UNIVERSITY OF NAIROBI

Faculty of Political Science

The Influence of Privatization on Service Delivery in the Public Health Sector in Kenya: A Study of Kenyatta National Hospital

By

Joyce Wanja Mwangi

C50/68332/2011

This Research Proposal has been submitted to University of Nairobi in partial fulfillment of the award of Masters of Arts in Public Administration

November, 2013

DECLARATION

I the undersigned, declare that this research project in its form and content is my original work and that the same has never been presented to any other college, institution or university for academic or other purpose to the best of my knowledge.

Signed …… Date ……

JOYCE WANJA MWANGI
C50/68332/2011

This project has been presented for examination with my approval as the appointed supervisor.

Signed …… Date ……..

Dr. OWUOCHE SOLOMON

Lecturer, Department of Political Science
University of Nairobi

TABLE OF CONTENTS

DECLARATION i
TABLE OF CONTENTS ii
LIST OF TABLES iv
ACKNOWLEGEMENTS v
DEDICATION vi
LIST OF ABBREVIATIONS vii
ABSTRACT viii
CHAPTER ONE 1
INTRODUCTION 1
1.1 Background 1
1.2 Statement of the Problem 3
1.3 Research Question 3
1.4 Objective of the study 3
1.5 Justification of the Research 4
1.6 Scope and Limitations 5
1.7 Definition of Terms 5
CHAPTER TWO 7
LITERATURE REVIEW 7
2.1 Introduction 7
2.2 Commercialization in the Public Health Sector in Kenya 7
2.3 Delegation 9
2.4 Efficiency 10
2.5 Cost Reduction 11
2.6 Conceptual Framework 13
2.7 Research Hypothesis 14

CHAPTER THREE 15
RESEARCH METHODOLOGY 15
3.1 Introduction 15
3.2 Population Frame 15
3.3 Population of the study.....16
3.4 Data Collection Methods.....17
3.4 Data Analysis and Presentation.....19
CHAPTER FOUR 20
PRESENTATION OF STUDY RESULTS.....20
4.1 Introduction 20
4.2 Presentation of results 20
4.3 Discussion of results.....35
4.3.1 Service delivery at KNH before Commercialization 35
4.3.2 Quality of service delivery after Commercialization 36
4.3.3 Success of cost-sharing structure 38
CHAPTER FIVE 42
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.....42
5.1 Introduction 42
5.2 Summary 42
5.3 Conclusions 42
5.4 Recommendations 42
5.5 Suggestion for Further Research 44
REFERENCES 45
APPENDICES 47

LIST OF TABLES

Table 4.1: Population of the Study 17
Table 4.2: Staff Competency 20
Table 4.3: Availability of Drugs 21
Table 4.4: Hospital Insurance Cover 22
Table 4.5: Professionalism of Doctors and Nurses 23
Table 4.6: Feedback on follow ups 24
Table 4.7: Functioning Machines/Equipment 25
Table 4.8: Customer Care 26
Table 4.9: Service Delivery Time 27
Table 5.0: Treatment Procedures 28
Table 5.1: Complaints Addressed and Feedback Given 29
Table 5.2: Referral from other Public Hospitals 30
Table 5.3: Sufficient Space 31
Table 5.4: Health Care Services in KNH better than other Public Hospitals 32
Table 5.5: Adequate Machines/Equipment 33
Table 5.6: Accessibility of Health Services 34

ACKNOWLEGEMENTS

The completion of this project has been made possible through contributions of many people.

I would wish to acknowledge with sincerity the support of the following persons who in one way or the other contributed to the success of the study. Dr. Owuoche Solomon my supervisor has given me guidance throughout the project. My son Mark Kibera has been patient during the times I had to spend long hours reading through books and preparing for the research. My able Research Assistant Susan Wanjiku who helped a great deal in data gathering. To all my friends especially Milka Boit and Leah Muge for their prayers and encouragement.

Thank you all.

DEDICATION

This project is dedicated to my son Mark Kibera as the effort I have put in the study will serve as a motivator for him to work hard and achieve his career dreams. As for my mother Margaret Wairimu Mwangi, I salute you for your encouragement in this journey which has not been easy.

LIST OF ABBREVIATIONS

ALOS Average Length of Stay

BODs Board of Directors

CEO Chief Executive Officer

KNH Kenyatta National Hospital

MOH Ministry of Health

NPM New Public Management

NHIF National Hospital Insurance Fund

PEs Public Enterprises

PSBR Reducing the Public Sector Borrowing Requirement

SAPs Structural Adjustment Programmes

SOEs State Owned Enterprises

ABSTRACT

Over the past years, governments have gradually turned to “privatization” or commercialization of health care to boost equality and improve service delivery. KNH, originally a native civil hospital, was built in 1901 with a capacity of bed capacity of 45 and later renamed the King George VI Hospital in 1951. The hospital provided medical care to white settlers in the colonial Kenya but after independence in 1963 it was renamed Kenyatta National Hospital becoming a national referral and teaching hospital. In the 80s, it was turned into a semi-autonomous institution as the government sought to improve efficiency in the referral hospital. Since then, its bed capacity has increased over the years to currently stand at 1,800. Before commercialization, challenges that affected quality health care at KNH were overcrowding, insufficient supply of affordable, quality health care, shortage of equipment, drugs and lack of committed well trained staff. These were attributed to funding constraints, management weaknesses and the absence of good controls and systems. The main objectives for the study were to evaluate the influence of the commercialization on the public health care service delivery at KNH. The research design used was a case study. The method was found suitable because it gives an in-depth account of how the commercialization process has changed operations at KNH. Primary data was collected through interviews with patients, employees of the hospital, stakeholders in the public health sector such as the MOH and NHIF. Secondary data was also used to show if services have improved in the hospital. The research found that after “privatization”, the hospital has made strides in improving service delivery. Infrastructure has improved following the increased funding allocation and sourcing of funds from donors. However, the biggest referral hospital in the country is still grappling with limited funds as the steady increase in patients seeking treatment has not matched with the growth of physical facilities like wards. Although granted autonomy, KNH relies heavily on the government for funds and there is a lot of political interference since the executive and political functions are not separated.

CHAPTER ONE

INTRODUCTION

1.1 Background

The concept of the commercialization of public entities which is a key element of privatization has been in existence in the past two decades according to Megginson, 2000 and relies on market mechanisms. As Ricci, 2001, points out that since the 1970s the contracting out of services had become increasingly popular in practice as well as in managerial theory. For example both the public and private sectors use outside contractors, but when public agencies contract with private organizations to perform public services, the term "privatization" is used. However, Pact, 1998, argues that the public sector has always contracted out goods and services from the private sector.

On the other hand "privatization" re-oriented its basic purpose from the political goal of providing employment and towards the economic objective of maximizing profits and wealth for shareholders continues Megginson, 2000. Although according to Pack, 1987, governments worldwide have engaged in “privatization” or commercialization the public services in order to reduce the size of the public sector.

According to Amoako, 2003, “privatization” in Africa occurred mostly in thePublic Enterprises taking many forms including joint ventures between government agencies/ministries and private entities. The countries in Africa being convinced that commercialization of public entities was the right thing to do to promote efficiency. Fadahunsi, 1995 argues that they were also cajoled if not compelled by the International Financial Institutions to face the challenges of their Structural Adjustment Programmes (SAPs).

The introduction of SAPs in Kenya occurred during the 1980/1981 fiscal years due to economic difficulties. The implementation of SAPs involved the “privatization” of parastals or government corporations. This was specifically aimed at restoring efficiency

in all sectors of the economy and leading to economic growth (Rono, 2002). Inefficiency in the public sector was as a result of gross misuse of government resources (Swamy, 1980). Consequently, the Parastatal Advisory Committee was formed according to Fadahunsi, 1995 in order to promote efficiency in government institutions in Kenya. This was to be achieved through increasing competition and allowing firms to borrow from the capital market; reducing the public sector borrowing requirement (PSBR); easing problems of public sector pay determination; reducing government involvement in enterprise decision making; widening the ownership of economic assets; encouraging employee ownership of shares in their companies and redistributing income and wealth.

Although "privatization" mainly focused on the PEs which was classified as "non-strategic" enterprises, the public health sector classified as a "strategic" enterprise was also brought on board. The classification was according to the core functions performed by the public entity. Hence the Public Health Sector classified as a "strategic "enterprise along with security and environment sectors since its core function is the provision of public health care services. A function traditionally performed by the government.

In Kenya like many other developing countries, the public hospitals within the Public Health Sector, consume large portions of scarce health care resources which they utilize either ineffectively or inefficiently. According theCollins,Njeru & Meme, 1996, in 1980 two problems seriously affected quality health care at KNH. Firstly it was the overcrowding resulting from insufficient supply of affordable, good quality, alternative of primary and secondary services from other health centers. Secondly shortage or appropriate inputs such as working equipments, drugs and supplies and committed well trained staff. This was due to funding constraints, management weaknesses both in structure and staffing, absence of good controls and systems and decision making being centralized in the Ministry of Health (MOH). This led to the commercialization of Kenyatta National Hospital (KNH) the largest national referral and teaching hospital in Kenya into a state corporation in 1987.

The commercialize of the health care services by the government aimed at overcome the numerous challenges and foster policies and plans to deal with the replacement of the old

medical equipment; increase revenue generation; change the of staff culture, attitude and resistance to change eradicate corrupt practices and improve productivity and eventual provision of quality health care services to the public.

1.2 Statement of the Problem

Before the transformation into an autonomous agency (1987), KNH operated as a department of the Ministry of Health (MOH). That fact that decision making was centralized in the MOH, the hospital experienced numerous problems related to overcrowding, quality health care, shortages of equipment, supplies and committed trained staff. These challenges that negatively affected service delivery were attributed to management weakness, absence of good controls and systems leading to wastage of resources. Although this study appreciates the numerous challenges the Public Health is facing, there are several measures with various consequences that could have also been put in place to address them. Therefore, this study only identified one such attempt, the commercialization of KNH as a viable strategy to reduce costs and hence the provisions of quality health care service delivery. To guide the study Kenyatta National Hospital was identified for a case study approach.

