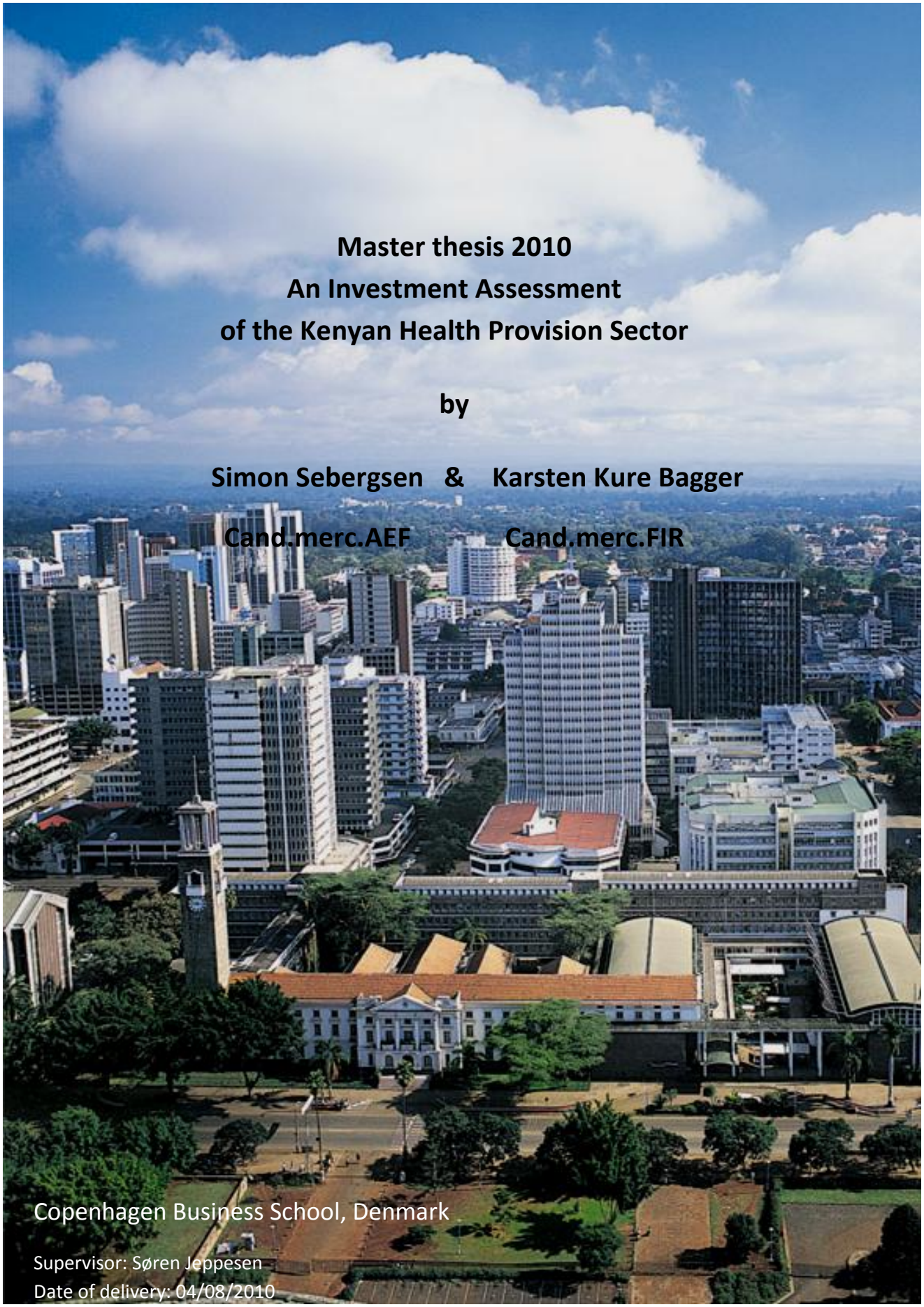

# Master thesis 2010
# An Investment Assessment
# of the Kenyan Health Provision Sector

by

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"***If we respect ourselves and our* uhuru[1], *foreign investment will pour in and we will prosper.***"
Jomo Kenyatta, first president of Kenya

[1] Swahili for freedom

**List of abbreviations**

| | |
|---|---|
| AFRICOG | African Centre for Open Governance |
| AIDS | Acquired Immune Deficiency Syndrome |
| AKI | Association of Kenya Insurers |
| AKUH | Aga Khan University Hospital |
| AMREF | African Medical and Research Foundation |
| AOP | Annual Operational plan |
| b | Billion |
| BOP | Bottom-Of-the-Pyramid |
| CBK | Central Bank of Kenya |
| CHAK | Christian Health Association of Kenya |
| COMESA | Common Market for Eastern and Southern Africa |
| DANIDA | Danish International Development Assistance |
| DFIF | UK Government Department for International Development |
| DP | Democratic Party ¨ |
| EABI | East African Bribery Index |
| EAC | East African Community |
| EADB | East African Development Bank |
| ERS | Economic Recovery Strategy |
| FBO | Faith Based Organisation |
| FDI | Foreign Direct Investment |
| FORD | Forum for the Restoration of Democracy |
| GDP | Gross Domestic Product |
| GNU | Government of National Unity |
| GOK | Government of Kenya |
| HENNET | Health NGOs' Network |
| HIV | Human Immunodeficiency Virus |
| IFC | International Finance Corporation |
| IGAD | Intergovernmental Authority for Development |
| KACA | Kenya Anti-Corruption Authority |
| KACC | Kenya Anti-Corruption Commission |
| KADU | Kenya African Democratic Union |
| KAH | Kenya Association of Hospitals |
| KAPH | Kenya Association of Private Hospitals |
| KANU | Kenya African National Union |
| KEPSA | Kenya Private Sector Alliance |
| KHF | Kenya Healthcare Federation |
| KHPF | Kenya Health Policy Framework |
| KNH | Kenyatta National Hospital |
| KMA | Kenya Medical Association |
| KSH | Kenyan Shilling |
| m | Million |
| MDG | Millennium Development Goals |
| MOH | Ministry of Health |

| | |
|---|---|
| MOMS | Ministry of Medical Services |
| MOPHS | Ministry of Public Health and Sanitation |
| MP | Member of Parliament |
| MW | Mega Watt |
| NARC | National Alliance Rainbow Coalition |
| NDP | National Development Party |
| NHIF | National Hospital Insurance Fund Coalition |
| NGO | Non-Governmental Organisation |
| NHSSP | National Health Sector Strategic Plan |
| NQCL | National Quality Control Laboratories |
| NWH | Nairobi Women's Hospital |
| ODM | Orange Democratic Movement |
| PDM | Progressive Democratic Movement |
| PNU | Party of National Unity |
| PM | Prime Minister |
| PMO | Provincial Medical Officer of Health |
| PPP | Public Private Partnership |
| PSNS | Political System Nationalisation Score |
| SADC | South African Development Community |
| SAGA | Semi Autonomous Government Agency |
| SDP | Social Democratic Party |
| SIDA | Swedish International Development Cooperation Agency |
| TB | Tuberculosis |
| THE | Total Health Expenditure |
| UHMC | Upper Hill Medical Centre |
| UN | United Nations |
| UNEP | United Nations Environment Programme |
| UN-HABITAT | United Nations Programme for Human Settlements |
| UNON | United Nations' Offices in Nairobi |
| USAID | United States Agency for International Development |
| US$ | United States dollars |
| VDS | Vision Delivery Secretariat |
| WHA | World Health Assembly |

**Executive summary**

The objective of the thesis is to analyse the Kenyan institutional environment with respect to the health provision sector in Nairobi. Specifically, the research question in focus is ”How does formal and informal institutions shape the business environment for foreign investors seeking to invest in the Nairobian health provision sector?”. In order to answer this question in detail the thesis sheds light on; i) how is the Kenyan health provision sector structured, ii) which political-, legal- and economic systems affect the health provision sector, and iii) how do culture, ethics and norms affect the health provision sector.

The research question is developed based on the fact that the Kenyan Health provision system is currently going through significant health policy changes, and these changes will increase the importance of private sector participants in order to meet the future demand for healthcare services. Moreover, the institutional environment in Kenya is transforming as the country is about to enter into an East African community (EAC) and adapt a new constitution.

The thesis’ findings indicate that although the private healthcare sector already plays a significant role in the health provision sector in Nairobi, the private sector will be even more important going forward. Historically, the government in Kenya has not managed to allocate sufficient funds to healthcare, and this under-financing has made Kenya dependent on donors and private sector participants, both non-profit and for-profit. Recently, the Government of Kenya (GOK) has decided to increase its focus on the poor, and the GOK is willing to cooperate with the private sector in order to meet the growing demand from the middle class.

By solely looking at the mismatch between the supply and demand of health provision services, the health provision sector seems to offer great potential for investors. However, the institutional analysis confirms that investors have to recognise the importance of both formal and informal institutions in order to fully grasp the opportunities and challenges in the Nairobian health provision sector. The primary institutional obstacles when doing business in Kenya are the level of corruption and crime, the political and economic instability, and the complex tax system. The EAC Common Market and the new constitution addresses all of the above mentioned challenges, and thus holds great potential to facilitate the development of the private sector healthcare in Kenya. If the GOK manages to implement the policies they have formulated, the stage is set for a stable political and economic environment that will foster a sound business climate in the health provision sector with great potential particularly in the fast growing middle class segment in Nairobi that is estimated to quadruple by 2025.

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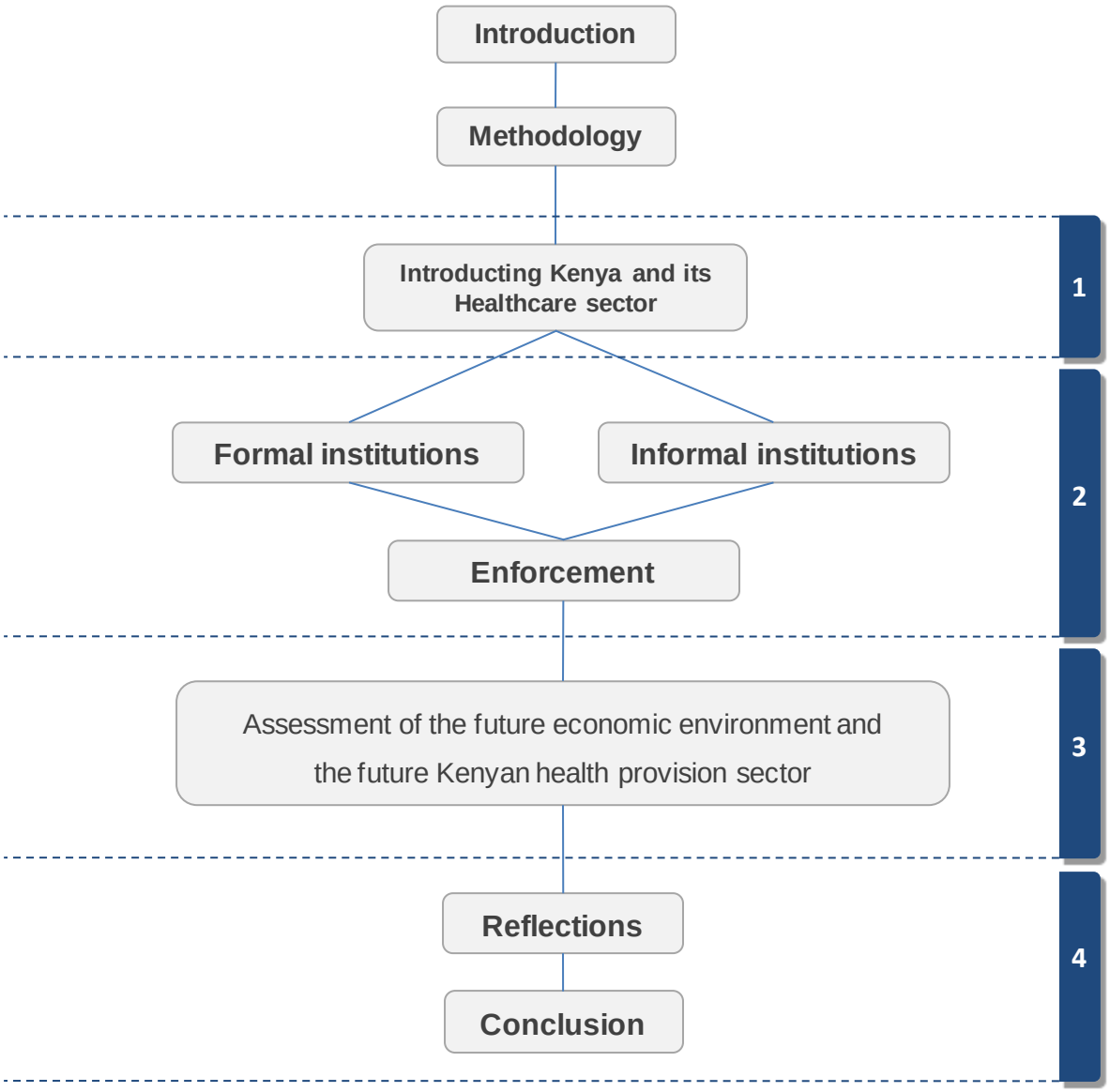
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# 1 INTRODUCTION

Following more than a decade with stagnation, the Kenyan economy began growing after Mwai Kibaki was elected president in 2002. Subsequent to getting in office Kenya's GDP grew steadily till 2007, unfortunately disrupted by the global financial crisis, harsh weather conditions leading to a food crisis, and the post-election crisis. They were all part of the reason for the sluggish growth rates in 2008 and 2009, but in addition they were all related to the institutional environment in Kenya. If this had been different it could have diminished or absorbed some of these shocks.

The global financial crisis should not have hit Kenya hard, but it was affected because of its large informal sector making it more likely to incur adverse effects of a crisis[1]. If the road infrastructure were more comprehensive it would have been easier to get food from other countries and reach the affected areas. The post election crisis was a result of centralised political power mostly controlled by one of the more than 40 Kenyan tribes. This would hardly have been a case had the political power been more decentralised and less ethnical.

The influence of the institutions in a country being formal or informal institutions and how they interact are essential in the context of foreign direct investments. If the investor does not understand the industry and the institutional framework that apply in the specific country he or she is likely to meet many unexpected expenses.

When considering investing in Kenya, Nairobi is usually the first stop to establish oneself particularly as a foreigner. The healthcare sector was recently highlighted as the most promising industry in Sub-Saharan Africa[2]. The region's increasing GDP growth coupled with a strong population growth and soaring rates of AIDS, TB and malaria are some of the factors that are driving demand for healthcare and an increase in per capita expenditure on health services going forward.

The Kenyan government is increasingly welcoming private-public partnerships as a mean of accomplishing capital intensive initiatives[3]. Kenya, but particularly Nairobi, is becoming more integrated in East African region through better infrastructure and cross-border investments. Companies investing in Nairobi still complain about the costs of corruption and crime, and bureaucratic procedures[4]. Hence, upon investing they need to take into consideration the weak formal and informal institutions, and how the institutional environment will affect the structure of the healthcare sector going forward from an investor's perspective. Seeing as Kenya is a developing country with a wide range of institutional issues,

foreign investors need to not only understand the current situation, but particularly the structure of the healthcare industry, how the market will look going forward, and which areas of the healthcare industry are worth investing in. As Nairobi is usually the starting point for investing the thesis will have its emphasis on the city's health provision system, and it will largely focus on how the national institutions affect the investor with respect to being in the capital now and in the near future.

## 1.1 PROBLEM AREA

Kenya has a heterogeneous population with diverse anthropological roots, varying traditional religious beliefs, many languages and ethnicities, all resulting in a broad spectrum of cultural traditions. It might be one country, but the population's ethnical differences and high level of corruption has created many difficulties with the latest being the post-election crisis in 2007-2008. Similar to most developing countries, Kenya's business environment is plagued by weak, ineffective and market-depressing institutions. Therefore, before entering the Kenyan market, investors need to understand the potential challenges they will face as a result of weak political, legal and economic institutions. Moreover, in countries with weak formal institutions, informal institutions are increasingly important, and thus investors have to understand how factors such as culture, ethics and norms yield support to or suppress the formal institutions. The thesis will therefore be largely descriptive to ensure the understanding of the healthcare market and the institutional environment. These will then be analysed and reflected upon with respected to a theoretical framework to conclude on the foreign investors' potential future environment.

## 1.2 PROBLEM STATEMENT

Based on the above discussions the thesis will investigate how institutional factors influence the investment climate for foreign investor's health provision sector. This is formulated in the following research question:

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*"How do formal and informal institutions shape the business environment for foreign investors seeking to invest in the Nairobian health provision sector?*

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This research question will provide the reader with a holistic understanding of the challenges and opportunities within the sector, and will serve as a connecting thread throughout the thesis. Since the research question is somewhat broad, it is necessary to elaborate on the following three sub-questions:

- *How is the Kenyan health provision sector structured?*
- *Which political-, legal- and economic systems affect the health provision sector?*
- *How do culture, ethics and norms affect the health provision sector?*

# 2 MOTIVATION

The motivation for choosing the topic "An Investment Assessment of the Kenyan Health Provision Sector" is threefold. First, it is to investigate the opportunities and challenges related to investing in a developing country. Second, the importance of formal and informal institutions, and how these shape the business environment for foreign investors. And lastly, it is to explore the for-profit opportunities for foreign investors in the healthcare sector. The best way to explore this was to conduct the thesis on a country where we did not have much knowledge or prejudices. We also wanted to be able to go visit this country in order to conduct interviews with the locals and hereby understand the environment on close hand and not just by reading about it.

The fact that the Danish state is engaged in Kenya and the health provision sector through the DANIDA programme, enable us to use our nationality to open doors that might have been closed for others. On the contrary to Kenya, Scandinavian countries are ranked high with respect to corruption and other important factors related to doing business, and seeing as we are not used to taking factors such as corruption, ethnicity and cultural differences into consideration when assessing the investment potential of an industry, the thesis have challenged us on a completely new level. We both have no prior experience analysing a developing country, neither of us have prior to writing the thesis used the institutional framework, and we therefore see this thesis as a good way to challenge ourselves.

## 2.1 STRUCTURE OF THE THESIS

In addition to the introductory chapters the thesis will consist of three main parts. The first part introduces the country and industry, whereas the second part analyses the institutional factors related to the health provision sector, and finally the third part postulate a most likely scenario of the future economic environment and the future health provision sector in Kenya. More specifically, part I starts by introducing Kenya as a country, its position in the African continent and its capital, Nairobi. Since the thesis is aimed at foreign investors with no prior knowledge of either Kenya or Nairobi, a basic introduction is necessary in order to fully comprehend the discussions in the upcoming sections. Part I also defines healthcare, the

Kenyan healthcare model, which major players are present, the general healthcare funding and the disease burden in Kenya.

Part II is divided into three sub-sections. The first sub-section analyses the formal institutions looking at the political, legal and economic systems in Kenya, and how they influence the business environment within the health provision sector. The second section analyses three main groupings of informal institutions, namely culture, ethics and norms. The last sub-section will endeavour to assess how the formal and informal institutions interact, and to which extent the informal institutions enhance or undermine the formal institutions.

Part III describes the most likely scenario for the health provision sector going forward. The scenario analysis is based on factors such as the economic environment, political reforms and the growing importance of the growing middle class. Based on the future prospects for the health provision sector, it will be attempted to assess the potential investment opportunities for foreign investors.

# 3 METHODOLOGY

Gobas 1990 scrutinises methodology on three levels; i) ontological[1], ii) epistemological[2] and iii) methodological[5]. It is pursued to clarify for the methodology keeping this in mind to ensure a thorough understanding of the research philosophy and approach throughout this thesis. This is followed with a coherent clarification of the used interview technique. It is pursued to include the reader in the considerations made throughout the process of writing the thesis.

As researchers a positivistic approach will be pursued[6], but acknowledging the social constructive paradigm and consenting with the fact that the observed reality both reflects a material and social constructed reality. The positivistic realistic perspective prevails as many measures are used throughout the research, and in order to answer the research question thoroughly it is important to have quantitative and qualitative data combined. The general belief will inevitably have influence on the result especially on the qualitative research but following a positivist perspective it will be strived to keep the thesis objective.

The qualitative data are conducted through semi-structured interviews with the objective of gathering descriptions interviewees' world with respect to how they interpret the importance of the described phenomena[7]. It is therefore pursued to understand the respondents'

[1] The science of being
[2] The theory of knowledge

perception of their world, their beliefs and norms, but simultaneously bearing in mind which factors are most important for a foreign investor. In the light of this the research interviews are constructed to fit different categories depending on the person's position being interviewed[8]. All interviews follow Kvale's (2006) analytical approach summarised with the important takeaways from the interviews to facilitate a better and easier accessibility of the reader.

In order to obtain to objective information as possible, it has been chosen to interview a wide range of respondents with different backgrounds and occupations. The respondents comprised of individuals with a medical background, the minister of healthcare, healthcare insurance companies, investors, the Central Bank, embassies and non-governmental organisations investing in the healthcare sector.

### 3.1 THE QUANTITATIVE AND QUALITATIVE DATA

The thesis consists of both qualitative data and quantitative data. The majority of the quantitative data used in the assessment has been gathered from local surveys, reports and strategic plans acquired from the interviewees in Nairobi and online information publicly available at international organisations such as the OECD, World Bank, IFC, World Health Organisation, and USAID. The qualitative data is mainly collected through interviews and conversations with representatives from public and private hospitals, governmental organisations, non-governmental organisations, ministries, banks and financing institutions, embassies and donors. Part 3 which describes the most likely scenario for the health provision sector going forward, and the opportunities in it, is primarily based on the impressions of the sector after speaking to various participants in it. The informal analysis was the most challenging when it comes to gathering data seeing as industry specific data on issues related to rather sensitive issues such as corruption and ethics are difficult to obtain.

### 3.2 CRITIQUE OF DATA

Since a large amount of the data used in the thesis is qualitative, the data may to some extent be biased as a result of people's subjective opinion. As much of the analysis is based on local reports and interviews, the information obtained could be prejudiced seeing individuals have their own perception of how things are. People in Nairobi for example are more likely to speak in favour of their city, and similarly are Kenyans inherently more optimistic toward its own tribe. The opinions regarding the role of the private sector differed widely among the individuals in the public and private sector, but seeing as it was managed to conduct

interviews with several participants from both sides it is believed that a high objectivity was maintained. Nevertheless, the validity of international reports is seen as the most reliable and unbiased source.

### 3.3 THESIS' FOCUS

The thesis both contains elements from macro, meso and micro level. However, it is important to emphasise that it primarily focuses on the challenges related to formal and informal institutions in the health provision sector. That is, the focus is not the traditional "doing business" indicators such as registering property, employing workers, and paying taxes at the micro level, but instead on the solidity of the political, economic and legal institutions that affects the health provision sectors.

As depicted in figure 1, the thesis focuses on the macro level when discussing Kenya's policies, initiatives and reforms, and how they shape the business environment for foreign investors. However, when discussing informal institutions, such as culture, ethics and norms the discussions is conducted on the meso- and micro level.

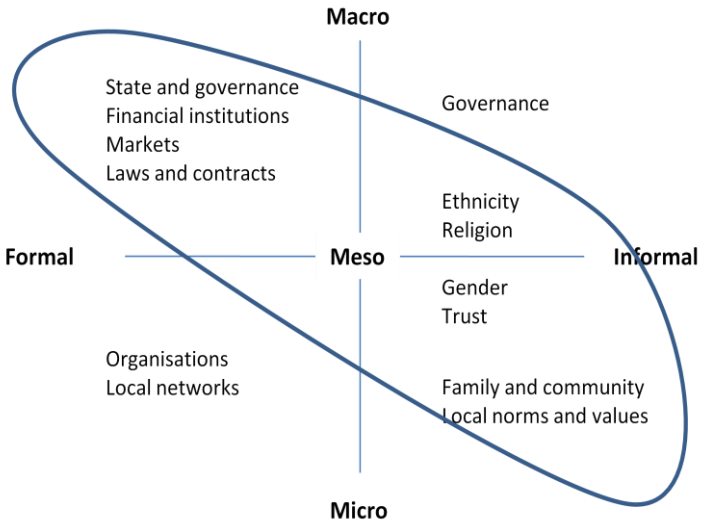



*FIGURE 1: THESIS FOCUS, SOURCE: OWN PRODUCTION*

### 3.4 DELIMITATIONS

To ensure that focus is kept on the central research question throughout the thesis and satisfies the requirement of a limited number of pages, the thesis will to contain a number of delimitations. There will generally appear a number of assumptions throughout the thesis that due to their simplicity will be a delimitation from what might be the actually truth. These assumptions are necessary due to the complexity of analysing a country and quantifying something that is not straight forward measurable.

