MANI Evidence Brief

Case Study

June 2018

Autonomy in the Bungoma County Health System: **Effects on Health System Performance**

Introduction

In 2013, Kenya transitioned into a devolved system of government. The resultant shocks to the health system have had mixed effects on health system performance overall. One of the challenges has been a perceived trend toward reduced autonomy among health facilities and other entities within the county health system. Reduced autonomy, in this context, means a fall in decision making authority by health facilities and management over the use of financial and other resources as well as the accountability that comes with it. This can have a negative effect on health system performance by weakening the link between local priorities and resource allocation; disempowering managers; and demotivating staff.[1]

This brief examines the current levels of autonomy in the Bungoma County health system and explores how this contributes to or diminishes the efficient and effective functioning of health facilities and county health management. It also assesses the effect of autonomy on overall health system performance and provides recommendations on how gaps can be met.

Approach

A phased approach was taken commencing with an inception phase in March 2018, followed by a main study phase from April to May 2018. During the inception, a conceptual framework was developed, drawing on existing frameworks, to guide the exploratory operational research study.[2–4] Autonomy is described as consisting of dimensions four of which were used to

frame the collection and analysis of the data: institutions, finance, human resources and political economy (see Figure 1 below).

Methodology

This brief presents the results of a qualitative exploratory case study with Bungoma County health system as the case and the county health management team, sub-county health management team and health facilities as the units of analysis.

Data were collected through semi structured interviews with key informants, and document reviews. Individual respondents from Bungoma County were purposively sampled based on their level of knowledge of county health systems and of the autonomy considerations under review. Additional respondents were identified through snow balling until saturation was reached.

Figure 1: Conceptual framework showing four dimensions of autonomy

Institutions	The organisational structures that are best placed to provide strategic management and administration of the county health system
Finance	The decision space around public financial management, including budget planning and implementation, management of revenues and expenditure, and accountability arrangements
Human Resources	The decision space around hiring, firing, distribution and overall management of health workers
Political Economy	The influence of key actors and stakeholders on the functioning of the county health system

We interviewed 3 front line staff, 2 health facility heads, 3 managers from sub-county level, 3 managers from county level, and 2 senior county officials. Additional data were collected through semi-structured interviews with key informants (n=6) from Kakamega, Makueni, Kilifi, and Kiambu to provide contextual information of autonomy arrangements at county level. To ensure validity, the primary data were triangulated with secondary data, such as peer reviewed and grey literature and conversations with experts.

Findings

What we learned from the literature

A review of the literature around hospital autonomy and governance was performed highlighting that:[5–11]

- Definitions of autonomy are context specific and questions regarding autonomy are nested within the wider agenda of health system governance;
- Governance reforms that are targeted at addressing the autonomy of parts of the health systems (e.g. health facilities) need to account for the wider health system to achieve desired results; and
- Autonomy is not a panacea for poorly performing health system.

Autonomy in the Kenyan Health System before 2013

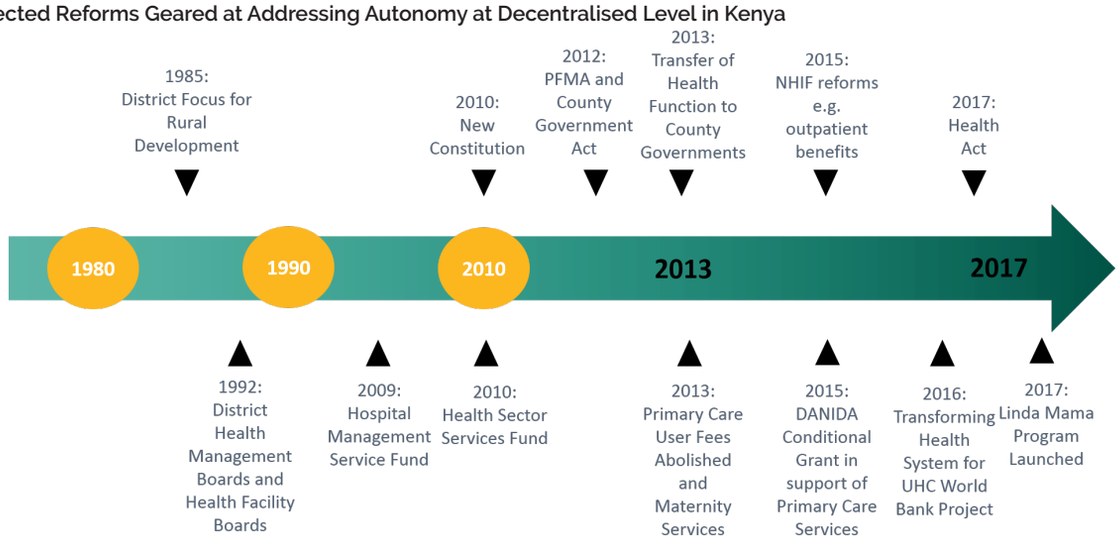
Kenya has a rich history of health system reforms targeting autonomy at decentralized level dating back to independence (Figure 2).[6,7,11] Prior to devolution, these reforms, centred around the region, province or district, and saw significant financial and operational autonomy of subnational health systems and health facilities. The District Health Management Teams (DHMT) and Health Centre Management Teams (HMT) were a key anchor of these reforms. However, evaluations of the functioning of DHMT suggested shortcomings linked, in part, to limited autonomy over staff performance management and resource use. As a result, Legal Notice No. 162 of the Public Health Act, established District Health Management Boards (DHMB), Hospital Management Boards (HMB) and Health Centre Management Committees (HCMC) in 1992 whose role was to support that of the existing DHMT.

