularly concerned about the form decentralisation is taking within the health sector - and about the impacts decentralisation will have on the quality of the service.

The workshop agenda was structured in three distinct phases, each focusing on a specific main question:

- What is the rationale for decentralising the health sector?
- What lessons can be learnt from other countries who have followed through similar decentralisation policies?
- What are the possible implications for implementing decentralisation here in Kenya?

Given that it was the AFS project that had initiated the workshop, there was the complementary objective of tapping the experience of the predecessor Health Care Financing Project, which since 1989, had assisted with the design and implementation of the cost sharing programme which involves a number of decentralised machineries - and the District Health Management Boards in particular.

In opening the workshop, Dr Mwanzia, the Director of Medical Services, welcomed the opportunity for debating a number of issues related to decentralisation that had become quite urgent, given the fast pace at which the health service reforms were proceeding. As well as reflecting on what had happened in the Health Care Financing Programme, he said that there was a need to look more closely at the roles and responsibilities of the Hospital Management Boards that had just been created, and at the capacity building programmes that will have to be designed - where there should be a closer link between the Health Reform Secretariat and the Health Care Financing Programme.

In the first phase, the brainstorming exploration of the participants' own perceptions of what decentralisation means for the health sector in Kenya, there was a tremendous variety of opinion about the meaning of decentralisation. However, three distinct notions did emerge:

- That decentralisation should lead to greater efficiency in decision making and implementation - because needs assessment will be more relevant and allocation of resources more precise.
- That decentralisation should be preferred because locally based control is more democratic than centrally based direction.
- That decentralisation will entail a greater degree of accountability because health service staff will have to subject themselves to the scrutiny of boards representing community interests.

Significantly, that decentralisation should ensure equity in health service provision - which is given high priority in policy papers - was not mentioned by any of the participants.

The focus of the second phase of the workshop was a presentation by Dr Wolfgang Munar, who, as the Assistant Minister for Health in Colombia, had coordinated the implementation of decentralisation of the health service in that country

In the first half of the presentation, Dr Munar elaborated a model that distinguished between

- **Deconcentration** in which activities of an organisation are dispersed, but control remains at the centre (Like the branch offices of a bank)
- **Delegation** in which responsibility for certain executive tasks (and the resources to carry them out) are transferred to various peripheral institutions of an organisation - making them legally created and independent subsidiaries
- **Devolution** in which discretionary authority and political decision making are transferred to local government - for example, a municipality

The key issues that should be considered when deciding which of the above forms of administrative decentralisation to adopt are, Dr Munar argued

Will the Government continue to subsidise hospitals or primary health care - or both?

What degree of autonomy will be given to institutions within the hospital sector, and who will own the buildings land and equipment - will it be the Ministry, the Province the council or the community?

Who will govern the institution(s) and what will be the relationship between the Boards and the Management Teams?

What sort of accountability is wanted - deconcentrated where the Ministry gives itself the authority to the people's need, delegated, where the Board has members who can voice community interests or devolved, where Board members are publicly elected?

On the current situation in Kenya, Dr Munar offered a number of observations

To resolve the uncertainty and ambiguity that exists over the purpose and forms of decentralisation there is a need to involve key stakeholders in a more effective communication strategy, to provide information, encourage discussion and build consensus

In as much as ensuring equity means targeting the poorest of the poor, this can only be achieved by retaining certain resource allocation functions at the centre - and by having a transparent formula for whatever decisions are made. Otherwise, decentralisation can mean 'the perpetuation of ancient and traditional inequalities'

Following this last point, Dr Munar suggested that three strategic frameworks need to be formulated

A mechanism for allocating resources - and an estimate of the costs of implementing decentralisation ("Because without the money a quick decentralisation would be a mess")

An organisational framework, that defines roles and responsibilities of the key professional teams and boards of community representatives

A legal framework, that enables the granting of any desired autonomy

In the concluding discussion of the third part of the workshop, a good deal of concern was expressed that there was a pressure to decentralise quickly - without a long enough pause to

reflect on its objectives or its impact. It became clear that a number of crucial issues relating to decentralisation are still not resolved.

Will the decentralisation of the health sector mean transferring responsibility for strategy formulation or only the management of operations?

Should the Health Management Boards of public representatives - for hospitals - and at both district and provincial levels - have executive or only advisory powers?

How will the Boards relate to each other, in terms of revenue generation, distribution and supervision?

What will happen to primary health care if the hospitals use their autonomy to retain all the cost sharing funds they generate?

How will the most vulnerable groups be protected?

What formula will be used for allocating resources?

#### *Follow up*

It was agreed that the workshop should be followed by the completion of the framework for health sector decentralisation in Kenya, which could then be used to guide the drafting of a policy statement by the Ministry - which in turn would guide the preparation of a decentralization implementation plan, the latter being an activity already planned to begin in late May with ODA and World Bank assistance.

Specific follow up actions would include:

1. Allow participants time to read and digest the materials presented to them and produced by them at the workshop.
2. Arrange for Dr Munar to return to assist with the completion of the decentralisation framework for Kenya.
3. Arrange in consultation with HEROS a suitable date and time to review the documentation and hold another workshop with the participants to assist them with the completion of the decentralization framework for Kenya. Dr Munar would facilitate at the workshop.
4. Submit the decentralisation framework to the Ministry for review and use by policy makers.