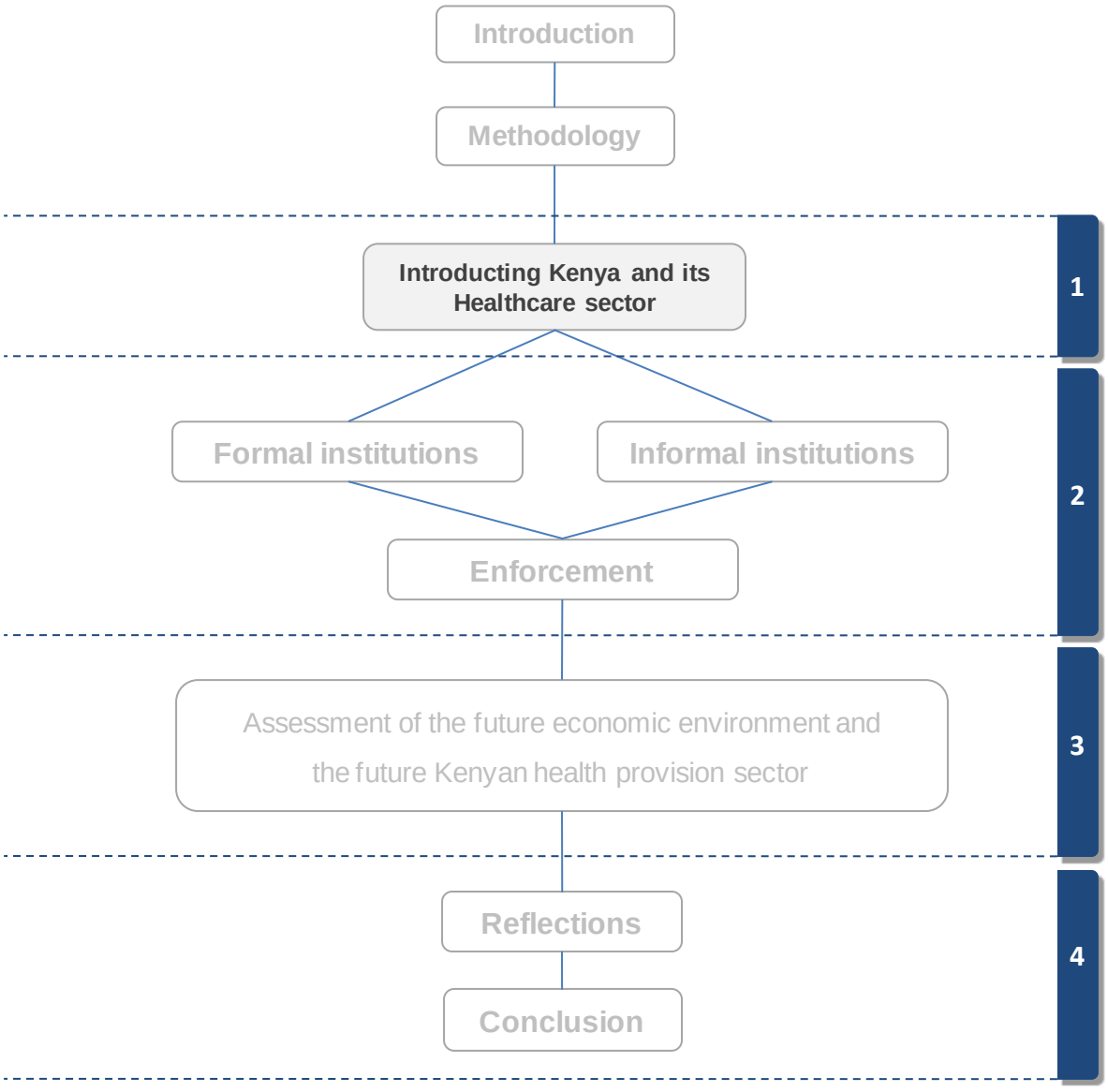
First of all, it was chosen to solely focus on Nairobi when evaluating the investment opportunities for foreign investors in the health provision sector. The reason for this is that it is difficult for for-profit investors to compete in rural areas since the majority of health

provision facilities in these areas are non-profit and receive a great deal of donor funding. Another reason for solely focusing on Nairobi is the fact that it is the capital, and thus it is easier to obtain relevant information and the most common place to locate a business upon establishing oneself for the first time in Kenya or even East Africa. Although the thesis specifically focuses on Nairobi when assessing the potential investment opportunities for foreign investors, the institutional analysis will discuss Kenya and Nairobi interchangeably. The reason for this is that the institutional factors are not necessarily Nairobi specific, but often apply to the nation as a whole.

Second, seeing as the term "foreign investor" is quite broad, a proper definition is necessary before commencing the thesis. The term "foreign" is defined as an individual coming from another country than Kenya and outside the continent of Africa. The term "investor" is often used when describing an individual who commits capital in order to gain financial returns[9]. However, the thesis is exclusively focusing on individuals willing to carry out long term investments in order to obtain ownership of physical assets. Hence, it will adapt the following definition of foreign direct investments: "[A] foreign direct investment reflects the objective of obtaining a *lasting interest* by a resident entity in one economy in an entity resident in an economy other than that of the investor. The lasting interest implies the existence of a long-term relationship between the direct investor and the enterprise and a significant degree of influence on the management of the enterprise"[10]. Investors may choose to engage in a joint-venture with another investor or enterprise, or start up a business single-handedly using local employees. Since the focus of the thesis predominantly is on how formal and informal institutions shape the business environment for foreign investors, it will not elaborate on methods of entry.

Upon reading the thesis it is assumed that the reader has a general economic understanding and awareness of doing business in other countries, furthermore should the thesis be seen as an indicator of the most important factors when investing in the Kenyan healthcare. Even though it might be interesting to further investigate the value of relationships in Kenya, this will not be investigated both due to the size, diversity of the healthcare market and nature of the individual investing in Kenya. Other general assumptions such as the partition of the income brackets is vague and should therefore be seen an indication. This is generally the case with quantitative data as a common convention rarely has been implemented in Kenya making it difficult to make correct comparisons.

## Structure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# 4 INTRODUCING KENYA

This section covers the geographic and demographic characteristics, economic performance and recent political history in Kenya. The heart of the thesis, i.e. the institutional analysis, will carry on with a more in-depth description of the formal and informal institutions.

## 4.1 COUNTRY AND PEOPLE

The republic of Kenya is a country in East Africa bordered by Ethiopia, Somalia and Sudan to the north, Uganda to the west, and Tanzania to the south[11]. The country is divided into eight provinces each headed by a provincial commissioner, and these provinces are sub-divided into 69 districts. At the regional level, the majority of the country's population is concentrated in the Rift Valley Province with a population exceeding 7 million. Nairobi, the capital city, is currently the fastest growing area in Kenya with a current population[3] of 4.7 million compromising the same area as the Nairobi Province[12], the second largest city is to comparison Mombasa with ca. 700,000 inhabitants. The Kenyan population in total has almost quadrupled since independence in 1969 from 10 million to nearly 40 million, with roughly 6 million people living in urban areas. In 1979 Kenya had one of the highest population growth rates in the world, but has decline and is now close to 2.7 percent which ranks Kenya as number 25 in the world[13]. The vast majority of Kenyans are Christian, with 45 percent regarding themselves as Protestants and 33 percent as Roman Catholic. The third largest group is Muslims (10%), and the remaining is listed as indigenous beliefs or other religions.

Kenya holds more than forty different ethnic groups, and the five largest groups are Kikuyu (22%), Luhya (14%), Luo (13%), Kalenjin (12%) and Kamba (11%), which constitute more than 70 percent of the country's population. Each of Kenya's ethnic communities has since pre-colonial time predominantly occupied specific territorial locations, and today most ethnic groups occupy exclusive districts with the exception of a few settlement districts in the former White Highlands, an area in the central uplands of Kenya. Ethnicity in Kenya is said to be both geographically specific and culturally distinct.

The Kenyan population is very young, with a median age for men and woman of 18 years, compared to 40 in Denmark, i.e. ca. 50 percent of the population is below 18 years. More specifically was ca 14.7 percent of the population in 2007 above 45, whereas 42.1 percent of the population was under the age of 15. The level of education in Kenya is relatively high

[3] When speaking of Nairobi it is referred to the metropolitan area of Nairobi, not the city limits

compared to its neighbour countries, with close to 50 percent of the population currently holding a primary education, 15.3 percent a secondary education and 26.4 percent without any education[14].

More than 80 percent of the population is currently located in rural areas, and the majority of households in rural areas are in the poorest quintiles. As table 1 illustrates, geographic location and wealth status are closely linked with the two wealthiest quintiles comprising ca. 91 percent of the urban population. The wealthiest quintile comprise of what it defined as the Kenyans who can afford middle and upper class healthcare.

| Quintile | Urban | Rural |
|---|---|---|
| Poorest | 1,2 | 98,8 |
| Second | 1,7 | 98,3 |
| Middle | 7,9 | 92,1 |
| Fourth | 31,0 | 69,0 |
| Richest | 82,0 | 18,0 |
| Percentage of total population | 19,8 | 80,2 |

*TABLE 1: KENYAN POPULATION BY WEALTH INDEX (2007), SOURCE: HHEUS 2008, P. 14*

Another interesting feature of the Kenyan population is Harambee. The word harambee is Swahili, and means "pulling together". Jomo Kenyatta, the first president of Kenya, introduced the word "harambee" following the independence in 1963 as a concept of pulling the country together to build a new nation. It quickly became a national slogan and a sign of unity among the Kenyan population. In the early 1970s the harambee initiatives focused mainly on schools, health facilities, cattle dips and roads, while later focusing on large agriculture and infrastructure projects. In cooperation with the GOK, Harambee self-help projects have been responsible for the building of over 200 schools, 40 health Centres, 60 dispensaries[4], 260 nursery centres, 42 bridges, 500 km of rural access roads etc throughout the country. In the case of schools and health centres, the GOK usually takes over the facilities once they have attained the required standards. During the period 1967 to 1987, contributions for Harambee projects in the country amounted to USD 3,707,580[15]. It still stands as a strong symbol of Kenya.

Geographically, Kenya is well placed to be the regional hub for financial, air- and sea transport, making the country attractive for investors targeting the entire East African region. Kenya's strategic location in the East African Community (EAC) and Common Market for Eastern and Southern Africa (COMESA) provides access to a population of respectively

[4] A charitable or medical facility that dispenses free or low cost medicine

126m and 385m people. Kenya is also the largest single exporter to the EAC and COMESA[16].

## 4.2 THE ECONOMY

Kenya's economic performance has varied considerably over time as a result of external shocks and various internal challenges. It is, however, possible to identify four distinct economic phases in the Kenyan economy since independence: a strong growth phase with an annual average growth rate of 6.6 percent (1964-73), a period of external commodity shocks from oil and coffee (1974-79), a period of stabilisation and the beginning of the structural adjustments in the 1980s, and an era of liberalisation and declining donor inflows from 1990 to 2002[17]. After president Kibaki took over on December 30, 2002, Kenya experienced a new strong growth phase reaching a GDP growth of 7.1 percent at the highest in 2007, illustrated in graph 4.2.1. Then, in 2008, the situation changed dramatically and the growth rate dropped to 1.7 percent following the post-election crisis, the international financial crisis and harsh weather conditions.

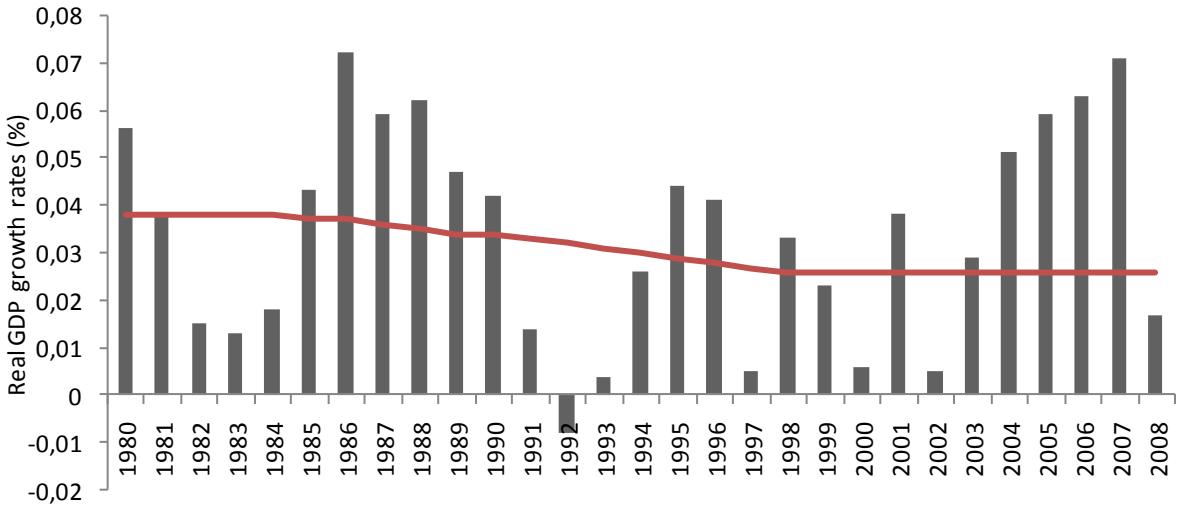



*TABLE 2: REAL GDP GROWTH RATE VS. POPULATION GROWTH 1980-2008, SOURCE:HTTP://DATA.WORLDBANK.ORG/COUNTRY/KENYA*

Agriculture remains the largest sector in Kenya, but there has been a gradual decline in overall GDP contribution from one third in the 1960s to less than a quarter in 2008. The second and third largest sectors are manufacturing and wholesale and retail trade, each contributing approximately 10% to real GDP growth[18].

Kenya also has the base to built a thriving economy, and is looking outside Africa to find emerging countries in a similar situation. How this is pursued and how the future institutional environment will facilitate will be elaborated later in the institutional analysis and the assessment of the future economy of Kenya[19].

# 5 THE KENYAN HEALTHCARE SECTOR

This section starts by introducing healthcare in Kenya, and then it defines what exactly is meant by healthcare and where the thesis' focus will be. The Kenyan health provision will then be described in detail explaining the referral system followed by segmentation of the market emphasising the main stakeholder, and how funding is obtained. The last part of the chapter discusses the disease burden in Kenya, and how this problem influences the health provision sector.

## 5.1 INTRODUCTION

Since independence in 1963, the Government of Kenya (GOK) has been responsible for the health of its people. The first initiative by the GOK after independence was an expansion of health facilities in rural areas aiming at meeting the needs of Kenya's poor and rural population. However, the first real change in health policy was in 1977, with the adoption of the World Health Assembly "Health for All by the year 2000", the 1978 Alma-Ata Declaration on primary healthcare, and the 1981 WHA "Global Strategy for Health for All by the year 2000" which formed the basis for the "National Guidelines for the Implementation of Primary Health Care in Kenya" published in 1986[20]. The new health policy led to a major reorganisation of the existing health systems and structures based on principles of decentralisation, community participation, and inter-sector collaboration[20].

In an effort to increase the access of primary healthcare in the districts and improve the performance of government health providers, a cost-sharing programme was introduced in 1989. The programme introduced fees in order to share costs with those receiving health services. The cost-sharing programme was heavily debated at inception, and even suspended for a short period in 1990. Nevertheless, in 1991 the programme was reintroduced in cooperation with the newly established USAID-funded Kenya healthcare programme strengthening the system of fee collection[21].

In 1994, the GOK approved the Kenya Health Policy Framework (KHPF), a milestone blueprint for the development and management of health services in the country. This document proposed long term strategic imperatives and established an agenda for health sector reforms going forward. In an effort to implement the proposals, the Ministry of Health (MOH) developed an action plan for the KHPF, later recognised as the National Health Sector Strategic Plan (NHSSP). The health sector vision behind the NHSSP was to create an enabling environment for the provision of sustainable quality healthcare that is acceptable and affordable to all Kenyans, whereas the mission of the MOH was to promote and provide

quality curative, preventive and rehabilitative healthcare services to all Kenyans[22]. The implementation of the policy agenda represented in the KHPF was said to be a challenging task, requiring better cooperation between government and non-government organisations (NGOs), the private healthcare sector and faith-based organisations (FBOs).

In 2005 the GOK introduced its second National Health Sector Strategic Plan 2005–2010 (NHSSP II) seeking to resolve the shortcomings of the NHSSP I. One of the milestone changes NHSSP II was a whole new approach to health service delivery. The new approach shifted the emphasis from the burden of disease to the promotion of individual and community healthcare through the Kenya Essential Package for Health (KEPH). Similar to the NHSSP I, the NHSSP II highlights the importance of NGOs and the private healthcare sector, and recognises that "reversing the trends" cannot be achieved by the government health sector alone[23]. The latter and how it has affected the healthcare sector is elaborated on in the institutional analysis.

### 5.2 DEFINING HEALTHCARE

The healthcare sector is comprised of several sub sectors[24], thus it is necessary to start out by defining these before moving into a more in-depth description of the health provision sector. For the purpose of the thesis, the healthcare sector is defined to include the six sub categories described below.

**Health provision:** involves the actual delivery of health services, which is usually provided on three different levels; primary, secondary and tertiary. Primary healthcare involves the widest scope of healthcare, and is generally the first point of consultation for all patients, whereas secondary and tertiary healthcare refers to service provided by medical specialists. Tertiary healthcare service is predominantly sophisticated specialist care, such as neurosurgery and cancer. Furthermore, the healthcare services provided are generally categorised as either inpatient, when the patient is admitted to a hospital because he or she needs to stay overnight, or outpatient, when the care does not involve hospitalisation for diagnosis or treatment. Outpatient care range from basic diagnostic services to specialised treatment such as eye care (Ophthalmology), skin care (Dermatology) or mental healthcare.

**Public health:** refers to preventive care rather than curative care, and includes i) sanitation and vaccination programmes, ii) creating public awareness around health issues and iii) surveillance of health development at the population level.

**Health Insurance:** is a type of tontine, i.e. a contract of paying money today to benefit and enhance economic stability in the future. It is chosen to mitigate the risk of incurring medical expenses in the future. Some insurance schemes only cover inpatient medical services, usually public, whereas other more expensive insurance schemes, usually privates, cover inpatient, outpatient and specialised services. The most important insurance scheme is the public National Health Insurance Fund which will be elaborated on in the upcoming part.

**Pharmaceutical manufacturing:** refers to the development and production of drugs licensed for use as medications.

**Distribution and retail of medical equipment and supplies:** A healthcare distributor is responsible for the procurement of medical equipment and supplies from a manufacturer, which in turn, sells to retailers. The retailer then sells the supplies to hospitals, clinics and health centres.

**Medical and health education:** Health and medical education involves the training of professional health personnel including nurses, clinical officers and doctors.

The main focus will be on the health provision sector mainly due to four reasons. First, health provision is the largest private healthcare segment in Kenya accounting for 69.4 percent of total healthcare expenditures[25,5]. Second, a considerable part of health provision is for-profit[26]. Third, the individual project size for investment in health provision is smaller than other parts of the healthcare sector, such as insurance and pharmaceutical distribution and retail. And fourth, the health provision sector is not dominated by a selection of multinational enterprises which is the case in the pharmaceutical industry[27]. Seeing as the health provision sector is closely linked to public health, health insurance, and medical and health education, these segments will also be discussed briefly. Pharmaceutical manufacturing and distribution is outside the scope of the thesis, and thus will this subsector not be covered in detail.

### 5.3 THE KENYAN HEALTH PROVISION SYSTEM

This section covers the distribution of health provision facilities in Kenya, the structure of the national referral system and the national insurance health programme.

The Kenyan health provision sector comprises of both a formal and informal sector. The formal sector consists of public and private health facilities regulated by the MOH, whereas

[5] THE is the sum of general government expenditure on health and private expenditure on heath in a given year.

the informal sector is made up of traditional healers over which the MOH has no control. As the focus is on the private for-profit sector, the informal sector will not be covered detailed here, but instead in the informal institutional analysis.

As mentioned in the previous section, health provision involves the actual delivery of health services, and these services range from basic primary care to sophisticated tertiary care. The MOH categories the facilities in which the health services are provided into five different groups depicted in table 3.

| Province | Dispensary | Health Centre | Hospital | Medical Clinic | Nursing Home | Total |
|---|---|---|---|---|---|---|
| Central | 397 | 67 | 57 | 654 | 24 | 1199 |
| Coast | 253 | 42 | 41 | 368 | 19 | 723 |
| Eastern | 555 | 91 | 61 | 218 | 17 | 942 |
| Nairobi | 147 | 69 | 43 | 109 | 19 | 387 |
| North Eastern | 113 | 11 | 21 | 45 | 8 | 198 |
| Nyanza | 405 | 132 | 86 | 64 | 29 | 716 |
| Rift Valley | 1076 | 210 | 102 | 234 | 26 | 1648 |
| Western | 194 | 73 | 35 | 58 | 17 | 377 |
| **Total** | 3140 | 695 | 446 | 1750 | 159 | 6190 |

*TABLE 3: NUMBER OF HEALTH FACILITIES BY TYPE, SOURCE: MOPHS 2009, P. 56.*

The number of hospitals in Kenya has grown from 148 in 1963 to 446 in 2008, whereas the number of health centres has grown from 160 to 695[28]. In the period 2004 to 2008, the total number of health facilities grew by 23 percent from 4767 to 6190. Recent statistics provided by the MOH indicates that 48 percent of the health facilities are manned by GOK, private enterprises 34 percent, FBOs 13 percent, NGOs 2 percent, communities 2 percent and local authorities 1 percent[29].

Table 4 provides a more detailed description of the number of public and private facilities in each group. Table 3 and 4 do not correspond exactly because of a two years difference and an inconsistent definition of public and private is inconsistent. Nevertheless, it provides an overview of the distribution of facilities between the private and public sector which most likely have not changed proportionally significantly, and it clarifies that the majority of dispensaries are public, and the ones that are private are most likely to be held by non-profit NGOs or FBOs.

| Facility | Public | Private | Total |
|---|---|---|---|
| Hospitals | 158 (53%) | 142 (47%) | 300 |
| Nursing homes | - | 191 | 191 |
| Health Centres | 459 | 193 | 652 |
| Dispensaries | 1,503 (67%) | 749 (33%) | 2,252 |
| Medical Clinics | - | 1,734 | 1,734 |
| Total | 2,120 (42%) | 3,009 (58%) | 5,129 |

*TABLE 4: HEALTH FACILITIES IN KENYA BY OWNERSHIP (2006), SOURCE: USAID 2009, P. 9*

In 1994, there were approximately 1,500 private health facilities in Kenya[30], which means that the number of private health facilities has doubled in the last 12 years. There are three commonly mentioned factors behind this rapid growth. First, the decision by the government in 1989 to allow nurses and clinical officers to set up their own private practice, second, the increased cooperation between the National Hospital Insurance Fund (NHIF) and the private sector, and third, a deteriorating quality in the public sector's hospitals[31].

The 6,190, public and private health facilities discussed above are divided into a pyramid referral structure, as illustrated in figure 2, with six different levels; 1) Teaching and referral hospitals, 2) Provincial hospitals, 3) District hospitals, 4) Health centres 5) dispensaries and 6) communities[32].

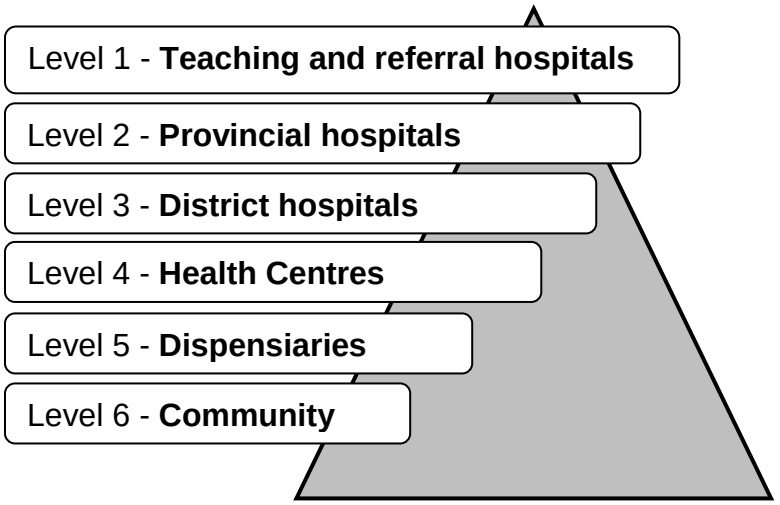



*FIGURE 2: HEALTHCARE DELIVERY IN KENYA, SOURCE: NHSSP II 2008, P. 17.*

The referral system only comprised of five levels until the NHSSP II was introduced in 2005 which included the community level as the sixth level. It was added to facilitate the communication between the dispensaries and the local communities, to provide better health services adapted to local needs. Another important task at the community level is to increase awareness concerning hygiene, diseases and preventive care.

The dispensaries, at the second lowest level, are meant to be the healthcare systems first line of contact with the patients. For the most part, these facilities provide preventive and not curative care, but some dispensaries offer treatment for less complicated and common illnesses such as maternity issues, uncomplicated malaria and skin diseases[33]. Seeing as the dispensaries only provide outpatient services, they do not receive reimbursements from the NHIF.

Compared to the dispensaries, the health centres provide a wider range of both preventive and curative services, including minor surgical services such as incision and drainage. Patients with severe and complicated conditions are not treated at the health centres, but referred to the district-, provincial or teaching and referral hospitals, depending on the care needed.

