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DEVOLUTION AND UNIVERSAL HEALTH COVERAGE IN KENYA: SITUATIONAL ANALYSIS OF HEALTH FINANCING, INFRASTRUCTURE & PERSONNEL

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Abstract

Availability and comprehensiveness of health services offered at a health facility is critical in realizing universal health coverage. This however partially requires a strong, efficient, as well as well-run health system, a sufficient capacity of well-trained, motivated health workers and a system for financing health services. The Kenya government with support of development partners has over the years initiated various policies and strategies aimed at realizing universal coverage. The paper aimed at taking stock of the country's health financing, infrastructure and personnel and how these impact on health care delivery as the country moves towards universal coverage. To accomplish this, both primary and secondary data were collected in terms of health care financing, health infrastructure and personnel and how they impact on delivery of health care services. Notable findings include government's commitment towards universal coverage through increased revenue allocation as well as investment in both health infrastructure and personnel aimed at enhancing geographical access. Notwithstanding this however, there is limited solidarity in financing of health care and that a significant portion of the financing is off-budget and skewed towards one donor raising sustainability and equity concerns. In terms of infrastructure there exist significant gaps, especially specialized medical equipment, maintenance of the equipment and the personnel to operate the equipment. Similarly, a number of the facilities in the country have dilapidated infrastructure coupled with disjointed health investments. Significant gaps were also identified in a number of key health personnel with a number opting to join private practice, while others opting for career change in spite of the resources invested in training them. In lieu of the findings, various recommendations are made including embracing financing mechanisms that embrace social solidarity, fast

tracking the enactment of Health Act, development of health investment policy that assures coordinated, prioritized and sustainable investment; finalization and implementation of schemes of service across counties. Other recommendations include policy guidelines and procedures that support public private partnership initiatives such as the "Beyond Zero" campaign for purposes of equity and sustainability; and finally continuous investment in human resources guided by policy guidelines.

Keywords: Devolution, Health care Financing, Health Personnel, Health Infrastructure, Universal coverage

INTRODUCTION

Devolution entails transfer of responsibilities for services to lower tiers that elect their own political leaders, raise their own revenues, and have independent authority to make investment decisions. In a devolved system, local governments have clear and legally recognized geographical boundaries over which they exercise authority and within which they perform public functions (World Bank, 2012). Globally, there has been a trend in the devolution of authority in healthcare whereby the authority that was often sitting with one central Ministry or Department of Health devolved over time (KPMG, 2015). For instance, Ethiopia has moved from centrally-organized authority to a situation where block grants are redistributed from regional governments to districts. The districts, in turn, set their own priorities and are free to allocate the budget to health facilities and are relatively free to spend their budget on whatever health facility they want. In Ghana, the situation is a bit more complicated where on one side there is the GHS to which the responsibility of managing health facilities has been delegated and on the other side, is the District Assembly with the district departments of health that act as devolved entities (World Bank, 2012; KPMG, 2015).

When governments devolve functions, they transfer authority for decision-making, finance, and management to quasi-autonomous units with corporate status (World Bank, 2014). In Kenya, following the promulgation of the new constitution in 2010, a devolved system of governance with two levels namely National and County government was created (Okech & Lelegwe, 2016). This system has been described by the World Bank as one of the most ambitious implemented globally since besides the creation of counties, the process also involved the creation of new systems of administration that have absorbed the prior systems of administration. In the system, the county governments replaced the provincial, district and local government administration governments that were created at independence.

At national level, health leadership is provided by the Ministry of Health (MOH). The key mandates of the MOH include development of national policy; provision of technical support at all levels; monitoring quality and standards in health services provision. Others include provision of guidelines on tariffs for health services; conducting studies required for administrative or management purposes. At the county level, the county governments are responsible for county legislation; executive functions - functions transferred from the national government and functions agreed upon with other counties; establishment and staffing of a public service. Other functions include provision of infrastructure and equipment for health facilities such as new wards, provision of ambulances, and recruitment of additional health workers. The two levels of government though distinct are interdependent and conduct business on the basis of consultation and cooperation (GoK, 2010; World Bank, 2014).