## OBJECTIVES

- To explore the rationale for decentralising the health sector in Kenya,
- To clarify the terminology being used,
- To develop a conceptual framework that could be used by the Ministry of Health in the drafting of a policy paper and an action plan

## AGENDA

08 30-08 45	Welcome	Ibrahim Hussein
08 45-09 15	Introductions and Expectations	
09 15-09 30	Outline of the Dav's Objectives and Agenda	Ian Siney
09 30-10 45	What Is Happening In Kenya exploration of definitions and goals related to the health sector decentralisation programme	Group discussion (Facilitator John Fox)
10 45-11 15	Tea break	
11 15-12 45	What Has Happened Elsewhere presentation of case studies, key issues, and a conceptual model	Dr Wolfgang Munar
	Lunch	
14 00-15 45	Where Kenya Fits discussion of implications, problems and potentials	Group discussion (Facilitator John Fox)
15 45-16 00	Tea break	
16 00-16 30	Conclusions	

## LIST OF PARTICIPANTS

NAME	TITLE
Dr James Mwanzia	Director of Medical Services
Mr K M S Kigen	Head, Department of Policy, Planning, and Development
Mrs M Kuria	Head, Department of Finance and Administration
Dr T Gakuru	Head, Department of Human Resources, Development and Training
Dr P K Gaturuku	Head, Department of Preventive and Promotive Care
Dr J O Gesami	Head, Department of Curative Care
Dr E Ogaja	Pharmacist, MOH
Dr C K Munene	Director of Mental Health
Dr Maina Kahindo	Department of Preventive and Promotive Care
Dr D M Kuma	Deputy Director of Mental Health
Mrs E Ndungu	Deputy Chief Nursing Officer
Dr B Hagembe	Deputy Director of Medical Services
Mr K Ajode	Chief Public Health Officer
Mr J M Nyamu	Division of Medical Engineering
Mrs D Sande	Division of Health Education
Dr Mwangi	Provincial Medical Officer, Nyeri
Dr S K Sharif	Provincial Medical Officer, Coast Province
Dr Muga	Provincial Medical Officer, Nyanza Province
Mr Isaac Githuthu	Chairman District Health Management Board, Nyeri
Dr Amolo	Chairman District Health Management Board, Kisumu
Mr Patrick Itumbi Njue	Health Reform Secretariat
Prof P Nvarango	Health Reform Secretariat
Mr Ian Slnev	MSH/AFS - Chief of Party,
Mr Ibrahim Hussein	Undersecretary, Head of Health Care Financing Division
Mr John Fox	Consultant on Decentralization Issues
Ms Margaret Ombai	Consultant on Decentralization Issues

## Opening Statements

In welcoming the participants, **Ibrahim Hussein**, Head of the Health Care Financing Division, apologised for the short notice that they had been given. But he said that their attendance was a good indication of their commitment and support, specifically for the business of the meeting - and, in general, for the health sector reforms now in train.

Our Ministry has taken very bold steps in health reform," he said. "It is very important that the Ministry's vision for health policy reform is realised. In my own view, this is one of the most innovative reforms in the history of the health service in this country. Certainly, some things in our current system are not working well, and there is a need for other players to come on board to assist with the management of the health services. But, with the development of cost-sharing, we have some useful experience to contribute.

There are a number of important issues to discuss, in relation to the reform agenda. But let me highlight just one or two. In my own view, decentralisation cannot be sustained if appropriate legislative changes are not enacted. We have appointed District Health Management Boards with certain defined responsibilities and roles. We also now have hospital-based Boards. As we are moving power from the centre to the periphery, it is also important that existing legislation that is likely to constrain the reform agenda is looked upon. And I am sure that HEROS will be dealing with such problems.

Second, the objective 'Better health for all' cannot be realised unless there is great improvement in the management of health services - and in the allocation and management of resources.

Dr **Mwanzia**, Director of Medical Services, noted that, because of the urgency of certain issues, there would have to be a number of meetings of this kind. And he gave the example of the meeting for Provincial Medical Officers the previous week. "There is likely to be hassle at this point in time," he said, "and we hope you will understand the problems we are facing."

He suggested that the meeting should be seen as part and parcel of the overall health reform programme that is ongoing. "Decentralisation is a key strategy in the reforms." He emphasised that the overall goal of the reforms is to improve efficiency. "There is a need for change - because we appreciate that what we are doing now is not adequate." He reminded the group that the Ministry started off the reform process with a major policy statement - and followed that with a major reorganisation. "Now," he said, "the work of reform is proceeding under a good deal of policy pressure."

He then singled out a number of issues that he hoped would be treated in the course of the day.

The need to reflect on what has happened so far on the Health Care Financing Programme which started in 1989 and which is now a good vehicle for the reforms. ("We are very happy that we have now started on the second phase of the USAID supported programme, the theme of which is *sustainability*."

The need to look at certain institutions that have made health care financing successful, particularly its Steering Committee and its Implementation Committee, the DHMBs and the institutional boards that have come up. ("Is there some confusion about the roles of these boards?")

Many issues related to these Boards need to be taken into consideration ("If the Boards that have been created cannot assist the Medical Superintendent and his team then we must look at ways and means of making them successful. In thinking about capacity building for the Boards, there should be a link between HEROS and HCF.")

