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The Strategic JOURNAL of Business & Change MANAGEMENT
ISSN: 2312-9492 www.strategicjournals.com
Vol. 5, Iss. 4, pp 33 - 43, October 2, 2018. www.strategicjournals.com, ©Strategic Journals

RESPONSIVENESS AS A GOVERNANCE FACTOR INFLUENCING PERFORMANCE OF DEVOLVED HEALTH CARE SECTOR IN KENYA

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Accepted: September 1, 2018

ABSTRACT

The general objective of the study was to determine responsiveness as a governance factor influencing the organizational performance of devolved health sector in Kenya. The study adopted survey descriptive and correlational designs. Systematic sampling was utilized to arrive at the 5 selected county referral hospitals out of the 47 counties in the country. The 5 county referral hospitals selected were; Machakos, Thika, Longisa, Kajiado and Msambweni. K'reije & Morgan. Table formula was used to calculate the sample size of 360 health workers from a target population of 6383 health workers in the five county level five hospitals. A proportionate random sampling was used to select 72 health care workers per facility. The study combined the elements of both quantitative and qualitative data collection methods. The primary data was collected using questionnaires whose content was appropriate to test the hypothesis and address the research questions being studied. Multiple regression analysis often referred to simply as regression analysis, was utilized to examine the effects of multiple independent variables (predictors) on the value of the dependent variable, or outcome. The study findings indicated that responsiveness had a positive influence on organizational performance of devolved health care sector. The findings suggested that there was need for the health care sector function to be devolved to the counties to allow for more budgetary allocations, citizen inclusivity in decision making, timely response to health care needs, government planning and interventions and management accountability and transparency. The study recommended further research on the challenges that may influence the implementation of devolved health care sector in Kenya.

Key words: *Responsiveness, Devolved Health Care Sector*

CITATION: Mutangili, C. M., Waiganjo, E., & Njeru, A. (2018). Responsiveness as a governance factor influencing performance of devolved health care sector in Kenya. *The Strategic Journal of Business & Change Management,* 5 (4), 33 – 43.

INTRODUCTION

Many countries particularly developing ones experience massive problems in their health care provision with regard to location of health facilities, A study in Burkina Faso, Banglandesh and Brazil showed that vehicle costs represented around 28 percent of the aggregate expenses of utilizing clinic administrations. As per one survey of postnatal passings in North-East Brazil, in an expected 25 percent of cases, moms detailed that postponements in transportation may have added until the very end (Baker & Liu 2006).

In China, the government's capacity to shape the sector is further undermined by the role of the Communist Party. Hospital managers are often prominent party officials, or are closely connected to those who are prominent, which affords them opportunities to shape government priorities. When the government adopts measures controlling hospitals" behaviour in response to popular angst, the managers" party affiliations help to dilute their content and implementation, (Chen, 2011).

Turin (2010) argued that Kenya, a country of approximately 41 million people has struggled to build a health system that can effectively deliver quality health services to its population. He further noted that access to health care varies widely throughout the country and is determined on numerous factors, though in particular, major divides exist between rural and urban communities, and between the moneyed elite and the poorer masses. In Kenya, the poorer masses, those living below the national poverty lineconstitute approximately 52% of the population.

In Kenya, Health services are provided through a network of over 4,700 health facilities countrywide, with the public sector system accounting for about 51 percent of these facilities. The public health sector consists of the following levels of health facilities: national referral hospitals, provincial general hospitals, district hospitals, health centres, and dispensaries. Health services are integrated as one goes down the hierarchy of health structure from the national level to the provincial and district levels (GOK, 2011).

Although there has been ranging controversy regarding the devolving of the health sector between the national government and the county governments to date, experts argue that it is necessary to devolve the sector. The highly centralized government system also led to the weak, unresponsive, inefficient, and inequitable distribution of health services in the country (Ndavi *et al.*, 2009). It is worthy to note that devolution of health care would promote efficiency and quality in the delivery of health services across the country.