In the Constitution, the government provided the necessary legal framework for ensuring a comprehensive and people driven health care delivery aimed at enhancing access to quality health care. The county and national governments aimed at improving geographical access by the populace including the poor and other vulnerable groups. The constitution also provides for the right to access emergency health services by all including children and persons living with disabilities. In 2013, the national government announced the abolition of user fees at primary health care facilities and introduced free maternal health care services in public health facilities. Similarly in the draft Health Bill of 2015, the government declared access to reproductive health and emergency medical treatment as a right by all persons (Okech & Lelegwe, 2016). All these initiatives it can be argued are aimed at realizing universal health coverage. Further, in the Health Financing Strategy, the government reiterated its commitment towards universal coverage by emphasizing social health protection to all Kenyans. This has been compounded by introducing social solidarity mechanisms founded on complementary principles of social health insurance and tax financing aimed at protecting the poor and other vulnerable groups (NHIF, 2015). Recently, the government edged closer to implementing universal coverage and settled on NHIF as a vehicle towards the realization of universal coverage (NHIF, 2015; Okech & Lelegwe, 2016).

Universal health coverage ensures that all people use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship has continued to dominate debate in health care (WHO, 2010). This embodies three related objectives namely i) equity in access to health services so that those who need the services should get them, not only those who can pay for them; ii) that the quality of health services is good enough to improve the health of those receiving services; and finally

iii) financial risk protection which aims at ensuring that the cost of care does not put people at risk of financial hardship (WHO, 2010). Four key elements are identified by World Health Organization (WHO) necessary towards the realization of universal coverage. One, a strong, efficient, well-run health system; two, a system for financing health services; three, access to essential medicines and technologies; and finally a sufficient capacity of well-trained, motivated health workers (WHO, 2010). In addition to the above initiatives aimed at universal coverage, the Kenya government continued to fast track other initiatives including developing and piloting a national referral strategy, strengthening of private public partnership (PPP) such as the *"Beyond Zero"* campaign, health insurance subsidies targeting disadvantaged groups. Considering that a strong, efficient, well-run health system and a sufficient capacity of well-trained, motivated health workers among other pillars are important in realizing universal coverage, the paper aimed at taking stock of the country's health infrastructure and personnel and how these impact on health care delivery. However, before enumerating these, the methodology utilized as well as a brief of the health situation and health service delivery is provided in that order.

METHODOLOGY

Both primary and secondary data were collected regarding health infrastructure and personnel. In terms of secondary data, a review of relevant literature on key policy initiatives aimed at universal coverage and how they have impacted on health infrastructure and personnel was undertaken. This information was obtained from various sources including Ministry of Health official documents such as the draft Kenya National Health Sector Strategic Plan (KHSSP) III, draft Health Policy Framework, 2012 - 2030, draft Health Care Financing Strategy, and National government documents such as Vision 2030, Medium Term Expenditure Framework (MTEF) paper, National Hospital Insurance fund documents (Manuals, strategic plans, operational plans, among others), the Constitution and the Draft Health Bill, 2015. Additional data was also collected from relevant commissioned studies such as Kenya Health Labour Market Assessment report, status of the Managed Equipment Scheme, journal articles, among others. This was supported by in-depth interviews with key stakeholders in the sector at both National level and county levels.

Health Indicators

The Government of Kenya is committed to the improvement of the health and welfare of its citizens. The government has taken important steps towards this goal over the years, emphasizing that the provision of health services should meet the basic needs of the population

and be geared towards providing health services within easy reach of Kenyans (Okech & Lelegwe, 2016). It has also placed considerable emphasis on preventive, promotive and rehabilitative health services without ignoring curative services. The initiatives have contributed towards improvements in the health indicators as shown in table 1.