'We must avoid creating the impression that the Ministry still has vertical programmes,' Mr Hussein went on. "We must keep reminding ourselves that however much support we get from our donors, that the Ministry must be in the driving seat of the reform process. The reform process is ours. We are fortunate to have a Donors' Coordination Group, which meets every three months and is chaired by the Permanent Secretary. Let us make sure we understand what each donor is doing - and that way we can avoid duplication."

"This meeting and the one we had last week with the PMOs - perhaps they should have been combined in a two day meeting. Perhaps we need better coordination. And on decentralisation we need to delineate roles very clearly at each of the operational levels. Let us brainstorm about them, and be very open."

**Ian Slaney**, Chief of Party for the AFS Project, explained why AFS had called people to the workshop. He suggested that it is not only in Kenya - that it is the case in Europe and the US too - that a word such as "decentralisation" can become a buzz word without there being a shared understanding of what it means. "It can mean so many things to so many different people."

He said that the days work would be only the beginning of a process - a stage in which a conceptual framework would be developed - one that would assist the Ministry of Health in formulating a decentralisation policy for the health sector and an implementation plan - behind which the donors could rally.

He then outlined the key components of the APHIA Financing and Sustainability project - part of the wider APHIA health sector programme for which USAID has made a grant of \$60 million to the Kenya Government, over a period of five years. Unlike the preceding Health Care Financing Project which concentrated on cost sharing just within the Ministry of Health, this new project will reach out beyond the Ministry to the private sector and NGOs.

He explained how the objectives for the AFS Project relate to the global strategic objectives of USAID for the health sector in Kenya:

- Increased financial resources for health and family planning services
- Increased organisational capacity and self-sufficiency of private sector health and family planning service providers

There are four main components:

- MoH Health Care Financing Programme (taking up 45% of the level of effort)
- Private sector health financing (20%)
- Family Planning NGOs financial management and self-sufficiency (20%)
- Reliable public sector supply of key expendable commodities (15%)

With respect to support planned for the Ministry of Health there are nine categories of activity:

- Institutional development (with a focus on developing institutional capacity for the sustainability of the programme within the Ministry)

the members of the training team had different views of the main role of the DHMBs - whether they were purely advisory or whether they had any executive functions. He suggested that the lack of clarity and agreement of what "superintendent" was meant to mean, for instance, bedevilled, not only the understanding, but also the actual performance of the DHMBs.

Each member of the workshop was then asked to write his or her own definition of the word 'decentralisation' as it relates to the health sector reforms in Kenya.

This was the outcome:

*Giving authority to one at the periphery to make decisions and carry them out*  
*Transfer of authority and responsibility from a centralised organisation (Afya House) to closer to the operational (community) level*  
*Responsibility with authority to execute away from centre or HQ*  
*Process of empowering the majority stakeholders to participate in improving their health reform policy*  
*Giving authority and responsibility to plan and manage the institutions in all aspects*  
*Sharing of power*  
*Resources authority and responsibility at the peripheral level*  
*Decentralisation devolution democratisation*  
*Planning and finances pushed to the districts*  
*Delegation of authority with a view to implement policy supervise operations and report back to the policy makers*  
*Delegation of authority and responsibility from top to bottom but not accountability*  
*Devolution of power and authority to the periphery*  
*Delegation of power to the periphery*  
*Transfer of both authority and responsibility to make decisions and take necessary actions to the districts*  
*Giving more authority responsibility and accountability from the centre to the periphery to minimise bureaucracy*  
*Defining roles and responsibilities and taking action based on the defined roles and responsibilities at the lowest level*  
*Giving more say to others not necessarily in the headquarters*

There is agreement here on the core meaning that decentralisation means a movement from the centre to the periphery. But there is an interesting variety of options as to what is being moved: authority, responsibility, power, accountability, "say" - concerning planning, decision making, implementation, management, resources, finances. There could be a very significant difference between "giving", "devolving", "sharing", and "delegating" any of these things! Also, it might be significant that there is a mention of movement to the districts - but no reference to the provinces.

From the implied motives embedded in the definitions, it can be seen that many of the members put an emphasis on "efficiency" as a reason for decentralisation - because it means that decisions will be more relevant ("closer to the action") and less constrained by bureaucracy. Others had a concern for democracy - in as much as decentralisation means greater public participation in decision making. Also, the concept of accountability is clearly an important one - in the sense that decentralisation will increase the possibilities of managers and professionals having to subject themselves to the scrutiny of boards representing community interests.

The two goals were seen to be inter-related. "We are assuming," said one group after a short brainstorm on the reasons for decentralisation, "that if a decision is made in a participatory manner, then it will be democratic and the quality of that decision will be enhanced." But others argued that a democratic system is not necessarily more efficient than a non-democratic one. (Dr. Munar suggested that efficiency can mean "doing within the health sector those things that have the greatest benefit at minimum cost - for the nation as a whole, or for the system". Efficiency, defined from an organisational perspective, can also mean "increased productivity and enhanced quality".)