The district hospitals are the first referral hospitals and provide quality clinical care by a more competent staff than those of the health centres. The major difference between the health centres and the district hospitals is that the district hospitals offer twenty-four hour inpatient services compared to just basic outpatient services. The district hospitals also offer a wide range of clinical services including; obstetrics and gynaecology, child health, medication and more sophisticated surgery.

The provincial hospitals are the next level of referral, and they provide specialised healthcare services not readily available at the district hospitals. The specialised services range from advanced intensive care to dental services. Several provincial hospitals also provide teaching and training for healthcare personnel, and supervision and monitoring of district hospital activities[34].

At the national level there are two teaching and referral hospitals, Kenyatta Hospital and Moi Referral and Teaching Hospital. These hospitals offer a wide range of sophisticated healthcare which requires high-technological equipment and highly skilled personnel. In addition to providing complex curative tertiary care, the national hospitals also enforce quality standards, conduct health research and provide both basic and post-graduate training for health professionals[35].

The following section will cover the national insurance scheme due to its importance in the Kenyan health provision market, and to understand its current and future coverage of patients with respect to the Nairobian market.

### 5.3.1 THE NATIONAL INSURANCE HEALTH FUND

The NHIF is a government-owned corporation originally established in 1966 as a sub-department of the MOH. Today, the NHIF is no longer a part of the MOH, but operates independently with a wide network of over 400 accredited governmental private and mission[6] health providers spread across the country[36]. In short, the NHIF provides basic inpatient insurance cover to a wide array of individuals, both within the formal and informal sector.

Previously, the benefits from NHIF were quite limited and the members were mainly in the high- and middle income bracket. This is no longer the case, and today the NHIF membership is compulsory for all persons engaged in formal employment, and voluntary for the self-employed or informal employed who have attained the age of 18 years. The NHIF operates under the social principle that "the rich should support the poor, the healthy should support the sick and the young should support the old"[37]. In order to ensure countrywide coverage for its members, the NHIF cooperates with both public and private health providers certifying that the certain minimum requirements are met and divides them, depending on the hospitals price level,, into three different categories each with a different level of coverage. Category A comprises of government hospitals providing full cover for maternity and medical diseases including surgery. Category B corresponds to private and mission hospitals[7], and these offer similar coverage as the government hospitals except for surgery. Category C is mainly private hospitals, and members will only receive limited services such as overnight bed coverage. The additional expenses that are not covered through NHIF can either be paid out-of-pocket or through a more inclusive private insurance plan, i.e. the NHIF insurance provides base level coverage.

| Sector | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|
| Formal sector | 1,938,419 | 1971372 | 2,010,800 | 2,061,070 | 2,102,291 |
| Informal Sector | 264,244 | 819,156 | 1,228,735 | 1,843,102 | 2,764,653 |
| Indigent | 0 | 975 | 1,316,250 | 1,711,125 | 2,138,906 |
| Total Contributors | 2,202,663 | 3,765,528 | 4,555,785 | 5,615,297 | 7,005,850 |

*TABLE 5: MEDIUM TERM PLAN (2008-2012) AND VISION 2030, SOURCE: CBK 2009*

Today, the NHIF has approximately 4,6m memberships, as shown in table 5, with respectively 2m people in the formal sector, 1,2m in the informal and 1,3m indigents, i.e. a person so poor that he cannot provide the necessities of life for himself[38]. Through the mandatory payments the fund receives approximately 5.3b Kenyan Shilling (KSH) in

[6] Health provider run by non-profit Christian organisation
[7] Christian non-profit hospitals

premiums, but pays only KSH 2.8 to hospitals[39]. This lack of canalising the money to the hospitals instead of using almost 50 percent on non-healthcare costs has been highly criticised by the press and cement the lack of focus also stated by the Permanent Secretary of the Ministry of Medical Services[40].

According to the CEO at NHIF[41], more than 90 percent of the Kenyan population is currently uninsured, which is primarily a result of ignorance and lack of awareness, and not the ability to pay. The Nairobi province has the highest coverage with almost 25 percent of the population insured, while the North Eastern region has the lowest coverage with less than 3 percent insured. In terms of income, coverage is highest for those in the richest quintile (31%) and lowest for those in the poorest quintile (1%). The level of education is also an important factor affecting the use of health insurance, and for those with college and university education 42.6 and 59.7 percent are insured, respectively[42]. Barely 7 percent of those with only primary education have insurance. Out of the total number (600,000) of private insurance members in Kenya, 25 percent is located in Nairobi[43], i.e. 150,000.

## 5.4 HEALTH PROVIDERS IN NAIROBI

This section covers the participants in the public and private health provision sector in Nairobi, and describes the organisation of the private sector in detail.

### 5.4.1 PUBLIC HEALTH PROVISION IN KENYA

In order to get a better overview of the inpatient capacity in the public sector, a list of all the public hospitals in Nairobi has been compiled and arranged according to number of beds in table 6.

| Hospital | Beds |
|---|---|
| Kenyatta National Hospital | 1,595 |
| Mathare Mental Hospital | 1,138 |
| Mbagathi District Hospital | 250 |
| Pumwani Hospital Management Board | 350 |
| Kamiti Hospital | 195 |
| Other | 30 |
| **Total** | 3,767 |

*TABLE 6: PUBLIC HOSPITALS IN NAIROBI BY BEDS, SOURCE:WWW.NHIF.OR.KE/HEALTHINSURANCE*

Kenyatta National Hospital (KNH) located in the heart of Nairobi is the second largest hospital in Sub-Saharan Africa with a total bed capacity of 1,804 which are both public and private. KNH has 50 wards, 20 outpatient clinics, 24 theatres, and an Accident and Emergency Department[44]. The hospital hosts between 2,500 and 3,000 patients a day, and on average the hospital caters more than 80,000 inpatients and 500,000 outpatients annually.

### 5.4.2 PRIVATE HEALTH PROVISION IN KENYA

As previously mentioned, the private health provision sector comprises of for-profit and non-profit entities, such as for-profit enterprises, FBOs and NGOs.

The FBOs in Kenya are organised into three branches based on religious views, respectively Protestant, Catholic and Muslim. The leading FBO is the Christian Health Association of Kenya (CHAK), representing Protestant churches' health facilities and programmes countrywide. In total, CHAK has more than 450 health providers ranging from large hospitals to small dispensaries, as well as nurses training colleges[45]. In cooperation with the Muslim and Catholic branch, CHAK has recently established a working group with the MOH in order to better compliment the GOK effort to provide health services to people through the NHSSP II.

NGOs in Kenya provide, similar to the FBOs, a wide range of health services, ranging from healthcare delivery, policy planning and community mobilisation. One difference, however, is that the NGOs in general are more positive towards cooperating with the for-profit health sector[46]. In 2005, the Health NGOs' Network (HENNET) was established as a result of the growing number of NGOs – HENNET aims at facilitating the allocation of health resources through cooperation. It has 72 registered members at the national and district level, and hosts workshops regularly on health related issues. Their most recent forefront initiative is the Public Private Partnership (PPP) programme, which aims at increasing the cooperation between the MOH and the private sector, both for-profit and non-profit[47].

On the contrary to common beliefs, more than 95 percent of the FBOs' and NGOs' operations are financed by user fees but still non-profit seeking[48]. Their strong dependency on user fees is currently threatening the private non-profit sector as a result of an increased use of public health facilities. Since the FBOs and NGOs play an important role providing health services to remote and rural areas and the GOK has recently decided to extend their support to these providers to prevent their facilities from collapsing[49].

The for-profit health sector is represented through the organisation, Kenya Private Sector Alliance (KEPSA), comprised of more than 60 business membership organisations and more than 180 enterprises[50]. KEPSA has 11 different boards working on various private sector issues, such as infrastructure, agriculture, tourism and health. The health specific department is named Kenya Healthcare Federation, and provides a unified voice for the private health sector in the policy process[51].

In addition to KEPSA, there are sub-sector specific associations within the private insurance, pharmaceutical and health provision sector. The Association of Kenya Insurers (AKI) is one of the largest private sector associations within the health arena, and comprises of 42 insurance companies covering various types of insurance[52]. As previously mentioned, a very small percentage of the Kenyan population make use of either public (NHIF) or private health insurance, and the AKI is working towards increasing the health insurance coverage through improved awareness among the general public.

The hospital sector is not very organised compared to the insurance sector. There are currently two associations organising healthcare in Kenya; the Kenya Association of Hospitals (KAH) and the Kenya Association of Private Hospitals (KAPH). These associations, in cooperation with Kenyan hospitals, prepare and implement policy guidelines directed by the MOH. The KAH and KAPH recently came together with the Kenya Medical Association (KMA), a voluntary membership organisation open to all medical practitioners, to form the Kenya Private Healthcare Consortium[53]. The consortium is an umbrella organisation focusing on improving healthcare through private sector participation. It should also be stressed that the largest private and public hospitals, such as KNH, Nairobi Hospital and Aga Khan Hospital, play a crucial role in the policy-making process related to healthcare delivery.

### 5.4.3 PRIVATE HOSPITALS

The Nairobi Hospital is the largest and oldest private hospital in Nairobi and offers a wide range of tertiary and secondary healthcare services as well as health education for nurses. Today the hospital holds approximately 320 beds, and according to the director of nursing services of the Nairobi Hospital[54], the number of hospital beds has increased by 120 over the last five years. The Nairobi Hospital operates on a for-profit basis, but acts as a not-for-profit hospital in the sense that it does not distribute its surplus funds to owners or shareholders, but instead reinvests all surpluses in further expansion.

The second largest private hospital in Nairobi is the Aga Khan University Hospital (AKUH) established in 1958. AKUH is a part of the Aga Khan Development Network, an organisation operating in over 25 countries around the world with more than 60,000 employees[55]. Similar to The Nairobi Hospital AKUH combines secondary and tertiary care services with health education. According to the Manager of Strategic Planning at AKUH[56], the hospital currently holds 230 beds, a number that is expected to be around 400 within five years. 70 percent of the doctors at the hospital also teach at the hospitals education facility, and the typical AKUH

customer belongs to the middle-income bracket. AKUH is also a not-for-profit hospital and reinvests all their proceeds in further expansion and development.

As previously mentioned, the KNH is the largest public hospital in Kenya located on the top of the healthcare delivery pyramid. However, the KNH also provides services from their private wing. Out of the total bed capacity of 1800, 209 beds are dedicated to private customers seeking descent quality tertiary services. According to the Chief Public Relations Officer of the Kenyatta Hospital[57], the rationale for having a private wing is to retain professional staff and simultaneously increase the hospital's financial base.

The Mater Hospital established in 1962 started out as a missionary hospital with 60 beds aiming at poor and indigenous Kenyans. However, the missionary role of the Mater Hospital has spread to more rural areas, and today the Mater Hospital operates as a private hospital and charges fees for the health provided services. The hospital currently holds 135 beds in addition to providing a wide range of outpatient services at their satellite clinics.

The Karen Hospital is on the contrary to the above mentioned a new, for-profit hospital located in the outskirts of Nairobi with 102 beds, but built so it can increase the number of beds. It was established in 2006 by two Kenyan doctors and 35 shareholders and is the second major hospital that has been built since independence. According to the Chief Executive Officer of the Karen Hospital[58] it aims at adapting a similar business' model as AKUH by combining secondary and tertiary healthcare provision with health education.

In 2001, the Nairobi Women's Hospital (NWH) was set up with the aim of providing healthcare to women and children of the society. Today the hospital has roughly 150 beds divided into two facilities in Nairobi, and 200 beds in Mombasa. In comparison to the majority of private hospitals in Nairobi, who aim at the upper-middle-class, the NWH aims at the lowest bracket in the middle class. The NWH is also the first hospital to receive funds from the African Health Fund, a fund launched in June 2009 backed by the International Finance Corporation (IFC), the African Development Bank, DEG[8] and the Bill & Melinda Gates Foundation. The Africa Health Fund is managed by Aureos Capital, a leading private equity fund company specialising in investing in small to medium-sized businesses in emerging markets. The US$ 2.66 million in funding will be used to the expansion of facilities such as clinics, beds and theatres in the East African Region. The CEO of NWH[59] is planning

[8] DEG, a member of KfW Bankengruppe (KfW banking group), is one of the largest European development finance institutions.

to make the NWH the largest private hospital in the East African Region with more than a thousand beds within 2015[60].

Table 7 provides an overview of the various private enterprises operating within inpatient health provision in Nairobi. Out of the total inpatient bed capacity in Nairobi, 40 percent is provided by private health provision enterprises.

| Hospital | Beds |
|---|---|
| The Nairobi Hospital | 320 |
| Aga Khan University Hospital | 230 |
| Kenyatta National Hospital (Private Wing) | 209 |
| The Mater Hospital | 135 |
| The Karen Hospital | 102 |
| Nairobi Women's Hospital | 140 |
| Other small hospitals (45) | 1,315 |
| **Total** | 2,451 |

*TABLE 7: PRIVATE HOSPITALS IN NAIROBI BY BEDS, SOURCE: WWW.NHIF.OR.KE/HEALTHINSURANCE*

#### 5.4.4 PRIVATE OUTPATIENT CLINICS

Doctors and health practitioners working in the private sector either operate alone, at out-patient clinics in hospitals or through a medical centre. In Nairobi, there are two large medical centres, the Upper Hill Medical Centre (UHMC) and the Doctor's Plaza.

The UHMC comprises of 37 doctors with their own specialised out-patient clinics in a 6-storey complex near the Nairobi Hospital. The medical centre is strictly for-profit, and their services are primarily provided to corporate clients in the high-income bracket. The UHMC offers a broad spectrum of services ranging from day care surgery to hearing aid consultation. Since UHMC was established in 2001, the medical centre has managed to build a strong brand in Nairobi and a solid portfolio of corporate clients. The General Manager of UHMC[61] stated that a strong brand is the key in order to attract customers, since similar services are available through Kenyatta's private arm at subsidised prices. Arguments for choosing UHMC over less expensive services are mainly shorter queues and high quality services.

The Doctor's Plaza is a part of the Nairobi Hospital and located adjacent to the hospital thus located close to UHMC and it also operates as a hub of clinics similar to the UHMC. However, the outpatient clinics at the Doctor's Plaza do not share the same brand and offers services to a wider range of customers, and not just high-income corporate customers as the UHMC.

The medical centres generally target the growing middle- and upper-income population in urban areas. Besides attracting high income patients, the medical centres are also able to attract highly skilled health personnel as a result of higher wages and being centralised in the medical hub of Nairobi.

### 5.4.5 Private Insurance

In addition to the traditional hospitals and clinics, there are also a number of hybrid enterprises operating in both health care provision and insurance. Compared to the NHIF, the private insurance sector is quite small and comprise of approximately 600,000 members in total[62]. These members are for the most part individuals receiving insurance through employee insurance plans. The private sector insurance coverage out of the insured population is highest in Nairobi with 25 percent, i.e. 150,000, and lowest in the North Eastern province with only 4 percent[63].

## 5.5 Segmenting The Kenyan Health Market

This section attempt to decompose the supply of health provision in order clarify who provides what to whom, and to what extent the different providers overlap each other. Although the importance of the private sector is recognised in the NHSSP II, there is no clear-cut consensus regarding the roles of each sector going forward[64].

In 2007, private outpatient provision in rural and urban areas accounted for respectively 23.6 percent and 33.8 percent of total health provision[65]. In Nairobi it is 42.9 percent with the private sector covering 40 percent of this activity[66]. Seeing as inpatient services are predominately provided by hospitals, it is reasonable to use the number of hospital beds as a measure of private sector participation in inpatient services. As depicted in table 1 and 2, the number of beds in the private sector in Nairobi is 2,451, compared to the public sector which has 3,767 beds. Based on the number of hospitals and beds, it is likely that the public sector covers roughly 50 to 60 percent of the inpatient market in Nairobi, but as private hospitals more efficiently use the beds with shorter bedtime than public it is estimated at approximately 50 percent. According to the NHIF, mission hospitals in Nairobi only provide 166 beds, less than one percent of the total number of beds in the private sector[67].

Table 8 illustrates the public and private participation by sector and service based on the distribution of hospitals in table 1 and 2, and qualitative data gathered at the interviews in Nairobi.

| Sector | Inpatient | Outpatient |
|---|---|---|
| Public | 60 % | 50 % |
| Private, FBOs and NGOs | 10 % | 10 % |
| Private, Commercial | 30 % | 40 % |

*TABLE 8: THE HEALTH PROVISION MARKET IN NAIROBI, SOURCE: INTERVIEWS, WWW.NHIF.OR.KE*

The utilisation of private health providers varies substantially between the different income brackets and geographical location. In 2007, seventeen percent of rural residents visited private health facilities for illness compared to 29 percent in urban areas. In Nairobi, the use of private health facilities is 34.6 percent, i.e. twice as high as in rural areas[68]. The richest quintile of the population represents 35.5 percent of the total utilisation of private providers, whereas the poorest quintile represents 15.7 percent[68] illustrated in figure 3. Insurance also plays an important role regarding the use of private providers, and Kenyans with insurance are twice as likely to use private providers as are the uninsured[68].

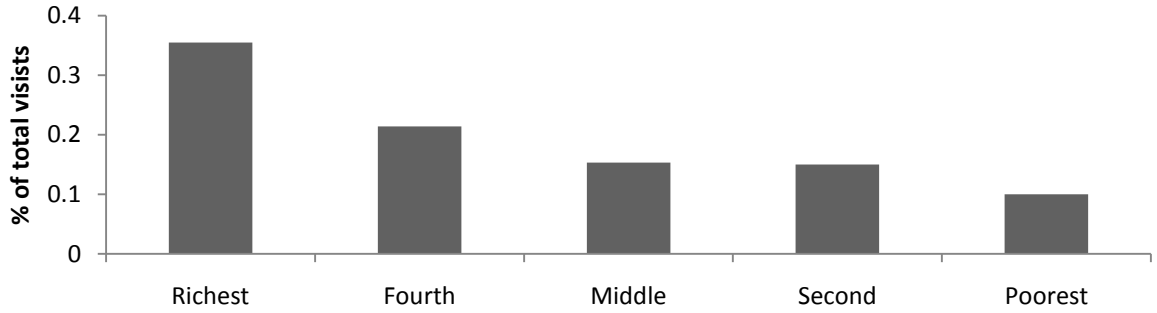



*FIGURE 3: UTILISATION OF PRIVATE HEALTH PROVIDERS, SOURCE: HHEUS 2007, P. 14*

The utilisation of outpatient services also differs substantially between the different income brackets. The wealthiest fifth of the population spend twice as much on outpatient care as the next wealthiest quintile, and seven times as much as the poorest, i.e. the wealthiest quintile therefore comprise ca. 50 percent of all spending on outpatient care. According to the MOH, wealthy individuals make about the same number of outpatient visits as the poor, but they more often seek expensive care provided by private facilities[69]. Poor individuals are more likely to choose public, lower-priced and subsidised service providers.

Based on the preceding description of the health provision sector in Kenya and Nairobi, it seems evident that the public sector, the non-profit sector, and the private commercial sector provides health services to different population segments based on geographical location, income and consumer preferences, but with some overlapping. The private commercial sector focus more on outpatient services than inpatient services, and the services provided are primarily to urban high- and middle income individuals. The private non-profit sector, on the

other hand, plays an important role in providing healthcare mainly to low, but also middle, income individuals in remote and rural areas.

### 5.6 SOURCE OF HEALTH FUNDING

This section investigates the major sources of healthcare funding in order to get a better picture of who pays for healthcare in Kenya.

The government's percentage of total health expenditure (THE) fell from 8 percent to 5.2 percent in the period 2001 to 2005, which is said to be a result of an increase in the GOK spending seeing as the absolute amount per capita increased[70]. But the total health expenditures in Kenya were close to US$ 1 billion, i.e. an increase of 24 percent over 2001 when compared in absolute numbers. This was equivalent to about 4.8 percent of GDP and corresponding to health spending per capita of approximately US$ 27, an increase from US$ 23 in 2001[71], and ca. 85 percent of Kenyans rate their health good or very good[72]. Similar to the other countries in the SSA region, Kenya does not meet the WHO recommended level of health spending per capita (US$ 34)[73].

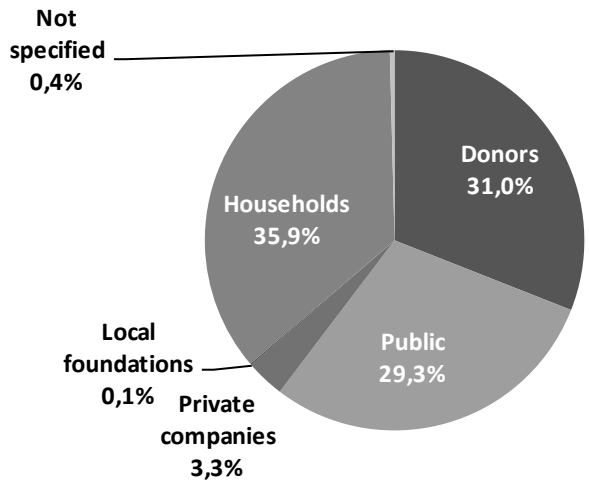



*FIGURE 4: HEALTHCARE FINANCISING, SOURCE: NHA 2005/2006, P. 17*

As depicted in figure 4, the private sector, comprised of household payments, private companies and local foundations, contributed 39.3 percent of total health expenditures, with 35.9 percent coming from households through out-of-pocket payments[71]. The share of donor contributions to total health expenditures increased from 16.4 percent in 2001 to 31 percent in 2005, from US $118.9 million to US$ 298.6 million. The remaining 29.3 percent is contributions from the public sector.

As mentioned earlier, the GOK has increased their effort to organise healthcare in Kenya through the NHSSP II, i.e. to functionalise the referral system, increase HC coverage to the low income brackets of the population and improve preventive care. This is also reflected in the increased share of THE going to health administration in table 9. The negative side effect is that this will decrease the available funds used on inpatient- and outpatient care.

| Category | 2001/02 | 2005/06 |
|---|---|---|
| Inpatient care | 32.1 % | 29.8 % |
| Outpatient care | 45.2 % | 39.6 % |
| Prevention and public health programmes | 9.1 % | 11.8 % |
| Health administration | 5.0 % | 14.5 % |

*TABLE 9: DISTRIBUTION OF MOH'S BUDGET, SOURCE: NHA 2006, P. XVI*

The different sources of healthcare financing are managed by so-called financing agents, which are institutions that receive funds to pay for or purchase health goods or services. Examples of financing agents are the MOH and other ministries, NHIF, private insurance companies, donors, NGOs and households through out-of-pocket payments. In 2005, about 57 percent of the resources mobilised was channelled through the private sector, an increase of 7 percent since 2001. The remaining 43 percent was channelled through the public sector, with the MOH as the largest agent controlling 34 percent of the total resources.

The beneficiaries receiving financing through the financing agents consist of a wide range of facilities, both private and public. Poor coordination and a lack of transparency between the financing providers, financing agents and beneficiaries, have posed challenges to the GOK's implementation of integrated healthcare that are aligned to prioritise healthcare needs. According to the MOH[74], poor management of available health funding is one of the main limitations towards reaching the Millennium Development Goals (MDGs) for healthcare. The MDGs are goals set forth by the United Nations (UN) for developing countries. They are made in order to clarify areas where the incumbent government should focus on to address and decrease poverty, hunger, underweight, persecution, inequality, lack of education etc[75].

### 5.7 THE KENYAN DISEASE BURDEN

This section looks at the diseases that are the largest burden on the Kenyan health provision sector which primarily driven by infectious and parasitic diseases including HIV/AIDS, tuberculosis (TB), malaria, and diarrheal diseases. These will be compared to other leading causes for inpatient and outpatient care. The disease burden in Kenya has been and continues

to be a major threat to the healthcare sector and the economy as it takes up large sums of the healthcare budget through the costs of curative care.

Today, 1.4 million Kenyan adults live with HIV/AIDS with a prevalence rate of 9 percent in urban areas, and 7.4 percent in rural areas. In 2006, the MOH estimated that approximately 50 percent of hospital beds in use were occupied by HIV/AIDS patients, and the total spending on HIV/AIDS as a percentage of total health expenditures was close to 27 percent[76]. Moreover, HIV/AIDS ranks as the main cause of death for all ages and represents 38 percent of the total deaths in Kenya. Nevertheless, only 1 percent of hospitals admissions are due to HIV/AIDS[77]. Malaria is also a major health concern for Kenya, with 70 percent of the population living in malaria epidemic areas[78]. Malaria is the most common cause for hospital admission, and in 2007 malaria accounted for 31 percent of all outpatient visits and 23 percent of inpatient visits[77].

| Diseases | Percentage |
|---|---|
| Malaria | 23.0 % |
| Respiratory infections | 17.8 % |
| Accidents and injuries | 6.3 % |
| Normal delivery | 5.5 % |
| Diarrhoea | 4.9 % |
| Diabetes | 3.4 % |
| Treatment/surgery for cancer | 3.0 % |
| Tuberculosis | 1.9 % |
| HIV/AIDS | 1.0 % |
| Other diseases | 33.0 % |

*TABLE 10: MAJOR CAUSES OF INPATIENT ADMISSION (2007), SOURCE: MOPHS 2009, P. 87*

In 2008, the estimated TB prevalence in Kenya was 184 cases per 100.000 and the incidence rate was 328 new cases per 100.000 per year[79]. In the period 1990-2006, Kenya has experienced a growing TB epidemic, increasing from 11.625 to 116.723. However, in the period 2006-2008 the number of TB cases dropped by 59 percent to 73.600. The most common causes for inpatient admission are summarised in table 10.