Table 1: Key Health Indicators (check the KDHS)

- Total Fertility rate - 3.9
- Contraceptive prevalence rate 58% for married women and 65% for sexually active unmarried women
- Infant mortality rate - 39 deaths per 1,000 live births
- Under-five mortality rate - 52 deaths per 1,000 live births.
- Delivered in a health facility – 61%
- Full vaccination - 68%
- Stunted growth (too short for age) - 26%
- Use of ITN - 48%
- HIV testing 53% and 46% for women and men, respectively
- Neonatal mortality 22 per 1,000 live births
- Access to delivery in health facility - 61%
- Assisted delivery by skilled health worker (doctor, nurse or midwife) - 62%
- Post natal care 51% with 65% and 42% in urban and rural areas, respectively

Source: KDHS, 2014; PRB, 2015

Although the health indicators have improved over time, most still fall below the 2015 Millennium Development Goals (MDGs). Similarly, the indicators continue to lag behind those of the rest of world including sub-Saharan Africa (SSA).

KENYA'S POLICY REFORMS TOWARDS UNIVERSAL HEALTH COVERAGE (OKECH & LELEGWE, 2016)

Upon attaining independence in 1963, the Government of Kenya (GoK) in recognized the pivotal role of health towards socioeconomic development, embarked on wider policy reforms aimed at enhancing access to quality care. A number of government policy documents and successive national development plans were developed wherein policies and strategies were mooted towards enhancing geographical access which then was limited to the whites who were the minority. As a result of these policies, health indicators such as infant and child mortality, and

life expectancy started to improve (GoK, 2010). This was partially attributed to enhanced provision of primary health care (PHC) and continued training of skilled health workers in line with WHO guidelines. Similarly, the government expanded the training program for the various cadres of health personnel and health infrastructure in various parts of the country as key elements of providing comprehensive health care.

In 1980's the policy shift from purely government provided for care to cost sharing was followed by the 1993 institutional and structural reforms, and market orientation of the health services. This period however coincided with policy reversals with mixed equity implications. For instance, following the reduction in donor funding and the macroeconomic problems the country experienced over this period, the health sector became too large for the government to handle single handed. To cope with this, the government introduced cost sharing in public health though this was abandoned before it was reintroduced a few years later. To caution the poor, and other vulnerable groups, the government with support from key stakeholders, introduced a system of waivers and exemptions which was however riddled with implementation weaknesses with minimal realization of the intended objectives (Okech & Lelegwe, 2016).

In the recognition of the role of a well run health system and financing play in contributing towards universal coverage, the government in 1994, developed the Health Policy Framework and a five-year National Health Sector Strategic Plan (NHSSP) of 1999-2004 wherein targets and processes driving the health sector development, as well as healthcare service delivery were articulated. The reforms relating to the way the healthcare services were not only reorganized but also financed, delivered and evaluated were initiated. In the document, equitable allocation of government resources to reduce disparities in health status and increased cost-effectiveness and efficiency of resource allocation and use were emphasized. Others included enhanced regulatory role of the government in health care provision; creation of an enabling environment for increased private sector as well as community involvement in service provision and financing; and increase and diversify per capita financial flows to the health sector. All these measures it can be argued were key ingredients necessary in universal coverage.

A few years later in the mid 1990s, the Kenya Health Policy Framework Implementation Action Plan was developed, followed by the establishment of the Health Sector Reform Secretariat (HSRS). This was meant to spearhead the implementation of the health care financing policies for purposes of coordinated planning and implementation. Around this time, a rationalization programme within the Ministry was also initiated aimed at responding to the financing of the public health sector in order to enhance access to quality care amongst the poor and other vulnerables. The National Hospital Insurance Fund Act was repealed in 1998 for

purposes of enhancing financial protection and broadening the coverage, while enhancing governance of the institution. NHIF service coverage however, was not expanded at that time while the envisaged benefit package remained narrow (Okech, 2014; Okech & Lelegwe, 2016).

In 2007, the government launched the country's development blue print dubbed "Vision 2030" where the health sector was accorded the recognition of driving the country towards a competitive environment and a medium income country (GoK, 2007). This was to be realized through the provision of robust health infrastructure in terms of equipment, strengthening health service delivery, development of risk pooling financing mechanisms, while at the same time ensure AID effectiveness and harnessing social solidarity in the country.