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For another group the rationale for decentralisation was “Sharing of responsibility for resource creation, resource allocation and resource use by the various stakeholders leads to increased participation - and improves quality of health care and the chances of sustaining it”

The third group had begun its discussions by asking the question “Who is sanctioning decentralisation is it donor-driven, Ministry of Health-driven, or the Government of Kenya-driven?” It was regarded as a very important question, because, were it to be donor-driven, then ‘after five years the Ministry could be left somewhere in between centralised and decentralised’ As for the rationale, the group decided that the Ministry is decentralising in order to improve health care efficiency, by maximising community participation in matters affecting their health - and by introducing cost-effective interventions

But no-one mentioned ‘equity’ - which is the foremost reason given in the Ministry’s policy paper, *Kenya’s Health Policy Framework*

## Models of Health Reform

Presentation by Dr Wolfgang Munar

*What follows is a full transcript of the presentation*

I wish that the same kind of debate could have happened in my own country, Colombia when it embarked on a similar reform process Because such consensus building is crucial - not only for academic reasons but also for real political ones

### Types of Change

I am going to present a simple conceptual framework for health reform, for distinguishing between kinds of change that are possible in a health service A way of separating what are essentially political processes, so that they can be more easily grasped and understood

<b>Systemic change</b>	Which means changing the whole system making changes that impinge upon every organisation institution and actor within the system These changes are usually moving in the direction of a more political nature If the goals are related to achieving equity for example addressing an inappropriate distribution of resources in a country then you are talking about major systemic changes It therefore means targeting those who are the poorest of the poor - and making sure they receive the most possible public financed health services It means saving We are a poor country but there are some people who are worse off than most and because they are so poor they are entitled to receive public-financed health care
<b>Programmatic change</b>	Reforming a system in a less profound way by changing priorities perhaps stopping doing some things because they are not efficient for example or doing more of other things because they are more efficient concentrating because of efficiency reasons on selected programmes We’ve been talking about primary health care since Alma Ata but have we really gone beyond the rhetoric? Are we really investing public resources in those programmes that produce the most benefit at the least cost?

<b>Organisational change</b>	Where the concern is how an organisation can do what it does in a way which is more productive and in a way that produces things of better quality. The key concern is productivity - doing the most with whatever one has - whether it is a little or a lot. Usually a good way to begin: "What can we do to make our health organisation work in a more efficient way - in the least costly manner but also of high quality?"
<b>Institutional change</b>	"Donors should very much think about this one" because it relates to capacities to ways of doing things. The implication is that you can reform a health system by making changes in human resource development (through training and retraining), technology development (scientific management, for example) information development (sharing data)

## Frameworks for Formulation

### *Strategies or Operations?*

A basic question behind decentralisation is whether we want to decentralise strategies or operations (day-to-day activities) - or both. Operational activities are usually routine and of low technology and easy to formalise. And if they are easy to formalise then this means that manuals can be easily created and training programmes designed. Training can be given in a standardised manner all over the system.

Decentralisation of strategic tasks is something that needs some thinking about - because this relates to policy making. For hospitals, for example, it may make sense to decentralise strategic decision making because to compete with the private sector they might as well have the capacity to decide what their business plan is going to be - rather than for somebody in the centre telling them what to do. But often it doesn't make sense to decentralise other strategies such as whether to allocate \$10 million to this hospital and \$1 million to that hospital. Or \$10 million to this province or \$1 million to that province. These allocation decisions usually require, technically speaking, a strong centre - making transparent decisions about the allocation of resources.

Another important question is: To what level do we want to decentralise? Here, the confusion grows. Are we talking about decentralisation within the Ministry of Health - or are we talking about the creation of new organisations? Are we talking about a breaking up - and then creating linkages between the different pieces? The linkages have to be spelled out very clearly.

### *Why Decentralise?*

There are two major "Whys". First, social and political goals. And these go beyond the health sector. They are, as some of you have used the term today, "government-driven". For some countries decentralisation is a way of reforming the state.

Second, there are some sector-specific reasons for decentralising. **Technical efficiency** is one obvious one - and that has come up quite clearly in what you have said today. **Accountability** came up today. **Better fit between sector priorities and local needs** - this also came up today.

### *What to Decentralise*

I came to decentralisation as a believer. You could have called me a fanatic. From the early sixties to the late eighties in my country, decentralisation was a major buzz word. Not necessarily donor-driven. Very much a political issue. There was a major conflict between the regions and the centre. Decentralisation there was managed in an administrative way - some types of authority and power were given to the provinces and the municipalities. But the real allocation of resources did not change. By the late eighties the process was a major political conflict. I was given the chance

to do some things, because there was a law which was passed in 1990 which created a framework for any province or municipality to do, as much as the law permitted, in terms of decentralisation. The health sector was the first to be decentralised. Many of us just took the opportunity and just did things.

So I was a believer. Then I was a doer. I had to be the Secretary of Health - and decentralise a province. Then I became a policy maker when I was made the Vice-Minister of Health. Now I am more like a 'constructive critic'! Because I have learnt by doing. And I have learnt that some of the beliefs and ideologies - though well intentioned - may produce unwarranted effects.

Until two years ago, decentralisation was a "given". No single donor or international agency or university, would care to discuss what it was all about. After some of these unwarranted effects, it has become once again an important issue.

It could be

**Giving authority to make decisions.** Authority is normally given within a legal framework - so it can easily be decentralised. Authority is legal by definition. At least in a modern state it is.