Additional reforms resulted in financial autonomy of hospitals and primary health care facilities. The Hospital Management Services Fund (HMSF) started in 2009 and drew funds from cost-sharing, donations and government budgets. It was used to fund service delivery at hospitals including "to give more powers to hospitals and medical facilities to plan and manage the resources under them".[12] The 2010s saw additional approaches to health facility reform including financial autonomy such as the Health Sector Services Fund (HSSF) which targeted primary health care facilities. HSSF, which was then funded by the World Bank and DANIDA, has been credited with increasing quality of care, patient satisfaction, staff motivation and community involvement in running facilities even in the face of difficult financial reporting arrangements and delays in receiving funds. See Figure 2 below.

Autonomy in the Kenyan Health System Since 2013

Kenya's transition to decentralised arrangements was abrupt and did not follow the transitional arrangements planned for in the Constitution. These arrangements included ensuring the capacity of county governments to undertake assigned functions such as health. There is evidence to suggest that the health system was poorly prepared for the transition to decentralisation.[13,14] County governments are free to manage county health systems as they wish within the broad confines of national health policy. Key national level documents such as the Health Act were only enacted recently (2017), while those that were present in 2013 (e.g. the Kenya Health Policy) were contested owing in part to the lack of county government involvement in their development. The Kenya Health Policy [15] recognises that decentralised systems will need to meet the objective of operational autonomy and suggests that county governments may establish semi-autonomous entities as per their need. No further guidance is provided, and the Health Act [16] does not address this issue. Public finance legislation is also not prescriptive

Figure 2: Selected Reforms Geared at Addressing Autonomy at Decentralised Level in Kenya



on the issue of autonomy (see Table 1). This absence of policy and statutory guidance may have impacted county health system arrangements, with early, though limited, empirical evidence indicating loss of autonomy at sub-county and facility level.[1,13,14,17,18] See Table 1 below.

Main Study Findings

INSTITUTIONAL AUTONOMY

We examined whether the organisational structure of Bungoma County health system optimises strategic management and administration. This is because institutional autonomy, including decentralizing decision making and other management responsibilities, can impact health system performance. Our findings were as follows:

1. **Clear delineation of roles and responsibilities is important in ensuring the mandate the County Department of Health (CDOH) is well understood and met.** Even though the county government has retained and adapted most pre-decentralisation organisational structures, there is evidence that there is a lack of role clarity in Bungoma County. This mainly affects the relationship between the county health management team (CHMT), sub-county health management team (SCHMT) and facility managers. The CHMT has taken up roles that should be performed by SCHMT and facility managers which has eroded their institutional, administrative and strategic management autonomy.

"SCHMT has delegated duties but no power. They have lost what they had as DHMT."
Bungoma Respondent

Lack of clarity in the presence of multiple reporting lines are also a concern for example for accountants who report to both the department of finance and department of health. Health system managers report that this leads to parallel information flows and negatively impacts trust and team work.