In the Health Financing Strategy of 2010, the government further committed itself towards universal coverage by emphasizing social health protection to all Kenyans by introducing social solidarity mechanisms founded on complementary principles of social health insurance and tax financing for purposes of financial protection of the poor and other vulnerable groups. In order to achieve the set objectives, the government reiterated its commitment to amend the NHIF Act for purposes of enhancing access, and broadening benefit package. In the new constitution promulgated in 2010, the government provided the necessary legal framework for ensuring a comprehensive and people driven health care delivery aimed at enhancing access to quality and affordable health care. The Constitution introduced a devolved system of governance with two tier government systems namely the County and National government with the goal of enhancing utilization and geographical access to quality care by all Kenyans. The constitution further provides for the right to access health care including emergency health services by all including children and persons living with disabilities as key areas of focus in health services delivery.

In 2013, the government announced the abolished user fees at primary health care facilities and introduced free maternal health care services in public health facilities. This initiative may be considered a populist policy meant to enhance access to quality care, especially the poor and other vulnerable groups, its implementation was technically unattainable. The concern was that at the time, the initiative lacked technical and necessary legal and operational policies. Technical input to inform the policy initiative is necessary otherwise the intended objectives may remain unattainable. For instance, following the policy pronouncement, cases of delays in the disbursement of funds to counties have been common with a few opting for bank overdrafts to meet operational expenses not withstanding the embedded charges. As noted earlier, a system for financing health services is pivotal in UHC and if not carefully addressed, will negate the realization of UHC. Cases of stock outs of drugs

and other medical supplies, poor maintenance of equipment, lack of transport, and medical facilities have continued to be experienced in many public health facilities countrywide.

Recent initiatives of "*Beyond Zero Tolerance*" campaign for expectant mothers, children and breast cancer are some of the latest efforts towards UHC. This has seen many stakeholders pull resources towards the initiatives although there are still no reliable statistics to inform policy dialogue on the pack of the initiatives. Whereas this is positive step in the right direction, there is lack of policy to support the initiative to ensure sustainability in the event of political regime change, which is undoubtedly expected in a democratic society. It may be necessary to learn from economies where such initiatives have been mooted and implemented like in the United States under the *Obama Care* initiative. Recently the government identified and settled on NHIF as official vehicle for the successful implementation of universal health coverage for the country (NHIF, 2015). The Government *gazetted* increased contribution rates to cater for both in-patient and out-patient cover in an enhanced benefit package partially contributing to increment in revenue. The national scheme envisages universal coverage in which both in patient and out-patient services for members are catered for (Okech & Lelegwe, 2016).

THE HEALTH SERVICES DELIVERY

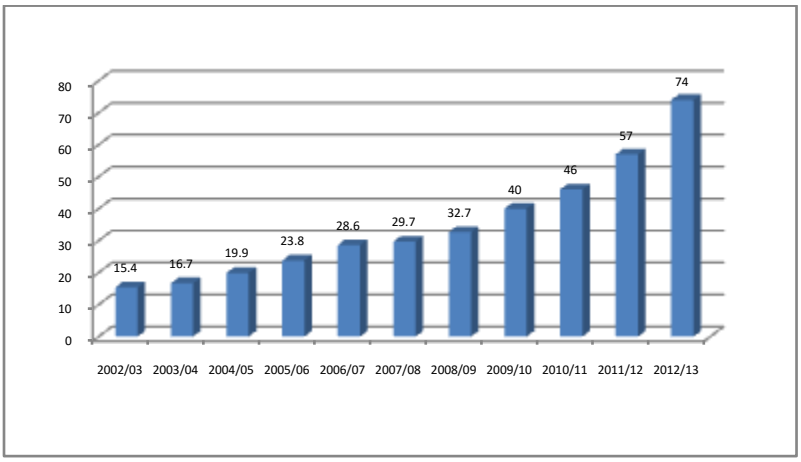
Background

Availability and comprehensiveness of health services offered at a health facility is critical in realizing universal health coverage (WHO, 2010). This depends partially on the number and quality of health workers at facilities and the appropriate health infrastructure as well as a system of financing the services. Similarly, a healthy population plays a critical role in boosting economic growth, poverty reduction and realization of social, economic and political goals (GoK, 2007; Sohnen *et al.*, 2015). Key areas of focus for Kenya's health sector, as laid out in the Kenya Vision 2030 document, are access, quality, capacity and institutional development. Achieving these healthcare goals depends greatly on the financing mechanisms, having the necessary human resources for health and infrastructure to deliver the healthcare services.