**Giving responsibilities.** This is a newer concept. It is fairly recent that states have begun to think about their responsibilities - which can be either operational or strategic.

**Giving resources: human, physical, financial.** In Colombia we were given responsibilities ("Here do this!") but we were not given the resources. We learnt quickly that giving responsibilities without resources is a waste of time. It is a politically dangerous exercise.

**Giving opportunity to raise revenues: tax or non-tax.** Kenya did this as soon as the cost-sharing programme was put in place. Perhaps people outside Kenya do not realise the strategic importance of this non-tax revenue decentralisation. Local authorities can also be told to raise their own taxes. "Keep the money - apart from 10%, say, or more." This is called 'fiscal federalism'.

### *How to Decentralise*

There are four basic types

**Political** A process by which political power, or representation, or democratic institutions are transferred from the centre to the periphery. In Kenya this might mean, for example, giving the provincial governments the power to raise taxes. Provincial Commissioners are elected by popular vote - or the same story at the municipal level. Health can be part of this process. But this kind of decentralisation is mostly done by changing fiscal and electoral laws. But I think that this is not what we are talking about in Kenya.

**Spatial (or Geographical)** This is what urban planners love to talk about! You look at the whole country and say "I have a steel plant - where am I going to put it? So that I can create an area of development - a new centre where I want economic growth to occur." Again, this is not what we are talking about.

You are all talking about some of these things - but you are not all talking about the same thing. You will have to define which model - or a combination - you want to have. So I would like to give some examples and highlight some experience in other places.

In the health sector, it is a very simple thing to create branch offices - or to deconcentrate. That is happening right now. First, you can do it within existing governments (they don't have to be independent governments to be deconcentrated) like the existing provincial or district structures. Or you can create new institutions. The DHMBs make a good example. Or you can delegate and create subsidiaries. This is where hospital autonomy fits in. The provincial hospitals could be like parastatals or public corporations. They are going to be independent. "You report to us, because you are in the health sector - but you are independent. You will develop your own systems of management. You will have your own Board. You are going to be accountable to your customers."

If the hospital is still accountable to the centre rather than to its popularly governed, then it is not a fully devolved system. To be devolved there has to be some form of autonomous sub-national government.

## Priorities

What are the main issues that should be considered when you are thinking about which type of administrative decentralisation to go for? The first one, and one the AFS project thinks about a lot, is: What's going to happen to primary health care? We are thinking about what is going to happen to PHC, to community participation, to public accountability - and the future of the cost-sharing programme - if there is a move towards decentralisation. We would like to understand what is going to happen. Will there, or will there not be, explicit targeting of public expenditures on health. Are we going to target the poorest of the poor - and make sure that those people receive public health services? Or will we try to give the same to everyone? Remember that this is a key component of a primary health care strategy. Is Kenya going to define some package of benefits?

If you do these things, the shape decentralisation is going to take will be different from if you don't. If you create a package based on PHC concerns, then most of the public resources will have to go there - instead of going where they are going now. This is not easy - because you can't have both. How much for this? How much for that? And you need to decide these things before decentralising - or by decentralising you will be creating sunken costs, and the change will be more difficult. This decision is the responsibility of the Government of Kenya - it cannot be left to the private sector. It cannot be left to the donors. It is a major political issue. Is this hospital care/primary health care a dilemma - or is it a necessary duality? The answer has to come from you.

Kenya is currently spending a large proportion of public health resources on hospitals and it is making huge efforts to move more resources on PHC. But it is clear that the resources available are not enough to do both at the same time. In my personal opinion, this is a question that shouldn't be a dilemma.

On hospital issues, some of the questions are

- What is financially viable?
- Do you have enough beds?
- Do you have too many beds?
- Do you have too many facilities?

Financial constraints should actually illuminate these discussions.

To what extent is there a political will to discuss openly the restructuring of the hospital sector? Then, only then should one discuss autonomy or "corporatisation", which is the same thing. Autonomy, in this case, would be the result of the analysis of the financial constraints faced by the Kenyan system. It would also be an analysis of the political implications of any of the changes. If you begin by simply giving autonomy, you will have no idea what you are going to get in the end.

I wish I could take you over to Colombia so that you could see what is happening there. Because that is what we did. We discovered that though there was an intention to give less to hospitals and more to PHC, the opposite happened. Salaries in the hospitals went up. There was a higher need for managerial capacity in the hospitals. You cannot even think about running a hospital in an autonomous manner if you don't have good managers. Auditing, cost accounting, strategic planning - the costs went up.

## Hospital Autonomy

When you are discussing hospital autonomy, there are three main considerations. First, there is **ownership**.

Who is going to own the building, the piece of land, the equipment?

Will they belong to the MoH, the nation, the province, the council, the community? (Some countries are trying to make the local communities the shareholders of public hospitals.)

Or are you going to appoint trustees?

Are you going to establish some form of social control through a Board that owns as representatives of the national government? (There are many legal implications here.)

To whom are these "owners" of these public hospitals accountable to - legally?

Who hires, who fires?

Which brings us to the second matter - **governance**.

What will be the relationship between the Board and the management team of the hospital? How do you avoid overlap - in defining the roles and responsibilities of the Board and the management team?

