



Healthcare systems: A case study between Kenya and Germany

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Introduction.

Health systems and healthcare can be understood in several perspectives. World Health Organization (2014) gives the definition of health system as “all the organizations, institutions and all the resources that are devoted to producing health actions” with the primary intend of promoting, restoring and maintaining health. This incorporates all the public, profit-based and non-profit private institutions or groups as well as international donor and aid foundation. Every health system of a nation poses and experiences a wide range of challenges depending on the health policies and performance criteria put in place as pertains access, equity and quality. Access to health care can be limited physically in terms of availability or financially according to availability.

There must be adequate availability of physical health care services and facilities with ease of access to the general population. It is reported that 63% of the Kenyan population have a physical access to healthcare that is an hour of proximity from the areas of residence and the greater distance has significantly reduced demand for healthcare services (International Rescue Committee, 2015). The ministry of Health (2014) connotes that health services are not equally distributed across all the counties with Turkana county recorded among the worst affected counties in terms of access and availability of healthcare. The health care facilities are located in the far-flung corners within the county.

Many African countries including Kenya are signatories to the Abuja Declaration that 14% of the national budget should be diverted towards health services. This is on the contrary that Kenya was reducing its revenue allocation for health from a 2010 figure of 7.2 of 100 to 5.7 of 100 in 2014. This has greatly led to poor health services, inadequate drug supply with frequent looming medical personnel strikes amongst the health workers, furthers hampering services provision within the country (Commission on Revenue Allocation, 2014).

Inadequacy in health personnel especially nurses, and doctors have led to rising unrest among the medical workers resulting into repetitive industrial strikes, overworking and understaffing being among the greatest contributors (Kariuki 2014).

Devolution of health services into the county management was something to grasp provided there was a smooth and gradual transition of power, resources and functions from the central government. This was to allow essential capacity and ability at the county level. However, this did not happen or achieved practically owing to if happening overnight. This therefore led into the handing over of healthcare services flawed by inconsistencies, understaffing, managerial problems and lack of proper harmonisation between the county and the central government. This resulted eventually into poor management and resource allocation by the central government and poor working conditions and poor salaries at the county level. (Ministry of Devolution and National Planning 2015: pg. 37).

Germany

C. F. Dietrich (2012) reports that, Germany Health Care System (GHCS) is faced with challenges, majority of the population being the aged and economy related challenges to mention but a few.

Medical errors and recording pose a great challenge in the Germany Health Care System (GHCS). Worries pertaining patient safety, risk assessment and management together with malpractice are crucial for health service delivery. Records on Medical errors are limited to access currently in Germany. Documentation errors in Germany are reported to be an approximate number of 40,000 cases annually. 5-10% of the patients experience a so-called avoidable undesired event (Dietrich CF, Riemer-Hommel P. 2012).

Dietrich CF, Riemer-Hommel P. (2012) further reports that Healthcare reforms in Germany is moreover cautious and sluggish for the fear of decisions disturbing key stakeholders. Political verdicts are still at the mercy of parties in power consequently the risk over stressing of political benefits over healthcare needs.

Germany Health Care Systems is that of a narrow index of vulnerability to financial and economic shifts in the service-oriented economy. Absent stringent measures on the evaluation of the effectiveness of the health service practices and pharmaceutical services pose another critical challenge. This however predisposes to these services being over utilized (Schrappe M., 2005).

Germany healthcare is a meta-corporatist health system consequentially leading to inflexibility and stand-off situations rendering innovations difficult. This is also contributed to the several different levels and actors involved in the policy making process (Nassehi A. et al., 2008).

The issues faced by each system related to quality, access and cost of health care.

Kenya

Every individual Kenyan is entitled to quality healthcare services at any level. Employee capacity has been of great influence on the provision of healthcare services within the public healthcare sectors. Nursing workforce reports that there has been massive brain-drain of nursing personnel in search of greener pastures overseas leading just but a few qualified health personnel in the country. Also, a huge number of medical personnel left the public sector for the private sector. To provide quality health services, hospitals should secure sufficient allocation of health personnel as a text by Cohen and Levinthal (2008) reports. Proper monitoring of nurses and physician to ensure that they achieve the expected performance standards is paramount.