Healthcare in Kenya varies tremendously, depending on location, choice of hospital and need for treatment. In April 2014, the government launched a collaborative health insurance subsidy programme (HISP) to extend financial risk protection to Kenya's poorest by providing them with a health insurance subsidy, which covers both inpatient and outpatient care in public and private health facilities. The first phase of the program covers 125,000 Kenyans in 23,500 families, selected from a poverty list developed by the Ministry of Labour and Social Protection and Services, across the country's 47 counties. The results are then validated at

community level to ensure the programme benefits the most needy (Gok, 2015d).

Statement of the Problem

In understanding responsiveness by county government on performance of health care, two issues are critical, satisfaction and quality of care. Patient satisfaction represents acomplex mixture of perceived need, expectations and experience of care (Smith, 1992). Quality of care can cover a wide spectrum. Structural quality can be definedas relating to dimensions such as continuity of care, costs, accommodation andaccessibility while process quality involves the dimensions of courtesy, information,autonomy and competence (Campen *et al.,* 1998).

Health staff unrest has been witnessed since the advent of county governance; affecting service delivery thus posing health risks to thousands of county residents and scaring away potential investors. Health care workers have pointed issues of poor remuneration, lack of facilities, local politics by board members and resistance from the locals as some of the reasons for the unrest. Both the national and county government together with the various development stakeholders have paid little attention to such a situation despite the fact that if it remains unchecked could jeopardize service delivery, (Mwatsuma,Mwamuye, &Nyamu, 2014).

The counties are now the units of service delivery and resource allocation. The shift into the new orientation requires restructuring of health governance and healthcare delivery systems to align with the Constitution. The counties are already embroiled in institutional and governance challenges such as, lack of facilities, poor remuneration of health care staff, resistance from the locals, "my people syndrome" and local politics from the board members (Wambui, 2013).

There are already challenges related to capacity gaps, lack of infrastructure and personnel, frosty relationships between the national government and the county governments. Further there is lack of understanding of devolution among citizens and proper structures to support devolution are not yet in place. In view of the foregoing unsettled health care concerns including the persistent strikes by medical staff, the current study focused on the governance factor namely responsiveness which was likely to influence the organizational performance of devolved health sector in Kenya.

Objective of the Study

The General objective of the study was to determine the influence of responsivenessas a governance factor on organizational performance of devolved health sector in Kenya.

Research Hypothesis

H_1: Responsiveness has a significant influence on organizational performance of devolved health care sector in Kenya.

Theoretical Framework of the study:

Organizational Theory

In Weber's original formulation (1978), the first modern complex organizations appeared in governments. They were more efficient because they raised taxes, fielded armies, and were thus, able to control the means of violence in a given territory. Their hierarchical, bureaucratic structure meant that orders issued by people higher up in an organization were likely to be executed by those lower in the organization. The cooperation of lower order participants was

secured by providing a salary and a career. It was this reliability and certainty that made modern states able to control more territory and help them fend off their competitors (i.e. other states or less organized groups such as the nobility or peasantry).

The second strand of thought emerged in economics, which of course, was mostly interested in organizations as firms. The firm has played a complex role in economic theory. Before neoclassical theory came to dominate economics after World War II, there were a variety of views about the firm and entrepreneurship in economics (Yonay, 1998).

Coase (1937) was one of the first economists to recognize that the existence of firms presented a problem for economics. He reasoned that if markets were the most efficient way to organize transactions, then all transactions would take place between individuals and firms would not exist. But the fact that firms existed implied that under certain conditions it was more efficient to organize a firm (or a hierarchy), than to use a market. He invented the idea of transaction costs which were simply the costs associated with engaging in transactions. His early work tried to identify some of the kinds of costs that might come into play including the uncertainty of securing a supply for the goods and services that a firm produced. This article was ignored until its rediscovery in the 1960s.