What I am hearing from people I have talked to in Kenya, is that the current personnel managing the hospitals need a lot of retraining - maybe it means the appointment of new people to be able to manage in a modern scientific manner these enterprises or corporations - because that is what these hospitals are.

The third consideration is **accountability**.

Where should it lie?

Perhaps we should define it a little bit. Let me do it through a comparison. If we go to a restaurant, a hotel, or a petrol station, we have two means of making the provider of the services responsive to our desires. We can tell the manager that we didn't like his service and we are not going back there again. That is called "Exit". It is a very important right that we can exercise within a market. We have all done it many times. Now this doesn't happen in the health sector - especially for the

poor The poor usually do not have any way of saying "I am not going back to that hospital because they treated me badly" They don't have the money to go elsewhere

But if you can provide something similar to this, then you are building accountability Those who provide the service are going to bear in mind the possibility of customers exiting This is difficult But the AFS project has the idea to analyse some ways of testing community-based participation insurance schemes, and so on

The other thing that you are doing to create accountability is called "Voice" In the market sense, it's what happens when we go to a bank, say, or an office, and write a letter saying "Listen Mr Manager, this is a terrible service You have to do something to improve it"

You are doing something like this when you create health committees at the community level You are doing something like this when you have senior officers going to Boards When you have some form of social control, some form of representation within the health sector The combination of these two things may provide accountability

So it's important to know where you want that accountability to be, because that will define which kind of decentralisation you want You can have accountability at the national level - like through the branch office model In this case, the MoH gives itself the authority to respond to people's needs The MoH or its branches decides "We are responsible, we interpret what people want" And everybody within the hierarchy will respond It is an internal locus of responsibility

You may want to have, for certain institutions like hospitals a shared accountability between consumer representatives and government officers For instance, in the delegation model, when you have a subsidiary in which the Board has community members, then you will have Voice

The third and more revolutionary form of accountability, and the one that physicians all over the world are deciding it's a tough one for them is when you make consumers voters at the same time "So we are going to devolve we are going to decentralise within the health sector and make, for example, autonomous hospitals We are going to give them publicly elected officials"

That makes the hospitals' customers the ones who are going to be watching what is happening - and expressing their opinions, not only in terms of Voice but also in terms of Vote There is, of course, a relationship between community participation and accountability - the more community participation you have, the more public accountability you will have

So devolution which has a lot of political implications, is right now the paradigm - because of its degree of community participation and public accountability The professionals, the Chairman of the Board, or whatever, they are all made accountable to the users of the health facilities and the voters

The branch office model has less public accountability - but it is better than having none Here, the decisions are made by the headquarters

## Some Key Lessons

Let's talk a little bit about Kenya. I think there is a need to define certain processes that should move forward in a coordinated manner. And for quite some time you will be facing a huge challenge - and having to juggle many balls at the same time. Right now, I would recommend trying to reduce the ambiguities and uncertainties surrounding the process of health reform.

### *The Need for Communication and Information Strategy*

Uncertainty is the consequence of a lack of information - if I don't know what is the likelihood of something happening, I am going to be very anxious. If you want to reduce uncertainty, you need data. Ambiguity is the result of different interpretations of the same phenomena. So we need a communication and information strategy that allows everybody participating in the process to, first of all get the information, and second, build consensus. This has to happen if you want this, as the DMS said, to be a ministry-driven process. Otherwise it will be just new paint on old walls.

You need to formulate and communicate a policy for decentralisation - what, where, how - and how much is it going to cost? And you need to have a plan.

### *Conditions for Ensuring Equity*

I am going to show you what I found in Kenyan documents about the "whys" and the "whats". In Kenya it seems that there are some demographic pressures - growth in population, growth in the demand for health care, and an economy that is not growing at the same rate - that have outstripped the government's capacity to provide a health service. So there you have a problem. And because of this you want some form of decentralisation - to improve equity and increase the participation process in the districts and the community. This is in the *Health Policy Framework*. And that's why John was asking you why equity didn't show up in the discussions before the tea break.

If we want equity, we are talking about systemic change - we are talking about how we make sure the poorest, or the most vulnerable, manage to be better off through decentralisation efforts. I tried to look at the way in which policy is transformed in Kenya in priorities - and how priorities are transformed in action. What everybody tells me is that what is planned at the periphery is not necessarily what is done. And what is given as responsibility is not implemented because the funds are not there.

In most developing countries there is usually a national policy - but it is often believed that the people at the centre have no clue about what is happening in the districts. But, though people in the districts are better placed to diagnose what their problems are - will they be able to manage to transform that diagnosis into action, by themselves? The participation of the centre is usually needed - not only for resources but also for technical support. And many of the tough allocation decisions have to be made at the centre. At the local level people will never agree to ration themselves.

But if the centre does not listen to the priorities defined in the districts, then the result can only be cynicism. But once there has been an agreement about priorities, then what is needed is a transparent formula for allocating the resources in such a way that the priorities will be addressed. It seems that the allocation of resources in Kenya is not very clear. Certainly I have not been able to grasp it in the three weeks I have been here.