1.3 Research Question

How has commercialization helped KNH to overcome the numerous challenges in health care service delivery such as high operation costs?

1.4 Objective of the study

The overall objective of the study was to access the influence of commercialization on public health care service delivery at KNH.

The specific objectives of the study were:

i) To determine whether the commercialization of KNH has reduced costs through the cost sharing scheme resulting to better health care service delivery.
ii) To access the quality of health care service delivery at KNH after the commercialization of KNH.

1.5 Justification of the Research

As Mills, 1995, points out that the government through the Public Health Sector has the mandate to ensure access to quality health care services as a right of citizenship. This accessibility however should be independent of individual income or wealth as this leads to inequality. In addition, quality health care services is a social pillar in the country's blue print Vision 2030 as Kenya aims at improving the overall livelihoods of its citizens., It is however through the support of the private sector and the commercialization of the national health-care system that an efficient, integrated and high quality affordable health care could be availed to all the citizens (Kenya Vision 2030).

The Public Health Sector is nevertheless, faced with numerous challenges despite the importance of quality health care as a key element of economic production. KNH the biggest referral hospital in Kenya is not an exception. The hospital has been experiencing personnel strikes, brain drain, collapsing infrastructure, and overwhelming influx of patients among others over the years (Meme et al 1996). Therefore it has become paramount to invest ways of addressing such challenges in order to provide quality health care services.

Therefore outcome of the study could be used to achieve Kenya's vision 2030 of providing "equitable and affordable health care at the highest affordable standard" to her citizens. Also they could be used to monitor and evaluate the progress of commercialization at KNH to make corrective measures where necessary. The government could make the results of this study a reference point in any future plans to roll out the same mechanism to other public health facilities countywide. However, more specifically the results of the study will help:-

i) In the formulation of better public health policies for the Public Health Sector by the government of Kenya through the Ministry of Health.
ii) In the management of KNH by evaluating the health care service delivery after commercialization and develop systems to mitigate any hindrances to the delivery of quality health care services.

1.6 Scope and Limitations

The study is focused on KNH as a representative of the Public Health Sector in Kenya due to the timeframe. Commercialization or use of market mechanisms in the public sector as an element of public health sector reforms concept might not be comprehensively covered in the study. This is due to major disagreements and problems that arise when health care services which are traditionally provided by the government are subjected to the private sector. There were challenges in collecting primary data due to the suspicion expressed by the respondents especially from the hospital. The fact that many respondents at the hospital were experiencing personal difficulties was also a limitation to the study. Another limitation to the gathering secondary data was the fact that privatization on public health care KNH in particular has not been widely explored thus the available of written literature in this area of study.

1.7 Definition of Terms

Commercialization and "privatization" are used interchangeably in the study, according to Amoako, 2003, is a principle element of the New Public Management which adopts market principles within government activities. However, according to Savas, 2000, it is an act of reducing the role of government or increasing the role of the private institutions in public sector aimed at satisfying the needs of the society. Through the commercialization of KNH, the hospital gained autonomy in decision making, planning, management and resource allocation from the central government. Out-sourcing or buying in goods and services from external sources instead of providing such services in-house can also enable the hospital to save on costs. Out-sourced services include non-clinical health services (cleaning, laundry, catering, security, maintenance and billing).

An indicator of commercialization at KNH is the erection of the private wing and the private doctors' plaza. This private amenity was meant to generate revenue by charge raised fees for those who can afford. The doctor also serving at KNH would rent offices in the doctor's plaza and this meant more revenue for the hospital. The generated revenue could reduce the hospital's dependence of government funding and also make it financially reliable. The doctors being at the plaza would also mean close proximity to the patients' thus timely health care services provision.

Public Health Sector could be defined as an area of the economy concerned with providing primary healthcare for the entire population a core function of the government[8]. The Public Health Sector in Kenya constitutes of government institutions that are responsible for the financing, regulating, purchasing and providing public health care. Government institutions include the Ministry of Health (MOH) and National Hospital Insurance Fund (NHIF) among others. Kenyatta National Hospital the largest referral hospital is also part of the Public Health Sector in Kenya. The government through the Public Health Sector is accountable to the public for the provision of equitable quality health care services.

Service Delivery is the provision of health care services to the public in an efficient and effective manner. For purposes of this study services being delivered are exclusively health care services. This includes consultations, diagnosis, administering of drugs, and admission of patients among others. Parameters for measuring efficient and effective health care service delivery include delivery time and reduced operation costs.

Indicators of efficiency in health care service delivery according to Mills, 1995, are cost-effectiveness (obtaining maximum health benefit using the least cost). Also technical efficiency where a given output is achieved with minimum inputs and operating efficiency where given outputs is produced using the least cost combination of inputs. In KNH efficiency can be measured by Average Length of Stay (ALOS) for inpatients and the length of time a patient takes to be served at the hospital. Effectiveness could be measured through the savings on cost as a result of minimal wastage of available resources.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Commercialization or "privatization" is a key element of public health reform policies; it can be either a comprehensive or partial/incremental change. The former involves the establishment of a new and expanded national health insurance system and substantial changes in financing, regulation, and service delivery. The latter is the introduction of new financing mechanisms like user charges or new forms of management and organization such as decentralization and hospital autonomy (Mills A., 1995).

2.2 Commercialization in the Public Health Sector in Kenya

Although the literature on the "privatization" of many public functions has been reviewed Ricci *et al*, 2001, little attention has been given to the public health care service delivery. However, "privatization" is quickly and quietly becoming commonplace in public health sector and public health services becoming a special concern. Scholars like Fadahunsi, 1995, who have mainly focused on the commercialization of public enterprises and parastatals in Kenya emphasis on the urgency to improve performance. Similar echoes have been made by Kumaranyaka, 1997, that "privatization" is also a partial response to the government's poor performance and lack of resources. This led to a regulation, The Kenya Privatization Act 2005 adopting commercialization as a strategy to improve infrastructure; and delivery of public services with the involvement of private capital and expertise was introduced[7.] This was after a recommendation to increase private sector activity in the public sector (Fadahunsi, 1995). This is in regard to the fact that an increase in the role of the private sector is seen as a means of improving health service provision through improved efficiency and quality. However commercialization of the health care sector has received little attention as Pack, 1998, points out that there has been controversy in this area of study.

"Privatization" involved the classification of state corporations/public enterprises into either "non-strategic" or "strategic" enterprises depending on their core functions in the public domain. In the "strategic" enterprises the government retained ownership with the

participation of an active board in decision making as was the case with KNH. It is worth noting that "privatization", whether in strategic or non-strategic enterprises aim at embracing efficiency in the utilization of public resources. Despite the many methods of "privatization" used in the PE's not all of them have reaped the intended benefits. For example Kenya Airways, a non-strategic enterprise has been a success story of privatization. On the contrary Kenya Railways Corporation (non-strategic) has continuously been dependent of the government for financial support[8]. The commercialization of KNH Mills A., 1995, involved the introduction of new financing mechanisms like the cost sharing scheme and decentralization or hospital autonomy new forms of management and organization. Although this process is often associated with the health sector reform policies Kumaranayaka, 1997; the benefits of commercializing health services at KNH which is a strategic enterprise are yet to go on record since it is an ongoing process.

In developing countries such as Kenya, Amoako, 2003, argues scarce resources are inefficiently and ineffectively utilized leading to wastage and poor public service delivery. Consequently gross inefficiency and inequitable resource allocation; declining quality and demoralized work force in the health facilities becomes the norm (Berman, 2000). To prevent these shortcomings the Public Health Sector engages in incremental and purposeful changes in the health systems to improve health care service delivery.

Similarly, KNH the biggest referral hospital in Kenya is envisioned to serve as the national referral hospital, provide innovative and specialized health care and provide

facilities for teaching and research[4]. In an effort to address the challenges that hindered

health care service delivery Strategic Plan, 2008-2012, it was in the interest of the government to seek a viable management strategy. Considering the large size and complexity of the hospital, Blackwell, 1987, "privatization" was identified as a viable

strategy. This was realized through the formation of an Executive Board independent from the MOH. The board was tasked with the responsibility of generating revenue through cost sharing, procurement goods and services, recruitment staff and use of the available resources to accomplish the mission of the Hospital. The main objective being to improve revenue generation, cost containment and efficiency of service delivery, increased managerial autonomy especially in planning, budgeting and fee collection (Meme et al, 1996).

Nevertheless Gaebler, 1993, contends that even with the involvement of the private sector in the public activities; the public sector tends to be better at policy management, regulation, preventing discrimination or exploitation, ensuring equity, social cohesion, continuity and stability of services. This offers the explanation of commerciaizationl instead of comprehensive privatization of KNH. It is also mandatory for the government to provide public health services that the private hospitals would discriminately render to the public (Ricci *et al*, 2001).

2.3 Delegation

Public Enterprises referred to as "strategic" including public hospitals within the Public Health Sector were commonly privatized using the delegation method. Delegation is where the government retains responsibility and oversight but uses the private sector for service delivery through contracting out or outsourcing for services (Savas, 2000). It is also termed as partial privatization since the government transfers partial authority and control over certain functions while retaining others.

Delegation or partial privatization is replicated at KNH where the MOH even with the existence of an executive board still controls activities such as remuneration and budgeting (Meme et al, 1996). This makes the "health sector reform" in the Public Health Sector in Kenya Berman, 2000, through delegation an incremental and purposeful change. As Mill, 2000, contends "privatization" also ensures equity in the provision of health care services. Although equity in health care service delivery is assured at KNH, the quality of service are still below expectation of many people due to the negative of health providers and inadequate funding from the government (Strategic Plan 2008-

2012). Has this delegation improved service delivery at KNH? This is the question that the study investigates.