The third strand of thought in organizational theory originates with the practical concerns of managers. As soon as the large corporation emerged at the turn of the 20thcentury, the question of how best to organize it came into being. Taylor (1911) provided the most famous perspective. He viewed the main problem of managers as figuring out how to cut labor costs by reducing the discretion of workers and increasing managerial control over their labor process. He viewed this primarily as an engineering problem that involved breaking down the tasks workers were asked to perform and reducing the number of motions and actions each worker would contribute to a product.

LITERATURE REVIEW

Previous work by Vigoda (2000) identifies two approaches to understanding public administration's responsiveness. These approaches can be defined as controversial but also as complementary. They provide distinct views of responsiveness, but, in addition, each approach contains checks and balances missing in the other. According to one approach, responsiveness is, at best, a necessary evil that appears to compromise professional effectiveness and, at worst, an indication of political expediency if not outright corruption (Rourke, 1992). According to this line of research, responsiveness contradicts the value of professionalism in G&PA because it forces public servants to satisfy citizens even when such actions run counter to the required public interest. In the name of democracy, professionals are almost obliged to satisfy a vague public will. Short-term considerations and popular decisions are put forward, while other long-term issues receive little and unsatisfactory attention. In addition, there is a risk that powerful influences of some may ring out loudly and wrongly pretend to represent the opinions of many. Such influences can result in an antidemocratic decision-making pattern and simply may not represent the true voice of the majority.

The other approach to responsiveness suggests that democracy requires administrators who are responsive to the popular will, at least through legislatures and politicians if not directly to the people (Stivers, 1994). This approach is more alert to the need to encourage a flexible, sensitive, and dynamic public sector. It fact, it argues that only by creating a market-derived environment can G&PA adopt some necessary reforms that will improve their performance, effectiveness, and efficiency.

Responsiveness is a generic concept that applies to the relationship between a public service and the citizenry, and to the relationship between the state and civil society. The fundamental concern is the improvement of the quality of life in society, including within that broad concept the quality of citizen/state relations. The achievement of responsiveness in this sense is likely to re-establish the public's trust not only in the particular public services concerned but also more broadly in the state and system of governance Thomas and Palfrey (1996) argue that citizens are clients and main beneficiaries of public sector operations and thereby should be involved in every process of performance evaluation. In their study, responsiveness of the public sector to citizens demands is mentioned as an important part of performance control since it refers to the speed and accuracy with which a service provides replies to a request for action or for interactions.

Gaventa (2006) regards participatory governance as "deepening democratic engagement through the participation of citizens in the processes of (local) governance". In participatory democracy, citizens should be actively involved in matters that affect them by demanding accountability from the state ensuring government responses to service delivery and other societal needs (Weale, 1999). This justifies why citizens call on elected officials to account.

METHODOLOGY

The study adopted descriptive and correlational research designs. The study, adopted this design since it was easier to obtain information concerning the current status of the phenomenon and described what existed with respect to variables of the study. It was also possible to collect a large amount of data for detailed analysis since the study covered respondents from five level five county hospitals selected from 47 counties in Kenya. Through correlational analysis, the study was able to determine the relationships between the independent variable and how it influenced the dependent variable.

The target population included the health care workers in the five selected level five county hospitals. The cadres considered were; the medical doctors, clinical officers, nurses and other category of health workers classified as "others" who included; pharmacists/pharmaceutical technologists, Dentists, records information officers, radiologists, Physiotherapists, nutritionists, lab technicians and public health officers. These category of respondents were considered to have information on health sector now (devolved) and the previous arrangement (centralized) and provided the necessary information for the current study. The five selected hospitals included; Bomet county referral hospital (Longisa), Kwale county referral hospital (Msambweni), Machakos county referral hospital, Thika Level 5 referral hospital and Kajiado referral hospital.