Health Care Financing System

Government's commitment towards the financing of the health sector is exhibited through increased allocations to the health sector in absolute terms. This is illustrated in figure 1.

Figure 1: Health Sector Resource Allocation (Ksh. Billions)



Notwithstanding the allocations which continue to show an upward trend in absolute terms, the Ministry reports reveal existence of high out of pocket spending which continuous to be a challenge to access. Also, the financing is skewed towards one partner mainly US government and that a great proportion of the financing estimated at 65% is off – budget in 2012/13 financial year. This raises issues of long term sustainability if history is anything to inform the future. Other reports also show that financial access to health care services is still a serious problem in Kenya. For instance in P4H report of 2014, it was noted that, while average total health expenditure (THE) per Kenyan was estimated at USD 42.2 in 2009/10 considered sufficient to buy a basic package of essential health services, there is strong variation (P4H, 2014). During this period, out-of-pocket spending was 25% of THE, an indication that many Kenyans may not rely on equitable pre-paid financing mechanisms (MOH, 2010; P4H, 2014).

Similarly, about 15% of Kenyans spent more than 40% of non-food expenditure on health care. This P4H avers if not carefully addressed could lead to catastrophic health spending and in the process impoverish the already impoverished households. If transportation costs, accommodation and food for those who accompany the patient are considered the percentage could be much higher. Considering that health is not only a consumer good but also an investment, households have devised various coping mechanisms which in the process impact on them negatively. These include mortgaging their limited assets such as land, household items or seek alternative health care or simply opt to stay at home.

The share of government spending in the government budget depicts general under-financing of publicly provided for services, even though for some services especially for non-communicable diseases, the gap is bridged by donors (Bultman, 2014; P4H, 2014). This according to P4H is related to the co-existence of several different coverage schemes with the

main ones being the GOK free-care initiatives at primary health care facilities and free maternal care at higher levels, GOK subsidized access for other care at referral levels, the NHIF, as well as Private Health Insurance (PHI). Devolution according to P4H adds to the complexity, as counties are now expected to finance health service provision for both primary and secondary care services from their block grant allocation.

The gloom situation is further made worse with the existence of fragmented financing of the health system which creates obstacles for an integrated service provision (P4H, 2014). Fragmented financing mechanisms are likely to create incentives working against this principle. Ordinarily, patients have an incentive to seek care where they are covered against the costs of treatment. Where hospital treatment is covered, patients may bypass primary facilities where adequate treatment can be provided at the lowest possible costs (P4H, 2014). Whereas some areas in need may fall between the gaps of different funders (especially if the areas are poor and providers are motivated by profits), some may be oversupplied with care, especially high-cost technologies. This does not only reduce available funding for investments into disadvantaged areas, but also increases recurrent costs. This is especially the case for diagnostic devices, where providers can induce demand while quality of care may suffer notwithstanding the expected disparities in terms of access (P4H, 2014).

Health Personnel

The country's health sector still faces significant human resource shortages, in spite of the investments the government has made over the years since independent and following the devolution of health services (MoH, 2015). The situation is attributed to the increase in population growth rate which has continued to put pressure on demand for health care augmented by the freeze in recruitment of health personnel over time. The Ministry of Health notes that human resource investments need to be designed to address the availability of appropriate and equitably distributed health workers, attraction and retention of required health workers, improving of institutional and health worker performance, and finally training capacity building and development of the health workforce (MoH, 2015).