It is the sole responsibility of the government to ensure that an appropriate share of the public revenue Cassel, 1995 is allocated to health care. Also that the public has protection from exploitation; customer satisfaction and ownership of the services offered. Therefore delegation of authority to the BOD at KNH to make decisions was an empowering tool that would in turn negate gross inefficiency; inequitable resource allocation; declining quality public health services and a demoralized workforce (Berman, 2002). Through delegation efficiency is embraced and the health status maximized with the limited resources available (Pack, 1989).

2.4 Efficiency

The three dimensions of efficiency of public provision of health care according to Cassels, 1995, are; allocating efficiency through cost-effectiveness that is selecting those interventions which improve health at least cost, or maximize health gain for a given budget; technical efficiency, where maximum possible output is obtained from a given quantity of inputs, or a given output is achieved with minimum inputs; and operating efficiency, where the least cost combination of inputs is used to produce given outputs. Evidence abounds that privatized enterprise offers greater efficiency and subsequently offer better use of scarce economic resources. The commercialization of KNH aimed at achieving allocating and technical efficiency due the prior gross inefficiency leading to poor service delivery.

Many scholars like Mills, 1995, contend that there has been a widespread concern about efficiency of public health services. This is despite the fact that the health care sector in developing countries Cassel 1995) are faced with acute problems of inefficient utilization of scare resource, inaccessibility of health care services by all and wastage due to underutilization of resources. KNH faced similar problems of allocating and technical inefficiency before “privatization”. The issue of underutilization of some service (e.g. diagnostic services, occupational and physiotherapy) and staff culture (attitude and resistance to change) is an indication of these problems (Strategic Plan, 2008-2012). The

central issue is whether after commercialization KNH has performed better in the utilization of the available scarce resources.

The performance of the public health sector in Kenya is critically dependent on worker motivation since it is highly labor intensive. Consequently, service quality, efficiency, and equity are all directly mediated by workers' willingness to apply themselves to their tasks. While resource availability and worker competencies are essential, they are not sufficient in themselves to ensure desired worker performance. Worker performance which leads to quality service delivery, is also dependent on workers' level of motivation stimulating them to come to work regularly, work diligently, be flexible and willing to carry out the necessary tasks (Franco M., Bennett S., Kanfer R. 2002). While Kanfer et al, 2002, avers that the level of motivation among workers results in quality service delivery; this contradicts the scenario often reported in the media of nurses and doctors at KNH threatening to go on strike and paralyzing the health sector. Does this also apply to KNH? What measures have been put in place to increase the level of motivation? And how has it impacted on service delivery at KNH?

2.5 Cost Reduction

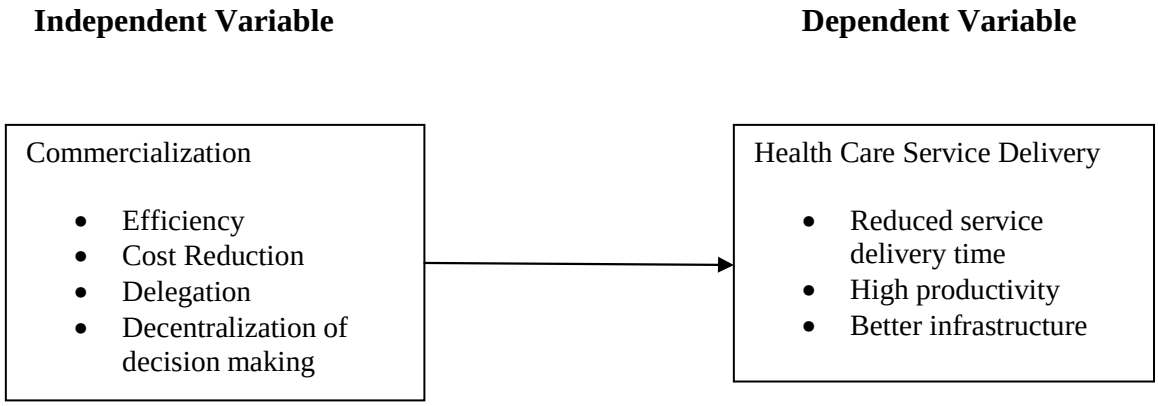
The benefits of commercialization will not be achieved unless sufficient funding is generated. No hospital in Kenya will be able to fully finance the development and operation of services from fees while ensuring access to all those in need (Meme et al 1996). Besides the Public Health Sector consumes a large portion of the government revenue Berman, 2002, therefore cost containment is paramount. Prior to privatization, KNH experienced gross misuse of government resources allocated to facilitate health care service delivery (Swamy, 1980). This resulted from misappropriation and poor procurement procedures (Meme at el, 1996). According to Berman, 2000, health reforms or change in the health sector should be sustainable, purposeful and fundamental which can only be realized through effective revenue generation and cost containment.

Therefore to improve health care service delivery at KNH cost savings and revenue generation was necessary. As Mills, 1995, points out cost savings can be enforced through divesture (tertiary facilities). This is achievable by either giving health facilities

independent status within the public sector and requiring them to raise their own income; or shifting them into the private sector. By giving KNH an independent status and requiring it to raise their own income is a preferred option to cost savings. Shifting the health facility into the private sector could also generate income and reduce costs. However according to Pack, 1989, it could jeopardize the mandate of the hospital of providing accessible and affordable quality health care services to the public. For example by denying patients with low-priority conditions who would have prior received free or subsidized care subsidized treatment. Therefore to ensure equitable services and at the same time generate revenue the hospital operates a cost sharing scheme. The construction of a private wing and a doctor's plaza has contributed to generation of revenue. For instance the affluent patients seeking medical attention from the private wing pay medical fees equal to the private hospitals. Similarly, the doctors practicing privately at the same time serving at KNH are charged rent for occupying the offices in the doctor's plaza[4]. The occupation of plaza by doctors is also a benefit to the hospital and as it facilitates service delivery due to the close proximity to the KNH. Moreover, cost savings from inefficient bureaucracies that mostly satisfy the producer groups than consumers has a core positive impact of privatization on performance.

As an emphasis on efficiency and quality service delivery, Amoako, 2003 argues that private contractors are penalized for delays, lack of reliability and poor quality in "privatization". This prevents the losses that could otherwise have been incurred from such behaviors and saves on costs. The fact that the management of KNH has power to sanction both employees and supplier for acts that lead loss of public resources has a positive impact on cost saving (Meme et al, 1996).

2.6 Conceptual Framework



Like many other countries public hospitals in Kenya, consume large portions of the scarce health sector resources which are usually used ineffectively or inefficiently. This has led to the tremendous deterioration of health care service delivery. In order to mitigate the misuse of public resources and promote quality health care delivery in the public health institutions commercialization has been introduced. Commercialization emphasizes on the managerial improvement and organizational restructuring through the use of market tailored practices (Gaebler, 1999).

KNH the largest national referral hospital in Kenya was commercialized by being transformed into a state corporation in 1987. However, operating in a challenging dynamic political and socioeconomic environment, the hospital previously experienced numerous challenges. These included overcrowding, inadequate funding, poor health care services, and shortage of equipment, supplies and committed trained staff (Strategic Plan, 2008-2012). Therefore, in order to promote efficient and effective specialized health care service delivery through managerial improvement and organizational restructuring; an Executive Board of Directors (BOD) independent from the MOH was formed. The BOD was tasked with making decisions pertaining planning, personnel, finance and accounting procurement which were otherwise centralized at the MOH (Meme at el, 1996).

The features of commercialization that positively influence health care service delivery are cost sharing, contracting out, efficiency and decentralization of decision making.

A cost sharing a scheme introduced by the hospital purposed revenue generation and enabling accessible and affordable health care service at KNH. Contracting out commonly known as out sourcing the functions that are not core business of the hospital are contracted to the private sector. This reduces huge expenditures, saves on costs and better performance as employees can concentrate on their duties. The decentralization of decision making enables KNH focus only on the issues the directly affect the operations of the hospital such as funding and cutting on costs. This is unlike the decisions made by the MOH that influenced by the bureaucratic characteristic of government (Denhardt 2002). This is notwithstanding the fact that health care reform is a highly political and fiercely contested process and lack of political leadership can impede gains from "privatization" (Cassels, 1995). More flexibility in decision making have also contributed to improved hospital supplies due to increased financial resources; speedier payment of bills; freedom to procure directly; and some internal decentralization of supplies management.

2.7 Research Hypothesis

The commercialization or "privatization" of health care services at KNH has led better service delivery due to reduced costs and increased revenue generation leading to better service delivery.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The objectives of the study were to examine how privatization has influenced public health care delivery in Public Health Care Sector in Kenya. The study focused on the effects of the transformation of Kenyatta National Hospital to a State Corporation after 1987. This chapter describes the research design of the study and specifically looks at the population of the study, data collection and analysis methods.

3.2 Population Frame

The population frame for the study consisted of KNH and two government agencies namely MOH and NHIF. The relevance of the two agencies to the study was as follows:-

Kenyatta National Hospital (KNH) because the hospital has a long history (1901) and it is well equipped with both human resources (medics) and other machines required health care services delivery. In addition to undergoing through a transformation to a State Corporation, it is also the biggest referral hospital in Kenya and with Eastern and Central Africa.

The MOH segment of the Public Health Sector is the parent organization of KNH. However, KNH operated as a department in the MOH until 1987 when it was transformed into a State Corporation. Nevertheless the ministry has the responsibility of public policy formulation on health issues. It also ensures conformance with legislation, standards and guidelines by the public health institution such as KNH. Government funds allocated to KNH in the form of personnel emoluments and capital expenditure are channeled through the MOH.