2. **The lack of institutional autonomy also impacts governance and accountability arrangements in the Bungoma County health system.** Respondents and evidence from literature highlight that entities such as the SCHMT play a critical role in ensuring accountability in financial and service delivery areas.19,20 The loss of autonomy, and concentration of functions with the CHMT results in reduced levels of oversight. Respondents noted that current levels of supportive supervision, for example, are inadequate to guarantee good governance and accountability in the health system. This means that the health system is less likely to guarantee service delivery and quality.

"Devolution promised to lead to decentralisation. But we still feel very far away from the county government. Most of the planning and policies do not involve us."
Bungoma Respondent

Table 1: Constitutional and Statutory Provisions in Support of Delegation of Autonomy
Source: National Council for Law Reporting in Kenya (Kenya Law) http://www.kenyalaw.org/lex//index.xql

Act	Provision
Constitution of Kenya 2010[19]	**Article 176(2)** Every county government shall decentralise its functions and the provision of its services to the extent that it is efficient and practicable to do so
County Governments Act 2012[20]	**S116(2)** A county shall deliver services while observing the principles of equity, efficiency, accessibility, non-discrimination, transparency, accountability, sharing of data and information and subsidiarity
	S6(2)(c) Without prejudice to the generality of subsection (1), a county government may delegate any of its functions of its officers, decentralised units or other entities within the county
	S31(c) The governor may appoint an accounting officer for each department, entity or decentralised unit of the county government
Public Finance Management Act 2012[21]	**S148(1)** A County Executive Committee member for finance shall, except as otherwise provided by law, in writing designate accounting officers to be responsible for managing the finances of the county government entities as is specified in the designation
The Public Finance Management (County Government) Regulations 2015[21]	**S23(1)** The Accounting Officer of a county government entity may delegate to a public officer, in writing, any of the Accounting Officer's powers or functions under the Act or these Regulations
	S23(3) The delegation in this regulation may include the authority to incur expenditure in accordance with any limits prescribed by the Accounting Officer
	S24(1) An accounting officer may authorize a public officer under their county government entity to be an Authority to Incur Expenses (AIE) Holder

Text Box 1: Institutional autonomy and role clarity are key for good health system performance

The importance of institutional autonomy and role clarity for the SCHMT and facility managers was highlighted in two counties: Makueni and Kakamega. In both, respondents provided examples of managers using their institutional autonomy to address issues efficiently and in a manner that reflected local priorities. For example, in Kakamega County, respondents noted the flexibility they enjoyed with determining development priorities, staffing mix and needs. A draft report from 2017 on MakueniCare, Makueni County's UHC programme, notes: "Cases of low workload in a facility are easily flagged and supervisory team from the DHS (Department of Health Services) visits to establish the cause and respond to it such as lack of certain services, low staffing, and poor staff attitudes etc."

3. **Loss of decision making responsibility affects planning and budgeting.** Sub-county and facility managers are disengaged from the planning and budgeting process. They view the annual work plan (AWP) process as a wasted exercise given that they receive little guidance on the process including information on budget ceilings. The process is seen as top-down with lower level managers contributing little to the process even though they retain institutional memory on planning and budgeting which could improve the process.

"The annual work planning process is just a formality; only the top managers are involved."

Bungoma Respondent

4. **Managerial independence is key to the motivation of health system managers at sub-county and facility level.** Respondents at sub-county and facility level say that the loss of autonomy leaves them feeling disengaged, disempowered and demotivated.

"We do not have a voice. We try to bring good ideas but no one is listening. People are demotivated."

Bungoma Respondent

They are of the view that any existing bottlenecks are possibly the result of challenges with delegation, communication or power relationships. A number of respondents have communicated their concerns to senior county officials in formal and informal settings but without resolution of the problem. Respondents at all levels agree that health system managers at sub-county and facility level have the capacity to undertake more tasks than were currently assigned to them. They note that even where roles were assigned, financing gaps meant activities are not optimally performed.

FINANCIAL AUTONOMY

We examined the distribution of functions and responsibility for public financial management within the county health system. Our findings were:

1. **Contrary to interpretations by some Bungoma county officials, the provisions of the Public Finance Management Act (PFMA) and related regulations do not restrict delegation of financial autonomy.** While the S116 of the PFMA establishes the County Revenue Fund into which all money that is raised or received by or on behalf of the county government will be paid, other funds can be established with the approval of the county executive committee and the county assembly. Other relevant legislative provisions are presented in Table 1.