### *Targeting and Transparency in Allocation of Resources*

Using a transparent formula for allocating resources is the only way of achieving equity. Otherwise you might be sharing poverty in ways that make the worst off even worse off. And this might be what happens if you give more to hospitals than to primary health care. Or if you

allocate resources on the basis of population figures, then you might end up by giving the prize to the urban areas. Is that what you want? If you allocate on the basis of poverty - then that is targeting. In Colombia we realised that's what we had to do - otherwise we would have had a revolution. Because in our two hundred years of history, the poorest areas of the country had received the least. Until a new constitution defined equity as giving the most to those who had the least. But that's Colombia.

In Armenia the poorest of the poor are identified as the wives and children of the men who were killed in the war. In the Dominican Republic it is women who are heads of households. Once you have a definition you can create a formula that guarantees that those are the real beneficiaries of both the priorities and the resources. So you are using the little public money you have to benefit some of the poorest at the expense of those who already have more and can afford to spend a little of what they have.

#### *A Formula for Allocating Resources*

You might, for example, decide to work with a formula that out of a 30% of available resources given according to total population of an area - 60% of the 30% would be based on the proportion of children under 5, 35% would be given according to the measure of poverty, and another 35% be given according to public health factors in an area. And then you have to decide how to measure poverty - taking an indicator such as "those who don't have electricity" - or a rigorous means test.

Decentralisation doesn't necessarily help in this effort to achieve equity. Because, unless you have some formula like this - then decentralisation might just mean the perpetuation of ancient and traditional inequalities.

#### *Community Participation*

As for examples of community participation in Kenya I have seen your DHMBs and the various community committees, the promotion of Bamako initiatives - and the *Harambee* phenomenon for which Kenya is famous. These various strands need to be woven together to make a truly Kenyan method of promoting community participation.

I found that people are saying that the provincial levels need to be strengthened to enable them to perform effective coordination of the districts. This can be done through various training programmes - but resources have to be made available too.

#### *Roles and Functions of the New Boards*

I found statements about the need to define roles and functions of the DHMBs and DHMTs. Yes, these have to be spelt out very clearly. One way of looking at the Boards is that they should have social control functions. Voice. Public servants are made to listen to what the public are saying. But if they are to have executive functions - to become managerial boards - then the two roles do not go together very well. If you have an executive Board - what happens to the professional managers and the DHMTs?

But if you give these Boards, especially the ones for the hospitals, strategic responsibilities, don't also give them operational responsibilities - these operational responsibilities should be exercised by the management teams. The Boards shouldn't be interfering with the day-to-day functioning of the hospitals. I get worried when I read "hospital management boards - combining and consolidating functions of executive expenditure committees and hospital management teams". You don't want to combine. You want to separate and clearly define.

So there is still need to decide what is it that you want to decentralise, and with what kind of authority. You will need to look into the Public Health Act and see what kind of authority can be deconcentrated, delegated or devolved.

*Need for New Legal Framework*

The new definition of responsibilities will require a new legal framework. And this goes beyond the health sector. You can't, for example, just decide to transfer responsibility for hiring and firing to the provinces without changing the civil service laws. You can't give autonomy to hospitals without doing something about the laws governing parastatals.

Finally, Dr Munar presented two small case studies that are included in his Trip Report.

- Central funding for decentralising the health care of sub-national governments in Colombia  
State Purchasing Agency in Armenia

In summary, he argued that three frameworks need to be formulated in Kenya.

- **Mechanism for the allocation of resources**, and an estimate of costs of achieving decentralisation, how it will be secured, and over what period - because without the money a quick decentralisation would lead to a mess.  
**Organisational framework**, and organisational rearrangements - that defines the tasks to be carried out by all the key actors - and this will mean a lot of training and retraining before tasks are properly reallocated.  
**Legal framework** - because some of the proposed changes - like hospital autonomy, shouldn't be done until you are sure they can be done within a legal framework.

## **Points from the Discussion**

### **Hospitals or Primary Health Care?**

On whether the hospital/primary healthcare issue is a dilemma or a duality "It is bound to remain a dilemma, because, even if the Ministry decided to give priority to primary health care the public tend to measure the success of the health service mainly by the performance of the hospitals Whatever the achievements of primary health care, the public tends to focus on the shortcomings of the public hospitals "

### **Voice or Teeth?**

"We have talked about the DHMBs having a voice - but they themselves regret they have so few teeth!"

### **Quality of Elected Officers**

"Councillors are elected in, they fail, and then they are elected out - the councils remain very bad, their services are poor, the health centres are under-utilised Just electing people may not be the answer to ensuring accountability "

### **Qualities of Board Members**

"I am a Chairman of a School Board - and I am aware that many schools fail just because of the poor calibre of the Board members, who totally misunderstand their role Selecting the right people to be on these Boards is an essential matter "

"What we have seen with the DHMBs is that where the selection of Board members was carefully made they have contributed greatly to the proper management of the health services in their districts, but where the selection was not properly done, they contributed to the problems of managing the health services "

"You are asking these members to perform some difficult technical tasks Hospitals are complicated corporations - to manage them you need people who know how to manage

### **Conflicts of Interest**

"I foresee a situation where Boards will fight one another because their terms of reference are not defined "

### **Ownership**

"In the long run we want the hospitals to belong to the community "

### **Advisory or Executive Boards?**

"The Boards should not be executive, because we already have the District Health Management Teams, the technical people - they should be the ones to execute The Boards should represent the Voice "

### **Coordination or Confusion?**

"In Kisumu we have the Provincial Hospital Board, we have the Kisumu District Health Management Board - and now we have Kisumu District Hospital Board How are they going to relate to each other?"