Based on the Ministry's staffing norms and standards, Kenya's forecasted occupational composition shows that specialists (physicians) with the most training (of nine years) are the smallest number followed by medical officers (general practitioners with six years of training), clinical officers (with 4 years of training), registered nurses and other occupations (with three years of training). The largest are the least expensive and least trained personnel - community health workers (Sohnen *et al.*, 2015). Sohnen *et al.*, (2015) however, posits that less than 2,500 community health workers are currently deployed compared to an estimated 120,000 trained

based on the projected number. Sohnen *et al* avers that there is little consensus about the role of community health workers, despite their high benefit/cost ratio, the budgetary resources for providing them with stipends.

Notwithstanding this, reports show that more than 5,000 Kenyan trained doctors have emigrated for reasons attributable to poor pay and 3,000 more have left health to join others sectors, leaving 3,440 doctors for the nearly 46 million Kenyans who undoubtedly depend on national and county hospitals (Kenya Health Labor Market Assessment Report of 2015). According to Kenya Medical Practitioners, Pharmacists and Dentists Union (KMPP&DU), the report did not however capture the fact that majority of these doctors had either emigrated or left the health sector after 2013, following the devolution of health services to the county government. Many have cited negative effects of devolution including lack of schemes of service at county level that continued to negatively impact on human resources' practices such as recruitment and retention, promotion, delayed salaries, lack of harmonization of salaries, lack of opportunities for continuous medical education, among others. Measured against the World Health Organization's staffing norms and standards, Kenya has a shortage of 83,000 doctors.

Most acute gaps based on numbers required, and proportional gaps are for general clinical officers, public health officers, public health technicians, enrolled nurses, pharmaceutical technologists and patient attendants (Kenya Health Labor Market Assessment Report, 2015)**.** Doctors according to KMPP&DU are poorly paid and the end result is that most doctors only work for the government to fulfill their internship requirements, while mark timing for greener pastures in other parts of the world such as Australia, USA, United Kingdom or South Africa. This is partially attributed to availability of opportunities for continuous medical education for career growth and advancement in skills, and appropriate infrastructure (medical equipment). Other challenges cited include dysfunctionality of human resource management at the devolved level with cases of low morale, disjointed promotions, salary differentials amongst workers in the same job group across counties, among others.

On the positive side however, some of these challenges are currently being addressed through the proposed staffing norms, private public initiatives such as "Beyond Zero" tolerance, managed equipment scheme, construction of teaching referral hospitals in most of the counties. Also, hard to reach counties are committed towards investing in human resources for health while at the same time attract and retain them in services and have initiated various incentives to attract and retain health workers such as performance best financing, risk allowance, provision of air ticket and bonuses, among others. Planning and development of human resources for health must be immediate action by the Ministry beyond the political poetry of equipping county hospitals that doctors seem to have long deserted.

In both the Ministry's published norms guidelines, and in its actual practice, the tendency has been to allocate more budget for the middle categories requiring three years of training, exemplified by registered (diploma-level) nurses, and significantly fewer jobs for less costly occupational categories such as enrolled (certificate-level) nurses (two years of training), and nursing assistants and patient attendants (one year of training). This trend resonates with global trend towards professionalization of nursing, including higher levels of training and education. Also, while some healthcare professionals flow out to join teaching and/or research, others upgrade to special consultants and/or venture into administration, business, teaching, or Information and Communications Technology (ICT). Although the occupational structure of each facility will depend on the actual capacities of the clinical staff and the needs of the patient population served, at the aggregate national level, one would expect a country with a shortage of training capacity and an excess supply of less-educated workforce to have a health workforce that exhibits a pyramid structure (Sohnen *et al.*, 2015).

Currently, a number of health facilities have acquired specialized machines and equipment through the National government's Managed Equipment Scheme with through in-depth interview with key stakeholders in the facilities, it was pointed out that a number are however lying idle and gathering dust, despite costing the county government millions of every month in lease fee. This was attributed to lack of necessary personnel to operate the machines and equipment as well as lack of proper infrastructure for their installation. Like most countries in Africa, the shortage of healthcare workers is not unique to Kenya. Indeed, Kenya is one of the countries identified by the WHO as having a "critical shortage" of healthcare workers. The WHO has set a minimum threshold of 23 doctors, nurses and midwives per population of 10, 000 as necessary for the delivery of essential child and maternal health services. Kenya's most recent ratio stands at 13 per 10 000. This shortage is markedly worse in the rural areas where, as noted in a recent study by Transparency International, under-staffing levels of between 50 and 80 percent were documented at provincial and rural health facilities (Transparency Intrnational, 2015).