2. **The lack of financial autonomy in Bungoma County includes the centralisation of the power to authorise expenditure at the Chief Officer – Health (COH) level.** This process leads to delays which impacts service delivery and quality. It also demotivates facility and sub-county level managers who have lost independence and self-efficacy and erodes existing capacity in financial management. This centralisation also contrasts greatly with pre-decentralisation arrangements as summarised in Table 2 below.

   A related concern is the shrinkage in the financial resource envelope over which facilities have autonomy. Pre-2013, facilities enjoyed a resource envelope that included money and in-kind resources (commodities). Facilities were free to utilise these resources in keeping with the broad conditions of the allocations: for example, DANIDA was restricted to operations and maintenance. The current sources of facility revenue in Bungoma are inadequate for the proper functioning of the health facilities (Table 3 below). Available resources are also subject to further reductions as a result of waivers which were increasingly subject to political influence.

3. **Respondents report inadequate knowledge of the size and disbursement schedule of funds that were available to them**. The absence of budget ceilings for facilities and other CDOH entities means that annual work plans (AWPs) are more wish lists than focussed documents that can assist financial management. Respondents cite experiences of funds being channelled to them but without information on the sources of these funds; which conditions apply to them; or when they might next receive funds. These experiences erode managers' motivation to participate in the planning process and weaken the overall CDOH planning process.

4. **SCHMTs are severely affected by the absence of funding.** This is because they receive no budgetary allocation, while key donor sources such as DANIDA have ceased allocating money to supportive supervision activities in the belief that this role will

Table 2: Comparison of Pre-decentralisation Financial Autonomy Arrangements with Current Arrangements in Bungoma County

Domain	Pre-decentralisation	Current situation
Authorisation to Incur Expenditure (AIE)	AIE delegated to facility and district level	AIE centralised with Chief Officer Health and County Director of Health
Approval of spending plans	Delegated to Provincial and District level	Centralised with the Chief Officer Health and County Accountant
Resource envelope over which facilites have autonomy	Primary care facilities: User fees, Health Sector Services Fund (HSSF) and Budgetary allocation from MOH Hospitals: User fees (Facility Improvement Fund), budgetary allocation from MOH	Primary care facilities: DANIDA, Transforming Health Systems for UHC Project and Linda Mama, Conditional grant for compensation for user fees foregone, Hospitals: User fees (Facility Improvement Fund), National Hospital Insurance Fund (NHIF) reimbursements and Linda Mama
Supply of commodities	Facilities assigned drawing rights from the KEMSA Emergency commodity and non-pharmaceutical procurements from facility funds	Centralised procurement of commodities without drawing rights Emergency commodity procurements from facility funds

Table 3: Description of funding sources available to health facilities in Bungoma County

Fund source	Description
DANIDA	On-budget funding provided by the Danish International Development Agency as a conditional grant to county governments in support of activities of primary health care facilities (dispensaries and health centres). Conditions include that funds be transmitted to these faciltiies for use for operations and maintenance
Transforming Health Systems for UHC Project	On-budget funding provided by the World Bank as a conditional grant aimed at improving the use and quality of maternal and child health service through primary health care. No conditions on allocation of funds to facilities but encouraged to do so through other conditions used e.g. need for progressive increase in health budget and submission of annual work plans.
National Hospital Insurance Fund	Payments provided directly to facilities for services offered under a number of schemes: • **National Scheme**: main scheme offering benefits to formal sector (compulsory members) and informal sector (voluntary members) • **Linda Mama:** managed scheme offering services to mothers and infants in the perinatal period • **Enhanced schemes** e.g. the Civil Servants and Disciplined Forces Medical Scheme: managed schemes offering services to beneficiaries who are drawn from organisations e.g. the national or county civil service. • **Sponsored schemes** e.g. the Health Insurance Subsidy Programme for the Poor offering services to beneficiaries receiving premium subsidies e.g. orphans and vulnerable children No condition that facilities must receive funds paid to them.
Conditional Allocation to Compensate Forgone User Fees	Reimbursement to primary care facilities for forgone user fees at primary care level based on estimates of workload made by the national Ministry of Health. No condition that health facilites should receive funds allocated to them.
User fees	User fees charged to patients at point of service. Currently prohibited at primary health care level. Rates determined at county level.

be taken up by county governments. This affects not only supportive supervision, but also key health system functions such as monitoring (inspection of facilities), disease surveillance and response, data collection and management, and functioning of the community health system. One CHMT member suggested the need for a health care financing bill to enable devolution of decisions to the SCHMT.