Outpatient care, such as Malaria and respiratory infections makes up a higher percentage (56%)[80], and other reasons for seeking outpatient care are immunisation, skin diseases, diarrhoeal and prenatal care each representing 5 percent of total outpatient visits.

Maternal morbidity and childhood diseases are also a major contributor to the Kenyan burden of disease. In 2003, 88 percent of women received antenatal from a medical professional, 2 percent received care from a traditional birth attendant, and 10 percent did not receive any antenatal care[81]. Furthermore, close to 40 percent of births are delivered in a health facility,

while 59 percent are delivered at home. The most recent health reform has recognised the growing magnitude of the disease burden, and by restructuring the health provision system the MOH hopes to battle diseases through improved preventive health care and sanitation. This new approach to healthcare delivery will be covered more in dept in the institutional analysis.

### 5.7.1 THE POTENTIAL OF THE NAIROBIAN HEALTH PROVISION MARKET

The Nairobian health provision market is very different from the rest of Kenya, as it does not lack medical employees and the GDP is significantly higher leading to a stronger purchasing power compared to the rest of the country. Due to this more of the inhabitants of Nairobi have insurance and work in the formal sector with 825,000 being NHIF-insured and 150,000 having a private insurance. This does not mean that almost one million are insured as basically all privately insured Nairobians have NHIF-insurance, but it does provide a large health provision hub. The capital is also a popular health provision destination for Kenyans living in the proximity of Nairobi and for nearby East Africans due to the city's well-renowned quality of hospitals and high connectivity to Eastern and Central Africa.

The City of Nairobi has 6,218 hospital beds of which 3,767 are public and 2,451 are private. If the same public patient per bed ratio of Kenyatta National Hospital is assumed, this results in approximately 45 patients per bed giving a total number of public inpatients of 169,515. Due to higher efficiency in the private health provision sector it would be unjustifiable to use the same ratio, but instead the ratio of Nairobi hospital is used with approximately 70 patients per bed including low seasons and general slack giving a number of 171,570. The total number of inpatients in Nairobi is therefore estimated at 341,085 p.a., as the duration of days in the hospital vary, with more days spent at public than private hospitals, and it may also depend on where the inpatient is from. Due to the large influx of foreign health tourists coming to Kenya they comprise, depending on the hospital, of 1 percent to 10 percent at Karen Hospital[82]. Several patients are also being referred to large Nairobian hospitals for inpatients operations from the rest of the country. It is therefore likely that the public hospitals have approximately 10 percent non-Nairobian inpatients and private hospitals approximately 12 percent[83].

An estimate of the total number of outpatients from Nairobi is easier to derive seeing as the average annual outpatient visits in Nairobi is publicly available. The average annual outpatients' visits in Nairobi is 2.94, the highest in the country with a country average of 2.59[84], and with a population of 3.3m this result in a number of 8,547,000 outpatients' visits

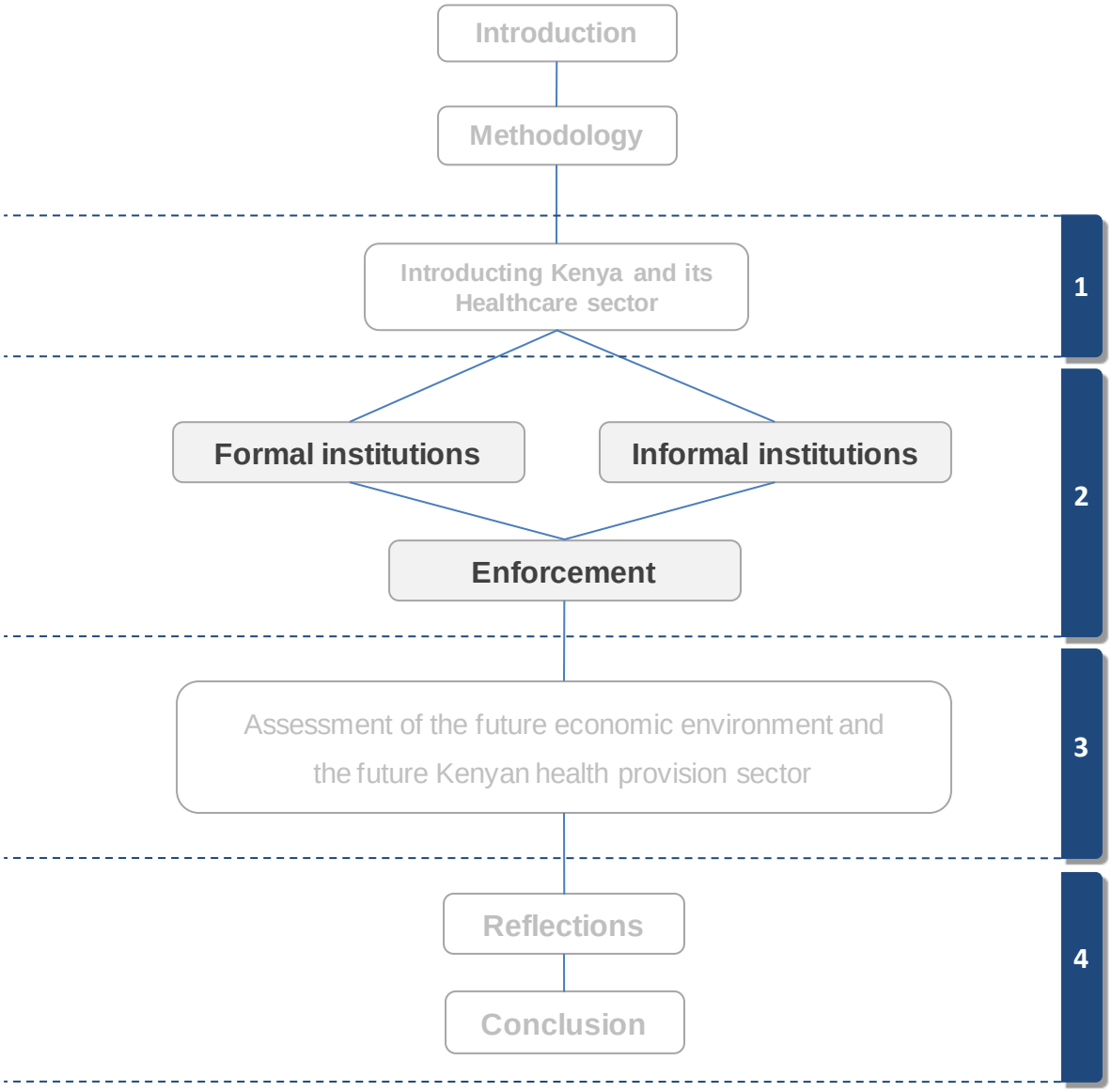
in Nairobi. As most outpatient visits can be done locally the number of outpatients' visit from non-Nairobian is estimated to be down to 5 percent of the total outpatients giving a total of almost 9m outpatient visits. Table 11 shows the allocation of Public and Private, and the latter comprising an increasing part of the outpatient market. Chemists are a private operation that dispenses drugs both prescription and over-the-counter, and they are usually located in the poor areas of Nairobi, such as Kibera, i.e. they are unregistered but basically private.

| | Public | Private | Chemist | Others |
|---|---|---|---|---|
| In % | 34.6 % | 42.9 % | 18.6 % | 3.9 % |
| Total | 3,112,907 | 3,859,645 | 1,673,413 | 350,877 |

*TABLE 11: MARKET SHARES IN THE OUTPATIENT MARKET IN NAIROBI, SOURCE: IFC 2007, P. 10*

Many African countries are plagued by HIV/AIDS, TB and Malaria, but of the three areas it is currently only the latter that has a significant importance for the Kenyan health provision market comprising 31 percent of inpatient and 23 percent of outpatient. Malaria is a large expenditure for the MOH, but it is not consider a real threat in Nairobi as it is not an infested area. The most important health provision area in Nairobi is therefore respiratory infections comprising 25 percent of inpatients and 17.8 percent of outpatients. Seeing as only 40 percent of all deliveries are carried out at health facilities today, it is reasonable to believe that this segment will grow and play a more important role in the future.

The following chapter will analyse the most important institutional factors for foreign investors considering investing in the Nairobian health provision sector, and how these co-exist.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# 6 INSTITUTIONAL ANALYSIS

Douglas North emphasises that institutions have a substantive effect because they provide the basic structure that humans have built to reduce uncertainty. High uncertainty avoidance cultures in general try to avoid uncertainty by providing stability for their members through established, formal and social protocols, intolerance for new ideas and behaviours, emphasising consensus and resistance to change[85]. They connect the past with present and future and are connected by the continuity of the society's institutions. Institutions shape the growth of knowledge that applied through the individuals' thoughts and actions are influenced by the existing institutional structures. Hence they affect the performance of the economy by their effect on the costs of exchange and production, which means they affect the respective industries[86]. It is therefore important to understand the institutions of a society upon investing in order to know the cost of capital and avoid straightforward missteps such as selling pork to a Muslim population.

To do this, it is important to clarify what is meant by institutions in the case of this paper, as definitions vary widely depending on the academics within the field. The chapter will therefore first clarify the theory of the institutional framework and how it will be pursued to be applied. This will be followed by the institutional analysis with respect to the Kenyan health provision sector from the perspective of a foreign investor.

## 6.1 INSTITUTIONAL THEORY

The New Institutional Economics is yet to have a generally accepted definition, but the vast majority of scholars follow the definition by Douglas North *"the humanly devised constraints that shape interaction. In consequence, they structure incentives in human exchange, whether political, social, or economic"*. Or simply put the rules of the game[87]. This definition is widely interpretable, and consists of 3 dimensions; i) formal, ii) informal, and iii) enforcement. The formal and informal institutions lay the ground for the enforcement, why these two need to be defined and constrained according to the interest area of the research.

It is unfortunately not clear cut how to distinguish between formal and informal institutions, and many papers generalise by a state regulation and non-state regulations, but since many institutions within the state are also informal and rules governing many non-state organisations are widely considered to be formal, this generalisation and the ad nauseam of definitions are likely to cause more confusion, than clarification. Helmke[88] makes, in a supporting paper to Douglas North, a more in-depth analysis on this dilemma and define

formal institutions as *"rules and procedures that are created, communicated and enforced through channels widely accepted as official, this include state institutions and state-enforced rules".* So rules initiated by the state such as the legal framework of a country are formal institutions. The informal institutions are defined as; "*socially shared rules, usually unwritten, that are created, communicated, and enforced outside of officially sanctioned channels".* This is often a term covering the values, ethics and norms in a society, such as using knife and fork when eating and not your hands, the latter may be reverse in some cultures.

Many institutional analyses often neglect or treat the analysis of informal institutions as a residual category, and define it as virtually any behaviour that is not accounted for in the formal institutions, or that they are extensions of formal rules. This might be the lack of understanding what they really are, and why they are so important. The fact that Kenya is a developing country generally imply weak formal institutions, which to a large degree increase the influence and importance of understanding the informal institutions. The institutional framework can be customised to fit the object of the analysis of the specific country's situation. There are three points of potential confusion which are worth emphasising to avoid any ambiguities of the meaning of formal and informal institutions[89]:

1. Weak and ineffective formal institutions do not necessarily entail the presence of informal institutions, e.g. abuse of executive authority is not understood as informal institutions, but as non-institutional.
2. An informal institution is a behavioural regularity that must respond to an established rule or guideline, like taking off your hat when entering a catholic church, where as not wearing a coat in the summer is simply a behavioural regularity.
3. Organisations both formal and informal are, following Douglas North, useful to separate from the rules they follow, but this contradicts what is the common norm among scholars. According to Selznick[90] many organisations become institutions if they pose a value and influence on the way the society works other than its definitive objective as is the case with informal organisations, such as clans, mafias etc., and formal organisations, such as political parties, banks etc. Such organisations may be included as they largely influence the environment and rules of health provision sector.

Informal institutions are often classified in two sharply contrasting categories, one camp treating it as problem solving (functional), by actually enhancing efficiency, which can be

exemplified by the South African Stokvels, which are community saving clubs where each member contribute and work to save up for funerals or general saving[91]. The second camp treats it as a problem creator (dysfunctional), such as clientelism, corruption and patrimonialism which undermine the formal markets performance. However recent studies suggest a fusion of the two camps where some informal institutions supports the existing formal institutions either being effective or ineffective and they either converge or divert from the formal institutions to support an unmet need for certainty. This typology is based on two dimensions, the first to which degree the formal and informal institutional outcomes converges or diverges, and the second is the effectiveness of the relevant formal institution. This belief is illustrated in the figure 5 with four different scenarios.

| Outcomes | Effective formal institutions | Ineffective formal institutions |
|---|---|---|
| Convergent | Complementary | Substitutive |
| Divergent | Accommodating | Competing |

*FIGURE 5: A TYPOLOGY OF INFORMAL INSTITUTIONS, SOURCE: HELMKE 2004, P. 728*

Complementary informal institutions do, as the name says, fill in the gaps of what the formal institutions lack to cover, and is what generally corresponds to the problem solving type. This is usually the myriad of norms, routines, and operating procedures that simplify decision-making in bureaucracy-heavy areas. This may also function as a foundation for formal institutions, creating or strengthening incentives to comply with formal rules that might otherwise exist merely on paper. In each case, informal institutions do not merely exist alongside effective formal ones, but built on the formal institutions to make the rules of the game more effective.

Accommodating informal institutions are commonly less covered in literature. They create incentives to behave in ways that alter the effects of formal rules, but without directly violating them. They contradict the spirit, but not the letters, of the formal rules. Although accommodating informal institutions may not be efficiency enhancing, they enhance the stability of formal institutions by dampening demands for change. This was the case for Kenya after the post-election crisis when they agreed upon sharing the political power with the opposition to dampen the skirmishes throughout the country.

Competing informal institutions are when formal rules and procedures are not systematically enforced, which enables actors to ignore or violate them. This structures incentives in ways that are incompatible with the formal rules, i.e. to follow one rule, actors must violate another.

This is the case with clientelism, patrimonialism, clan politics, corruption etc.. An example is the Kenyan Matatus, who are the informal sector's busses. They drive in the wrong side of the road or on the pedestrian street without being chased by the police and their conductance in traffic reminds more of ambulances than busses[92]. Competing informal institutions are often found in postcolonial contexts where formal institutions have been imposed which do not fit with the indigenous rules and local authority structures.

Substitutive informal institutions are like complementary institutions employed by actors who seek outcomes compatible with formal rules and procedures, but they exist in environments where formal rules are not continuously enforced. Hence, substitutive informal institutions achieve what formal institutions were meant to achieve, but failed to do. Substitutive informal institutions tend to emerge where state structures are weak or lack authority. This can be exemplified by Kenya's harambees which before independence supplied the rural areas of Kenya with the basic needs such as general water supply, building schools and health centres, and roads. The British colonists did not have an interest in providing this even though they were supposed to[93].

These four categories embody a wider definition of the relationship between the formal and informal institutions and cement the fact that their relationship cannot be described in simple dichotomous terms, i.e. functional versus dysfunctional, but help to rubric and simplify for further analysis. Accommodating and substitutive institutions might be helpful in the short run, but whether they constrain or enhance future institutional efficiency or to what extent they are part of making a society easier to invest in, is difficult to determine. Matters are that in order to invest in a society a comprehensive understanding of the institutions should be in place. As the informal institutions are empirically more apparent in a developing country, it is important to understand their role, and how they create constraints, threats, opportunities and strengths for a company investing in the Kenyan healthcare sector.

The strength of formal and informal institutions depends on the enforcement of these. The enforcement of both institutions can be either weak or strong, and the stronger it is the more apparent is the institution. The enforcement of informal institutions may be a second-best strategy, but it might be enforced because the formal institution is i) not achievable, ii) too difficult to achieve, iii) too costly, iv) ineffective or v) not publicly acceptable (domestically nor internationally). The best solution might be to disregard it and enforce the informal

institution instead. The latter is a widely discussed subject, know as lax enforcement[9], and it depends on the current norms of the population. An example of the latter is soft drug, which is legally acceptable in the Netherlands, but this would most unlikely be legal through formal institutions in a highly Christian country as Kenya, even though it is widely used among the population especially in Mombasa[94]. To comprehend the institutional framework it is not enough just to understand the work they are designed to do, but to what extent they are enforced and how this affect the interrelationships which will determine the overall investment environment that the investor will face.

The clarification of the formal- and informal institutional relationship, and the role of enforcement imply an initial descriptive part of the formal and informal institutions highlighting the institutions that shape the business environment of investing within the healthcare sector, ranging from political, legal and economic systems to the more informal institutions such as family structure, gender, tribalism, customs and norms. These two sections will not be as clear cut as earlier described, as it will be necessary at some points to include perspectives from one another to provide the best illumination of the institutional situation in Kenya.

After this the emphasis will be on the interdependence and independence of the formal and informal institutions' relationship to form a clear picture of the actual environment and what makes the "rules of the game". The categories of the institutions' interaction are not always possible to assess, as things are not black and white, but will be applied after best possible ability. The framework should therefore be seen as a supportive mean of analysing the institutions, and not a stringent framework where everything has to be categorised.

### 6.2 FORMAL INSTITUTIONS

Kenya's formal institutions have, to a large extent, been influenced by the period when Kenya was a British Crown Colony, especially when it concerns their formal institutions and how they are written. This system might have worked well with the British, as it was developed and accommodate to their norms and values for centuries, but this does not imply that it function likewise with the Kenyan society.

[9] or Gedogen in Dutch

There are many ways to divide the formal institutions, but the overall goal is to cover the relevant systems of the state to clarify the structure of the systems, who the law makers are, which laws and regulations are made, and which policies exists.

The analysis will allocate system in three different types of systems, respectively[95]; i) the political system, ii) the legal system, and iii) the economic system. The political system contains institutional policies, infrastructure policies, fiscal policies, the legal system covers the laws and regulations, and the economic system cover the residual monetary policy and financial sector policies[96]. The three categories' structure and functions will be described with an attempt to include the historic influence of the postcolonial period, the diversity of the people of Kenya, and her influence from many parts of the world.

### 6.2.1 POLITICAL SYSTEM

The general view of the state is as the overarching political reality of a particular country, and the government as its organisational structure or ruling authority. This section elaborates on the underlying political system of Kenya. The business environment of the health provision sector depends largely on the government, as it may decide to regulate activities because of market failure, including externalities such as pollution, information asymmetries and the inability of consumers to judge the quality of medicine. The GOK's history, structure and future plans are enlarged on in the following chapter.

The health provision sector is foremost influenced by the MOH, but fundamental things such as enough trained medical staff, functional infrastructure concerning roads, water and energy to facilitate better sanitation and ease of doing business. At last the analysis will cover the Kenya Anti-Corruption Commission, the Inter-Governmental organisations and NGOs of importance, and how they influence the general business climate.

#### *6.2.1.1 POLITICAL HISTORY*

The Kenyan African National Union (KANU) ruled Kenya for nearly 40 years after its independence from British colonial rule in 1963 till 2002. The first president was Jomo Kenyatta belonging to the Kikuyu tribe[10]. He convinced the only other party, the Kenya African Democratic Union (KADU), to merge with KANU shortly after, and until his death in 1978, he tried to include all major tribes in Kenyan politics. Daniel Moi was the vice-president of Jomo Kenyatta from 1967 and took over as president in 1978[97].

[10] The word "tribe" is left out after it has co-appeared with the respective tribe name once.

In 1982 a coup d'état was attempted to overthrow President Daniel Moi, but the attempt failed and Daniel Moi enforced one-party rule formally in Kenya. Implicated in the coup attempt were Jaramogi Oginga Odinga, a former Vice President to Jomo Kenyatta, and his son Raila Amolo Odinga[98]. The one-party rule was dissolved in 1991 when party competition was legalised resulting in a myriad of new parties that over the next 20 years emerged, merged and dissolved. The first major party was the opposition that initiated the Forum for the Restoration of Democracy (FORD), which included all major tribes. But only few months after, it was split up into two parties respectively FORD-A ruled by Kenneth Matiba from the Kikuyu tribe and FORD-K by Oginga Odinga from the Luo tribe to follow the interests of respectively the Kikuyus and Luo/Luhya tribe. The latter further disintegrated into a Luo supported National Development Party (NDP) and Luhya supported FORD-K[99].

In addition to the FORD, the Democratic Party (DP) emerged in late 1991 as a breakaway faction from the KANU under the leadership of the Kikuyu Mwai Kibaki and John Keen from the smaller Maasai tribe. But equal to FORD's situation it was unable to stay united with the non-Kikuyus leaving back to KANU or took over the hitherto unknown Social Democratic Party (SDP) leaving DP as a Kikuyu ethnic party[100].

By early 1998 Kenya had gone from a political system including all different ethnic groups to ethnic factionalism and rivalry, with the Kenyan democratic opposition having reached a situation of almost complete fragmentation into several ethnic parties. During the same period the KANU started to show ethnic bias in favour of Daniel Moi's own Kalenjin tribe and other small tribes[101] not presented in the aforementioned parties clearly marginalising the Kikuyus and Luos[102]. A political rhetoric had commenced with heavy ethnic undertones and the KANU e.g. threatened the Meru tribe with no further government assistance if they do not vote for them[103].

In March 2002 the KANU and the NDP led by Raila Odinga merged to the New KANU, but Daniel Moi did not, as promised, endorse Raila Odinga as the KANU presidential candidate, and as a result he and former NDP leaders left the party. They joined the People's Coalition group and the National Alliance of Kenya to form the National Alliance Rainbow Coalition (NARC) bringing together 15 parties and representing all major ethnic tribes in Kenya represented by the Kikuyu Mwai Kibaki[104].

NARC was able to avoid ethnic turmoil till the election of December 2002 where it came into office through a peaceful political transition receiving 62 percent of the votes in the

presidential elections inducing great optimism in Kenya for fundamental reform[105]. But just two weeks into the presidency tensions became visible with the Kikuyus' members of parliament (MPs) voting for fellow Kikuyus in the opposition, Kibaki himself appointed several ministers from Kenyatta's Kikuyu elite[106], and last Kibaki refused to initiate constitutional reforms to create a strong executive prime minister (PM), which he had promised Raila Odinga as a part of the agreement upon emerging his party with the NARC. This led to disintegration of the NARC with the Orange Democratic Movement (ODM) driven by Luo and Kalenjin politicians and Odinga as presidential candidate led. The other party was the Party of National Unity (PNU) led by Kibaki and primarily comprising Kikuyu politicians. Both parties included representatives from all tribes, but failed to bridge the Luo-Kikuyu and Kikuyu-Kalenjin division[107].

In December 2007, President Kibaki[11] narrowly won the re-election under the PNU against the ODM. Nevertheless, the supporters of the ODM alleged electoral manipulation, which led to the supporters going on rampage in several parts of the country, especially resulting in clashes in the Rift Valley Province and Nairobi slums with approximately 1,300 casualties and several hundred thousand being displaced between December 2007 and March 2008[108], today referred to as the post-election crisis[109]. The violence continued throughout the countries for several months, until both sides came to a power-sharing[110] agreement called the National Accord and Reconciliation Act[111]. This has resulted in the creation of the Government of National Unity (GNU), including the ODM opposition appointed Odinga to sit as non-executive PM and Kibaki remaining as President. Under this power-sharing agreement, both candidates appointed cabinet ministers, i.e. doubling the amount of ministers and thus the number of ministries. The government has proposed a constitution to reform the structure of the Kenyan political system that if followed according to schedule, as has been the case till now, will be accepted in June 2010. The GNU is collaborating on reaching the Vision 2030 which will be elaborated further on later in this chapter.

#### *6.2.1.2 STRUCTURE OF THE KENYAN POLITICAL SYSTEM*

Kenya is a presidential representative democratic republic and has since 1992[112] had a multi-party system, meaning that three or more parties have the capacity to gain control of government separately or in a coalition depending on the number of votes they receive. The country has four levels of government; i) the central government, ii) eight provincial

[11] From now just Kibaki

administrations, iii) 71 districts, and iv) 175 local authorities. The provincial and district administrations are essentially extensions of the central government, while the local authorities are directly elected by the regional inhabitants[113]. The powers of the central government are divided into three main organs, which are the Executive, the Legislature and the Judiciary[114]. These three arms are suppose to be independent, but the Judiciary is the most independent, as the Legislature contains members of the Executive (President and Cabinet ministers)[115,116].

The Legislature is the parliament and makes the laws of Kenya. Since the election of 2002 it has been vested in the unicameral National Assembly with 224 members. It is made up of 210 elected members by universal adult suffrage serving on a 5-year term basis. 12 nominated members are appointed by the President but appointed by the political parties[117]. The two residual members are the Attorney-General and the House Speaker who are ex-officio members. The Parliament can be dissolved by the President at any time, or by the Parliament by a 2/3 majority vote.