The study applied both random sampling procedures to obtain the respondents for questionnaires. In particular to select the health care workers, Purposive sampling was used. The current study adopted the use of the Krejcie& Morgan (1970) table and arrived at a sample size of 360 respondents out of a total population of 6383 health workers from the five selected counties. Out of the population of 360 health workers, it was divided into 5 sub-populations of 72 per each of the selected county level five hospital.

Table 1: Sample size

	Name of county Hospital	Sample size
1.	Machakos Level Five Hospital	72
2.	Thika Level Five Hospital	72
3.	Kajiado Level Five Hospital	72
4.	Msambweni Level Five Hospital	72
5.	Longisa Level Five Hospital	72
	Total	**360**

Source: Survey Data 2017

The study combined the elements of both quantitative and qualitative data collection methods. For the current study, the researcher utilized the use of questionnaires. The study adopted a likert scale of 1-5 (1= strongly agree, 2 = agree, 3 = don't know, 4 = disagree, 5 = strongly agree).Multiple regression analysis often referred to simply as regression analysis, was utilized to examine the effects of multiple independent variables (predictors) on the value of the dependent variable, or outcome.

RESULTS AND DISCUSSIONS

Descriptive statistics results showed that on average 67.18 percent agreed that responsiveness by county government factors influenced organizational performance of devolved health care sector, 24.2 percent indicated they had disagreed and 8.53 percent did not know at all. Time taken for a patient to be treated had greatly improved to an average of 15 minutes compared to over thirty minutes spent earlier (67 percent). This was a positive impact on the performance of devolved health care sector. Communication had helped to improve the performance of devolved health care with 62 percent of the respondents confirming that. The facilities were now more responsive to the health concerns of the locals. According to vincent-Jones (1998), democratic control serves to strengthen responsiveness in local governance. This can take the form of community forums, citizen panels and citizen charters, among others.

The pearson correlation coefficient shown in table 2 indicated that there is a positive relationship between responsiveness by county governments and organizational performance of devolved health sector in Kenya as indicated by the correlation value of **0.439.** This implied that a positive change in responsiveness by county governments causes organizational

performance of devolved health sector in Kenya to change positively. A unit change in participatory engagement causes performance to change by a positive 0.439.

Table 2: Responsiveness by County Government's Correlation Analysis Results

		Organizational Performance of Devolved Health Sector	Responsiveness by County Government
Organizational Performance of Devolved Health Sector	Pearson Correlation	1	.439**
	Sig. (2-tailed)		.000
	N	351	351
Responsiveness by County Government	Pearson Correlation	.439**	1
	Sig. (2-tailed)	.000	
	N	351	351

****. Correlation is significant at the 0.01 level (2-tailed).**

Source: Survey Data 2017

In Africa the majority of deaths (60%) occur at home without any health system contact (UNICEF, 2002). It is at the level of the household that primary decisions and actions that influence the health outcomes of a community are made. It is because of this that health workers that are close to the households such as community based workers have been useful in accelerating health status improvement (Kaseje *et al*., 1989; Taylor & Taylor, 2002).

Table 3 presented the regression model on responsiveness of county governments versus organizational performance of devolved health sector in Kenya. As presented, the coefficient of determination R square was **0.193** and R was **0.439** at 0.05 significance level. These results indicated that **43.9** percent of the variation on organizational performance of devolved health sector in Kenya can be explained by responsiveness of the county governments.

Table 3: Regression model summary for Responsiveness by county government

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.439	.193	.190	2.60593

Predictors: (Constant), Responsiveness by County Government

Source: Survey Data 2017

The study further determined the Beta coefficients of responsiveness by county governments on organizational performance of devolved health sector in Kenya. Table 4 showed that responsiveness by county governments' influences organizational performance of devolved health sector positively since the coefficient of

responsiveness of county governments is 0.778 which implied that a single unit change in responsiveness by county governments causes organizational performance of devolved health sector to increase by 0.778 units. The associated significance level was 0.000 which was less than the threshold of 0.05 indicating that responsiveness by county governments is statistically significant in explaining the variations in organizational performance of devolved health sector in Kenya. The fitted model can be given by $Y = 3.776 + 0.778X_2$ (where X_2 is responsiveness by county governments).