Health Infrastructure

To realize universal coverage, a strong, efficient, well-run health system is necessary (WHO, 2010). This in turn requires a robust health infrastructure in terms physical infrastructure, medical equipment, communication and ICT, Transportation. Kenya's health care provision and implementation infrastructure include the national teaching hospital, provincial hospitals, district and sub-district hospitals, health centers, and dispensaries, as well as a host of other operators within the private, non-governmental, and traditional/informal sectors. The system is a

hierarchical-pyramidal organization comprising five levels, the lowest being the village dispensary with Kenyatta National Hospital (KNH) at the apex. The health sector requires establishment of an effective organization and management system to deliver on the KEPH. Based on current populations, Table 2 provides the required units at each level.

Table 2: Organization and management system to deliver on the KEPH

- The sector is targeting to have a community unit for every 5,000 persons, giving an overall target of having 8,000 functional Community Units
- At the primary care level, there are 7,568 units that qualify to function as such primary care units – 2,526 dispensaries, 3,929 private clinics, 935 health centres, and 178 maternity homes.
- For the County level, there are 489 hospitals, representing public and non public level hospitals at district / sub district levels
- Finally, the National referral hospitals are 12 – Kenyatta National Hospital, Moi Teaching and Referral Hospital, Spinal Injury hospital, Pumwani hospital, Mathari hospital, plus the 7 Provincial General Hospitals
- Sub County management units are 360, while Counties are 47 in total. National Management Units are 5, and include Ministry of Health Headquarters, Kenya Medical Research Institute, Pharmacy and Poisons Board, National Quality Control Laboratories, National Public Health Laboratories, Government Chemist, National Blood Transfusion Services, and Radiation Protection Board.

There are concerns however that many primary care facilities are not offering comprehensive package of primary care services and that facility investments is not matched with other investments (HRH, commodities, etc), leading affecting functionality after completion of investments (GoK, 2015). Similarly, there is limited investment in maintenance of physical infrastructure although investments in medical equipment are ongoing in selected hospitals. Of concern however, is lack of comprehensive, coordinated investment leading to gaps in some facilities and limited investment in maintenance of medical equipment. Reports show that purchase of ambulances is ongoing, at hospitals, and model health centres though there still exist significant gaps in utility vehicle availability (some ambulances also used as utility vehicles as a result) (GoK, 2015). The ministry is however, undertaking some measures to enhance transport possibilities in the sector such as outsourcing of certain activities to the private sector,

like courier companies to collect/deliver stocks/specimens, car hire for referral in rural areas with appropriate reimbursement and ambulances for bigger hospitals.

Availability and functionality of diagnostic and medical equipment is critical in treatment however, most of medical equipment used in public health facilities is more than 20 years old (some double their lifespan) and characterized by frequent breakdowns. Furthermore, most public facilities do not have modern equipment such as dialysis machines, radiology equipment, laundry machines and theatre equipment. The available equipment falls far short of the required numbers, of those available, about 50% of the equipment is too old to pass required standards and that maintenance of equipment has been inadequate (MoH, 2015).

Distribution of health infrastructure remains skewed with some areas of the county facing significant gaps, while others have optimum/surplus numbers (MoH, 2015). With establishment of Counties, the National level prioritize establishment of a minimum number of health facilities, based on the expected services as defined in the KEPH. According to the most recent health management information system (HMIS) data, there are over 5,000 health facilities across the country operated by three owner systems, with the government running 41% of the facilities, non-governmental organizations (NGOs) 15%, and private businesses 43%. The government owns most of the hospitals, health centers, and dispensaries, while clinics and nursing homes are entirely in the hands of the private sector. Health facilities are unevenly distributed across the country. For instance, the best-off Central Kenya has about twice the number of facilities per population as the worst-off provinces (Nyanza and Western). Central, Coast, and Eastern regions have better ratios than the national average. On the other hand, Nyanza has a higher number of hospital beds and cots per 100,000 population than Central. Northeastern and Eastern regions have the worst ratios of hospital beds and cots per 100,000 population, while Coast has the best (144, 145 and 274, respectively). Because of their relatively small geographical sizes, Nairobi followed by Central has the minimal distance to a health facility. (Wamai, 2004; MoH, 2010; MoH, 2015).