The Executive is an elevation of the Legislature, and are meant to execute the wishes of the Legislature and consists of the president, who is both the head of state and Commander-in-chief of the armed forces. He is selected for a 5-year term and is available for re-election and is usually assisted by a Vice-President and a cabinet[118]. The president used to be head of government as well, but in the aftermath of the post-election crisis, the disputed was partly resolved by the creation of a temporary executive PM's office for Raila Odinga. The position may be fully created with the enactment of the new constitution, but currently the position only gives him "authority to coordinate and supervise the execution of the functions and affairs of the Government of Kenya including those of ministries", i.e. he basically has no authority[119].

The Judiciary is the High Court of Kenya. It has unlimited criminal and civil jurisdiction at first instance and acts as the Court of appeal from subordinate courts in both criminal and civil cases[120].

After Kibaki's NARC came into government in 2002, many believed that a new era of Kenyan politics would commence. Kibaki held a speech promising to disrupt corruption, and his first initiative was to give free primary education, thereby abolishing school fees[121] and initiating the Economic Recovery Strategy (ERS) resulting in a GDP growth rate from 0.5 in 2003 to 6.9 per cent in 2007, see table 12[122]. The ERS further resulted in increased GDP per

capita, lower poverty levels, an increase in primary school enrolment and improve the HIV/AIDS problem in the country. The ERS did what most thought was impossible, and showed that it was possible to change the institutions to coexist functionally to enable high growth and improving Kenyans' living conditions.

| Indicator | 2003 | 2007 |
|---|---|---|
| GDP Growth Rate in % | 0,5 | 6,9 |
| Per capita income US$ | 400 | 600 |
| Poverty level in % | 56,8 | 46,0 |
| Primary school enrollment | 6,1 | 7,8 |
| HIV/AIDS prevalence rates in % | 13,0 | 5,1 |

*TABLE 12: ERS ACHIEVEMENTS (2003-2007), SOURCE: MWAI 2008, P. 2*

On the 30th of October 2006 Kibaki unveiled the Vision 2030 which briefly states how Kenya could be transformed into an economic powerhouse with a sustainable growth of 10 per cent by 2030.[123] The post-election crisis reversed the positive development, almost bringing the entire economy to status quo. The GNU is now trying to find a way to unite Kenyans to strive for the Vision 2030, which will be elaborated further in the next section.

#### *6.2.1.3 VISION 2030*

The vision is the continuation of the successful ERS for Wealth and Employment that was initiated in 2002 and ended 2006. It is planned for the period 2008 till 2030 and aims to transform Kenya into a new industrialising "middle-income country providing a high quality of life to all its citizens by the years 2030"[124]. The implementation happens in a successive five year medium term plan, having "flagship" projects to take the lead in generating rapid and widely-shared growth. In 2015 it is supposed to meet its Millennium Development goals (MDGs) consisting of 8 internationally agreed goals for socio-economic development[125].

The ambition is that by 2030 it should be impossible to refer to any part of the country as remote. The country should then be interconnected through a network of roads, railways, ports, airports, water and sanitation facilities, and telecommunications. Kenya should continuously increase energy supply, generate more energy at a lower cost and increase the efficiency of consumption by encouraging more private generators of power and separate generation from distribution. Exploration of geothermal power, coal, renewable energy sources will be increased, and connect Kenya to energy surplus countries in the region. The vision for security is "a society free from danger and fear". This will facilitate a lowering of the cost of doing business and provide a more secure living and working environment.

These visions will be reached through three pillars consisting of an economic, social and political pillar. The economic pillar's overall goal is to obtain a GDP growth rate of 10 % by 2012, due to the post-election crisis postponed to 2015, and to sustain it to 2030. This will require increased efficiency of resources, a rise in savings from 17 % in 2006 to 30 % in 2012, and address the significant informal economy employing about 75 % of the country's workers. The latter should be done by raising productivity and increase jobs, owner's incomes and built up public revenues. The social pillar will focus on reducing illiteracy and encourage public and private universities to expand enrolment. Through an efficient and high quality healthcare system Kenya shall reach the highest standards and promote public-private partnerships (PPPs). A National Health Insurance Scheme should be created to promote equity in the industry, e.g. how to increase the amount of donor funds which is low relative to other SSA countries[126].

Other areas of focus are to get more high quality water supply, and make water and sanitation available and accessible to all. A clean, secure and sustainable environment needs to be secured with increased forest areas, better waste management and the commissioning for PPPs for improved efficiency in water and sanitation. The increasing urban density needs to be planned with decent and high quality urban livelihood for Kenyan's population. As well as reducing the large number of people living in absolute poverty.

The political pillar has the goal of "a democratic political system that is issue-based, people centred, result-oriented and accountable to the public", so the system will respond to the needs and rights of the citizens, with an open and transparent system, where the leaders are accountable to the citizens. Good governance should be attained to achieve this goal and will be realised through i) promoting and sustaining fair, affordable and equitable access to justice, ii) more transparent, accountable, ethical and result-oriented government institutions, and iii) secure all persons and property rights throughout the republic. A Semi Autonomous Government Agency (SAGA) is created to oversee the implementation process, and a Vision Delivery Secretariat (VDS) to provide strategic leadership and direction in the realisation of Vision 2030 goals. They will closely collaborate with the ministries in developing the Five-year Medium-term plans, and have a close link to public and private institutions, structures and organisations. [127]

Since Kibaki came into office many of these initiatives have helped improve the ease of doing business in Kenya, e.g. reducing the number of formal procedures within construction to 11,

explaining a construction boom since 2004[128]. The Vision 2030 requires each ministry to develop a strategy, which will be further discussed in the following.

#### *6.2.1.4 OTHER MINISTRIES*

After the post-election crisis many blamed the so called tribal rivalries, particularly between the Kikuyu and the Luo, but some believe this is just a guise, with the real problems being access to land, water, and housing for the poor who are still getting poorer[129]. This section will elaborate on the Ministry of Health and briefly on other relevant ministries in Kenya who are found to have the largest influence on the general economic environment with emphasis on the Kenyan health provision sector. These ministries will be briefly described and elaborated on with respect to their current Five-year Medium-Terms plan that have been worked out as a consequence of the earlier described Vision 2030.

##### *6.2.1.4.1 MINISTRY OF HEALTH*

In 2008 the MOH was divided into two different divisions, the Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS), as a result of the GNU. The MOMS is responsible for the clinics and hospitals, sexually transmitted infections, curative services, NHIF, and medical services policy. The MOPHS manages public health and sanitation policy, preventive health services, and health education. The implementation of policies and activities established by the MOH are coordinated on three different levels: national, provincial and regional. The MOMS and MOPHS have each year both before and after the separation developed an Annual Operational Plan (AOP), which is at heart build on the objectives and goals of the five year plan; the Second National Health Sector Strategic Plan II (NHSSP II) from 2004 till 2010. The key policy documents forming the framework for the AOPs are the Kenya Vision 2030.

The AOP 3 was partly interrupted by the post-election crisis, and to recover the health sector is facing a number of key challenges such as the insecurity and ethnic tensions related to the displacement that did not spare the health workers or the health service providers. The logistical and referral systems got their service continuity interrupted in affected districts. The health sector was prior to the event engaged in a sector-wide approach (SWAp) to harmonise government and align support to one plan. In an effort to address these challenges, a "Post-Election Recovery Plan for the Health Sector" was developed to outline the strategies, interventions and outputs needed to rebuild the capacity of national institutions and communities and to restore health services to achieve the goal of NHSSP II.

The overall goals of NHSSP II[130] focuses on; i) ensuring equitable allocation of GOK's resources, ii) increase cost-effectiveness, iii) enhance the regulatory role of the government in health provision, iv) create an enabling environment for increased private sector and community involvement, and v) increase and diversify per capita financial flows to the sector[131]. These overall imperatives are followed up through sub-imperatives such as the AOP, and the ad hoc plan to deal with the post-election crisis. These plans differ depending on the region because of Kenya's diversity especially with respect to her climate, purchasing power and regional supply of medical staff. Nairobi particularly does not lack skilled labour[132], as it has a doctor-patient ratio of 1:20,000, but this is the case in the rest of the country with the North Eastern province having the worst conditions with only one doctor per every 120,000 patient[133].

Today, the different sectors providing healthcare are competing for consumers in the middle- and upper-income groups, while leaving large numbers of consumers in the rural, lower-income groups underserved[134]. Prof. James Ole Kiyiapi, the permanent secretary of the Ministry of Medical Services, supports this view and states that the private sector tends to exploit short term gaps left by the public sector instead of addressing the long term demand for healthcare.

The MOMS has been very active in the process of involving private companies in building up the hospital referral system which for many years has been dysfunctional. The PPPs have focused on building on a functional referral system and not filling in holes which are to be fixed in the short term. The Permanent Secretary of the MOMS[135] elaborates on three overall goals for Kenyan healthcare which is to make it accessible, affordable and transparent. And to make this possible the fundamentals need to work, he accentuates five critical areas that has to addressed[136] :

- *Strengthening the current referral system* to function from level 1 to 6; many patients go straight to the Kenyatta National Hospital (KNH), but this is supposed to be a referral hospital, i.e. not to take in patients without a referral.
- The *issue of medical commodities*; as there presently are a large shortage because of the dysfunctional supply chain that lacks proper roads, electricity and water accessibility to enable this. Environmental and infrastructural improvements as well as community involvement need to be addressed to build up the preventive care instead of only focusing

on the curative care. This will reduce the morbidity rate particularly through improved sanitation in the rural areas.

- *The commodity supply*; the pharmaceutical industry needs to be thoroughly regulated and ensure a good quality insurance to fight counterfeit drugs as the consumers are not able to differentiate a real drug from a counterfeit. Better enforcement will enhance Kenyans trust to the health provision system.
- *Financing*; the government is currently using 7 % of the budget on Healthcare that is about KSH 45b which is the same as the private sector is investing. Kenya was one of 53 SSA-countries who in 2000 pledged to allocate 15% of their national budget to healthcare and reaffirmed to do this in the Gaborone Declaration in October 2005. But Liberia is currently the only SSA-country that has been able to fulfil this goal[137].
- *PPP*; the money invested in the private healthcare sector are at the moment not invested in an established system. The interventions are minimalistic, the investments are inefficient and there are not a clear set of priorities. The public sector therefore needs to work together with the private and have a focused strategy – addressing this through a sectorial approach trying to cooperate and encourages the respective players to invest so complementary to obtain a functional and sustainable health provision system.
- Deal with *the inadequate human resources*, i.e. educate more medical staff. There is a current need of 38,000 nurses, but only 17,000 are available but has increased from 14,073 in 2008 and there was only 10,657 in 2005, see table 13. It is not just nurses, but also doctors where the number has increased dramatically. The number of students at medical colleges has further increased by 50 percent and is still rising. The scarcity of staff is mostly in the rural areas of Kenya, as Nairobi has 50.8 percent of all doctors and 12.2 percent of all nurses in the country[138].

| | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|
| Doctors | 5 446 | 5 889 | 6 271 | 6 623 |
| Registered nurses | 10 657 | 10 905 | 12 198 | 14 073 |
| Health institutions | 4 912 | 5 471 | 5 589 | 5 712 |
| # in medical colleges | 4 180 | 4 941 | 5 932 | 6 090 |

*TABLE 13: HEALTHCARE PERSONNEL, SOURCE: KNBS 2009, P. 24, ES 2009, P. 61*

The MOMS's strategy involves building up the infrastructure of the current system, standardising and make it more efficient so it responds quickly and robustly ensuring a functional referral system to attain sustainability. To reach the accessibility the system needs to be more widespread than it is today hereby focusing on finding a solution to reach the less

populated regions and repair their staff shortage. The latter is already dealt with having built and added more medical training facilities in the country and having more Kenyans educated as doctors and other medical staff. The MOMS is optimistic that Kenya will have enough doctors and nurses by 2013. The overall mission is *"to deliver better service tomorrow than today"*[139].

#### *6.2.1.4.2 OTHER MINISTRIES*

After Kenya's independence one of the major constraints in reaching her MDGs was a shortage of skilled labour and low literacy. The percentage of total government budget used on education has decreased from 22.2 percent in 2005 to 17.7 percent in 2008[140] making new initiatives difficult. Fortunately Kenya's education is still improving following the initiative of free primary education in 2003 and has helped cementing Kenya's strategy of being an education hub in Africa[141,142]. Following the free primary education initiative the literacy has increased from 73.6 percent in 2000 to 86.5 percent in 2008[143]. This growth is not just contributable to the government's initiatives, but the harambees have made a great impact as they have established schools before and after independence. The literacy in Kenya would be higher if it was not for the increase in HIV/AIDS which has emerged the past 10 years as one of the reasons for school dropouts[144].

Currently only 10-20 percent of Kenyans have electricity in their home with the current capacity of 1,480 mega watts (MW), including temporary energy of 290 MW. Unfortunately the grid is not used efficiently and provides only 1050 MW, i.e. more than 30 percent energy is lost. Experts from the Ministry of Energy have estimated that Kenya requires at least 2,013 MW in additional power supplies to the national grid by 2014.[145] This large increase in demand of electricity exists because of economic growth and increased coverage of electricity in the country, but especially the past years droughts have been harsh as the country is largely dependent on energy from hydropower plants, i.e. mainly dams[146]. Another factor troubling the government is a high electricity price almost three times as high as in South Africa[147] which especially makes manufacturing-heavy companies prefer neighbouring countries instead of Kenya.[148]

The Ministry of Energy is starting to react to Kenya's need for a larger energy supply and lower prices, but has also learnt from past mistakes. Hence, they are diversifying their portfolio of energy sources, so they do not rely solely on easily affected energy, but instead spread to renewable and durable energy. The Ministry of Energy has put great pressure on

KenGen, the largest supplier of electricity to the Kenyans providing ca. 80 percent of the total energy supply. Much focus is on renewable energy and Kibaki has recently announced a plan to produce additional 2,000 MW within 10 years, with 85 percent coming from geothermal plants[149,150] and there has been a further talk on increasing the electricity generated from geothermal to a minimum of 5,000 MW by 2030[151,152,153]. The largest project is the Lake Turkana Wind Power[154] project which will be able to supply Kenya with approximately 300 Mega Watts by July 2012[155]. The consortium is hoping to increase the project further to 3,000 MW which would also enable Kenya to provide neighbouring countries with electricity.[156]

Besides the large investments in Kenya within renewable energy there is a need for cheap energy[157]. Ethiopia and Kenya have made an energy-sharing deal this year that will make Kenya tap into cheaper electricity from Ethiopia. The project is not straight forward as the electricity has to be connected through an area plagued by bandits and with a dreadful road infrastructure.[158]

The Ministry of Water and Irrigation was created in 2003 following a separation from the Ministry of Environment and Natural Resources. The ministry plays an important role in reaching the MDGs, such as water accessibility particularly for the poor and those living in arid and semi-arid lands areas. To get their strategic plan implemented the ministry face a number of challenges; lack of unified framework for the management of water resources; inadequate regional cooperative frameworks for the management of shared water resources pollution; continued human settlements in water catchment areas; and destruction of forests.

Many of these challenges would also be easier to solve if fundamental infrastructure of electricity and roads were more comprehensive, a Land Policy existed, and security both of the individual and property to ease investing in Kenya and her water facilities. Currently ca. 91 percent of the urban households have access to safe drinking water, compared with 51 percent of rural households[159]. Easier access and supply of water especially in the rural areas will reduce water-related conflicts hence enhance security principally in the Turkana and the Pokot areas, i.e. the North-Western part of Kenya. This will help general sanitation for the population and decrease the amount used on easily preventive diseases so focus instead can be on the more serious diseases. It will also facilitate investment in horticulture and the agriculture. Better water accessibility is crucial for the economic performance of Kenya and the rebuilding of the Kenyan Healthcare referral system as it will increase the overall level of sanitation.

The Ministry of Roads and Public Works was divided into Ministry of Roads[12] and Ministry of Public Works in 2008. They have both been very the last years and the road infrastructure has improved dramatically nationally and particularly in Nairobi. The capital with a metropolitan population 4.7 million and more than half a million cars[160] in the city has 7.500.000 person trips per day, but the infrastructure has not been able to absorb this amount of traffic leading to daily traffic jams. There awaits great anticipation for the longed by-passes to be completed as soon as possible to enable traffic, not needing to go to the centre, to bypass the city instead of driving through the centre. The main project is the Northern, Southern and Eastern bypasses around Nairobi, which will bring the congestion out of the city and help decreasing the current worsening pollution in the capital[161]. The city is projected to have a metropolitan population of 9m by 2025 thus almost doubling, making these investments very necessary to avoid matters getting too difficult to fix[162]. The latest improvement of road networks are continuously in focus as it is one of the Presidents main focus areas in order to make Kenya attractive for foreign investors. The future projects are connecting Kenya to her neighbouring countries and her ports[163].

The port of Mombasa is considered the single most important infrastructure in East Africa, and it has increased its efficiency the past years, but there are still room for expanding and making it more efficient. The roads to from Nairobi and Mombasa are already improved, but in order to improve the generally business climate the harbour needs to have a lower a higher turnover of containers with less bureaucratic procedures. The government is also discussing building an additional harbour north of the port of Mombasa to ease the business climate in the country[164].

The Ministry of Public works has recently ensured Kenya access to the international fibre optic cable system by expanding their recent inter-connected cables to Eastern and Southern Africa to both India and Marseille, France through the Mombasa harbour last year. The initiative, called The East African Marine System (TEAMS)[165], was launched in June 2009 augmenting the bandwidth to provide Kenyan retail carriers with equal, fast and open access to Internet[166]. Other recent projects have been the establishment of the Tie line network to link all Ministries and governmental institutions in the country. This network is much faster and with a high capacity.

[12] Their website has not worked in the course of writing the thesis

#### 6.2.1.5 KENYA ANTI-CORRUPTION COMMISSION

Kenya got its first anti-corruption legislation in 1956 called the Prevention of Corruption Act. This was initially enforced by the police department, but this did not prevent corruption that grew over the years. In 1997 the act was amended to establish the Kenya Anti-Corruption Authority (KACA), but in December 2000 the High Court made a ruling that KACA undermined the powers conferred on the both the Attorney General and the Commissioner of Police by the Constitution of the Republic of Kenya and was thus dismissed.
The new government with President Kibaki revived the fight against corruption through two new legislations in April 2003. The first Act established the Kenya Anti-Corruption Commission (KACC) as a corporate body. The Commission officially started functioning in 2005 and has been a mean for the government of Kenya to follow their intention of eradicating corruption and foster transparency. The KACC vision is; a world class institution fostering zero tolerance to corruption in Kenya, reached through its mission to combat corruption and economic crimes through Law Enforcement, Prevention and Public Education. To fulfil this, and not end up in a similar situation as during President Moi, the KACC makes monthly, quarterly and annual reports on their investigations composing the institution/asset/network, particular offense, persons charged, and the involved amount.

According to the KACC's annual report they received 4,335 reports in the financial year 2008/2009 compared to 4,485 reports in 2007/2008 and 8,188 reports in 2006/2007[167]. Many of these reports are internally received, but they also receive externally through anonymously report which is informed to the public through their website. The decrease may also be partly due to both the establishment in June 2007 of the Public Complaints Standing Committee[168] geared towards enhancing accountability in public institutions, which through an ombudsman is mandated to receive and process complaints against public officials[169], and finally the implementation of the Witness Protection Act 2006 in May 2008. There is furthermore in front of every Kenyan ministry and public building a large sign stating; "THIS IS A CORRUPTION FREE ZONE ! – Report all Forms of Corruption to Tel.: 2738870"[170].

#### 6.2.1.6 INTERGOVERNMENTAL ORGANISATIONS

Organisations between governments both in their region and internationally have different degree of influence depending on the country, the strength of the organisation, and if they are present in the country. African countries are renowned for being members of many intergovernmental organisations building a matrix of organisations between all the countries, but this makes it difficult to execute with too many agents involved. Many of the

organisations have high ambitions of bringing peace, stability, establishing a common union, monetary union or improving cooperation. Unfortunately this is often hindered by conflicts, lack of determinations etc. Kenya's most profound memberships are IGAD, COMESA and EAC, but while IGAD does not have a great influence on Kenya, and even less on the Kenyan health provision sector, as it focuses on severe drought, other natural disasters and live stocks.

COMESA is a preferential trade region with nineteen member states in Eastern and Southern Africa consisting of a population with more than 400 million people. It is aiming to achieve sustainable economic and social progress in all member states through increased cooperation and integration in all fields of development[171]. Its main achievement is a unified custom tariff for the member countries, besides this achievement COMESA has not had significantly impact on Kenya's economy and health provision sector as whole.

The only organisations that have been able to impact on more than one level is the East African Community (EAC) and the global intergovernmental organisation United Nations, with its only headquarter outside the western world in Nairobi. The World Bank and IFC have their East African headquarter in Nairobi, but due to their minor presence and impact, only United Nations and EAC will be elaborated on in the following two sections.

#### *6.2.1.6.1 UNITED NATIONS' OFFICES IN NAIROBI (UNON)*

The United Nations chose to establish office in Nairobi in 1964, just after independence. The UNON did not experience much growth during President Kenyatta or in the first terms of President Moi. But in the 1990s UNON saw sustained growth with the United Nations Environment Programme (UNEP) and the UN Programme for Human Settlements (UN-Habitat)[172]. Through these new initiatives UNON employ a total of 4628 persons in 2006 of which 90 % worked in Nairobi and 30% were internationals, paying a total wage bill of $150m. The UN also helps to develop ideas and promoting the political discourse and social development in Kenya, in addition influencing by UN projects on water, electrification, drought relief, HIV/AIDS etc.

After 40 years in Kenya the UNON contributes significantly to the economy through its programmes, having more than 1,500 meetings with about 30,000 international participants each year. A study showed that it is the single largest source of foreign exchange contributing with over US$ 350 million annually ranging fourth compared to industries[13], and it continues

[13] Tourism: 919,289,000, horticulture: 760,517,00, tea: 737,768,00. Source: Nairobi as a hub

to grow as UN expand its activities particularly through its UNICEF[173] activities in Sudan, Somalia and the great East African region. It also provides $20 million worth of business to the local food, pharmaceutical and transport industries[174].

#### *6.2.1.6.2 EAST AFRICAN COMMUNITY*

The EAC is an intergovernmental organisation aiming at increasing the cooperation between its partner states, Burundi, Kenya, Rwanda, Tanzania, and Uganda to promote regional trade and co-operation, and the advancement of Kiswahili in the region[14]. This makes up a population of 125 million people and an area that is shares common interests such as Lake Victoria, which is shared by the three original members. The EAC mission is to widening and deepening co-operation among the partner states, among others political, economic and social fields for their mutual benefits[175]. The union also existed 40 years ago from 1967 to 1977 with the East African Cooperation between Kenya, Tanzania and Uganda, but was demised because of disputes[176]. In 2000 the cooperation was re-established, and in 2004, Kenya, Tanzania and Uganda signed a customs union protocol setting up a regional three-tier external tariff system. The tariff system placed a 0 percent tariff on raw materials, 10 percent for intermediate goods and 25 percent for finished goods[177].

On the 1st July 2010 the EAC Common Market went into force with the main objective of forming a single customs territory with free movement of services, capital, labour and goods in the five EAC countries[178]. Consequently goods and people can now move unhindered and tax-free in the region without seeking work permit. This has simplified travelling between the countries and eased doing business in EAC. Going forward, objectives of the EAC include harmonising tariffs and customs regimes, free movement of people between boarders and improving regional infrastructure[179]. The next big step for the EAC is the integration stage of preparing for a Monetary Union towards establishment by 2012, where the last strategic meeting was in Nairobi, 4th March 2010[180]. All five central banks are said to currently have too high interest spreads, budget deficits, domestic debt, and high level of non-performing loans which needs to be managed before this can be established, why the current deadline is very optimistic[181].

EAC investment conference has been held at least annually to ensure implementation of the best possible policies within EAC and to create a platform for Public-Private Sector Dialogue at the highest political and business level with the last conference highlighting the success of

[14] This is covered more in-depth in the institutional analysis

PPPs. The fast moving pace of the EAC has been accredited as one of the fastest reforming regions in the world by the World Bank and UNCTAD, with Rwanda topping last year as the most reforming country in the world[182].

The EAC Health Secretariat has launched the Regional East African Community Health – Policy Initiative (REACH-PI). It aims towards reforming the national health systems in the EAC towards a common system that can foster better links between researchers, policy and decision makers with preferential engagement accorded to the EAC-countries. It is building up to or currently implementing policy reforms in its priority thematic areas namely healthcare financing, human resources for health and non-state sector[183].

#### *6.2.1.7 NGOS AND EMBASSIES*

Not many cities in the world can present themselves as a "capital" for NGOs, but if any city Nairobi is one of them. The UNON's long presence in the country is one of the determining factors for many NGOs to choose Nairobi as many use UNON through their work. Being located in the same area as UNON makes it easier to meet and to establish without meeting political resistance.