Table 4: Regression coefficient of responsiveness by county government

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.776	.696		5.427	.000
	Responsiveness by County Government	.778	.085	.439	9.123	.000

Dependent Variable: Organizational Performance of Devolved Health Sector
Source: Survey Data 2017

Efficiency is key to performance outcomes and 65 percent of the respondents confirmed that the county level five hospitals were currently offering efficient services to patients. The interpersonal component of quality is defined as the quality of interaction between the patient and provider or the responsiveness, friendliness, and attentiveness of the health care provider (Haas-Wilson, 1994). The literature suggests that the aspects of personal interactions in quality strongly correlate with the issues of respect of persons in responsiveness.

The findings further showed that the health care services at the county level five hospitals was now more effective as most services were being performed at the facilities (69 percent). Most decisions on health care needs were now being taken at the county level five facilities (62 percent).

SUMMARY & CONCLUSIONS

The findings established that responsiveness by county governments impacted positively on the organizational performance of devolved health care sector in Kenya. This is because the county governments are required by law to be responsive to health concerns of the citizens within their jurisdiction as per the Kenya constitution (2010).

The findings revealed that most decisions on health care needs were made at the county level. However as indicated in other earlier studies, devolution does not automatically bring greater government responsiveness and accountability to the public, especially if accountability mechanisms are not put in place. At the county level the governance risks that can undermine expected performance include; elite capture, clientelism, capacity constraints, and competition over balance of power with the national government.

Further, the study showed that most of the health care service procedures were now being performed at the county level five hospitals. This also implies that the local communities may have better information on what goods and services are needed than outsiders, and are in a better position to recognize and quickly respond to inefficiency or corruption in implementation.

In being responsive, the county referral hospitals were broadly developing greater transparency and engagement within a context of representative democracy where primary decisions are made through the representative process. As Curtain (2003) notes, with such citizen participation, the role of government is a relatively passive one, simply offering a degree of access to those 'participants' who choose to become involved.

Responsiveness by county governments is attractive because it offers solutions to many problems commonly associated with centrally administered services and projects. The health care services at the county level five hospitals were now more effective and the results from the study indicated that the time taken to be treated was now shorter compared to the long hours a patient had to wait before. From the study findings, it took patients between ten and fifteen minutes to be treated.

Although devolution of health care sector has had positive significant impact, health workers in the county level five hospitals indicated that it had come along with a number of challenges in the implementation process. The preparedness was not timely and the counties were not fully prepared for the shift of health care sector being handled at the county level rather that the central government.

Recommendations

Responsiveness is about prompt attention and refers to timely service so as to avoid potential anxiety and inconvenience created by any delays in receiving attention or care. The study found out that responsiveness by county government factors which influenced performance of devolved health care sector included; management response to health concerns, communication, effective and timely services, efficient delivery, satisfaction and devolution of health care services.

The county level five facilities should be able to offer timely communication to citizens about the health services offered, costs and the treatment options available to them. Further, the health workers should encourage patients to ask questions and in turn provide them with adequate and accurate information. This can help improve on the overall satisfaction and contribute towards better long term outcomes.

The county governments to work towards the Improvement of the county level five hospital's infrastructure. For the county governments to achieve effective services there is need for the level five hospitals to be equipped with modern equipment. This would include; expansion of ward facilities and repairs on the existing buildings to ensure there is timely and efficient delivery of services.