The NHIF holds information on the number of patients of KNH that have insured their healthcare needs with the insurance agent (Strategic Plan 2008-2012). This is through a

partnership between KNH and NHIF and the information is important to the topic under study. The health insurance cover offered by NHIF enables the ordinary citizens to access medical health care service with minimum limitations. Therefore the objective of NHIF is to provide accessible, affordable sustainable and quality social health insurance through effect and efficient utilization of resources to the satisfaction of stakeholders.

The representatives in the population frame were knowledgeable on the hospital either before or after privatization. KNH which comprise of the general public include the patients, nurses, doctors and hospital administrators. It was a heterogeneous representation as they constitute of people with different professionals, occupations and from diverse backgrounds. They were also direct or indirect beneficiaries of the hospital's operations. That is they were either receiving services from KNH or rendering health care services at KNH.

3.3 Population of the study

The population frame for the study included the patients who directly or indirectly benefit from the health care services of KNH and the employees of KNH (administrator, doctors and nurses). The population was heterogeneous because the individual comprise of different professions, occupations, ages and gender. They were also representative of the study because they are all receive health care services from KNH either through the casualty or being referred from other public health facilities.

Table 4.1: Population of the Study

Target Respondent		Methodology	Sample
KNH	**Patients**	Questionnaires	300
	Hospital Administrator	In depth Interview	1
	Patients	In depth Interview	4
	Doctors	In depth Interview	4
	Nurses	Focus Group Discussion	5
STAKEHOLDERS	**Ministry of Health**	In depth Interview	1
	NHIF	In depth Interview	1

3.4 Data Collection Methods

The researcher collected primary and secondary data that was relevant for the research. Primary data was collected from the general public seeking health care services like patients and employees of Kenyatta National Hospital. The data was collected using the following tools.

a) In-depth Interviews (IDIs)

This study will target 10 IDHs. In-depth interviews were carried out with those believed to have an elaborate understanding of the study subject. It was carried out with

- Hospital administrator – In-depth interview was carried out with the hospital administrator because he had 10 years' experience working as an administrator in the Administration/Human Resources Department. He had also worked in the department in various managerial positions.

- Four doctors – The 4 doctors were selected for the in-depth interviews because of their years of service at KNH and the fact that they are from different units of the hospital. That is Out-patient, Cancer, Orthopedic and Renal units. .

- The Medical Director of the Medical Services at the MOH – The in-depth interview was carried out with the director of medical services because of his many years of

service in the Ministry of Health. By profession he is a doctor who has service in the Public Health Sector for many years.

- The Regional Manager at the NHIF - Westlands branch – In-depth interview was carried out with the Manager Westlands Branch because of her experience of more than 10 years in the Insurance Fund. The fact that Westlands branch is strategically located and issues insurance covers for a large population residing in Nairobi and its environs contributed to the selection of the respondent.

b) Focus Group Discussions

The focus group discussions targeted five nurses brought together to discuss an issue of common interest. The focus group discussion provided an opportunity to obtain information freely regarding the feeling and attitudes because of the unstructured nature of the questions..

c) Questionnaires

The data was collected by way of face-to-face interviews using a semi-structure questionnaire. Some questionnaires were also left at KNH and respondents filled and the researcher collected them from the KNH officials. A sample size of 300 respondents was picked.

The sample was stratified in terms of divisions to ensure proportional coverage across the various operations of the hospital. A randomized one-stage stratified sampling with PPS (Probability Proportional to Size) was used to extract the sample. This meant that the divisions with the highest number of patients per day got the highest number of interviews.

The questions were developed with due consideration of the published literature on the area of study. Prior conducting the interviews the questions were distributed (for pre-testing) to colleagues at work and friends undertaking MPA at University of Nairobi who could provide useful suggestions especially on appropriateness, structure and relevance of the questions for the study. Their suggestions were incorporated into the final version of the questions that will be used in the interviews.

About 300 questionnaires were distributed randomly with others left at KNH offices for distribution to willing respondents. 254 respondents returned the questionnaires, representing 84.7 per cent representation.

d) Secondary data

The researcher also collected secondary data from publications, newspaper cuttings, journals, performance audit reports of the Auditor-General on KNH and web sites of KNH, The Ministry of Health (MOH), The National Health Insurance Fund (NHIF) and Ministry of State for Planning, National Development and Vision 2030.

3.4 Data Analysis and Presentation

The data collected was analyzed using graphs, tables for ease of interpretation and content analysis. This was also to show where most responses featured and in the process help make conclusions on the factors focused in the research.

CHAPTER FOUR

PRESENTATION OF STUDY RESULTS

4.1 Introduction

This chapter analyses the results and discusses the research findings. The data from the respondents interviewed in this study was analyzed and presented in discussions with use of diagrams. The 254 respondents were best placed to know the measures KNH took in its quest to be a privatized firm, a move aimed at boost service delivery. The respondents were top officials at KNH and in the health sector charged with the responsibility of running the hospital and who draft strategies to guide in efficient public service delivery in Kenya. In the questionnaire which was based on likert scale, the responses ranged between 1 for strongly agree to 5 for strongly disagree.

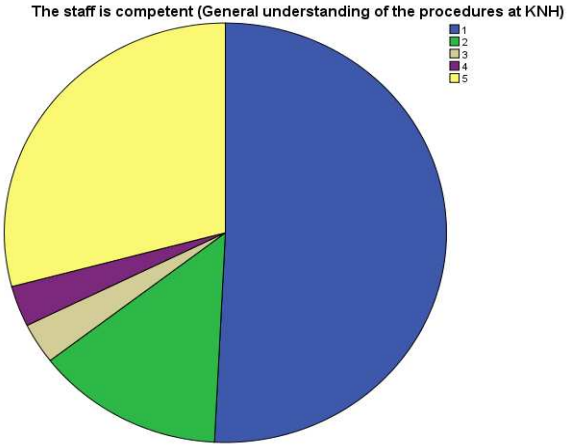
4.2 Presentation of results

The Staff is competent (General understanding of the procedures at KNH)

In terms of competence at the referral facility, slightly more than half of respondents strongly agreed that the staff at the hospital are well qualified in provision of various healthcare and related services at the hospital at 50.6 per cent, while 29.1 per cent strongly disagreeing, 13.8 agreed while those were undecided and disagreed were 3.1 per cent each.

Table 4.2: Staff Competency

	Frequency	Percent
1	129	50.8
2	35	13.8
3	8	3.1
4	8	3.1
5	74	29.1
Total	254	100.0

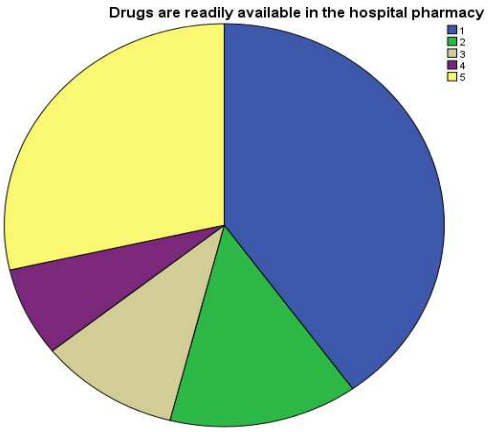


Drugs are readily available in the hospital pharmacy

On availability of essential drugs at the hospital's pharmacy, 39.8 per cent strongly agreed compared to 28.3 per cent who strongly disagreed, while 13.8 per cent agreed with those who neither agreed nor disagreed being 10.2 per cent.

Table 4.3: Availability of Drugs

	Frequency	Percent
1	101	50.8
2	35	13.8
3	26	3.1
4	18	3.1
5	72	29.1
Total	252	100.0

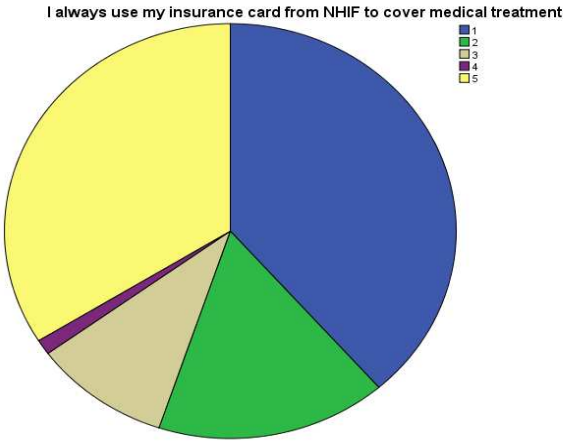


I always use my insurance card (NHIF) to cover for treatment at the hospital

Patients who use the National Health Insurance Fund cover for the services at the referral hospital were 38.6 per cent while 33.9 per cent did not use the card. 16.5 per cent agreed, meaning they used the cover on rare occasions. While those who neither agreed (used) nor disagreed (did not use) were 9.8 per cent. The reason why the card may not be in common use at the hospital could be that most patients are either not covered or they are out patients since NHIF covers in-patients only. Those who remained neutral or did not make use of the cover may also not be aware of the NHIF services.

Table 4.4: Hospital Insurance Cover

	Frequency	Percent
1	98	38.6
2	42	16.5
3	25	9.8
4	3	1.2
5	86	33.9
Total	254	100.0



Doctors and nurses attend to patients professionally

Most of the respondents strong agreed at 42.6 per cent and 15.7 (agreed) compared to 26.4 per cent who did not strongly agreed as well a 7.5 per cent disagreed and 7.9 per cent who were neutral. This implies that most of the patients who attend the referral facility are satisfied with the health care services they receive at the hospital.

