Policy brief
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EARLY EXPERIENCES AND EFFECTS OF HEALTH SECTOR DEVOLUTION IN KENYA

Introduction

Devolution, in theory, is argued to promote community participation, accountability, technical efficiency and equity in the management of resources. Whilst the potential benefits of devolution in the health sector are well documented, it is important to monitor the actual implementation experiences of devolution and how it impacted on health service delivery in practice.

In 2010, Kenya passed a new constitution that introduced 47 semi-autonomous county governments, with substantial transfer of responsibility for health service delivery. Since devolution was implemented in 2013, researchers from KEMRI-WT have been tracking its effects on key health sector management functions at county level in Kenya.

This brief gives an overview of the effects of devolution on several management functions including: health sector planning, budgeting and financial management; human resources for health (HRH) management; and management of Essential Medicines and Medical Supplies (EMMS). It highlights the early effects of implementing devolution generally, as well as the effects on the health system and health service delivery. Finally, the brief gives recommendations to policymakers that are considering devolution in their own countries.

Key points

- Since 2013, researchers from KEMRI-WT have been tracking the effects of devolution on key management functions in the health sector.
- The research found that transfer of functions from national to county levels occurred before appropriate county-level structures and institutions had been established, and before counties had capacity to undertake new devolved tasks.
- The lack of preparedness initially caused serious disruptions to health services including a loss of funding to facilities, delays in salary payments to health workers and health worker strikes.
- Whilst the devolved system has significantly increased county level decision-space; harnessing the full benefits requires policymakers to clarify the roles and responsibilities of different actors at all levels of the system, and to build capacity of counties to undertake specific tasks.
- For countries with similar settings to Kenya, individual and institutional capacity considerations should always be taken into account when allocating functions between the centre and local levels.

Early experiences in the health sector

1. Rushed transfer of functions to county governments

The constitution outlined a seven-year process of transferring functions from national to county governments, beginning in 2010. However, reacting to growing pressure from the county governments, the President directed that all government functions to be undertaken in counties be transferred in June 2013. At this time most counties had not fully established their structures and institutions to operate effectively.

2. Delays and tensions in establishing county structures

The national government did not provide guidelines for the composition, roles and mandates of county-level health sector management and coordination structures. In addition, the appointment process of senior county departmental officials was marred by high-level political lobbying and canvassing. For these reasons, there were major delays in establishing department management structures and in some counties, the department of health did not have a Chief Officer for more than a year.

3. Lack of clarity between county and national Ministry of Health roles

There were no guidelines outlining the management roles and responsibilities of the County Department of Health (CDoH) and how these should be shared with other county level structures, including County Treasury, County Public Services Boards.

4. Lack of capacity of county actors to undertake their strategic management roles

Counties lacked the personnel with the skills and experiences necessary to undertake key management tasks such as developing strategic plans and budgets.

"This is a primary school teacher who was picked from the classroom and made Chief Officer. She has no capacity to do any planning, and you're telling them today – develop a strategic plan."

Effects on health sector planning, budgeting and financial management

Planned changes under devolution:

- County governments to establish County Treasuries to facilitate and oversee planning and budgeting and overall management of public finances for devolved functions.
- County governments to develop five-year sector specific strategic plans, which are consolidated to form the five-year County Integrated Development Plan. The development and consolidation process should include public participation and be implemented by each county department through Annual Work Plans.
- National Ministry of Health (MoH) is to provide overall policy and strategic direction for organisation, coordination and delivery of health services in the country.

1. Continued misalignment between planning, budgeting and financial management

The historical challenges of poor alignment of health sector planning and budgeting processes and poor community involvement, did not improve during the early days of devolution at county level.

2. Recentralisation of financial management from health facility to county level

A significant level of re-centralisation of operational financial management functions was observed within the health sector - from health facilities and sub-county units to CDoH level, and from the CDoH to the County Treasury. This caused significant delays for facilities in undertaking routine tasks and frustrated frontline health sector managers, contributing to their low morale.

3. User fee lock-down in hospitals

Before 2013, public hospitals collected user fees under the Facility Improvement Fund policy and used them at their discretion. After devolution, the user fees that hospitals collected were deposited to the County Consolidated Revenue Account. The CDoH lacked the power, appropriate relationships and communications capacity to influence the County Treasury to reverse this decision, and hospitals experienced a drastic loss of revenue for routine recurrent expenditure needs.

4. Loss of Health Sector Service Fund (HSSF) for Primary Health Care (PHC) facilities

Prior to devolution, HSSF provided an additional source of funds to support service delivery in PHC facilities. In the early days of devolution there were contestations over the roles of national and county government in the management of these funds. This led to donors, who had previously contributed, to withhold their funds, thus resulting in a loss of funding for PHC facilities.

Recommendations specific to budgeting, planning and financial management

- Introduce interventions to improve county level capacity for health sector planning, budgeting and financial management.
- Re-introduce decentralised routine operational financial management processes at different levels of the health sector below the county level.

Effects on management of Human Resources for Health

Planned changes under devolution:

- Structures for HRH management moved from the National Public Services Commission to County Public Services Boards (CPSB).
- County Boards to serve as overall employer for public sector workers, and strategic management for county workforce.
- CDoH to undertake routine operational HRH management functions.

1. Lack of clarity over HRH management roles

In the early days of devolution there was a lack of clarity over the roles of the CDoH, the CPSB and national MoH regarding certain routine HRH management tasks. For example, it was not clear who was responsible for managing important welfare issues such as in-service training and career progression. There was also a lack of clarity as to how inter-county transfers for health workers would be managed.

2. Delays and discrepancies in salaries and staff payments

There were significant disruptions, delays and payroll discrepancies in health workers salaries, and some staff were missed from the payroll altogether. This was largely due to a rushed transfer of pay-roll management functions to county level and lack of capacity of counties to undertake this role.