The political stability has been more apparent in Kenya, then its neighbouring country that has been plagued by dictatorships, genocides and wars. The strategic position of Kenya makes the NGOs more accessible to facilitate aid provision in an easy and secure manner. Another essential factor attracting them is the good work and living conditions, and climate. These factors has resulted in Nairobi being a popular location for international gathering, and the country now has more than 5000 NGOs of which 1,200 are based in Nairobi.

One of the largest organisations related to the health provision sector is the Kenyan African Medical and Research Foundation (AMREF) that was founded in Kenya in 1957, and focus on health issues. One of its most important projects in Kenya is educating nurses. In addition have the World Vision, which is an international partnership of Christians, helped to provide clean water, education, healthcare and sanitation and spent $ 53m in 2005/2006 in Kenya[184].

The large international environment mainly operating within humanitarian agendas[15] also attracts the intention of countries humanitarian programmes such as USAID, DFIF, SIDA, DANIDA etc. which work closely with their embassies hence they ensure the presence of

[15] Such as relief work, slum upgrading, community services, schooling, employment, empowerment and emancipation, environmental preservation or refugee activities.

their embassies in Nairobi. Nairobi has 49 embassies and 19 consulates[185], considerably more than their two neighbouring countries Tanzania and Uganda[16], and embassies in Nairobi are usually of a larger size due to their humanitarian work, e.g. the US embassy in Nairobi is the largest in SSA.

Nairobi is a hub for Inter-Governmental Organisations, NGOs and embassies, and first of all they occupy a vast amount of space, affecting the immediate surroundings and their neighbourhoods. This creates many expatriate groups, i.e. consociations that produce information on the city and recreational activities, and they co-ordinate their presence making the city more liveable for foreigners[186].

### 6.2.2 LEGAL SYSTEM

All countries formulate and enforce rules, but it varies greatly how complex the legal system is and how business friendly it is, i.e. are they supporting other initiatives or are they actually working with or against the current strategy. Some countries might even over-regulate, which makes the implementation difficult and create more confusion than good. As the regulation of a country is an on-going process it is essential to understand the history of the legal framework, and how some laws might not be applicable to the current society, as they are outdated. Under-regulation can therefore be problematic, and an optimal balance is hardly obtainable as it is a timely process to formulate and pass laws. As a result of English administration, Kenyan law is still very similar to the legal framework that was implemented in the colonial period. The system is mainly based on the laws and the system of governance from England and English law in India. Unfortunately this was implemented without taking the Kenyan society into account and how their culture, values and norms will coexist with it. The natives were during the colonial period considered too primitive to understand the legal framework, and were therefore left with acting according to the simpler African Customary Law. Many Hindus and Arabs/Muslims immigrated to Kenya and were allowed to practice Hindu Customary Law and Muslim Law. Even though the English tried to phase out the other laws, the current system has become a mix of these legal frameworks, mostly influenced by the English legal system.

The Kenyan constitution of 1963, the Judiciary Act of 1967, is the supreme law of the country, and any other law that is inconsistent with it shall, to the degree of the inconsistency, be inferior. To the extent that the Customary Law does not conflict with the statutory law, it is

[16] that have respectively 29 embassies and 18 consulates, and 19 embassies and 9 consulates

used as a guide in civil matters. The three arms of the GOK have their respective role in the legal system, with the Executive having to implement the laws passed by the Parliament. The Legislature, being the parliament, is mainly responsible of formulating the laws. The Judiciary consists of the Courts, with the Court of Appeal being the highest court in Kenya. It has only appellate jurisdiction, in both civil and criminal cases and its decisions are binding both over the High Court and the subordinate Courts. The High Court is presided over by judges of the High Court, who are appointed by the president. It has unlimited original jurisdiction in civil matters. The subordinate Courts' jurisdiction is determined on a territorial and pecuniary basis. They are preceded by the magistrates, whose courts are in order of hierarchy, and this is where most average civil and criminal cases are put on trial[187].

Although the constitution provides for an independent judiciary, the president currently has considerable influence on the judiciary. As previously described is the agenda of Kibaki to decrease the amount of corruption in the Kenya society. One of the many initiatives has been to rewrite the current constitution to accommodate a Kenyan legal framework that will enhance transparency. Additionally to create a framework which is not a mixture of other legal systems, but instead a system that is understood and fits the Kenyan mindset, and most importantly will facilitate better business environment and living conditions for Kenyans.

Over the past years there has been a wide range of legal issues related to privacy, trial justice and excessive punishment. The authorities in Kenya have often been accused of violating people's privacy rights. Although the constitution states that "no person shall be subject to the search of his person or his property or the entry by others on his premises", the laws also permit searches without warrants "to promote the public benefit". Opposition leaders, politicians, students and journalists have complained that the government is subjecting them to surveillance, telephone wiretaps, or interference with written correspondence[188].

The constitution states that persons arrested or detained shall be brought before a court within 24 hours in noncapital offenses and within 14 days in capital cases. Nevertheless, subjects are often held for weeks, even months, before being brought to court. There have been cases where individuals have been held in pre-trial detention for several years. To make matters worse, the judiciary has often been accused of corruption. In March 2000, the Chief Justice was accused of taking a $450,000 bribe to rule in favour of a claimant. Malpractices in the judiciary are common, and according to the Kwach Commission, a special judiciary commission, "corruption, incompetence, neglect of duty, theft, drunkenness, lateness, sexual

harassment and racketeering" is widespread in the judiciary[189]. The new constitution is expected to deal with issues in the judiciary through the removal of incompetent judges, improved codes of conduct and judiciary independence and shifting prosecution responsibility from the police to the judiciary[190]. Although the current constitution states that "no one shall be subject to torture or degrading punishment or other treatment", police officers are often reported to use violence and excessive force also during political demonstrations, and there have been numerous situations were political activists and students have been beaten down by the police[191].

Bearing in mind as the thesis focus on foreign investments in particular, it is worthwhile to look closer at the Kenyan investment law. Similar to other laws in Kenya, the investment law is modelled according to the English investment law. Her investment law provides protection against expropriation of private property, and this protection is guaranteed by various bilateral agreements with other countries[192]. Although property and contractual rights are enforced, it is quite common to experience long delays in court. The Kenya investment law also protects and facilitates acquisition and disposition of all property rights, such as land, buildings and mortgages. It is, however, cumbersome to acquire title to land, and this is portrayed as a serious obstacle to new investments[193]. Moreover, Kenya has a comprehensive legal framework to ensure intellectual property rights protection. While the penalties and sanctions related to violations of intellectual property rights are sturdy, the enforcement of these laws is poor. In 2006, the Ministry of Trade and Industry indicated that more than $496 million is lost annually due to sale of counterfeit goods.

Before an analysis of the Kenyan constitution and the new draft it is worth pointing out one of the most pronounced and influential legal matters in Kenya, i.e. the Ndegwa Commission report of 1972. This made it possible for civil servants to establish private enterprises. Besides the corruption from politician this had led to, it is yet to be changed. As will be enlarged in the following section, it is one of the most significant changes in the new constitution.

#### *6.2.2.1 THE DRAFT OF THE PROPOSED CONSTITUTIONS AND THE CONSTITUTION*

The constitution has long waited for changes, and it is not the first time that Kenya tries to change it. The last draft was soundly defeated in 2003, setting up the ethnic-based political alliances that fought one another during the post-election violence in 2007/2008. The international crowd are applauding the new constitutions hoping it will be passed to help

unify the nation and end the corruption and violence that has characterised Kenya the past decades[195].

All the proposed deadlines have been met till now with the parliament passing the new draft late Thursday night the 1st of April[196] with a deadline of the 2nd of April, and the Attorney General published the proposed constitution Thursday the 6Th of May[197], long before the deadline of May 27[199]. The last deadline is August 12 when Kibaki promulgates the new constitution and set the ground for its implementation[200].

The post colonial and current constitution and its subsequent amendments gives the president nearly unlimited power and immunity from the law accounting for many of Kenya's current problems with corruption. The key objective of the proposed constitution is to change and obtain a constitution to enhance transparency and efficiency, and decentralise power.

The new constitution proposes that a State President will be directly elected and have executive powers sufficiently to oversee, unite and protect the country. The PM, currently Raila Odinga, will not be elected directly, but will be the leader of the party or coalition with greatest representation. He will also be head of government taking over the day-to-day running of government from the president. The Attorney General will be elected for a six-year term, while the present has been in office for 18 years[201]. The government will be decentralised by introducing regional and county governments limiting the size of the cabinet, and establishing a senate. It introduces devolved governments consisting of a regional government for each region with an assembly and an executive committee. The regional governments will have their own reliable sources of revenue and autonomy to govern. To fund this, the cabinet will be shrunk to 15-20 ministers and deputy ministers, from about 60 ministers that currently are in office. This will empower the citizens by indicating that Kenyans can use referenda to exercise their sovereignty[202].

The dividing of power between more people is proposed to reach a more Kenyan adapted constitution where power is not centralised as in many Anglo-Saxon countries, but instead is dividing power among many people. A model often proposed for African countries to avoid the wide use of corruption, building a system of government that serves and protects the interests of all, regardless of political affiliation, ethnic group or faith[203].

The solution to the post-election crisis was as earlier mentioned a temporary solution of both having a presidential and a parliamentary system, but this is also to be decided within the

draft, with the last published proposal of 4th of May proposing a presidential system. The last major and most discussed changes are legalising abortion which has led to great opposition from the church believing it to be too liberal, and for a continued recognition of Kadhis' Court[204].

In the context of health the current constitutions points to the following rights for the Kenyan people; i) social security and healthcare appropriately provided by the state if the person is unable to support themselves, and may not be refused emergency medical treatment, and ii) clean and safe environment and water in adequate quantities[206]. These articles are currently not properly applied, but if they were it would increase the market for healthcare, and as earlier mentioned in the political systems many projects have been initiated to supply Kenyans with clean and accessible water.

### 6.2.3 ECONOMIC SYSTEM

According Mike Peng an economic system refers to the rules of the game of how a country is governed economically. This governing can be through economic incentives, regulations and monetary policy[207]. A country's economy can be stimulated and dampened either through their fiscal and/or monetary policy, but as the fiscal policy is controlled through the political systems, it is only the latter that is covered in this section.

At a first glimpse the most obvious economic system is the Central Bank of Kenya, but as this only borrows to the government and banks, both regulated in their respective manner, it is not sufficiently just to cover this. The government is already covered, but the banks are on the contrary to other companies substantially influenced by the government/state through domestic and international regulation. They have a great societal importance that is vital for Kenya's economic performance and how well she will do in reaching her goals for Vision 2030. The competition in the financial industry helps making the system more effective hence better interest rates for the customers, i.e. the population of Kenya will be able to borrow cheaper to invest more in the future. The more available the banks are to the public, the more money can be invested today to contribute to economic activity in the future.

A study of Japan, Korea and Taiwan showed that industrial and infrastructural policy only has a minor influence, whereas good macroeconomic policy, including limited government deficits, low rates of inflation, and very stable real exchange rates where the main attributes[208]. The performance of the latter and their development are therefore necessary to cover being a largely dependent result of the Central Banks' policy.

The regulation of financial institutions in Kenya will not be covered as this is out of the scope of this thesis, but instead how the Central Bank of Kenya (CBK) and the financial institutions act in the Kenyan society to provide healthcare financing and their economic role.

#### 6.2.3.1 CENTRAL BANK OF KENYA

The Central Bank of Kenya (CBK) was established in 1966 as a desire of the Kenyan population to have their own independent monetary and financial policies. The CBK's areas of responsibility include; i) formulate and implement foreign exchange policy, ii) formulate and implement policies to promote the establishment regulation and supervision of efficient and effective payment, clearing and settlement systems, and iii) act as banker and adviser to, and as fiscal agent of the government[209],[210].

The CBK has lately had countercyclical policies because of the crises to provide more liquidity, bring down the interest rate, and stimulate the GDP growth, which it has done with tremendous success[211]. Going forward it will change focus on price stability, i.e. a fixed inflation target to keep inflation down, the same policy as the European Central Bank, but a higher target at 10 percent[212].

| Indicator | 1999-03 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|---|
| Inflation, % | 6,6 | 11,6 | 10,3 | 14,5 | 9,8 | 26,2 | 19,5 |
| Current account deficit/GDP | -1,0 | -0,8 | -1,3 | -2,2 | -3,8 | -6,5 | |
| Trade balance ($bn) | -1,2 | -1,6 | -2,1 | -3,3 | -4,3 | -5,7 | |
| KSH/USD | 76,0 | 77,3 | 72,4 | 69,4 | 62,7 | 77,7 | 75,8 |
| Total foreign debt/GDP | 41,6 | 34,4 | 29,9 | 26,3 | 22,0 | 21,0 | |
| Deposit Interest Rates, % | 5,69 | 3,34 | 6 | 5,13 | 5,18 | 5,62 | 5,9 |
| Lending Interest Rates, % | 8,44 | 8,04 | 8,07 | 5,73 | 6,87 | 8,59 | 6,82 |
| Interest Spread, % | 2,75 | 4,7 | 2,46 | 0,6 | 1,69 | 2,97 | 0,92 |

*TABLE 14: ECONOMIC INDICATORS, KENYA, SOURCE: CBK 2009*

Table 14[17] shows the development in the numbers that the CBK affect the most. The inflation was held stable until 2006, when it rose to 14.5 percent, and due to the post-election crisis and the financial crisis the inflation rose to a high 26.2 percent and the following year 19.5 percent. A large part of these increases can be traced to high petroleum prices and a world that was demobilising itself thus reducing global competition entailing higher prices. The current account deficit and trade balance have both seen a rise till 2008 unable to get below the 1999-2003 average shows the lack of focus. The exchange rate has almost continuously appreciated vis-á-vis the USD until 2009 when most smaller currencies were hit by flight-to-safety, i.e.

[17] Not all numbers for 2009 are currently available.

that investors put their money in the assets/currencies they find safest. The appreciation except in 2008 express a high trust to the KSH and that the situation is improving, unfortunately this is not good for its trade balance, as it makes the manufacturing and labour more expensive relative to other countries. The total foreign debt has halved compared to the 1999-2003 average making Kenya more independent of the world outside her boundaries, this is not just a trend due to the financial crisis, but has been a trend for the past ten years.

The deposit interest rate has stayed relatively stable throughout the period, and albeit it reached a low 3.33 percent in 2004. This was not reflected in the lending rate that was above 8 percent till 2005 where after it reached a record low in 2006 of 5.73 percent. The general decrease in the interest spread, i.e. the trust to economic and political stability, decreased from 2004 to 2006 indicates that the financial market was satisfied with the trend of the political agenda. Although the spread increased from 2007 to 2008, it never reached the same level as it had in 2004, and in 2009 it was below one percent again indicating that the CBK and the political trend are going in the right direction.

#### *6.2.3.2 FINANCIAL SECTOR*

The banks' role in the economy is essential for creating a sound business environment. Banks provide both deposit and lending facilities and are, therefore, key to satisfying the financing needs of businesses[213].

The Kenyan financial industry is currently experiencing a boom in competition, as the Safari.com is offering the possibility of transferring money through mobile phones. This initiative is known as MPESA and has enhanced the awareness and possibilities within aiming more at the bottom-of-the-pyramid (BOP) segment. The focus on this segment has arrived in shape of the new term "micro-loan", and the Malaysian Grameen Bank has shown that giving the poor the possibility to loan money over a short period can actually be a good lucrative business[214]. In the market there furthermore exist micro lenders, some only in the spirit of charity such as MYC4, whereas others want to do business[215]. The latter has been pursued by the Equity Bank Ltd with success, making it the fastest growing financial institution, not only within Kenya, but in the entire Eastern and Central African region. The bank now has more than 3.1 million bank accounts, and is the home of ca. 48 percent of all bank accounts in Kenya[216].

The two other large banks are the Kenya Commercial Bank, which by far is the largest bank in Kenya with respect to market capitalisation[217], and the other is the Co-operative Bank of

Kenya, known as Coop Bank. The latter was the first to launch Mobile-banking in 2004, a banking service delivered at mobile phones.[218].

The East African Development Bank (EADB) was established in 1967 under the treaty of the old East African Community, and re-established itself under the break-up in 1977[219]. The EADB has through one of its initiatives invested in the Karen Hospital through the Kenya Commercial Bank. The loan was according to Dr Ernest W. Mureithi[220] issued at KSH 700m at an interest rate of around 14 percent to be paid back over 20 years, but more than 40 percent was paid back after just 4 years, which arose the attention of Equity Bank, Barclays and even the Kenya Commercial Bank to offer a lower interest and shorter pay-back period, and in addition offer an increased loan amount. The loan was the first of its type to be given to the start-up of a hospital laying the first brick for more healthcare loans and enhance the awareness of the risks associated with lending to hospitals. The Equity Bank[221] offers a lending rate on new projects between 15 and 19 percent depending on collateral usually 70 percent predicated by the CBK and a strategic analysis of the industry risk, management, subsidies and so on. The lower interest rate is most likely a cause of the cooperation with EADB cementing its vital role to promote lending to businesses in Kenya and the region.

### 6.3 INFORMAL INSTITUTIONS

The enforcement is de jure done by the law and state actions, but businesses frequently use other means de facto, i.e. informal institutions, such as norms, values etc., either because the legal system is deficient or because non-state relationships seem more appropriate, easier to deal with or more effective. This is especially the case in developing countries and the population's exchange of goods particularly thrives if they share a common culture. This common culture converges because of the shared history of the different tribes within Kenya, and their customs, rules, traditions, norms and habits that has been transferred through generations. They were hardly interrupted or affected by the colonisation of the British, since British and ethnic Kenyans were kept isolated hence the impact of the colonisation was less significant.

This section discusses Peng`s main groupings of informal institutions; culture, ethics and norms[222], and how these institutions affect the business environment in Kenya, with particular focus on the health provision sector. A generalising analysis of the most important characteristics of these factors is essential to understand for an investor upon investing to comprehend which challenges and opportunities these will lead to.

### 6.3.1 CULTURE

Although culture is one of the most frequently discussed informal institutions, the term has no universal definition. There are, however, some common groups of agreement in the literature. It is generally agreed that culture defines the relationships existing between individuals within a given community, and between them and their environment[223]. Culture is also defined as a shared meaning system, found among those who speak a particular language, during a specific period of history, and in a definable geographic region[224]. While there are several competing frameworks analysing culture, Geert Hostede`s framework of national work related values is one of the most commonly cited. Hofstede suggest that culture is comprised of five different dimensions[225]: i) power distance, ii) uncertainty avoidance, iii) individualism vs. collectivism, iv) masculinity vs. femininity and v) long versus short term orientation. Hofstede`s five dimension framework of culture has been criticised for its simplicity[226], but for the same reason it is still extensively cited in the literature. In the context of culture in Kenya, the weaknesses of Hofstede`s framework becomes evident when investigating culture at the national level, seeing as there is no uniform national culture in Kenya, but numerous diverse sub-cultures. The thesis will refer to a selection of the cultural dimensions identified by Hofstede, but due to its simplification it will only be a mean of commencement to the analysis.

Prior to commencing a discussion of the Kenyan culture, some additional conceptual clarifications still remain to be dealt with. Bearing in mind that Kenya is comprised of a number of societies that uphold their own distinct cultural identity it is thus necessary to cover the various sub-cultures to avoid the risk of wrongly implying that there is homogeneity among all Kenyan cultures. A sub-culture can be defined as a sub-grouping of people in a society who possess characteristics that set them apart and distinguish them from the others[227]. Sub-cultures can be identified by various features including age, sex, class, ethnicity, or some other distinct characteristic such as job occupation. It is furthermore vital to emphasise that these sub-cultures will share elements of the dominant national culture. Kenyans tend to identify first with their community/clan, secondly with their tribe or ethnic group, and only tertiary with the nation as a whole[228].

Since the term culture is not very specific the thesis will focus on five sub-groupings of culture. Thus, the upcoming sections highlight the following five components of culture in Kenya: ethnicity, religion, language, gender and family and community particularly with respect to the health provision sector.

#### 6.3.1.1 ETHNICITY

Kenyan culture can barely be discussed without reference to ethnicity which is referred to as the shared sense of cultural identity within a society or group of people based on language, religion, customs, and origin[229]. As mentioned in the introduction, Kenya has more than 40 ethnic groups, whom share cultural practises and a common history. The Kikuyu[18] represents the largest group (22%), and occupy primarily the Central Province, Nairobi and part of the Rift Valley Province. The second largest group, the Luhya (14 %)are located in the Western Province, whereas the third largest group, the Luo (12 %) are found primarily in Nyanza. As depicted in figure 6, ethnicity in Kenya is both geographically specific and culturally distinct. Although there are differences between the various tribes, families are usually grouped in areas that are located in clusters forming the basis for community interaction[230].

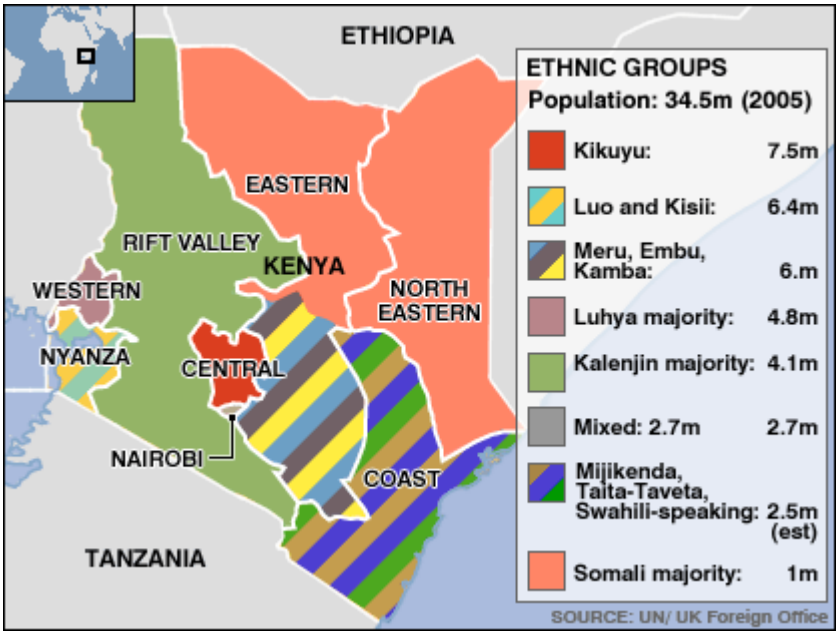



*FIGURE 6: ETHNIC GROUPS IN KENYA (2005), SOURCE: HTTP://WWW.UN.ORG/EN*

The ethnic tensions in Kenya are historically rooted, and for the most part due to the colonial labour policy. The British deliberately kept the tribes in Kenya separated during their colonial occupation fearing that the tribes combined power could bring down the colonial order. One example of this is the British effort to separate the Luo-Kikuyu alliance in the 1950s by drawing electoral boundaries to reduce the representation of the ethnic groups they thought might come together. This manoeuvre discouraged the cooperation between the Luo-Kikuyu alliance, and three years after Kenya became independent, the Luo-Kikuyu alliance collapsed.

[18] Also called (A-)gikuyu, Akikuyu, Kikuyo, Kikouyou, Gigikuyu, Gekoyo, Agekoyo, Ndia, Gichugu, Mathira

Today, the Kikuyu are known as highly educated, and the reason for this is also found in the colonial labour policy. When the Kikuyu worked as wage labourers in European owned plantations during the colonial times, they were offered the opportunity to attend school. The Luhya and Kamba are also highly literate groups, whereas the Kalenjin, the Mijikenda and Swahili groups are the groups with the lowest level of education[231].

There are large stereotypical differences between the ethnic groups in Kenya, and these differences are important to understand in the context of business. The Kikuyu and the Luo are known to hold practically all the positions of power and influence in Kenya[232]. Since the Kikuyu and the Luo have members of their ethnic communities in government and in politics, the two tribes are believed to have had easier access to opportunities and resources. Since the Kikuyu tribe is the largest and the majority are resided close to Nairobi, this also provides easy access to the best educational facilities and job opportunities, both private and public. The Kikuyu is often referred to as highly business-minded, private enterprise oriented, aggressive and scrupulous in business negotiations[233]. The Luos, on the other hand, are seen as less educated, pretentious and more interested in administrative jobs[234]. The coastal tribes are known to enjoy a peaceful life at the coast and the Kikuyu`s often refer to the coastal tribes as indolent and inefficient[235].

Despite the ethnic differences, Kenyans share certain common views of life, values, beliefs and social structures. Customs and traditions related to adulthood are very common across the different cultures[236]. Kenyans are known to be positive, open and outgoing, and generally approach life with great cheerfulness. Nairobians are generally quick to laugh and never reluctant to smile. In business they are hard working and business-wise. A reputation they enjoy in most of Africa.

As previously discussed, a key feature of ethnicity in the Kenyan context is the association of ethnic groups with territory. “Home” is very important, and can rarely be other than in the traditional home place. In Kenya, both immigrants and indigenous people tend to identify strongly with their ethnic groups and to find their primary social bonds within these groups. This creates social networks that are often transformed into supportive business networks. According to many observers, it is these networks that are the main link between ethnicity and business. The mixing of different ethnic groups through weddings, funerals, religious ceremonies, and informal social gatherings provides opportunities for network building that can be mined for business purposes. Such networks that underlie them are one reason for the

continuation of ethnic concentration in business, especially in settings where the resources needed for business are difficult to access through formal institutions [237].