The available infrastructure has however continued to impact negatively on the care as well as the ability to retain some key health personnel especially, specialized health workers in the public service. Cases where for instance specialized doctors complained of underutilization of their skills have been experienced with many opting to join private practice or resigning to pursue further studies. If the situation is not addressed, in the end, patients are likely to be left with no option but to either seek services of less qualified health personnel or providers or alternative health care services whose quality may not be guaranteed. Worse, others may seek services from private facilities which may be relatively expensive thereby negating the expected gains of financial risk protection currently being pursued under the enhanced National Hospital

Insurance Scheme (NHIF). Similarly, cases of significant gaps in essential specialized care capacity exists forcing individuals to seek these services abroad again impacting the pursuit of financial protection. Whereas the "*Beyond Zero*" tolerance initiative are lauded, human capacity remain a concern notwithstanding lack of policy direction for the sustainability.

CONCLUSION

Availability and comprehensiveness of health services offered at a health facility is critical in realizing UHC. This partially depends on the availability of a strong, efficient, well-run health system as well as a sufficient capacity of well-trained, motivated health workers and the financing system. Similarly, a healthy population plays a critical role in boosting economic growth, poverty reduction and realization of social, economic and political goals (GoK, 2007; Sohnen *et al.*, 2015). The Kenya government has over the years with support from key stakeholders' initiated various policies and strategies aimed at realizing these. These are laid out in the Vision 2030, Constitution, Proposed Health Bill of 2015, NHSSP III, among other documents. In a nutshell, there is considerable government commitment and political good will towards provision of quality and affordable health care while ensuring geographical access. The efficiency of the health system compounded by the capacity of well-trained, motivated health personnel negates the government's desires. There are significant gaps in health infrastructure particularly with regard to specialized medical equipment, maintenance of the equipment and the personnel to operate the equipment. Similarly a number of the facilities in the country have dilapidated infrastructure with disjointed investment which raises sustainability. Further, there seem to be significant gaps in a number of key health personnel with a number opting to joining private practice or changing career altogether.

There are also concerns that many primary care facilities not offering comprehensive package of primary care services and that facility investments is not matched with other investments (HRH, commodities, etc), thereby affecting functionality after completion of investments (MoH, 2015). Similarly, there is limited investment in maintenance of physical infrastructure although investments in medical equipment are ongoing in selected hospitals. Of concern however, is lack of comprehensive, coordinated investment leading to gaps in some facilities and limited investment in maintenance of medical equipment. Thus, despite the positive gains in terms of health indicators, Kenya's progress towards universal coverage exhibit matters of concern like other developing countries. It appears that the display of leadership by both national and county leadership can be a sword with two edges. For instance, the country's political leadership announced user fee removal policies for the public health sector out of the blue, without giving technocrats sufficient time to initiate necessary policies and strategies to

implement the provisions. This has been compounded by lack of policy guidelines to address health infrastructure and deployment of staff at the two levels of government.

Whereas devolution is expected to bring on board various positive gains as demonstrated in the improved health indicators, it is important that there is constructive engagement between the national government and county government and other key stakeholders on how to effectively deliver health care to the Kenyan populace through necessary concerted efforts in the financing of health care system, investing in both health infrastructure and personnel. Key issues that merit attention will fast tracking the implementation of health financing system that assures social solidarity; fast tracking the enactment of Health Act, development of health investment policy whereby proposals for investment in infrastructure should be geared towards addressing and achieving equitable geographical access to health care; the finalization and implementation of schemes of service across counties. Other recommendations include policy guidelines and procedures to support public private partnership initiatives such as the beyond Zero" campaign for purposes of equity; continuous investment in human resources guided by policy guidelines.

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