Q&A: COVID-19 exposes weaknesses in Kenya's healthcare system—and what can be done

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There are reports that Kenya's hospital beds are filling up because of a surge in COVID-19 patients. This highlights concerns since the start of

the pandemic, that the health systems of many African countries would quickly become overwhelmed. Moina Spooner from The Conversation Africa asked Professors Abdu Mohiddin and Marleen Temmerman to explain what must be done.

What are the major deficiencies in Kenya's healthcare system?

Kenya's healthcare system is made up of several systems: public, private and faith-based or NGO. About 48% are public and operate under the Ministry of Health, 41% are in the private sector, 8% are faith-based health services, and 3% are run by NGOs.

Healthcare in public hospitals is free for some services, such as maternity care, and for those with national health insurance, in-patient treatment is free. Healthcare provided by private hospitals, faith-based institutions or NGOs usually comes at a cost and charges will vary.

About 20% of Kenyans have some form of health insurance coverage, including national health insurance, but this varies by region. For instance, 41% of residents in Nairobi have cover, while under 3% will have cover in marginalized rural areas such as Wajir and West Pokot.

In the public sector, the 47 county governments deal with service provision at the local level, while the national level is concerned with policy and the referral hospitals.

Taking all the healthcare systems in Kenya together, the fundamental shortcoming is the mismatch between needs and the available care, in particular specialist care and the workforce—from doctors to technicians—needed to run it.

For instance, a nationwide study found major shortages in chest specialists, hospital physicians and emergency care nurses. An assessment of health facilities in 2018 also reported that just 12% had the standard items needed to prevent infections, such as gloves, infectious waste storage and disinfectant. Of the hospitals that offer emergency breathing intervention services, 78% offered administration of oxygen and 23% had invasive mechanical ventilation.

The mismatch between available care and needs manifests in two main ways: geographically and economically.

Geographically, there's a huge divide between what's available in rural areas and urban areas. Most Kenyans, about 70% of the population, live in rural areas. They mostly rely on community health volunteers and health facilities that are staffed by nurses who provide primary health care services like immunization. Sub-county hospitals provide more services and a few medical doctors are available.

Economically, those who are poorer or uninsured are less able to access what is available. If they can access healthcare, they risk huge bills which can push them into poverty.

Another challenge is corruption. This manifests dangerously in various ways throughout the system. For instance, a major concern is the cartels within the Ministry of Health which are accused of colluding to steal public funds. Such theft weakens health institutions and diverts valuable time and attention to its mitigation.

In addition, some officials from the main supplier of medical goods—Kenya Medical Supplies Agency – are under investigation for awarding protective equipment tenders irregularly.

Ultimately, the major challenge is that this is a healthcare system where

most people are able to access basic care but they face the barrier of potentially catastrophic fees.

What has contributed to this?

Over many years health has not had the political priority it needs with attendant impacts on investment, strategic thinking and planning.

Two examples show this:

First, Kenya's government health expenditure isn't enough. Over the last two decades, it has averaged about half the Abuja declaration's target of at least 15% of national budgets. This was set in 2001 by African Union heads of state.

Secondly, the local and national health systems aren't resilient to shocks. For instance, the 2017 national strike by health care workers caused major nationwide service disruptions and the closure of several facilities.

How will the COVID-19 pandemic heighten these challenges and what is the government doing to address them?

Overall, Kenya faces huge coordination and planning challenges between all health systems, at the local and national level. For instance, while the national government is showing leadership with COVID-19 taskforces on mitigation measures and communication, it's not being uniformly implemented at the county level.

There's also a lack of information on what is or isn't working. This includes data on whether national directives—such as curfews and lockdowns—have been effective in breaking transmission.

In addition to this, there's a huge lack of resources. For this pandemic, intensive care beds and ventilators are critical. But recent studies show that while Kenya has 537 intensive care beds, it has only 256 ventilators.

Many counties simply don't have specialist equipment. Only 22 out of the 47 counties have at least one intensive care unit. Hundreds more units and ventilators are needed as well as the staff to run them.

In addition there is the stress to the system when staff get sick or have to go into quarantine. The staffing challenges are already an issue so this is a serious concern.

The government is taking certain steps to address these challenges.

It recently increased health spending from Ksh73 billion (about US$678 million) to Ksh83 billion (about US$771 million) this year and reiterated its commitment to universal health coverage—though it's not clear how far we are off this. One firm positive step is that treatment for COVID-19 in government hospitals is currently now free.

Funding all of this will, it appears, come from international donors, government borrowing and the reopening of the economy to improve tax revenues and sustainability.

Healthcare workers have been concerned about the availability and quality of personal protective equipment such as protective clothing, helmets and goggles. Threats of strike action have been issued and the government responded with talks to avert them. But there are concerns over substandard items and fakes due to corruption.

What else needs to be done?

Given the constraints the government faces in resources, preventing the

spread of the virus and effective use of existing resources are critical. This includes firm commitments, and clear actions, by the country's leaders that they're taking preventative measures such as wearing masks and social distancing.

Leaders must also ensure that the regulations are enforced and there must be clear campaigns to deal with myths.

There must be better coordination between the government, private and faith or NGO institutions. This is particularly vital when it comes to specialist care. Coordination is happening but depends a lot on counties, which vary in their capacity.

Stakeholders, such as private facilities, are usually willing to work with the government provided the issues of delayed payments can be remedied.

In addition, there must be more research on how the pandemic is spreading in Kenya and any new or appropriate technologies needed to mitigate and treat it. More data is also needed on COVID-19's impact on health systems and society.

Some data are announced daily but detailed data are needed—for instance specific measures on how the virus is spread or information on how well the healthcare system is doing at all levels, such as length of stay in intensive care units, effectiveness of contact tracing teams or numbers of deaths in vulnerable communities.

Finally there are many routine healthcare system activities that are not happening or have been reduced. These include antenatal care, deliveries and immunisations. Mitigation actions and planning are urgently needed.