Table 4.5: Professionalism of Doctors and Nurses

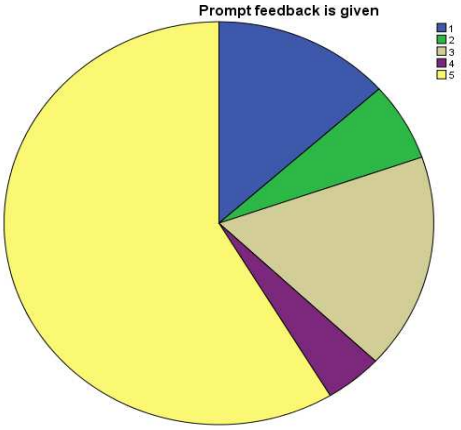
	Frequency	Percent
1	108	42.5
2	40	15.7
3	20	7.9
4	19	7.5
5	67	26.4
Total	254	100.0

Feedback on follow ups

According to the findings, most of the patients were not satisfied with the time it takes them to receive a feedback from the hospital at 58.7 per cent of respondents who strongly disagreed and 4.3 per cent who disagreed. Those who strongly agreed were 13.4 per cent and those who agreed with the research question were 6.3 per cent. However, 17.3 per cent were neutral. These findings imply that the hospital has a weakness in its communication system that could be the reason for slow response to patients' queries or notifications of diagnosis or interpretations of tests conducted at the facility.

Table 4.6: Feedback on follow ups

	Frequency	Percent
1	34	13.4
2	16	6.3
3	44	17.3
4	11	4.3
5	149	58.7
Total	254	100.0

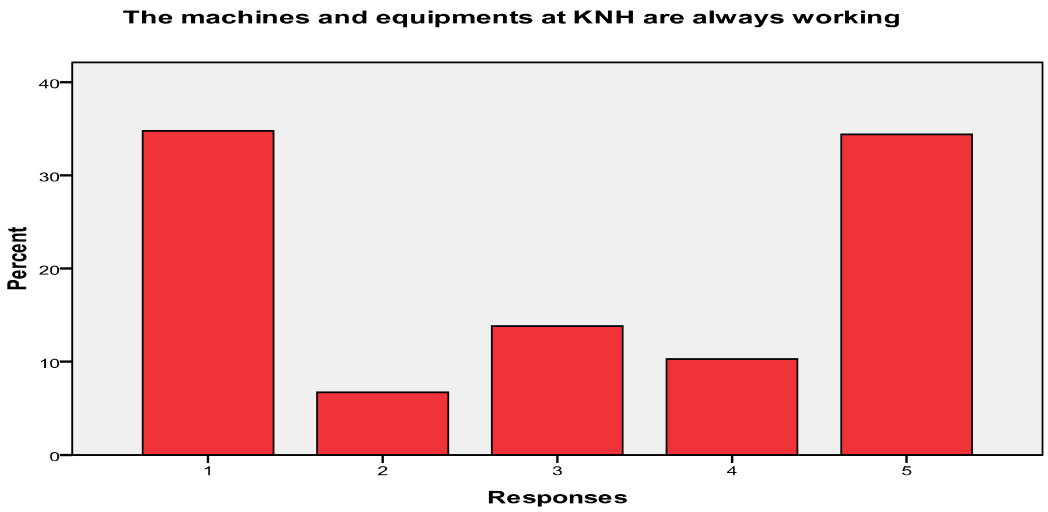


The machines and equipment at KNH are always working

On whether the facilities at the hospital were in a working condition, the opinion was divided with 34.6 per cent strongly agreeing while 34.3 per cent strongly disagreeing. Those who agreed with the statement were 6.7 per cent while those who disagreed were 10.2 per cent with those who were not sure being 13.8 per cent. The 34.3 per cent who disagreed are in line with secondary data that shows that outdated cancer machines always break down forcing patients to wait for months as spare months are no longer available in the market. A respondent at KNH noted that although the heads of Cancer Treatment Centre suggested that the machine is decommissioned in September 2008, the hospital management ignored the advice as it didn't have money to buy a new one.

Table 4.7: Functioning Machines/Equipment

	Frequency	Percent
1	88	34.6
2	17	6.7
3	35	13.8
4	26	10.2
5	87	34.3
Total	253	100.0

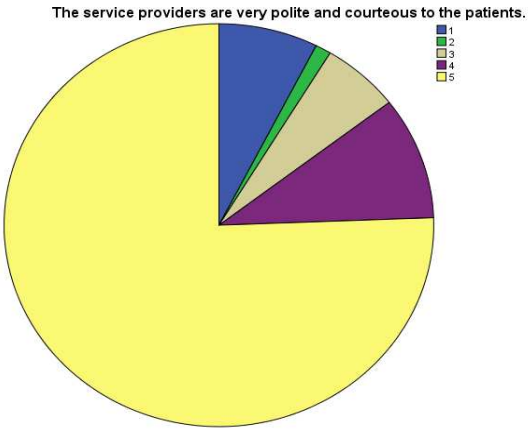


The service providers are polite and courteous with the patients

An overwhelming 75.6 per cent strongly disagreed that service providers at the hospital treat them well compared with 7.5 per cent who strongly agreed and a paltry 1.2 per cent agreeing. Those who neither agreed nor disagreed were 5.9 per cent while those who disagreed were 9.8 per cent. This could be a pointer to poor patient relations by those who handle patients at various points of service provisions from the reception to the time the patient leaves the facility. Interpretation: Poor customer care or a lack of good patient relations at the hospital.

Table 4.8: Customer Care

	Frequency	Percent
1	19	7.5
2	3	1.2
3	15	5.9
4	25	9.8
5	192	75.6
Total	254	100.0

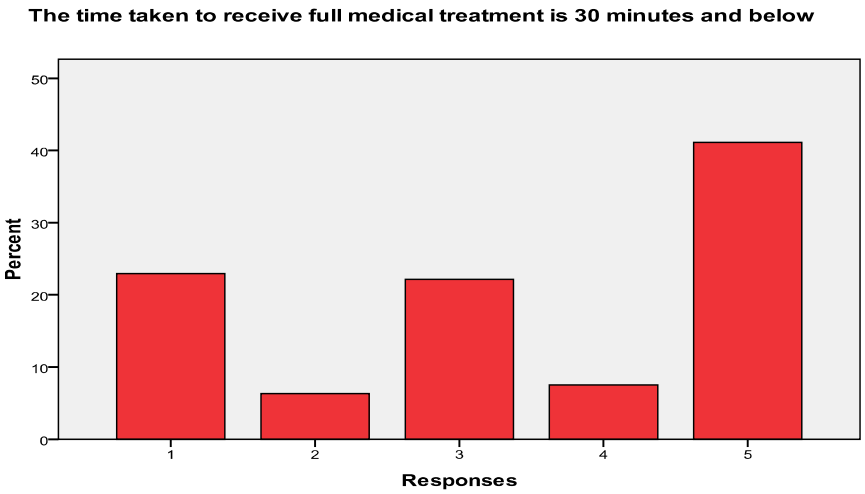


The time taken to receive full medical treatment is 30 minutes or less

According to the findings, 22.8 per cent (strongly agreed) and 6.3 per cent (agreed) of the respondents said they are attended to at less than half an hour after arrival to the hospital compared to 40.9 per cent who strongly disagreed. Those who neither agreed nor disagreed were 22 per cent while those who disagreed were 7.5 per cent. The fact that a majority of the respondents (48.4 per cent) did not agree with the statement is an indicator of some level of inefficiency in service provision such as use of manual systems, which are slower than automated ones in dealing with procedures or poor time management on the part of staff.

Table 4.9: Service Delivery Time

	Frequency	Percent
1	58	22.8
2	16	6.3
3	56	22.0
4	19	7.5
5	104	40.9
Total	253	100.0

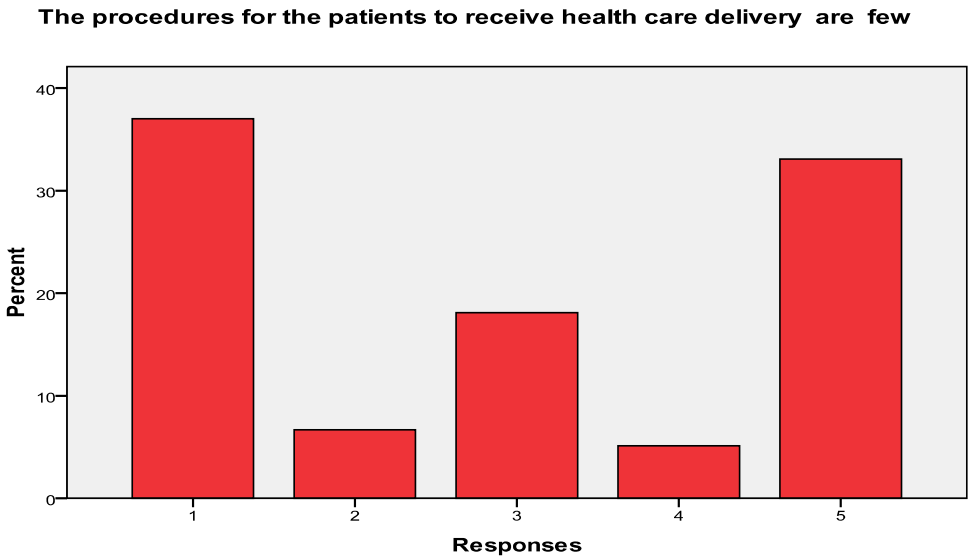


Procedures for patients to receive healthcare delivery are few

On this question, those who strongly agreed or agreed (37 per cent and 7.1 per cent) and those who strongly disagreed or disagreed (33.1 per cent and 5.1 per cent) were close. However, 18.1 per cent were neutral. The findings indicate a fair balance in the procedures involved in healthcare provision at the facility. Again, different conditions require varying amount of time to deal with and effectively treat the patients. Therefore, it may not be possible to prescribe a standard time for seeing each patient. However, with proper time management it is possible to cut down on time wastage regardless of the procedures involved.