3. Political interference and discrimination in HRH management

Some counties reported political interference over recruitment and deployment of staff as local staff began to demand that only health workers from their own county or tribe should be employed within the county.

4. Dissatisfied health workforce

The multiple challenges and uncertainties over health workforce management led to wide-spread anxiety and low morale among many healthcare workers who faced uncertainties about career progression, inter-county transfers and salary payments. This led to mass resignations and a protracted health worker strike calling for re-centralisation of health service delivery in 2013.

Recommendations specific to HRH

- Create clarity over HRH management roles between the CDOH, the CPSB and national MoH.
- Improve the county payroll management system to stabilise payment of salaries for health workers.
- Bring together all stakeholders to deliberate and build consensus on how certain HRH management roles, including in-service training and inter-county transfers, should be conducted across the country.

Effects on Essential Medicines and Medical Supplies Management

Planned changes under devolution:

- Prior to devolution, health facilities ordered EMMS from the Kenya Medical Supplies Agency (KEMSA), often experiencing delays.
- Under devolution, county governments procure EMMS for government health facilities, with KEMSA as first point of call.
- To facilitate the transition and allow county governments to set up structures and systems for the procurement role, the national MoH procured a buffer stock of six-months' worth of commodities

In the early days of devolution, an intergovernmental relations forum was convened to facilitate dialogue between national and county level actors about EMMS management issues and to develop an interim action plan for transition. This plan (of providing facilities with a buffer stock of commodities) helped to avoid common challenges relating to a lack of preparedness and capacity at the county level.

1. Delays in order-to-order turnaround time

The early days of devolution were characterised by an order-to-order delay for EMMS. This was occasioned by the lack of capacity at facility and county levels to do appropriate commodity forecasting and quantification to inform orders. This in turn resulted in long periods of commodity stock outs at facility level in between orders.

2. Improved order servicing through the county government

Whilst initial supplies to facilities were slightly delayed in 2014, when they arrived there was a feeling by facility managers that the order servicing by KEMSA had improved compared to pre-devolution. There was a better order-fill rate in health facilities, and the counties were able to ensure that all public facilities were supplied with EMMS, irrespective of registration status. This in turn allowed previously non-functioning facilities to operate, including in underserved areas. In this sense, devolution enhanced equity in the allocation of health resources and health service provision.

3. Political influence on procurement of supplies

There was an observed political influence and interference in procurement decisions for the health sector at county level. For example, some counties prioritised the purchase of ambulances, which are highly visible, at the expense of essential drugs for health facilities. Also, the routine exercise of drug distribution to facilities was, at times, turned into a political function, characterised by members of the public cheering on drug distribution trucks as they drove to health facilities.

Recommendations specific to EMMS

- Strengthen the capacity of health facility managers and CDoH managers in undertaking specifications and quantification of EMMS, to streamline and speed up the ordering and procurement process.

Conclusion

Devolution of the health sector initially caused serious disruption to health service delivery including: a loss of revenue to hospitals and primary health care facilities, delays in salary payments and health worker strikes.

The experiences from all three management functions point to a lack of preparedness at the county level to implement devolution. The organisational structures were not in place at the County Department of Health to manage the health sector effectively and there were no guidelines about roles and responsibilities for both national and county actors. Also at the county level, there was a lack of capacity to undertake key tasks, such as developing strategic plans, particularly during the early stages of implementation.

These challenges meant that the potential benefits of devolution, e.g. increased decision space at county levels to allow for targeted recruitment of health workers, and procurement and distribution of EMMS based on local level priority needs, were not fully met. For EMMS management, there was better dialogue between the national and county level to address potential challenges, and interim arrangements were put in place to maintain the delivery of essential medicines.

Many of the challenges and disruptions experienced were caused by the rapid transfer of devolved functions and responsibilities, driven by political motivations to implement change quickly.

Recommendations

For policymakers planning or designing technical strategies for health sector decentralisation

1. Pre-establish clear and distinct roles between national level and county levels
2. Consider individual and institutional capacity when allocating functions between the centre and the periphery
3. Ensure appropriate structures and capacity at county levels to undertake decentralised functions. If capacity is not yet available, develop interim measures with support from central government and development partners.
4. Be considerate of the broader political context and how this might affect implementation.
5. Integrate policy evaluation research during times of major health sector change to provide real-time understanding of the policy implementation effects, and provide a feedback mechanism to enhance implementation.

About the brief

This policy brief is based on research undertaken as part of RESYST Research Consortium, published in the following journal articles:

- Tsofa, Benjamin et al. "How Does Decentralisation Affect Health Sector Planning and Financial Management? A Case Study of Early Effects of Devolution in Kilifi County, Kenya." International Journal for Equity in Health 16 (2017): 151.
- Tsofa, Benjamin et al. "Devolution and Its Effects on Health Workforce and Commodities Management – Early Implementation Experiences in Kilifi County, Kenya." International Journal for Equity in Health 16 (2017): 169.

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Related resources and publications

- Barasa, Edwine et al. "Recentralization within decentralization: County hospital autonomy under devolution in Kenya" PLoS ONE (2017): 12 (8)
- Nyikuri,2 Mary et al. "We are toothless and hanging, but optimistic: sub county managers' experiences of rapid devolution in costal Kenya" International Journal for Equity in Health (2017) 16:113
- RESYST policy brief: Crisis and resilience at the frontline: Coping strategies of Kenyan primary health care managers in a context of devolution and uncertainty (2016)
- Tosfa, Benjamin "Health sector planning and budgeting in Kenya: recommendations to improve alignment" RESYST policy brief (2015)

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