"Decisions made by the sub-county are not currently supported by law."
Bungoma Respondent

Text Box 2: County health systems require adequate and predictable financing from county budgets and autonomy to use these funds: evidence from Kakamega and Makueni

Financing from county budgets boosts existing resources and are more predictable than Appropriations in Aid. In Kakamega and Makueni counties, facilities receive funding from county funds.

In Kakamega, all health facilities receive an allocation from the county in addition to other funding sources e.g. dispensaries receive about KES 30,000 and health centres about KES 110,000 per month. Under MakueniCare, Makueni County hospitals receive a reimbursement from the county government for services offered in addition to other funding sources available to them.

Respondents from both counties noted that they enjoyed autonomy over the use of their funds. They reported that the additional allocation of funds gave them greater ability to attend to facility needs including dealing with creditors. Also, the county allocation was fungible meaning that it could accommodate a wider range of expenditures than those allowed by the conditional grants.

Kakamega County also funded SCHMTs through a budgetary allocation which ensured that their role in supportive supervision was used to ensure sound financial management; good planning and budgeting; quality of services and monitoring of overall sub-county health system performance.

5. **Loss of autonomy over commodity procurement may contribute to commodity shortages and negatively affect ability to generate revenues.** The loss of drawing rights from the Kenya Medical Supplies Authority (KEMSA) means that facilities are unable to manage their commodities appropriately. Respondents note severe constraints in procurement of commodities in 2017 and preceding years, though supplies have improved more recently following the signing of the memorandum of understanding with KEMSA. The shortages also lead to unplanned expenditure. For example, hospitals are bound to provide drugs for all NHIF patients even when these were missing from their facilities . In the absence of supportive supervision, it is likely that there are gaps in forecasting and supply planning at primary care level.
6. **The combined effects of loss of financial autonomy and reduced resource envelope contributes to greater financial instability of health facilities.** In addition to this, outstanding facility debts remained unsettled after monies in facility accounts were channelled to the County Revenue Fund at the onset of decentralisation, but were not used to settle pending bills. The pending bills may have contributed to the loss of trusted suppliers as well as the inflation of subsequent prices in order to hedge against long repayment periods.
7. **The loss of financial autonomy demotivates sub-county and facility managers and frontline staff.** Facility managers are demotivated as a result of loss of independence and self-efficacy. They cite delays in receiving AIE as affecting service delivery, including making it difficult for them to deal with emergency events. They note they can no longer motivate frontline staff through providing support for work breaks, transport allowances or awards for good performance. They are angered that they are regarded as lacking integrity.

"Why do you suddenly believe nurses are thieves? Doctors are thieves?"
Bungoma Respondent

8. **Defunding of SCHMTs affects financial accountability arrangements.** This is because, without adequate funding, SCHMT cannot scrutinise key performance areas such as financial management of both revenues and expenditures; community participation in facility management; and efficiency in resource use. SCHMTs do not perform supportive supervision, ad-hoc visits, mentorship or on the job training (OJT) as desired. This had led to a great reliance on partners to support such activities which respondents viewed as not sustainable and occasionally not in line with the strategic goals of the county.

"If partners weren't here, we'd have no training."
Bungoma Respondent

HUMAN RESOURCES

We examined the distribution of decision making around hiring, firing, distribution and overall management of health workers. Our findings were as follows:

1. **The lack of clarity of roles between the CHMT and SCHMT; the lack of funding for supportive supervision; and the loss of the SCHMT's autonomy**

as a whole interferes with the effective functioning of human resource management. Respondents laud the development and launch of the Bungoma County Health Staff Deployment and Transfer Policy Guidelines 2018,but are concerned that the implementation process for these guidelines is slow. The consequences of ineffective human resource management reported include reductions in service delivery capability where staffing needs or mix were not well assessed; reductions in service quality where underperformance went unchecked; and low staff motivation where mentorship and supportive supervision were absent.

"Decisions by-pass the sub-county… let them recognise the sub-county."
Bungoma Respondent

Text Box 3: Managing human resources at facility and sub-county level

The key role of SCHMT and facility managers in human resource management were highlighted in evidence from the other counties and from literature e.g. Nyikuri et al 2015.20 SCHMT and facility mangers motivate staff through supportive supervision, ad-hoc visits, on the job training, mentorship and companionship. They also gauged staff performance and were an important first step in the disciplinary process where this was needed.