Table 5.0: Treatment Procedures

	Frequency	Percent
1	94	37.0
2	17	6.7
3	46	18.1
4	13	5.1
5	84	33.1
Total	254	100.0

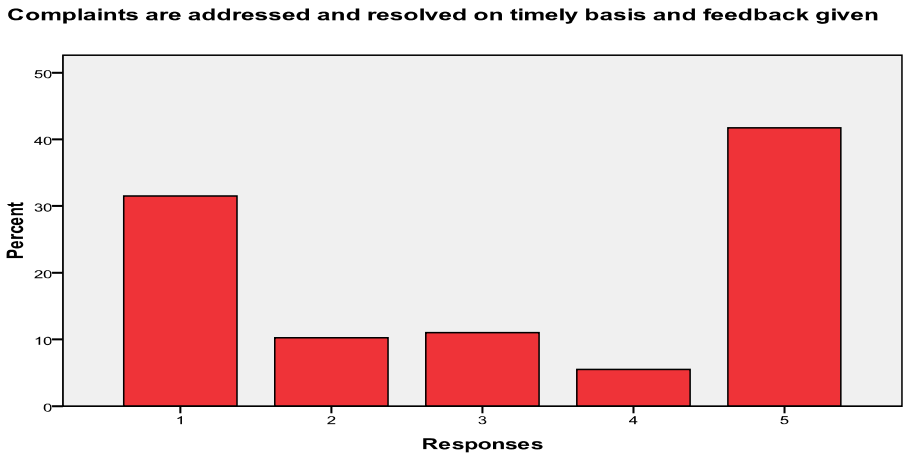


Complaints are addressed and resolved on timely basis and feedback given

Most of the respondents disagreed strongly with this question (41.7 per cent) compared to 31.5 per cent who strongly agreed. However, those who agreed were more than those who disagreed at 10.5 per cent and 5.5 per cent while 11 per cent neither agreed nor disagreed. The responses highlight further the issue of efficiency in the hospital's facilities and staff in handling patient queries and responding to them within reasonable time.

Table 5.1: Complaints Addressed and Feedback Given

	Frequency	Percent
1	80	31.5
2	26	10.2
3	28	11.0
4	14	5.5
5	106	41.7
Total	254	100.0

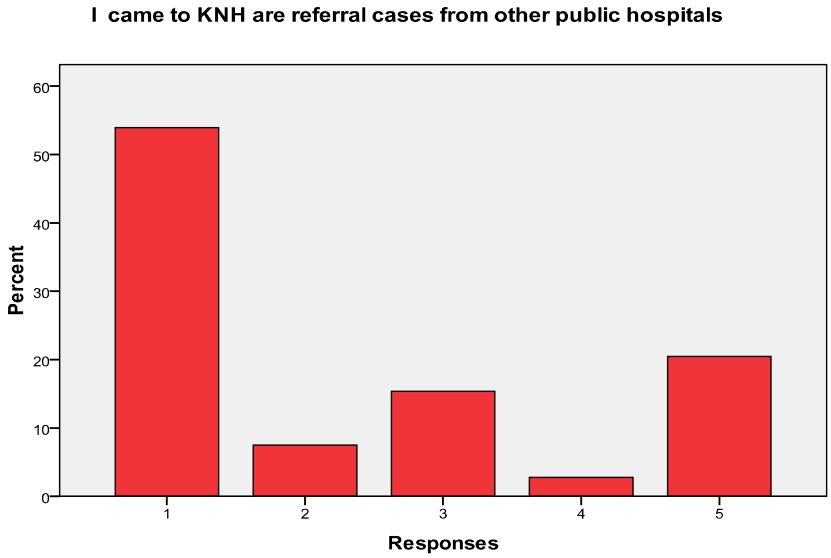


I came to KNH as referral case from other Public Hospitals

Those who strongly agreed with the statement were 53.9 per cent compared to 20.5 per cent of the respondents who disagreed. Those who agreed were 7.5 per cent while those who disagreed were 2.8 per cent with 15.4 per cent neither agreeing nor disagreeing. The findings imply that most public hospitals are either ill-equipped to handle patients who seek treatment at the facilities or lack skilled health staff (specialized doctors) to handle their cases, therefore, referring serious cases to the referral hospital. This could also explain the reason for long time patients take to receive treatment, given a large number of referral cases from different parts of the country, therefore, straining facilities and health workers at the referral hospital.

Table 5.2: Referral from other Public Hospitals

	Frequency	Percent
1	137	53.9
2	19	7.5
3	39	15.4
4	7	2.8
5	52	20.5
Total	254	100.0

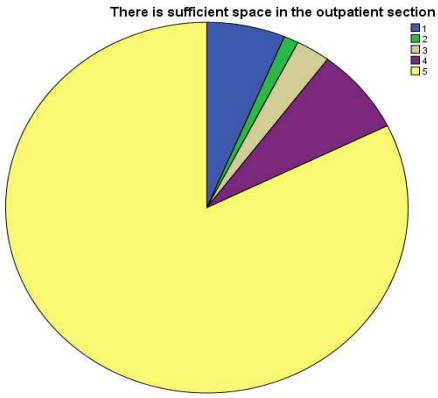


There is sufficient space in the outpatient section

Respondents to this statement had divided opinion with 82.3 per cent having strongly disagreed while 6.3 per cent strongly disagreed. Those who agreed were 1.2 per cent compared to those who disagreed at 7.5 per cent while 2.8 per cent of the respondents neither agreed nor disagreed. The findings could be an indication of the available outpatient facilities being inadequate shown by the higher figures of the respondents who were in strongly disagreed with the statement.

Table 5.3: Sufficient Space

	Frequency	Percent
1	16	6.3
2	3	1.2
3	7	2.8
4	19	7.5
5	209	82.3
Total	254	100.0

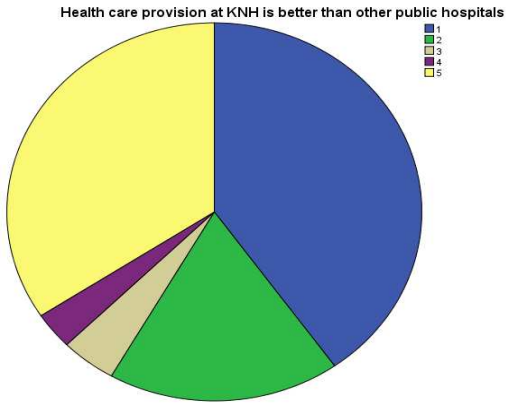


Healthcare provision at KNH is better than other Public Hospitals

On provision of healthcare services at KNH compared to other public hospitals, 40.2 per cent and 18.1 per cent of respondents strongly agreed and agreed respectively with the statement while 34.3 and 3.1 per cent strongly disagreed and disagreed respectively. The findings show that those who neither agreed nor disagreed were 4.3 per cent. Given that more than half of the respondents said that the services at the national referral hospital were better than those in other public hospitals indicate availability of better services at the referral facility than at public health centers in the counties. However, some patients seemed not to notice the difference at cumulative percentage of 37.4 per cent of the respondents who disagreed.

Table 5.4: Health Care Services in KNH better than other Public Hospitals

	Frequency	Percent
1	102	40.2
2	46	18.1
3	11	4.3
4	8	3.1
5	87	34.3
Total	254	100.0

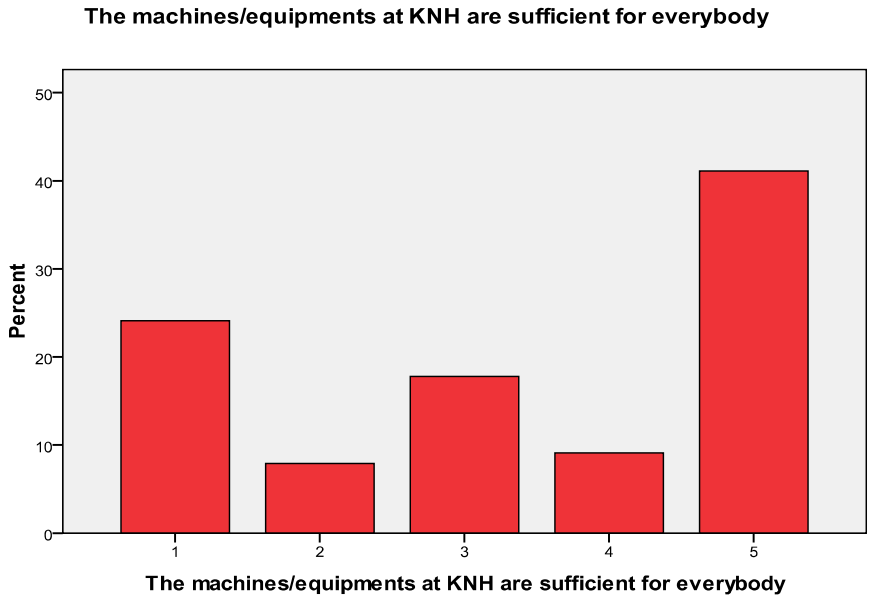


Machines/Equipment at KNH is adequate for everybody

On machines or equipment availability at KNH 24 per cent strongly agreed and 7.9 per cent agreed that they are sufficient while 17.7 per cent were not sure, but 40.9 per cent strongly disagreed while 9.1 per cent disagreed. The findings show that more than half of the patients do not perceive the facilities as adequate to meet their healthcare needs.