A recent survey conducted by Bratton and Kimenyi[238] investigates how Kenyans see themselves, and which specific group they feel they belong to first and foremost. The sample in the survey was designed to be nationally representative including all the major tribes in all provinces, both rural and urban. Out of the 1207 respondents, only 20 percent stated that they primarily identify themselves with an ethnic grouping such as a clan, tribe, language, race or sub-national geographical region. 43 percent of the sample elected non-ethnic identities, such as class, occupation, gender and religion. Out of the non-ethnic identities, occupation was the most common factor comprising 18 percent and social class and gender made up 7 percent and 4 percent respectively. The remaining 37 percent of the sample identified themselves first and foremost with the national identity as "Kenyans". The results are somewhat surprising, and based on the survey one can say that Kenya does not fit the stereotype of an ethnically driven society, at least as far as the self-depictions of citizens are concerned. The survey also investigated to which extent Kenyans take ethnicity into considerations in interpersonal relationships. Only 6 percent admitted to always choosing friends whose ethnic background is the same as their own, whereas 77 percent agreed that "my friendship with a person is not at all affected by his or her ethnic background"[239].

The attitude towards ethnic differences also varies greatly between the different age groups. According to Rachel Spronk, the younger generation in Kenya, and especially Nairobi, is much more inter-ethnic than the older generation[240]. That is, they do not choose friends or partners based on ethnicity, but focus more on common interests and lifestyle. Seeing as Kenya's population is very young, with a median age of 18.8 years, it is reasonable to believe that ethnic differences will play a much smaller role when the younger generations grow older, particularly in Nairobi where many have a mixed ethnic background. This is another reason why the post-election crisis were hardly felt in the capital despise its national impact.

#### *6.3.1.2 LANGUAGE*

Kenya is a multilingual country, with more than 60 languages spoken[241]. The most common languages are African with a minority of Middle-Eastern and Asian languages spoken by descendants of settlers. There are three different language families in Kenya: Bantu, Nilotic and Cushitic. The Bantu languages are spoken in the central and southeast region representing 65 percent of the population; the Nilotic languages are spoken in the west by 31 percent of the

population, and Cushitic languages in the northeast by the remaining 4 percent[242]. These groups are divided in a number of dialect clusters. Kenya`s Bantu speakers are commonly divided into three groups: western (Luhya, Kisii, and Kuria), central (Kikuyu, Kamba, Meru, Embu, Tharaka, and Mbere) and coastal (Mijikenda, Taveta, Bajun, Pokomo, Taita, and Swahili). The Nilotic language is mainly represented by one tribe in Kenya, namely Luo. The Cushitic speakers, except for the Gosha and some hunting groups, are farmers who speak Somali or Galla. Due to the Kikuyus important role within business and politics, business people from other tribes have had to adapt and learn their language as business is often conducted in the Kikuyu language[243].

Although there are numerous languages spoken in Kenya, Kiswahili[19] and English are the official languages. English is commonly used in relation to business, higher education and politics, whereas the Bantu language, Kiswahili, is frequently used in the media, such as television and radio. Kiswahili was depressed during the colonial period, but the language has steadily regained popularity after the independence, and today it is the only African language recognised in the African Union[244]. EAC has declared it as the lingua franca of the East African region, and it is essential to learn when doing business in Kenya, especially outside Nairobi, Tanzania and Uganda[245]. In recent years, a new hybrid language has emerged combining mainly Kiswahili and English, but also other ethnic languages called "Sheng". Sheng was originally developed by the poor in slums and informal sectors of Nairobi, but has slowly moved up the social ladder in the Nairobian society. Today, educated men and women in urban areas are speaking Sheng, and the language has become a mark of cosmopolitan coolness[246].

#### *6.3.1.3 RELIGION*

In Kenya, freedom of religion is guaranteed by the constitution[247]. As previously mentioned, the vast majority of Kenyans are Christian, with 45 percent regarding themselves as Protestants and 33 percent as Roman Catholic. Christianity came to Kenya in the 15th century through the Roman Catholic Portuguese, but they stopped colonising the country in the 17th century. It was revived at the end of the 19th century by Protestant British colonists and spread rapidly throughout the country. The third largest group are Muslims accounting for almost 10 percent of the population, and they are primarily located in the North Eastern Province and along the coast[248]. There is generally a great level of tolerance among religious groups, although some Muslims perceive themselves to be treated as second-class citizens.

[19] Meaning the language of Swahili

Marriage between the different religions is socially accepted, and common between the Protestants and Roman Catholics[249]. Prior to the arrival of Christianity to Kenya, the different local tribes had their own indigenous beliefs. Seeing as the traditional religions varied between the tribes, an attempt to generalise the nature of the traditional Kenyan religions is difficult, and as the thesis primarily focuses on Nairobi, traditional beliefs will only be covered briefly.

Despite the fact that close to 80 percent of the Kenyans are Christian today, nearly 25 percent of the population believe in witchcraft. Kenya is ranked 15th in Africa in its people`s belief in witchcraft, ahead of Ethiopia, Nigeria, Zambia and Rwanda[250]. Moreover, a quarter of Kenyans believe in the protective power of juju, i.e. charms or amulets, and many consult traditional healers. A day hardly passes in Kenya without news of witchcraft, especially the harassment of suspected witches. It is argued that the two main reasons for the widespread belief in witchcraft are lack of education and poor access to adequate healthcare. However, according to Fr. Laurent Magesa, a Tanzanian theologian, witchcraft is still present primarily because it has been a fundamental part of the African traditional religion[251]. Although Christianity is widespread today, the morality and ethics acquired through long religious traditions are still a part of the African culture. According to DANIDA's programme officer, close to 50 percent of the rural population, especially in the coastal areas, believe in witchcraft or similar supernatural beliefs. In Nairobi, however, she stated that the prevalence of witchcraft is less significant[252]. On the contrary to common beliefs, Western medicine has not replaced but instead increased the use of traditional medicine. This is because traditional healing is deeply embedded in wider belief systems and remains an integral part of the lives of most people[253]. Furthermore, studies have found that the use of traditional medicine has been on the rise in the 1990s[254] and covering ca. 23 percent of those seeking healthcare[255].

#### *6.3.1.4 FAMILY AND COMMUNITY*

The most significant feature of the African family is the importance of the larger kin group[256]. The typical kin group or extended family consists of a number of people in different generations, including parents, children, grandparents, uncles, aunts, and other more distant relatives[257]. Family relationships are undoubtedly important in Kenya, and these close family ties are often referred to as familism. The term familism describes a form of social structure in which the family is central, and all actions of individual members are evaluated by comparison with the fortune of the family as a whole[258]. As a result, the family ties influence the behaviour of the individuals in society. The responsibilities and distribution of power

within the traditional Kenyan family is usually determined by factors such as age, gender and income.

The rights and obligations in African collectivist families can be referred to as a mixture of altercentrism, egocentrism and reciprocity[259]. The family is very supportive and, if it is able to, helps family members by paying for education, providing jobs, covering healthcare or general social and emotional needs. This is also known under the term altercentrism, which is the family's responsibility to provide assistance to their parents, children and relatives, independent of the situation the person is in. This is illustrated in figure 5.6.1 that "money given by friends, relatives and family members" to pay for healthcare is the second most occurring mean to pay for healthcare in Kenya. The material and psychological safety net might however lead to complacency, which in turn can lead to egocentrism where individuals enjoy the benefits of their families without making any contribution on their own. If egocentrism and altercentrism is prevalent at the same time it will most likely reduce the wealth generation for families, or growth potential in the case of family enterprises. Nevertheless, the strong sense of reciprocity, i.e. a mutual or cooperative interchange of favours or privileges, which is common in Kenyan families, motivates individuals to work dutifully to sustain the growth of the family[260].

The majority of ethnic groups in Kenya are patrilineal and patrilocal. A patrilineal system is a social system in which the descents and inheritance is passed through the male line. Whereas the term patrilocal refers to a social system in which newly married couples live with the male`s family. In Kenyan families the elders usually make major decisions, often after consultation with others in the community. This acceptance of unequal distribution of power among family members is reflected Hofstede`s analysis of East Africa, which includes Ethiopia, Kenya, Tanzania, and Zambia. The Power distance dimension, i.e. the extent to which the less powerful members of organisations and institutions (like the family) accept and expect that power is distributed unequally, is ranked as high as 64[261]. This is substantially higher than the Danish rank at 12, but resembles France that have a score of 68 and where it is e.g. an important part of their culture to address people according to their title. Urbanisation has modified the classical Kenyan family structure as it is more difficult for the extended family to live together in the city. Therefore, urban families tend to be smaller than rural families and with loser family ties, i.e. less power distance compared to the rural areas although it is still prevalent.

Based on Hofstede's study of culture, the Kenyan people are closer to the collectivist of the "individualism vs. collectivism" dimension. As previously mentioned, the collectivist society is one in which groups protect the interest of their members, and in turn, they require their members to look after the interest of the groups in general. Hofstede`s analysis of East Africa ranks the region at 27 on an individualism scale from 1 to 100. On the contrary to East Africa, European countries are usually ranked in the region of 70, showing a high level of individualism. The way business is conducted in Kenya is affected by this strong sense of collectivism. This means that both workers and managers bring an appreciation of collective values to the workplace, but it also means that the workplace is likely to be less important to employees than their family and community if the work is not a part of these. It should be noted that the magnitude of the collective value systems is presumably less significant in Nairobi, where the inhabitants are, as earlier noted, capitalistic hence more individualistic.

In the light of the two cultural dimensions, power distance and individualism, the East African region bear a resemblance to Latin Europe[20], where people are more motivated by obtaining power than by achieving objectives, following the hierarchical lines and having precise answers to most of the questions raised[262].

#### *6.3.1.5 GENDER*

From the discussion of family and ethnicity it is evident that gender plays a central role in the Kenyan context. The African society is patriarchal, i.e. based on a family system in which men have more power than women, and it has strong informal institutions that divide rights and obligations as well as duties, opportunities, and societal expectations between men and women. Although the Kenyan constitution provides equal rights and freedom to men and women, discrimination against women is widespread. The gender gap in Kenya is generally higher than its neighbouring countries, and according to the Global Gender Gap Index, Kenya is ranked as number 83, compared to Tanzania on 34$^{th}$ place and Uganda on 50$^{th}$ place. In Kenya, 54 percent of rural and 63 percent of urban women live below the poverty line compared to 50 percent of the total population living below poverty line[263,264].
Gender roles affect many parts of the health provision sector, above all when it concerns decision making. If a woman experiences complications during pregnancy, she is usually not able to make her own decision about her maternity care. The husbands, family or community members are typically chosen as decision makers. Many women are also limited from

[20] Spain, France and Italy

utilising health facilities as they are not allowed to make their own decisions about seeking healthcare for their husbands. Moreover, employed women in the need of healthcare are often restricted to seek healthcare due to strict working hours or food rationing[265].

### 6.3.2 ETHICS

Ethics is derived from the word "ethikos" and means a system of moral values, with morals defined as the quality of being in accord with standards of right or good conduct. Moral tells us what is right and wrong, and good and bad deeds, and what is laudable and despicable to do. Ethics is about the philosophical reflections on the moral, reflecting on the daily considerations on what is morally responsible. On the intuitive level moral assessment of one's own and others actions are made, which are defended or criticised from simple and easy comprehendible rules and which consequences they will have[266].

A comprehensive study of the ethics of Kenyans would be out of the scope of this thesis, and not fit with the objective of it. It is therefore important to agree upon what area is most relevant to focus on when discussing ethics. After 3 weeks stay in Nairobi, studying investment climate reports and doing interviews in Kenya two areas of ethics prevails and that is corruption and crime. The residual of this chapter will therefore be devoted to an analysis of the corruption and crime in Kenya.

#### *6.3.2.1 CORRUPTION*

Corruption is by the World Bank called "the biggest obstacle of poverty reduction"[267] and just south of Kenya in Zimbabwe, Robert Mugabe exemplifies how corruption can destroy a developing country on its way to prosperity[268]. This analysis will not only focus on the level of corruption in the top management of Kenya which is usually the one that ends up getting caught by the KACC and receives all the media attention, but it is important to elaborate on the different level of corruption in the Kenyan society.

To start with a clarification of the definition of corruption is in place. Corruption is treated as behaviour, often defined by something in line with the World Bank definition "abuse of public power for private gain". The definition however does not preclude what is called private to private corruption. Earlier corruption was not blamed on the individual but rather it was argued that it was the system causing the problem, e.g. that monopoly made corruption blossom[269]. The definition has shifted from a systematic problem to a behavioural one, as corruption is defined as "the intentional misperformance or neglect of a recognised duty, or the unwarranted exercise of power, with the motive of gaining some advantage more or less

directly personal", not very different from the common definition used today "the use/abuse/misuse of public office for private gain"[270]. Corruption is mainly affiliated with bribery, but this leads to another problem as gifts and bribes can be misinterpreted. A good distinction is made in "The merchant of Venice" when they distinguish a bribe after a verdict as a gift, while if given before it is a corrupt bribery[271].

Many countries experience an increase in corruption when they have a transition in their institutional setting creating a stronger division between public and private sector. The change might be on the paper but as people's behaviour is hard to change over a short period it leads to corruption. This has often been the case in many African countries having introduced a new institutional setting after independence that does not fit the country's informal institutional setting[272], and Kenya was no exception. After its colonial period the country experienced many structural changes, and the country's self helping harambees started eroding. They started to evolve into a culture of political philanthropy, with political contests as the real purpose and participation predominantly from politicians abusing them to fund political campaigns[273].

The current level of corruption in Kenya is high, ranking her 147 out of 180 according to the Global Corruption Report. One of the focus areas of president Kibaki has been to revoke this, and he has expressed his understanding of the misfit of the institutional setting. He has tried to remove some of regulatory obstacles as their complexity is positively correlated with the graveness of corruption. The recent Licensing law bill, agreed on 11 October 2007, abolished over 140 different licences that were previously essential, and has entail less corruption according to the Kenya Bribery indices. This is just one of the ratification that has happened during president Kibaki to bring down corruption. The GNU may have prevented a continued and total breakdown of law and order in the immediate term, but it has also removed the presence of a large opposition to oversight the executive[274].

The Kenya Bribery Index has been published since 2001 to enhance transparency and decrease corruption, but according to the last report from a sample of 2,400 Kenyan adults a full 2,088 (87 percent) were confronted with a bribery-demand situation in the previous year. Of those, 1,832 (88 percent) made a bribery payment[275]. These figures illustrate the seriousness of the popular use of bribery in Kenya. In 2009 the East African Bribery Index (EABI) showed that Kenya has the highest incidence of corruption with 45 percent in the EAC, while Uganda and Tanzania that have respectively 35 and 17.8 percent.

The study of EABI's results in table 15 shows that the Kenya Police is the most corrupt organisation in East Africa[276] with a prevalence of 63.4 percent, i.e. the proportion of respondents who actually paid bribes during their interaction. They furthermore receive more than one fourth of all bribes in Kenya and are a serious problem for Kenya's future. Another organisation worth noticing is the Judiciary which has the second highest prevalence and an even higher likelihood of being paid than the Kenya Police. The corruption in both organisations has the highest impact on the Kenyan society being respectively number one and two. Due to the harsh and competitive employment situation in Kenya there has been a rise in employment related bribery from 6 percent in 2008 to 11 percent in 2009 with the total value of the bribes soaring to 279 percent increase because an increase in the bribe amount.

| Organisation | EABI (2009) | # | Likeli-hood | # | Preva-lence | # | Seve-rity | # | Impact | # | Share of bribery | # | Frequency of bribery | # | Av. Size | # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Kenya Police | 66.5 | 1 | 85.5 | 2 | 63.4 | 1 | 10.4 | 20 | 59.2 | 1 | 26.9 | 1 | 3.1 | 4 | 3,179.9 | 19 |
| Ministry of defence | 61.9 | 2 | 84.0 | 4 | 28.4 | 15 | 49.4 | 1 | 12.3 | 27 | 13.3 | 2 | 1.9 | 18 | 42,800.0 | 1 |
| Judiciary | 54.4 | 3 | 86.1 | 1 | 57.8 | 2 | 17.3 | 10 | 54.9 | 2 | 7.6 | 3 | 1.6 | 22 | 5,627.1 | 11 |
| Ministry of Public Works | 46.2 | 4 | 66.7 | 10 | 23.3 | 17 | 33.3 | 2 | 20.0 | 17 | 0.4 | 25 | 8.4 | 1 | 4,028.6 | 16 |
| Ministry of Lands | 45.6 | 5 | 77.7 | 5 | 46.0 | 4 | 15.8 | 12 | 43.2 | 5 | 3.5 | 8 | 2.4 | 9 | 4,058.6 | 15 |
| Nairobi City Council | 42.9 | 6 | 64.5 | 11 | 44.3 | 5 | 12.6 | 17 | 41.0 | 6 | 4.7 | 5 | 2.9 | 6 | 4,248.3 | 14 |
| Ministry of Labour | 41.7 | 7 | 84.4 | 3 | 31.3 | 12 | 31.3 | 3 | 28.1 | 11 | 1.0 | 17 | 1.1 | 32 | 7,330.0 | 4 |
| Mombassa City Council | 40.9 | 8 | 73.3 | 6 | 40.0 | 8 | 13.3 | 13 | 20.0 | 16 | 0.5 | 23 | 5.2 | 2 | 6,333.3 | 8 |
| Immigration Department | 39.6 | 9 | 63.1 | 12 | 49.4 | 3 | 6.3 | 26 | 44.4 | 3 | 3.5 | 9 | 1.5 | 23 | 3,279.5 | 18 |
| Kenya Revenue Authority | 38.3 | 10 | 57.0 | 14 | 44.0 | 6 | 5.0 | 31 | 44.0 | 4 | 2.8 | 13 | 2.3 | 12 | 4,734.1 | 13 |
| Ministry of Health | 21.4 | 22 | 37.3 | 22 | 27.5 | 16 | 7.8 | 24 | 23.5 | 13 | 0.2 | 29 | 0.6 | 37 | 1,310.0 | 37 |
| NHIF | 17.4 | 27 | 29.6 | 27 | 18.5 | 21 | 7.4 | 25 | 18.5 | 19 | 0.1 | 35 | 1.0 | 33 | 1,700.0 | 30 |
| Public hospitals | 16.9 | 29 | 29.6 | 28 | 24.6 | 26 | 5.2 | 27 | 13.7 | 23 | 3.4 | 10 | 1.3 | 29 | 1,339.1 | 35 |
| Private hospitals | 13.0 | 32 | 20.3 | 32 | 13.8 | 27 | 2.8 | 34 | 13.4 | 24 | 1.0 | 16 | 1.2 | 31 | 1,910.5 | 26 |

*TABLE 15: CORRUPTION BY ORGANISATION, SOURCE: EABI 2009, P. 19-28*

Even though many of the numbers are warning, the different governmental initiatives have resulted in a decrease of the propensity to bribe and not report falling by 13 percent from 64 percent in 2008 to 56 percent in 2009. It is promising as the current development has been meliorated both through governmental initiatives and a change in the population's attitude[277].

The situation of corruption in the Kenyan health provision has improved from 2006 when the National Corruption Perception Survey indicated that 22.9 percent of the respondents ranked the health facilities as the third most corrupt areas in their locality, and with 41.3 percent in 2006 believing that the MOH was the second most corrupt Kenyan ministry[278]. Neither the MOH nor the NHIF are now in the top 20, but the impact is ranked 13 and 19 signalling that it is still not insignificant.

The public hospitals were ranked as the fourth most corrupt institutions in 2006[279]. As seen in table 15, corruption still exists in public and private hospitals, and it prevails that the public

hospitals receive 3.4 percent of total bribes in Kenya compared to only 1 percent for private even though the two are almost equally divided. The difference signals the general high corruption within public institutions, but an improvement is present with both the public and private ranked respectively 29 and 32 out of 39 investigated Kenyan institutions.

The health provision sector is particularly prone to corruption due to the patients' difficulty to shop around for the best price and quality. This makes it difficult to detect corruption hence the sector needs to be monitored as it is difficult for patients to distinguish between legal and counterfeit drugs[280]. The counterfeit drug problem has increased lately and it is still thriving as many public hospitals often lacks supply of health related products because of bad procurement. Most drugs are also sold in small shops making it difficult to inspect[281].

Many private hospitals are actually gaining customers as a result of the counterfeit problem, seeing as the public have a hard time obtaining sufficient supply of drugs. Drug supplies are in fact one of the main reasons for customers to choose a private over a public hospital[282].

An additional problem within the HC sector is that focus is on raising more funds, instead of fighting the corruption that deteriorate the value of the funds in place. The corruption needs to be addressed and identified as this will remove the informal payments, fraudulent procurement and billing, inappropriate influence on the regulatory process and selling expired drugs in altered package, and will increase the overall quality of health provision. Some improvement are appearing as more inspections on public hospitals have raised the overall quality and hygiene, but there is still room for further improvements in order to enable the public hospitals to compete with the private[283].

Improvements are seen in both the Kenyan society and within its health provision, and the post election violation has increased the awareness of doing well. Uungwana[21] has campaigned for acting more socially correct, and more companies are focusing on helping the society[284]. The government's recent IPO[22] to sell off significant portions of the national airline, the main electric utility and a mobile phone company, were all regarded as comparatively clean by observers[285]. The clean privatisation is both helping building up the lack of public confidence in the government using non-corrupt practices and with the privatisation separating the powers which enhances transparency and entails less corrupt

[21] Kiswahili for doing good
[22] Initial Public Offering

practices, as is also the documented case for private compared to public hospitals. Despite this corruption is still the largest obstacle in doing business in Kenya today[286].

#### 6.3.2.2 CRIME

Crime has been and remains a major problem in Kenya. According to the IFC, Kenyan firms reported losses from crime averaging almost 4 percent of annual sales in 2009. Moreover, close to 35 percent of the firms in the IFC survey classify crime as a major or very severe obstacle to business. The real cost of crime, however, is even higher than 4 percent seeing as firms in Kenya, on average, spend 2.9 percent of sales each year on legal security services and 1 percent on illegal security services[287]. Illegal services include payments to organised crime in order to avoid theft. Hence the total impact on sales in Kenya is close to 8 percent, twice as high as Tanzania, the country with the second highest aggregated cost of crime in the survey. Figure 8 depicts the total cost in Kenya compared to China, India and four African countries.

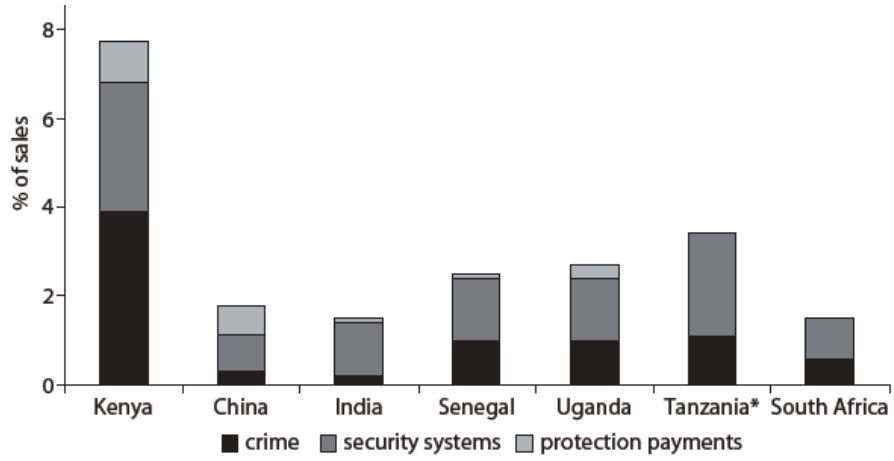



*FIGURE 7: TOTAL COST OF CRIME, SOURCE: LAROSSI 2009, P. 47*

In 2008, the number of crimes reported to the police amounted to 63,476, a marginal increase from 2007. The number of crimes committed decreased from 69,484 in 2007 to 61,438 in 2008. Theft of stock related offences increased by 44.7 percent, rising from 1,568 in 2007 to 2,269 in 2008. The number of traffic offences almost tripled from 46 to 120. However, the number of traffic offences may also be influenced by the fact that the Kenyan police have increased the number of controls in recent years[288]. The major reductions in crime reported to the police were corruption (24.9 percent), handling dangerous drugs (18.4 percent) and offences against morality (15.2 percent).

In the health provision sector, the largest crime related problem is dangerous drugs and counterfeits. A recent survey conducted by the National Quality Control Laboratories (NQCL) and the Pharmacy and Poisons Board of drugs in the Kenyan market and found that

almost 30 percent of drugs are counterfeits. The percentage is even higher for anti-malaria drugs (40 percent)[289], and they are the easiest to counterfeit since they are in high demand[290]. According to Dr. Hezekiah Chepkwony, the director of the NQCL, the fake drugs range from dangerous products to ineffective drugs made up by water or chalk. The market for counterfeit drugs is large, and the Kenya Association of Pharmaceutical Industry estimates that counterfeit drugs account for $130 million in sales annually. In an effort to fight counterfeiters the GOK introduced the Anti-Counterfeit Act in 2008 and established an agency solely working towards counterfeiters. Although the Anti-Counterfeit Act has increased the penalty for counterfeits, the largest pharmaceutical companies in Kenya, Pfizer and GlaxoSmithKline, still blame the Kenyan legal system for the widespread of counterfeits[291]. The counterfeit drug problem results in more sales for private hospitals, but also drive down the prices for the drugs, but with crime being seen as a less serious problem for medium and large sized facilities, as they need security no matter what.