Brown and Duguid (2008) stated that there is need for cautious recruiting of qualified and highly skilled staff with continued empowering and given opportunities for technical advancement in corporation with the hospital. The hospital needs to overemphasis on hiring and recalling top level health personnel like physicians and nurses and encourage team work amongst these medical fields incorporating the managers, social workers, pharmacists etc. to ensure quality.

Financial resources allocation and governance to the public health services have been of a great impedance and constrain to provision of quality services. There should be an “enlightened” approach towards finance in service organizations (Mills, 2001). There is a need to differentiate between “good costs” that eases of constrains and better service provision from “bad costs” that brings about bureaucracy thus posing hindrance to service delivery.

Kenya recognizes quality health care as a prerequisite for development has led to the improved financial allocation. This has however not improved the quality of healthcare provision in the public health sector due to lack of accountability and funds misappropriation as reported in the Global Corruption Report (2006).

The implications of modern advanced technology on healthcare services go without saying. Proper utilization boosts the quality of health services (Allen, 2011). This has not been the case

in the Kenyan health system given that this has not become a priority at the community level hospitals due to limited resources distribution.

Access to health care refers to the timely use of health care, acceptability, availability and the affordability of medical services in need to the general population (Institute of Medicine, 1993) or the ease with which medical services can be obtained. More than 50% of the population in the sub-Saharan Africa have limited or no access to healthcare facilities. In the rural Kenya community, there is limited access and availability of health facilities. (Kenya facts and figures 2008). Observable correlations are the few medical facilities and staffs with also physical accessibility in terms of impassable roads and distance.

James C. et al. (2006) studies indicates that limited access to healthcare in Kenya has been due to low income and the high costs associated with the healthcare services. There is, however, the evidence of plenty of other factors contributing to the limited access and timely use healthcare services in Kenya.

From the Daily Nation (2018) the saying goes, “we are one illness away from our financial ruin.”It states that 3 out of 4 Kenyans have no comprehensive insurance cover and 1 in every 5 Kenyans fall sick every month with 16% failing to seek medical services due to financial constraint. 40% reports to run for loans to cater for their medical expenses owing to the high cost of living. The Kenya President through the BIG FOUR agenda announced the hopes to tackle the financial burden through provision of Universal Health Coverage by 2022. Its stated that all people will have equal access to health services without suffering high financial damages or losses. Kenya will have to scale up insurance coverage to meet up their Universal Health Coverage target by 2022 to reduce out of pocket use by a huge gap of from 26% to 12%.

Germany

Germany has been enacting several progressive health reforms over the last few decades most of them implicitly and explicitly focusing on basic cost regulation mechanisms. This ranges from the Health Care Reforms Act of 1989 to the recent Act on the reform of the Market for Medicinal Products. Real competition among healthcare providers and insurance companies is lagging. The health reform has also focused though on a lesser degree on the quality of healthcare. However, generational accounting, prioritization and rationing arising matter have been greatly neglected (Riemer-Hommel P. and Dietrich CF. 2012).

Some of the factors that greatly contributes to the rising in the cost of healthcare in Germany include but not limited to: aging population thus the increasing burden of pensioners, level of unemployment, lack of incentive for the favour of competition, increased demand and supply for new technological advancement, increased need for proper and exhaustive documentation, the increase in the supply and demand of pharmaceutical companies and economic issues including inflation rates and the varying exchange rates (Stevens FCJ, and van der Zee J., 2008.).

Quality Assurance based documentation was implemented in 1970s in the form on registries. This was totally dependent on the state legislation on perinatal and general surgery interventions. On this report, identifying the best system was proving to be extremely difficult undertaking even when stringent measures and strategies were put in place. This is because systems evaluation and management put in place always evolved in response to national legislation, culture, demands and economics (Wagner C. et al., 2006).

Lack of coordination between the traditional self-government healthcare providers namely the representative bodies of physicians and health insurance funds act as a great impedance to the continuity and the quality care provision to the patients and therefore health outcomes. This problem however been subverted by the introduction of the Disease Management Programs (DMPs) together with integrative care concepts and institutionalized inter-sectoral forms in the healthcare system based on corresponding legislative changes (Breckenkamp J, et al. 2007).