Financial incentives are the most commonly used strategy to attract and retain health workers in rural and remote areas, and since three of the counties are in rural set up, this strategy can work. These can be direct monetary incentives such as allowances and bonuses, or indirect ones in the form of housing benefits, free transportation, paid vacations, health insurance, loans, and etc. To be effective, these benefits have to be larger than the opportunity costs associated with working in rural areas.

REFERENCES

Baker, J. B., & Liu L. (2006). "The Determinants of Primary Health Care Utilization: A Comparison of Three Rural Clinics in Southern Honduras." Geo Journal 66: 295-310.

Coase, R. H. 1937. *The nature of the firm*. In O. E. Williamson & S. G.Winter (Eds.). *The nature of the firm: Origins, evolution, and development:* 18-33. New York: Oxford University Press.

Curtain, R. (2003). 'What Role for Citizens in Developing and Implementing Public Policy?'. in NIG [National Institute for Governance], *Facing the Future: Engaging stakeholders and citizens in developing public policy,* NIG, University of Canberra, Canberra.

Gaventa, J, 2006. 'Triumph, Deficit or Contestation? Deepening the Deepening Democracy" Debate', Working Paper 264, Brighton, Institute of Development Studies

Government of Kenya (2010). Constitution of Kenya. Nairobi: Government printers

Government of Kenya, (2011).Kenya Demographics Profile. Nairobi: Government Printer Government of Kenya (2015a). Kenya Health Policy 2014 - 2030. Nairobi: Ministry of Health Mimeograph.

Haas, Wilson, Deborah (1994) The relationships between the dimensions of health care quality and price: The case of eye care. Medical Care, 32 (2) 175.183.

Kaseje, D., & Sempebwa, K.N. (1989). An Integrated Rural Health Project in Saradidi, Kenya. *Social Science & Medicine*, 28 (10), 1063-1071.

Mwamuye, K., & Nyamu, H. M. (2014). Devolution of health care system in Kenya: A strategic approach and its implementation in Mombasa County, Kenya. *International Journal of Advanced Research,* 2, 263-268.

Ndavi, P. M., Ogola, S. Kizito, P.M., & Johnson K. (2009). *Decentralizating Kenya's health management system: An evaluation.* Kenya Working Papers No.1. Callverton, Maryland, USA: Macro International Inc.

Rouke, R. (1992). *Mistaken Identity: The Supreme Court and the Politics of Minority Representation*. London: Princeton University Press.

Stivers, C. (1994). The Listening Bureaucrat: *Responsiveness in Public Administration Public Administration Review,* 54(4): 364–9.

Taylor,T., & Taylor, C. (2002). Just and Lasting Change: When the Communities own their Futures. Baltimore: The John Hopkins University Press.

Taylor, F. W. (1911). *The principles of scientific management*. New York: Harper & Brothers.

Thomas, P., & Palfrey, C. (1996). Evaluation: Stakeholder-focused criteria. *Social Policy and Administration*, 30,125-142.

Turin, D. R. (2010). *Health Care Utilization in the Kenyan Health System*: *Challenges and Opportunities. Student Pulse 2 (9).* Available at: http://www.studentpulse.com/a?id.

UNICEF/WHO (1978). Primary Health Care. *International Conference on Primary Healt Care*, Alma-Ata, USSR.

Vincent-Jones, P. (1998). Responsive Law and Governance in Public Services Provision: A Future for the Local Contracting State. *The Modern Law Review* vol. 61:3.

Vigoda, E. (2000). Organizational Politics, Job Attitudes, and Work Outcomes: Exploration and Implications for the Public Sector. *Journal of Vocational Behavior, 57,326–347.*

Weber, M. (1978). *Economy and Society*. Volume Two. Berkeley: University of California Press.

Wambui M. F. (2013). *Determinants of Self Directed Referral Amongst Patients Seeking Health Services At Kenyatta National Hospital:* Nairobi, Kenya: Kenyatta University.

Yonay, Y. 1998. *The Struggle over the Soul of Economics*. Princeton, N.J.: Princeton University Press.