Their role is also key in ensuring the proper functioning of the community health system through their supervision and interaction with community health volunteers. This latter role is critical in supporting successful functioning of county goals e.g. registration of persons for health insurance.

POLITICAL ECONOMY

We examined the influence of key actors and stakeholders on the functioning of the county health system with a particular focus on autonomy. Our findings were as follows:

1. **Respondents from Bungoma County highlighted the importance of political will and good leadership in determining the level of autonomy enjoyed within the county health system.** While changes in key offices had occurred following the 2017 elections, respondents pointed out tensions among key office bearers at the CDOH as contributing to the challenges with autonomy experienced in the period from 2013 – 2017. The power relationships at this level, for example, had led to contestation over the county organogram which may have contributed to the lack of clarity of roles between the CHMT and SCHMT. Also, several policies that might have assisted in improving the functioning of the county were not adopted or implemented. Frequent staff transfers undermined capacity building efforts, and resulted in maldistribution and demotivation of staff.

   Respondents were of the view that recent changes such as the enactment of the Bungoma County Health Staff Deployment and Transfer Policy Guidelines 2018 and the signing of the memorandum of understanding with KEMSA demonstrated strong political will to address the challenges within the county health system.

Text Box 4: Political Will and Leadership in Supporting Health System Performance

The case study counties highlighted the importance of considering political economy in developing and implementing county health system reforms.

- **Example of strong political support:** Makueni's and Kakamega's health systems' performance enjoyed success because of the Governor's ownership of the health system. Other actors who were important in ensuring the successful development and implementation of health system reform were members of the county assembly, the CDOH and the county treasury. The County Assembly were key in ensuring any legislation was passed. The CDOH were key in providing policy guidance on the reforms; with policies seen as critical in safeguarding the spirit of the reform even if this was not reflected in legislation. Finally, the county treasury played a facilitative role particularly in ensuring financial flows matched legislative or policy requirements.
- **Examples where political will was lost or eroded:** In Kiambu County, the loss of the CEC who initiated the envisaged health system organisational reforms meant that they were not fully implemented. In Kilifi County, a lack of sustained political support was reported as a contributor to the failure to implement the provisions of the Facility Improvement Fund Act.

Recommendations

Our assessment demonstrates a strong case for enhancing autonomy within county health systems. Bungoma County is making strides in addressing these consequences, for example through the signing of a memorandum of understanding with KEMSA to restore drug supplies. We make the following recommendations:

I. **Delegate responsibility for financial management to sub-county health teams and facility managers.** At a minimum, this should include the authority to incur expenditure, commodity drawing rights and responsibility for ensuring financial accountability. This would align public financial management practices in Bungoma County to those in the pre-decentralised setting and in counties such as Kakamega and Makueni as shown in Table 2 and Text Box 2 who are demonstrating strong performance.

II. **Provide specific, adequate and predictable budgetary allocations to health facilities and SCHMTs in order to realise the full potential of county health systems.** The allocations should be based on criteria that are easily understood, acceptable, and appropriate for Bungoma County for example workload, catchment population, extent of disease alleviated or potential for health gain. The allocation should also be used to address cash flow management problems that may results from other funding sources. The county government should also commit to the clearing of hospital debt to put them on a sound financial footing.

III. **Delineate the roles, responsibilities and reporting lines in the County Department of Health offices, office bearers and teams.** This should be expedient and draw from existing policies and strategies at county or national level. They should also account for officers seconded from other departments serving within the department. The process should seek to involve representatives of sub-county and facility management who poses institutional memory so as to tease out the "soft" issues that may be missing form policy documents.

IV. **Streamline the planning and budgeting process through clear designation of roles and responsibilities for sub-county and facility level teams.** This should include arrangements for linking work plans to budgets e.g. through the provision of budget ceilings that account for all relevant funding sources and cash flow information for those developing annual work plans. The process should also have adequate arrangements for regular communication and feedback to all involved in the process. There should be shared leadership and accountability for the process at all levels of the county health system.

V. **Implement the Bungoma County Health Staff Deployment and Transfer Policy Guidelines 2018 in full.** These guidelines provide an adequate basis for the management of human resources within the county health system with clear roles for facility and sub-county health system managers in staff management.

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