Even though medical insurance is obligatory in Germany, a vast majority of the population have no or only limited access to the health care system. In 2016, the official reported figure of men, women, and children residing in Germany with no comprehensive healthcare coverage was 80,000, according to the Federal Statistical Office. The actual number, however, is significantly higher (Camillen. D. M, 2018).

Compare and Contrast between Kenya and Germany Health systems on the overall health performance.

The ultimate goal of any healthcare system, whichever the model, is to improve the general health of its people, increase its timely response to legitimate healthcare demands within its population and also to ensure that the financial burdens are distributed equally amongst its people (World Health Organization, 2000). Several parameters exist for evaluating the performance index of a nation vasa vee another. Such factors include infant mortality rates,

mortality rates for cardiovascular disease, life expectancy for males and females, percentage of people with normal body mass, just to mention but a few.

To begin with, Germany has a population of 81, 915,000 by with a gross national income per capita of 444, 450 USD 2016 whereas Kenya has a total estimated population of 48, 462, 000 with a gross national income per capita of 2, 250 USD. Germany's expenditure on health per capita is 5,182 USD in 2014 with Kenya's expenditure on health per capita at 169 USD. Healthcare budgetary allocation in Kenya is 5.7% whereas Germany's Healthcare budgetary allocation of the national revenue is estimated at 11.2% (World Health Organization, 2020).

The under five mortality rates in Kenya is estimated at a figure of 51 per 1000 live births (Kenya Demographic and Health Survey, KDHS 2014). This indicates a low performance index in the healthcare is compared to that of Germany. Germany's under five mortality rates is recorded as at 4 per 1000 lives births. And a great indicator of good healthcare. The World Health Organization target is to arrive at a mortality rate figure of 25 per 1000 live births (World Health Organization, 2016).

Kenya Demographic and Health Survey, KDHS (2014) reports a Neonatal Mortality Rate of 22 deaths per 1000 live births. This incomparable with Germany having a documented Neonatal Mortality Rate of 2 deaths per 1000 live births. Compared to the World Health Organization (2016) target of 12 deaths per 1000 live births by 2030, Kenya has a long way to go to achieve this figure (World Health Organization 2016).

In Kenya there is a reported high infant mortality rate of 39 deaths per 1000 live births (Kenya Demographic and Health Survey, KDHS, 2014) compared to the one in Germany recording 3 deaths per 1000 live births with World Health Organization target of 12 deaths per 1000 live births. Kenyan performance is reportedly underperforming (World Health Organization 2016).

The average life expectancy in Kenya is 64 years for the male gender and 69 years for the female gender. This is quite a lower life expectancy observed in Germany as 79 years for male gender and 83 years for the female gender (Kenya Demographic and Health Survey, 2014 and World Health Organization, 2016).

World Health Organization, (2016) further report that Kenya in comparison to Germany, has a better mortality rate when it comes to cardiovascular diseases. Kenya records a mortality rate of 13% whereas Germany report mortality rate of 43.9% for the females and 36.1% for the male gender. The average mortality rate between the ages of 15-60 for the male gender is 88 deaths

per 1000 live population and the female at 49 deaths per 1,000 populations in Germany. In Kenya, the estimated deaths between the ages of 15 – 16 years stands at 256 for the male gender and 184 for the female gender according.

In a nutshell, the health system in Germany being the 1st world country is far beyond reach to be compared with that of Kenya as the 3rd world nation. All parameters of the performance index evidently work preferentially towards the German Healthcare system. The life expectancy in Germany is higher than that of Kenya. The neonatal rates, under five mortality rates, neonatal mortality rates and general mortality rates in a Germany is at par with World Health Organization and even better by far. The per capita income and gross domestic can also be and indicator of the general performance of the country's economy and there its healthcare performance in general. With all factors considered, Germany has a better healthcare system. It is however noted that Kenya besides the poor health state, it shows an improving trend towards the World Health Organization target over the last few decades.

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