Table 5.5: Adequate Machines/Equipment

	Frequency	Percent
1	61	24.0
2	20	7.9
3	45	17.7
4	23	9.1
5	104	40.9
Total	253	100.0

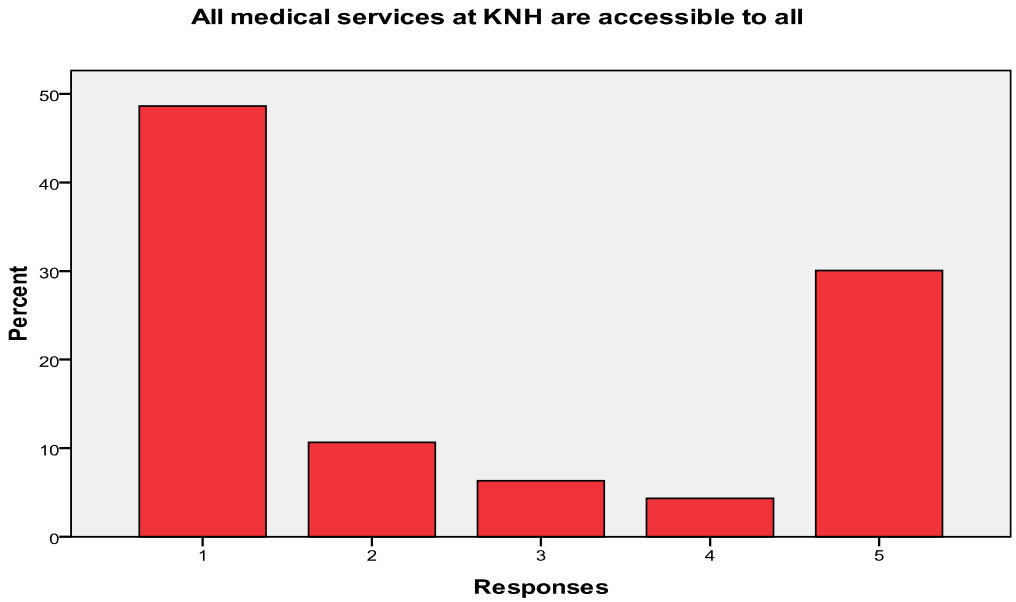


All medical services are accessible to all

On accessibility of medical services at the hospital 48.4 per cent of the respondents strongly agreed while 10.6 per cent agreed. Of the respondents 6.3 per cent were not sure whereas 29.9 per cent strongly disagreed and 4.3 per cent disagreed. The findings indicate that the medical services are accessible to more than half of the respondents.

Table 5.6: Accessibility of Health Services

	Frequency	Percent
1	123	48.4
2	27	10.6
3	16	6.3
4	11	4.3
5	76	29.9
Total	253	100.0



4.3 Discussion of results

4.3.1 Service delivery at KNH before Commercialization

The respondents interviewed noted that before KNH was commercialized it was marred by mismanagement of funds that impacted negatively on the service delivery. By the late 1970s, the respondents noted, KNH had no ambulances and minimal access to running water. In 1980s, the operating theatres closed a week for a completed lack of supplies. The situation was made worse in the 1980s by the economic stagnation under President Daniel arap Moi era, cutting of public spending. This impact of deterioration led to high mortality rates. Due to lack of equipped hospitals in other counties and KNH being the biggest referral hospital in Kenya continued to admit many patients, resulting in congestion in wards. A nurse respondent at the hospital noted that bed occupancy often exceeded the capacity and sometimes patients would get discharged even before they were really healed just to create space for more. This was mainly attributed to lack of capacity in other hospitals and health centers in the country.

The hospital lacked medical supplies and medicine, demoralizing staff who most of the time went on strike protesting poor working conditions, leaving patients unattended in wards. The limited medical supplies, coupled with the overcrowding and the low staff

morale led to the mistreatment of the patients, which led to the negative perception of the hospital by the public.

The respondent also noted that the hospital administrator had little authority in the management of the hospital due to interference from the government.

The Ministry of Health representative noted that the main problem with KNH before privatization was that the person in charge of the hospital did not have authority and lacked the funds to run the hospital efficiently.

The administrative and financial challenges that were threatening to bring the biggest referral hospital to its knees led to the decision by the government to give the hospital more managerial autonomy. The respondents noted that it was envisaged that this would improve expenditure control and revenue generation as well as improve service delivery. In an order made in the Kenya Gazette Supplement No. 29 under Legal Notice No. 109, KNH was established by presidential order as a state corporation under The State Corporations Act of 1986.

4.3.2 Quality of service delivery after Commercialization

From the findings, it shows that some of the respondents felt that service delivery has slightly improved compared to previous years. The doctors who responded noted that change in the last 10 years at KNH include; more doctors, less congestion and more order and better management style.

Given that more than half of the respondents said that the services at the national referral hospital were better than those in other public hospitals indicate availability of better services at the referral facility than at public health centers. However, some patients seemed not to notice the difference at cumulative percentage of 37.4 per cent of the respondents who disagreed. The findings are supported by secondary data that shows that KNH staff strives to serve all patients in a timely manner, having structured the process for delivery of services. Secondary data shows that the new patients are received at the accident and emergency, pediatrics or outpatient unit. A medic registers the patient and the patient is assessed by the doctor on duty before recommending treatment or admission.

On availability of essential drugs at the hospital's pharmacy, 39.8 per cent strongly agreed compared to 28.3 per cent who strongly agreed. This supports secondary data that shows that before privatization, most patients had to go outside the hospital to buy medicine. The respondents generally noted that the hospital has established a re-order scheme for all types of drugs to avoid the drugs from running out of stock. However, it occasionally experiences shortage of drugs used in Intensive Care Unit, operation theatres, resuscitation and burns units, the KNH respondents noted.

After commercialization, a respondent from KNH management team said the salaries of workers increased and paid on time compared to the days when the hospital was under MOH, motivating the employees to serve customers better. He argued that service delivery has improved because more doctors have been employed, the facilities improved and level of motivation has gone up.

However, the findings strongly lean towards poor service delivery despite commercialization. The KNH respondent noted that commercialization means being independent and a positive influence of health care service delivery because the decision made by the hospital will be focused on the needs of the customers, but has not been practical. The independence of KNH is limited because the administrators the directors and board members are government appointees and serve the interests of their employer i.e. the government of the day. As a result, efficiency is pegged on the current government; if the regime is committed to providing quality and affordable health care to it citizens then the service delivery will be good and vice versa.

About 37.4 per cent side with secondary data that shows that there are delays at the cancer treatment center, the renal unit, cardiology unit and the accident and emergency unit, proves that service delivery is still poor. Most cancer patients spend more than one month after diagnosis to receive chemotherapy and radiotherapy due to few specialized machines.

The doctors who responded explained that specialized patients wait longer than expected because there are only four oncologists against about 120 patients on review a week and 40 to 50 new patients a week. The respondents also attributed the delays to lack of new machines as one of the two old radiotherapy machines that is about 27 years old and keeps breaking down.

The hospital being a referral hospital continues to receive many patients who have been referred to the facility. Those who strongly agreed with the statement of being referred to KNH were 53.9 per cent compared to 20.5 per cent of the respondents who disagreed. Although KNH has experienced steady increase in the number of patients, the growth of has not matched expansion of the hospital facilities. The 1,876 beds, according to secondary data, cannot satisfy the demand and some are forced to share beds or wait longer to get admission.

4.3.3 Success of cost-sharing structure

The decision to grant Kenyatta National Hospital the State Corporation status was arrived at after the government realized that the hospital was faced with many challenges, including, low quality health care, shortage of equipment, overcrowding, low staff morale, lack of supplies that were hugely blamed on lack of funds.

While the hospital generates revenue through cost sharing, the government still funds the hospital through the Health ministry budget. Despite the government being KNH's main source of funding, the hospital has autonomy to use the funds. The KNH respondent noted that the board makes more informed decisions as far as hospital spending is concerned. The hospital generates some money through cost-sharing process and money awarded from Treasury is used in a better way because the board is able to lobby for more funding, either from the government or from external donors such as United Nations, DFID, USAID who fund projects directly through the hospital.

The hospital board is able to make decisions on procurement independently. The hospital has also managed to increase its finances through donor funds and from other operations. However, the cost-sharing structure has been blamed on lack of funds as allocation from Treasury cannot meet the needs of hospital.

KNH's annual costs stand at Sh6.8 billion against revenues of Sh5.3 billion, leaving it with a funding gap of Sh1.5 billion that is plugged by donors, secondary data shows. Of the Sh 5.3 billion, KNH raised Sh1.8 billion from patient fees while Treasury allocated it Sh3.5 billion. The hospital is also reeling under the weight of billions of shillings in debt owed to them by defaulting patients who cannot pay for the services rendered to them.

Secondary data shows that in the year 2009, patients owed the hospital Sh1,446,030,702 out of which a balance of Sh1,256,527,193 (over 86 per cent) was owed by those categorized as poor and unlikely to pay. The hospital has been forced to waive fees for those unable to pay, noted a respondent from KNH.

A respondent from the Ministry of Health noted that in November 2009, KNH was directed to release 480 patients and 32 bodies detained in the mortuary because of unpaid bills totaling Sh 36,273,795. The hospital was to forward the bill to the ministry for reimbursement and has not received the refund to date, the respondent noted.

The government's lack of adequate funds last year exposed the facility to employee unrest, derailing the hospital's daily operations and denying patients appropriate care. The hospital is faced with a spiral in costs caused by a spike in food prices, high cost of utilities and the volatile currency – which has pushed the cost of drugs and medical equipment to record levels.

This has prompted KNH like other top hospitals including Aga Khan and Nairobi Hospital to increase their bed and consultation charges to cover the additional costs and boost their revenues. KNH increased the cost its services by between 15 per cent and 30 per cent and this is expected to deepen its debt collection challenges.

A KNH respondent noted that the private wing does not generate as much money as planned and has not been as profitable as expected. The respondent noted that the wing reported losses amounting to Sh35.7 million in the financial year 2004/2005 and the loss

rose to Sh66.1 million in 2008/9 financial year. The respondent attributed revenue leaks due to lack of clear audit trail for the losses from the wing.