### **Decentralisation or Fragmentation?**

"Kenyans are very sensitive to hierarchy - so are we going to Balkanise the health services in this country?"

### **Role of the District Commissioners**

In many Boards, the DCs never attend. Perhaps it is one of the historical accidents that all district-based boards in Kenya are normally chaired by the DCs. The district-based Health Boards are the only ones where the DC is not Chairman. This can so easily lead to management problems. We have already seen conflicts - we have a current one where the DC and the District Accountant are refusing to participate in any transaction concerning the cost-sharing money. Yet by law, the District Treasury is the custodian of all government finances."

### **Carts before Horses**

"It's better to work out first what you want to change - before you make the changes. It's better that before the Boards are gazetted, the reason for them is established. Before any more structural changes, it might be a good idea to work out a strategy."

### **Concentration**

"Shouldn't we be concentrating on making the seven Provincial Hospital Boards work - before trying to do something with all the 61 District Hospital Boards?"

### **Funding of PHC**

"Currently, cost-sharing raises about 60 million shillings for PHC activities within the country. The R11 recurrent budget for PHC activities is less than 3 million shillings. So the impact for PHC is very small. When we are talking about shifts - they cannot be realised with such little money. You cannot control mosquitoes, improve sanitation, with these amounts. Somehow some other resources have to be generated. This is the broad policy issue that faces us."

### **Medicine or Health?**

"It seems to me that you have here more of a "medicalised" system than a health system. Most of you are talking about medical services and, as a doctor, I would warn you that it is not enough. The fact that the PMO is called a Provincial Medical Officer tells quite a lot. Why can't we think about Provincial Health? Ensuring the quality of water, quality of air, quality of food - these are things that certainly can't be done from the centre."

### **Reform Sequence**

"I agree with Dr Munar that there are three essential steps that need to be taken before you go ahead too far with decentralisation - to reduce ambiguity, to formulate and communicate policy, and then make plans, cost them and implement them. I think what's happening is that we are doing the third without enough attention to the first and second."

Just listening to the discussion today, it is clear that there is ambiguity about the 75%/25% split of cost-sharing money. There is ambiguity about how you target the poorest of the poor. There is ambiguity about the roles of the different Boards - whether they are having a Voice, or whether or not they have Teeth? There are differences of opinion as to whether the Boards should be elected or appointed. There are differences of opinion about the relative allocation of resources to the hospital sector and to primary health care. And there are differences of opinion about the "medicalisation" of the health service. All these are not resolved - and yet we are on the verge of making some major changes which will have long term implications."

### **Reconsiderations**

"Initially, when we thought about hospital autonomy, it appeared a very simple matter - about hiring and firing. But now we realise it is about much more than that. It has legal implications, it has political implications, it has financial implications, it has social welfare implications - many things we had not considered."

## Follow-Up

"We need more time to absorb the things that have been raised today, to compare notes with the Health Reform Secretariat - and then to plot our next steps forward"

## Closing

In his closing remarks, Ibrahim Hussein, commented that it was unlikely that anyone would disagree that decentralisation is a complex issue - and that the associated problems have no easy solutions. He argued that it is of vital importance that we should all be clear why the Ministry is going ahead with decentralisation, despite the confusions and challenges. "It is because we have realised," he said, "that the running of health services has indeed become a more complex enterprise - and the centre cannot really cope with the pressures from the periphery. So we have had to become more innovative in management structures and approaches."

He said that the workshop had been an opportunity to think differently about decentralisation. "For some of us decentralisation meant cost-sharing. That was true for me - and I have now enriched my decentralisation vocabulary!" But he also suggested that the workshop had highlighted certain ambiguities in perspectives and terminology. "These need to be clarified - and we have not exhausted the task yet."

He told the story of the man who was born blind and who suddenly had his sight restored - but only very briefly. When his eyes opened, it happened that a donkey was standing in front of him. And then his blindness returned. Afterwards, when he was asked what a human being looked like, he described how he had seen the donkey!

Ibrahim Hussein suggested that there is now an urgent need to move from clarifying definitions to formulating policy with respect to decentralisation - and drafting an implementation plan. And he made the case for a follow-up meeting where these tasks could be carried forward.

## Follow up

It was agreed that a suitable way forwards would be to make it possible for the workshop to be followed by the completion of the framework for health sector decentralization in Kenya which could then be used to guide the drafting of a policy statement by the Ministry, which in turn would guide the preparation of a decentralization implementation plan - the latter being an activity already planned to begin in late May with ODA and World Bank assistance.

Specific follow up actions would include

- 1 Allow participants time to read and digest the materials presented to them and produced by them at the workshop
- 2 Arrange for Dr Munar to return to assist with the completion of the decentralisation framework for Kenya
- 3 Arrange in consultation with HEROS a suitable date and time to review the documentation, and hold another workshop with the participants to assist them with the completion of the decentralization framework for Kenya. Dr Munar would facilitate at the workshop
- 4 Submit the decentralization framework to the Ministry for review and use by policy makers