4.3.4 Success of Commercialization

The doctors and nurses who participated in the focus group discussions noted that after privatization there have been considerable technical and procedural advancements which have contributed to improved service delivery in the following ways:

4.3.4.1 Management Restructuring

Secondary data shows that KNH has already re-organized its executive team through the merger of key business units and redeployed at least 20 senior managers. The referral hospital cut its business units from 45 to three –clinical, nursing and administrative services – that were put under deputy directors who report to the CEO. The re-organization of its management ranks was aimed at a lean executive team with fewer reporting layers to support the hospital's new growth drive and cut red tape that was holding back projects.

4.3.4.2 Automation of services

Secondary data shows that KNH is automating its operations including billing, procurement and back-office functions, effectively cutting back on paperwork and the numerous clerical staff.

Secondary data shows that the hospital deals with about 3,000 manual transactions daily and stationery expenses alone stand at Sh150 million annually representing 12 per cent of our administration costs. The hospital is in the process of automating 40 million records.

4.3.4.3 Partnerships with Medical Schemes

KNH is now seeking to shed its old image with a spruced-up corporate center for high-end outpatient clients – targeting employee medical schemes – who will ease the burden of non-payment by its low income patients.

KNH has also partnered with National Hospital Insurance Fund (NHIF) to improve the accessibility to affordable health care services.

The NHIF respondent noted that the Fund pays for all medical expenses including drugs unless a patient has engaged a private doctor.

The social fund covers the public both employed and unemployed. The employed make their remittance through the employer while those in the informal sector directly remit their contributions to NHIF directly. The people in the informal sector contribute a flat rate of Kshs 160/= monthly. The formal or employed have their deduction done by the employer who in-turn remits the money to NHIF. Deductions for these people depend on the income bracket. That is the higher ones income the more they are deducted, deductions range from Sh30/= to Sh. 320/=.

However, some of the respondents felt that the positive change experienced at KNH cannot be wholly credited to its autonomous status. There are other factors that might have brought this change such significant improvement in the health sector in Kenya, such as the full operation of other health facilities with access to medicine and medical commodities; more health workers have been employed in rural areas, slightly easing the burden on KNH compared to previous years and immunization coverage has been increased, contributing to a drop in number of patients contracting preventable diseases.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter gives a summary of the findings on the influence commercialization has had on health care service delivery at KNH. It also gives the conclusions derived from the data analysis and the recommendations with regard to the study's objectives.

5.2 Summary

KNH has tried to improve its services over the years but has not reached a level that satisfies patients and other stakeholders. It still faces many challenges in its quest to operate and be financially stable like other parastatals. However, healthcare being a basic need, KNH's main challenge remains balancing the delivery of quality health care services with low funds.

5.3 Conclusions

KNH does not deliver its services in an efficient manner according to its mandate of being a national referral hospital. The long waiting times before receiving treatment, supported by the majority of the respondents (48.4 per cent) who felt that they wait for more than 30 minutes before receiving treatment, the inadequate machines which have contributed to long delays in the cancer and renal unit has made patients suffer. The cost-sharing structure is not working very well as it still relies heavily on the government for funding. The management structures also lack transparency and the lack of performance targets for each department is making other sections lag behind in terms of reforming the hospital and boosting service delivery. The ill-equipped hospitals across the country have burdened KNH further and if the government does not fully devolve healthcare, the burden on KNH especially for specialized units like heart, orthopedic, renal and cancer are unlikely to ease.

5.4 Recommendations

Although KNH has derived significant benefits from its increased autonomy, a number of steps need to be taken to progress further towards the goals of improved quality service delivery, revenue generation, and cost containment. These include the follows:

i) **Infrastructure**

To improve efficiency, KNH should ensure systematic repair and timely replacement of machines to reduce the service delivery time to less than 30. The hospital should plan on expanding the private wing and hiring better qualified staff as a income generating project.

ii) **Funds**

Given the constraints on public funding, social insurance should be mobilized more effectively and government allocations must be targeted in accordance with need and performance of the hospital. Funding ceilings must be more flexible so that hospitals can seek, negotiate for, and receive funds from other bodies, such as donors, without affecting government funding for health. This is in addition to defining the role of KNH in the national system, and its desired type, range, and volume of services and expected client profile so that there is a sound basis for determining donor inputs and government capital and recurrent funding levels. Although the hospital operates a cost sharing scheme that generates income, it is not enough to meet the rising demands. Therefore government control may need to be further relaxed to allow KNH to pursue external funding. This would ensure that it meets its financial needs to serve the high numbers of patients. The funds will also enable KNH hire more specialized doctors and pay them well in order to retain them.

iii) **Debts**

The government should compensate KNH for unpaid bills, because it is the role of the government to provide quality healthcare to its citizens and set up a medical policy for the poor to lift the burden off the hospital. Given also given the type and level of services provided at KNH and the difficulty most patients have in covering these costs through fees, the government must ensure that as much of the cost as possible is covered by social insurance, leaving the balance to be covered through targeted government funding. Therefore more Kenyans should also make monthly contributions to NHIF for the funds to pay for hospital bills. NHIF should also revise its rules to pay for medical bills of patients with terminal illnesses like cancer which is expensive to treat. The cost-sharing

scheme should be reviewed to match with the current trends of costs of medical treatment. The social fund should cover more Kenyans and also educate the masses through civic education the medical benefits derived from joining the fund.

iv) Improve efficiency

The hospital should come up with waiting-time mechanism for patients seeking specialized treatment to save lives. The government should also open other cancer centers, renal units and others countrywide to reduce the numbers being referred to KNH.

KNH continues to need stronger mid-level management capacity and better systems, especially in the areas of finance and supplies, so that efficiency and quality can be maximized. The role of the Board remains critical and therefore the government should seek to maintain a good balance of skilled, experienced private-sector representatives and civil servants, and should continue to avoid appointments resulting from patronage.

As part of strengthening its policy-making and coordination roles, the government should define the role of the hospitals, in terms of both the type and volume of services provided and the range of patients served to ensure that public and donor funding is used cost-effectively.

Board members, managers, and staff should be properly oriented and trained with the MOH setting and monitoring targets for key aspects of financial performance and service coverage, efficiency, and quality. That is implementation of quality care assessment programmes and regular technical efficiency tests.

5.5 Suggestion for Further Research

The researcher felt there was need to do more research to find out:-

- The other challenges hindering the full realization of the benefits of commercialization (autonomy) on the health care service delivery at KNH.
- Whether a replication of this model of commercialization can be viable at other public hospitals in Kenya to improve on the health care service delivery.

REFERENCES

Amoako K. Y., (2003), Public Sector Management Reforms in Africa: Lessons Learned, Economic Commission for Africa Publications, Addis Ababa Ethiopia

Casels A., (1995), "*Health Sector Reform: Key issues in less Developed Countries"*, Journal of International Development: 7(3) 329-347

Collins D, Njeru G, Meme J., (1996), Hospital Autonomy in Kenya: The Experience of Kenyatta National Hospital

Denhardt, J. V & Denhardt, R. B. (2001), *The New Public Service*, Drive Armonk, New

York

Donald P. Moynihan & Sanjay K. Pandey 2007, "*The Role of Organizations in Fostering Public Service Motivation*", Journal of Public Administration Review, 67, 4-182

Fadahunsi O., (1996), "Privatisation in Africa: the way forward, AAPAM, Nairobi Kenya

Franco M., Bennett S., Kanfer R. 2002, "*Health sector reform and public sector health worker motivation"* Journal of Social Science a Medicine, 54, 1255–1266

Gaebler, Osborne, (1992), "Re-inventing Government – How the Entrepreneurial Spirit is Transforming the Public Sector" Prentice-Hall, New Delhi

Hospital Autonomy in Kenya: (1996), The Experience of Kenyatta National Hospital, viewed on 14 February 2012,

Hospital Autonomy in Kenya; Retrieved October 25, 2012 from The Experience of KNH; website http:www.hpsh.harvard.edu/ihsg/publications/pdf/No.37[4]

How a privatized Kenya Airways sees its role in building infrastructure for an East African Hub; Retrieved November 20 2012 from Kenya Airways: Case Study; Website http:www.aercafrica.org[8]

Kenyatta National Hospital Strategic Plan, (2012), Wilson J. Q, (2nd ed.), 2008, *Mastering Public Administration*, Raadschelders, Washington DC

Kumaranyaka L., (1997), , "*The role of Regulation Influencing private sector activity with health sector reforms*" Journal of International Development, 9, 641-649

Mills A., (1995), "Improving the Efficiency of Public Sector Health Services in Developing Countries: Bureaucratic versus Market Approaches" PHP Departmental Publication No 17

Pack R. J., (1987),, "*Privatization: Theory and Practice*", 6, (4), Journal of Policy Analysis and Management 523-540

Privatization Act – Kenya Law Reports; Retrieved October, 28 2012 from http:// www.kenyalaw.org/downloads/Acts/Privatization 20pdf[7]

Status of the privatization programme; Retrieved November 12 2012 from website http://www.pc.gp.ke/index.php[6]

The Background Kenyatta National Hospital; Retrieved November 20, 2012 from website
http: www.marsgroupkenya.org/K_N_H[5]

Thomas J. Bossert T., Berman P, (2002), "Appraising a Decade of Health Sector Reform in Developing Countries", Washington, D.C.

Unge P., Paepe, D., Groote D., (2005) *"Colombia: In Vivo Test of Health Sector Privatization in the Developing World"*, International Journal of Health Services, 35 (1), 125–141

Swamy G., (1980), Kenya Structural Adjustment in the 1980s, Policy Research Working Paper 1238

Rono K. J., (2002), "*The Impact of the Structural Adjustment Programmes in Kenya*", 17(1), Journal of Social Development in Africa, 134-148

APPENDICES

Appendix I – Likert scale questionnaire for the patients

Appendix II – Checklist for Director of Medical Services

Appendix III –Checklist for National Hospital Insurance Fund

Appendix IV – Checklist for KNH Administrator

Appendix V – Checklist for KNH Doctors and Nurses