### 6.3.3 Norms and Trust

A norm specifies what action a set of people regards as proper or correct, improper or incorrect. Norms are created and reinforced by socialisation. Acceptable patterns of behaviour are only sustainable when they are widely understood and firmly enforced by sanctions. Norms may be enforced either internally through guilt, or externally through shame or banishment. Norms can be viewed as standards of individual conduct that people follow in order to avoid sanctioning independently if the conduct is legal or illegal[292].
Seeing as it is difficult to pin point specific Kenyan norms, the discussion will commence on a more general level. As is described above, the Kenyan political environment is characterised by many years of misgoverning leading to a situation where the population do not trust its government. This is particularly the case when individuals are from a different tribe than the majority of the MPs, but the mistrust is also apparent on a lower level as public institutions such as the police are actively engaged in corruption and do not act according to the laws. As a result of the mistrust to the public law enforcement many Nairobians believe in self enforcement. One example of this is if a person yells thief or theft after a person who just pick-pocketed, the present crowd will start chasing the accused person, and if he is caught he will be punished with violence sometimes leading to a fatal outcome[293].

The misbehaviour of the police is reacted upon through lack of respect for laws that should be enforced by the police. Even though Nairobi has stop lights throughout the city, Nairobians will know that you are a foreigner if you stop at a red light. The stoplights are rarely

respected, and the general attitude towards driving is that you can get away with almost anything, especially if you are the driver of a Matatu. To stop this, a new unit under the police has been initiated with city council workers, but publicly known as "Kanjo", who stop cars that cross red lights, pulling the drivers out of their car, and bringing the car directly to the police station[294].

Trust is defined as "the bond that people share across a society and across economic and ethnic groups, religions and races"[295]. Moreover, trust eases exchange without the need for strict enforcement and thereby reduces transaction costs, promotes investment efficiency and forms the basis for social capital which has been argued to be important for a country`s institutional and economic development. In ethnically diverse societies, such as Kenya, trust appears to be low compared to homogenous societies[296]. Individuals can also develop particularised trust if they limit their interaction to a certain group, ethnic or non-ethnic. Particularised trust implies "deeper ties to a closer circle such as family members, friends, and others with similar background"[297]. As previously discussed, Kenyans families are characterised by strong family ties, which is why altercentrism is so strong and facilitate the formation of particularised trust. Particularised trust does not necessarily lead to lower levels of generalised trust, but when people develop trust based on similarities this may reduce generalised trust over time.

Trust allows people to take risks and is demonstrated when economic agents take risky actions in an environment of either uncertainty or informational incompleteness such as not being reluctant to use public hospitals. It permits exchange in these circumstances but conditions such exchanges in specific ways[298]. According to a survey conducted by Bratton and Kimenyi, 39 percent of Kenyans express "a lot" of trust in people to whom they are related by blood or marriage. However, when the respondents were asked if they trust people from other ethnic groups only 8 percent expressed a lot of trust in Kenyans from other ethnic groups. 13 percent of the respondents stated that they trust unknown individuals from their own ethnic group a lot[299]. For businesses to continue, a high level of trust must be maintained, and when trust is abused, there should be mechanisms for recourse. Kenyans are therefore mostly limited to doing business with people with the same ethnic background. In business relations across ethnicity other mechanisms have develop, and firms tend to work in ways that do not require trust, especially by inspecting all supplies before buying, requiring large upfront deposits, and eliminating credit transactions. Such approaches add to costs and reduce the number of potential customers. Sociologists, anthropologist, historians and economists

have for a long time recognised the importance of trust-based relationships at early stages of market development[300]. Kenya is therefore limited due to the lack of trust to other ethnicities, and this is one of the reasons why the Kikuyus have continued to do the majority of business in Kenya the last decades[301].

Trust is also one of the main factors that lead Kenyans away from public hospitals whenever they can afford private healthcare. A recent survey indicates that some patients fear to be tested for HIV/AIDS because they suspect that the nurses will tell their relatives and friends about their consultation[302]. There were also examples of patients who felt that the doctors and nurses did not understand their illness, seeing as the patients personally believed in witchcraft and traditional medical practises. Language barriers are another issue which have led to distrust among medical patients. Many patients, especially in rural areas, are incapable of speaking Swahili or English, and since the MOH does not regularly consider patients' ethnic background prior to consultation, this has led to a perception that doctors and nurses are uncaring. Ethnic differences pose a threat to trust within the health provision sector. If a doctor or nurse treating a patient is Luo, and the patient is Kikuyu this may lead to mistrust seeing as the two tribes have a long history of disputes[303].

### 6.4 ENFORCEMENT

It is widely recognised that institutions are central to the understanding of why some economies and their industries performed better than others[304]. This section focuses on the most relevant formal and informal institutions for the health provision sector, and discusses how these institutions interact. As previously noted, their relationship is often classified in two contrasting categories, i.e. functional and dysfunctional.

Formal institutions comprise all rules and sanctions that can be enforced through a formal process[305]. The degree to which formal institutions are enforced depends on the strength of legal institutions, and the leadership and incentives to ensure that formal institutions are effectively implemented. When formal institutions are inadequately designed or enforced, informal institutions, such as norms, culture and ethics, become stronger. On the contrary to formal institutions, informal institutions are enforced through a set of self-enforcing mechanisms such as; expectations of reciprocity, shunning, especially with respect to the Kikuyu-Luo relationship, threats and the use of violence[306]. This part will elaborate on the formal and informal institutions interaction whether they convert or divert and how this

relationship generally can be described according to the earlier mentioned theoretical framework.

The discussion going forward comprises of two respective parts. This partition is difficult as the respective institutions influence each other in a manner that can be compared to a matrix hence it is inevitable that the analysis will not be as rigid as it might appear from the heading of the section. The first part analyses how the informal institutions constrain or facilitate the business environment in the health provision sector such as corruption, trust and culture and is called enforcement of the informal institutions**.** The second part looks at public governance in Kenya, how it is influenced by the EAC and the current and proposed constitution, and more specifically how the politics of Kenya are affected by ethnicity, a section that could have been in the informal section as well, but is place here due to its relation to governance. This part is called enforcement of the formal institutions. The analysis is naturally closed with an analysis of the Ministry of Health and how it influences the health provision sector. The allocation of the enforcement section in an informal and formal section is lax, as it is unavoidable to elaborate on the formal and informal institutions relationship in both parts. They are therefore not exclusively nor exhaustively covering the heading, although their main takeaways will be present in these sections.

### 6.4.1 ENFORCEMENT OF THE INFORMAL INSTITUTIONS

The following section focuses on how informal institutions influence the business environment in the health provision sector for foreign investors. It accentuates the most prevailing informal institutions and is divided in three sections covering i) corruption, ii) trust, and iii) culture.

#### *6.4.1.1 CORRUPTION*

Kenya has a satisfactorily legal and regulatory framework[307], but the problem, however, is that the laws and regulations are not thoroughly enforced, and often simply ignored by the authorities. The matter of corruption in Kenya illustrates this clearly. Like most countries, Kenya has laws governing bribery and corruption. Nevertheless, norms and attitudes about how serious it is to engage in corruption and how one deal with it, determines the extent to which formal rules on corruption will be effective. The latest data shows that 88 percent of Kenyans confronted with a bribery-demand situation choose to make a bribery payment[308], i.e. the ethics of Kenyans compete with the formal institutions. Kenya's casualness and high level of corruption are rooted in the formal institutions that are saturated with corruption from

bottom to top. One example of this is the high rate of corruption in the Kenyan police force. A recent survey indicated that 93 percent of those questioned had been faced with a bribery incident while interacting with Kenyan police[309], hence bribery is more socially accepted as a result the majority of Kenyans believing that the authorities are corrupt and that bribing will not be sanctioned.

In 2009, the African Centre for Open Governance (AFRICOG) carried out an assessment of the effectiveness of the KACC in the fight against corruption. Although the AFRICOG recognises certain benefits from a specialised anti-corruption agency, it stresses that the KACC cannot replace a non-performing Attorney General, a compromised Judiciary and an endemically corrupt Police Force. According to the AFRICOG`s assessment the most important element of any anti-corruption effort is political will, which is currently not present[310]. Throughout the past decade the financial sector has prevailed as being one of the sectors that could not be tamed for its large amount of both political and executive corruption, resulting in poor sectoral and corporate governance making pensioners, creditors, employees and depositors extremely vulnerable. One of the main reasons for this is the structure of oversight institutions such as KACC, the CBK and Capital Market Authority which would all be more effective if they were independent of the GOK. But as they are influenced from an overbearing executive that greatly compromise the effectiveness, they are not able to do a thorough job. The other reasons that corruption has thrived is due to unenforced laws, poor financial sector oversight, a base sector culture and overbearing political and executive environment. The same ineffective legal system has enhanced the corruption within drug trade, illegal arms dealing and other crimes, as money-launders have funded political processes entailing political corruption. The last major example is the Charterhouse Bank in 2004 which supposedly money-laundered and tax evaded equivalent to 10 percent of Kenya's national income.

The formal institutions to fight corruption are still not effectively enforced, but will with the new constitutions be independent which means that these institutions' enforcement will improve and become more effective. The current competing relationship with the nature of Kenyans is therefore likely to change from competing to become more complementing. If the public officials start to act less corrupt and according to the laws the corruption will decrease as trust in the government being less corrupt is established. The incumbent PM has been very pro supervision of government institutions to ensure efficiency and remove corruption. The Ndegwa Commission report of 1972 that allowed civil servants to have private business is

also being removed soon. Instead the civil servants' wages will go up, as this has been a large source of income for many MPs. Following the Ndegwa Commission report has been seen as one of the main roots to corruption for Kenyan civil servants. It was further agreed to have an ombudsman to receive complaints on corruption. As this is implemented it will make the formal institutions more effective even though there is a long way to a corruption free political environment in Kenya[311].

Corruption in the Kenyan health provision sector has compromised the quality, effectiveness and equity in service delivery while raising the cost of discharging the same. To supply healthcare efficiently and not make corruption blossom it is important to entrench it on transparency, accountability and integrity on all six levels in the health provision referral system, but as the system is now it makes way for corrupt practices. The health provision sector is facing challenges as Kenya's location neighbouring Somali facilitate smuggling of counterfeit drugs into Kenya at cheap prices. Another hinder is that it is difficult to ensure good procurement of medicines as goods are sometimes held back at the border control. With the police getting better at enforcing the laws and corruption decreasing, it will help getting goods through customs that before were sustained in the prospect of receiving bribes.

#### *6.4.1.2 TRUST*

The issue of trust plays an important role in the context of health provision. Based on the preceding discussion issues related to trust are mainly rooted in ethnic differences and lack of understanding about medical practises. Since Kenyans often make use of private health facilities as a result of trust issues, trust as an informal institution can both accommodate and compete with formal health institutions. A field survey on trust in Kenyan rural health provision facilities show that only 16 percent of patients agree that people in general can be trusted. On the other hand, 85 percent of all the people interviewed stated that they would not mind accommodating relatives in their house while 59 percent would not mind holding group meetings in their homes. The survey argues that trust has been reduced to a very small network of relatives and close associates to the extent that one would argue that it will impact negatively on health service delivery[312].

The 50 percent of Kenyans living below the poverty line is a figure that has not changed significantly the past 20 years, and although initiatives such as the NHIF should have helped to increase the accessibility to formal healthcare, the number of Kenyans believing in traditional medicine such as witchcraft has increased in popularity. The general critism which

AOP 4 were to address through its guidelines for stimulating the restructuring of NHIF with emphasis on administrative efficiency, which has been criticised for being too low[313], e.g. ca. 40 percent are administrative costs[314]. Currently, the NHIF is increasing their member base, but lack the understanding of the potential in integrating the traditional medicine and education which makes the two competing instead of accommodating institutions[315]. Due to the dysfunctionality of the formal healthcare system the population is increasing using and trusting their "own" system. The NHIF has realised this problem and is looking for ways to include the informal sector and improve their coverage, but their strategy does not seem focused according to MOMS[316]. A mean to develop the market is to improve the cooperation between normal hospitals and traditional medicine, e.g. educate them on Western medicine and how these two roots can be combined to make a good fit for Kenyans. The belief in traditional medicine is therefore currently competing with the ineffective health provision system that lacks a functional referral system and good management to establish its trust. As the health system starts working efficiently the belief in traditional medicine will be accommodating the effective system with the potential for it to complement it if a functional cooperation is establish. Hence there exists potential for this relationship to develop into a converging relationship where the trust in the traditional medicine can be used to increase the overall trust in the health provision sector.

#### *6.4.1.3 CULTURE*

As previously emphasised the definition of culture consists of many aspects, but the most profound in a Kenyan context is their degree of altercentrism and reciprocity, and the harambee movements' significance in the Kenyan society. All three will be elaborated on in this section.

Families and communities are accommodating the MOH's goal in providing quality healthcare to all its citizens, as they fill in the gaps that the formal institutions lack to cover. On average, 18.8 percent of the total number of patients seeking inpatient care receives money by friends, relatives and family members. The number in the poorest quintile is 26.3 percent of the inpatients receive money from their family or friends[317]. The altercentrism and reciprocity of Kenyans improve the health provision market, as the disposable amount Kenyans have for healthcare are both for themselves, their family members and their community. This "local social security" approach increase the market for services oriented to the lower and middle class as most Kenyans through this will have available cash to pay to receive healthcare. Money is therefore informally moved from the richer population to the

poorer through their altercentric behaviour. Their expectations of reciprocity ensure that someone who has helped another through times, where he was unable to pay for healthcare, will be helped later on if he experiences financial problems. The altercentrism and reciprocity of Kenyans therefore complement the NHIF which is yet to cover the poor part of the population without them paying the NHIF fee. According to the CEO at NHIF, many Kenyans are hesitant to pay for health insurance today in order to avoid possible healthcare expenditures in the future[318]. One reason is due to the support from their family and/or community who they know will help them if they become sick. The NHIF is becoming more effective as a formal institution with the family and community accommodating it by helping the poorest Kenyans. But because of the Kenyan culture it will take time to include Kenyans voluntarily. In this respect NHIF is effectively enforced as it covers formal labour, but demands money from the informal sector if they want healthcare coverage. Hence the NHIF is yet to establish a fully converging relationship with the informal sector, particularly with the segment who knows that they can be covered through family and community, and these two institutions will continue to act divertingly under the current NHIF strategy.

The harambee movement, in addition to supporting certain political institutions, such as the MOH, also affects economic institutions e.g. banks and other formal financing entities. The various harambee initiatives are categorised into two broad groups, private and public. Private harambees typically raise funds for weddings, funerals, college fees and medical bills for family and friends, whereas public harambees raise funds for development projects such as schools, health centres, water projects etc[319]. Although the harambees have been responsible for the building of over 200 schools, 40 health Centres, 60 dispensaries, 260 nursery centres throughout the country, it has also been said to predispose people, and particularly, politicians to corruption. First, harambee provides an opportunity for people who steal public funds to legitimate themselves to the public. A survey of the Kenya Public Expenditures Management done by the centre for Government and Democracy for the period 1991 to 1997 indicated that the government lost more than US$15 billion through mismanagement. Wasteful expenditure was the main cause of loss of public funds, as a result of misuse of money given to harambees. Second, there is no accountability for contributions and few sponsors make the effort to see that their contributions were used for the intended purpose. Thus, there is no mechanism for sanctioning individuals who misuse the funds and fraudsters who raise money for fictional harambees[320]. Hence the substituting nature of the harambees has become more

dysfunctional for society, and as the formal institutions are not effective the relationship has evolved to be more competing.

### 6.4.2 THE ENFORCEMENT OF FORMAL INSTITUTIONS

The main emphasis on public governance is vital for the economy and health provision sector going ahead. The EAC Common Market and the PC are, as earlier accentuated, vital landmarks for Kenya's progress towards a more converging and functional institutional environment. Particularly the PC has been seen as a necessary mean to improve it. This part is thus divided in four subsections to elaborate on the governance starting with i) the EAC, ii) the constitution and proposed constitution, iii) ethnicity in politics, and closing with iv) the Ministry of Health.

#### *6.4.2.1 EAC*

With the fully established EAC Custom Union and commencement of the EAC Common Market, the EAC-countries are continuously harmonising their business laws, systems and administrative structures to improve the trade and investments within the EAC and build up a market that slowly constitutes one destination for investments. This will improve in accordance with the integration of the EAC Common Market and more liberal competition in the region. Certain legal matters are not changed in the draft of the new constitution, and in relation to investing in a country the most prevailing determinants are property, contractual and intellectual rights. The two first aforementioned are enforced properly, though delays in court exist, and are not subject to a high degree of corruption nor disfavouring due to non-Kenyan residency. Whereas the intellectual rights have experienced difficulties in Kenya and are hardly enforced, this may improve along with the EAC pressuring the lack of enforcement, but is currently an area to be concerned about from an investor's point of view[321].

One of the largest bottlenecks in Kenya is taxes, which now, mainly due to the EAC, seems to be ameliorating. Uganda, Tanzania and Kenya are harmonising their tax and VAT in order to simplify doing business in the three countries[322]. The tax administration has been the main problem of the Kenyan tax authorities who has now claimed that this will improve, and they will focus on improving dealing with them in the future[323]. These formal institutions are therefore strengthened hence improving ease of doing business. Improved law enforcement is widely supported by the different ethnic communities, who are mostly tired of lack of enforcement. The relationship will therefore become more complementary as this improves.

The Economic Recovery Strategy (ERS) was well executed and even though Vision 2030 has not had the best thinkable commencement, the GNU has been working toward its goals and the ministries have not been passivated, but many of their mid-term goals have been executed through a variety of initiatives. Water, electricity, road and security conditions have all improved to ease business, and the EAC Common Market is in many cases helping by sharing infrastructure and enhancing political stability by dividing the power on more states. The road from Mombasa through Nairobi to Kampala, Rwanda and Kigali connects the region. Another road is on the drawing board going from Sudan through Nairobi and Tanzania to South Africa. These two roads will make Nairobi connect to the rest of Africa and facilitate businesses' cross-border activities.

The EAC has additionally launched the REACH-PI to help harmonise and improve health provision in the region emphasising the importance of healthcare financing, human resources for healthcare and private sector involvement. The Vision 2030 is very ambitious, but with a more stable environment and transparent political scene integrating the region to benefit from the countries respective strengths, Kenya is on its way. The security situation in Nairobi has changed dramatically, and the city that was going under the name "Nairobery" is now ranked as "medium" developed by the UN Human Development ranking unit from "low", and in December 2009 the UN chose to re-categorise Nairobi as a level "B" duty station, although it had dropped to "C" in 2001 due to concerns on health and security[324].

#### *6.4.2.2 CONSTITUTION AND PROPOSED CONSTITUTION*

The constitutional draft is receiving great international attention from e.g. Barack Obama, the current U.S. President, who is interested in getting the constitution passed in order to ensure a more stable climate in his father's home country[325]. The decentralisation of power that the new constitution will entail is thought to enhance good governance and greater accountability to help the business environment in Kenya. Even though it is not perfect, it is a step in the right direction to decrease the more deteriorating problems in Kenyan politics such as corruption[326]. A passing of the constitutional draft will therefore enhance political stability and pave the way for a more stable business environment by decentralisation and providing independence for the judiciary. The current ineffective constitution will become more effective to let the informal institutions accommodate and complement the constitution facilitating less corruption and tribalism in Kenya.

The political ethnic divide seems only to be dealt with through the PC reform process, as there is a widespread perception of injustice. The PC is addressing this, and due to its support and pressure both domestically and internationally, it will most likely be passed in August this year[327]. The current system with high centralisation of power is by many considered to be the other main reason for the corruption and tribalism that has blossomed since independence. The new constitution will address this by dividing the executive power between the president and the PM, who will take over the day-to-day running of government. It will introduce regional governments, reduce the term of office for the Attorney General to 6 years, and bring down the amount of ministers from 60 to 15-20[328].

#### *6.4.2.3 Ethnicity in Politics*

Political networks of power based on ethnicity are restricted to include supporters whose mutual interest is dependent on a mutually shared perception of cultural kinship[329]. The Kenyan political society has consistently been divided along ethnic lines, and all significant parties have failed to integrate the major ethnic groups into one political party or coalition and sustain it. Seeing as the Kikuyu tribe hold the majority of the influential positions within politics and business, the Kikuyus' incentive to prioritise health provision outside the province is questionable. Although the importance of countrywide health coverage was recognised in the Kenya Health Policy Framework from 1994 and emphasised in the unexecuted National Social Health Insurance Strategy in 2003[330], lack of leadership and enforcement has entailed a scarcity of health services in rural areas which is still one of the greatest weaknesses in the Kenyan health system[331]. In this aspect the institutions' relationship can be described as competing, but if the new constitution is passed, Kenyan politics will be more decentralised with local governments to change this to a more complementary relationship.

Ethnic representation in political parties is a vital topic in the context of enforcement. To explain the representation in Kenyan political parties, the political system nationalisation score (PSNS) is used, which is calculated by PNS = 1 – Gini-coefficient. The Gini-coefficient takes the value 0 if a party has perfectly equal distributions of vote share across all the countries territorial units and as earlier mentioned ethnicity in Kenya is geographically specific[332]. Table 16 illustrates the PSNS of Kenya throughout the past 4 elections compared to Ghana. It shows that Ghana has a less territorial voting pattern than Kenya. In 2002 Kenya seems to have improved, but the higher PSNS is due to the large NARC coalition being an alliance of different parties hence many different ethnicities. Most of the parties left the

alliance shortly after the election thus the number is highly biased. The number in 2007 gives a more realistic picture of the political situation being highly ethnically divided and the lower number indicates that Kenya with its current system is not on its way to become a more integrated country.

| PSNS | 1992 | 1996/97 | 2000/02 | 2004/07 |
|---|---|---|---|---|
| Ghana | N/A | 0,7 | 0,7 | 0,74 |
| Kenya | 0,59 | 0,54 | 0,62 | 0,42 |

*TABLE 16: ETHNIC REPRESENTATION IN POLITICAL PARTIES, SOURCE: BOCHSLER 2010, P. 31*

A survey conducted shortly after the post election crisis indicates the clear split between Kikuyu and Luo. 86 percent of Kenyans feel equally or more Kenyan than their ethnic group and with respect to trust it can hardly be divided on ethnicity but instead is it the relatives that truly matters. These numbers does not show a clear ethnic split, but the Kikuyu and the Luo certainly have their disagreements when it comes to the power distribution in the incumbent government. One fourth of all Luos believe that the Kikuyu have more influence in national politics, but this difference is not nearly as significant as when it concerns if the economic conditions and treatment of government is worse than other groups. These categories has respectively 64 and 66 percent of Luos feeling discriminated compared to Kikuyus where it is only respectively 12 and 6 percent. There has been a clear improvement in this the past two years with PM Odinga receiving more media attention and becoming more influential. The numbers do confirm the harsh political ethnic divide that exists, but considering that the Kenyans regard the Luo as especially fitted for positions requiring education and intelligence compared with the Kikuyu, who are regarded as natural businessmen and politicians, it makes a good match for disputes[333]. The general environment is currently determined by the two groups finding a way to agree. The past two years cooperation with president Kibaki and PM Odinga has been characterised by stability and understanding from both groups, but future stability depends on a political agenda with decentralisation and the political agenda influenced simultaneously by the Kikuyu and Luo. The Kenyan population wants to vote non-ethnically and are pro-economic growth, hence with a politicising from both ethnic groups in a reforming positive direction effective formal institutions will converge with the wishes of the Kenyan citizenry complementing each other to reach a stable and fertile economic environment[334].

#### *6.4.2.4 MINISTRY OF HEALTH*

There are primarily six challenges facing the health provision sector today; i) low quality services, ii) old and run-down infrastructure, iii) inadequate financial resources, iv)

inaccessible healthcare especially in remote areas, v) unaffordable healthcare, and vi) poor health systems[335]. The MOH has gone through several reforms in the last decade in the pursuit of providing quality healthcare to all its citizens. The health policy reforms have defined the vision, mission and objectives to meet its goals, but the fact remains that health provision and the health status of Kenyans are still unsatisfactory. The problem relates to policy implementation, and not policy formulation. Although the health policy is supposed to be "bottom-up" with the district hospitals being identified as the source of policy direction and implementation, in reality it is "top-down", meaning that it is the National hospitals guiding the implementation[336]. One central issue related to coordinating the policy implementation is the lack of a clear definition of the role of various district level health officials, non-governmental health providers and communities[337]. The NHSSP I was not addressing the most critical issues in the health provision sector and the ones that it did address were not properly enforced. This led to a stagnating, even downward, trend during NHSSP I[338].

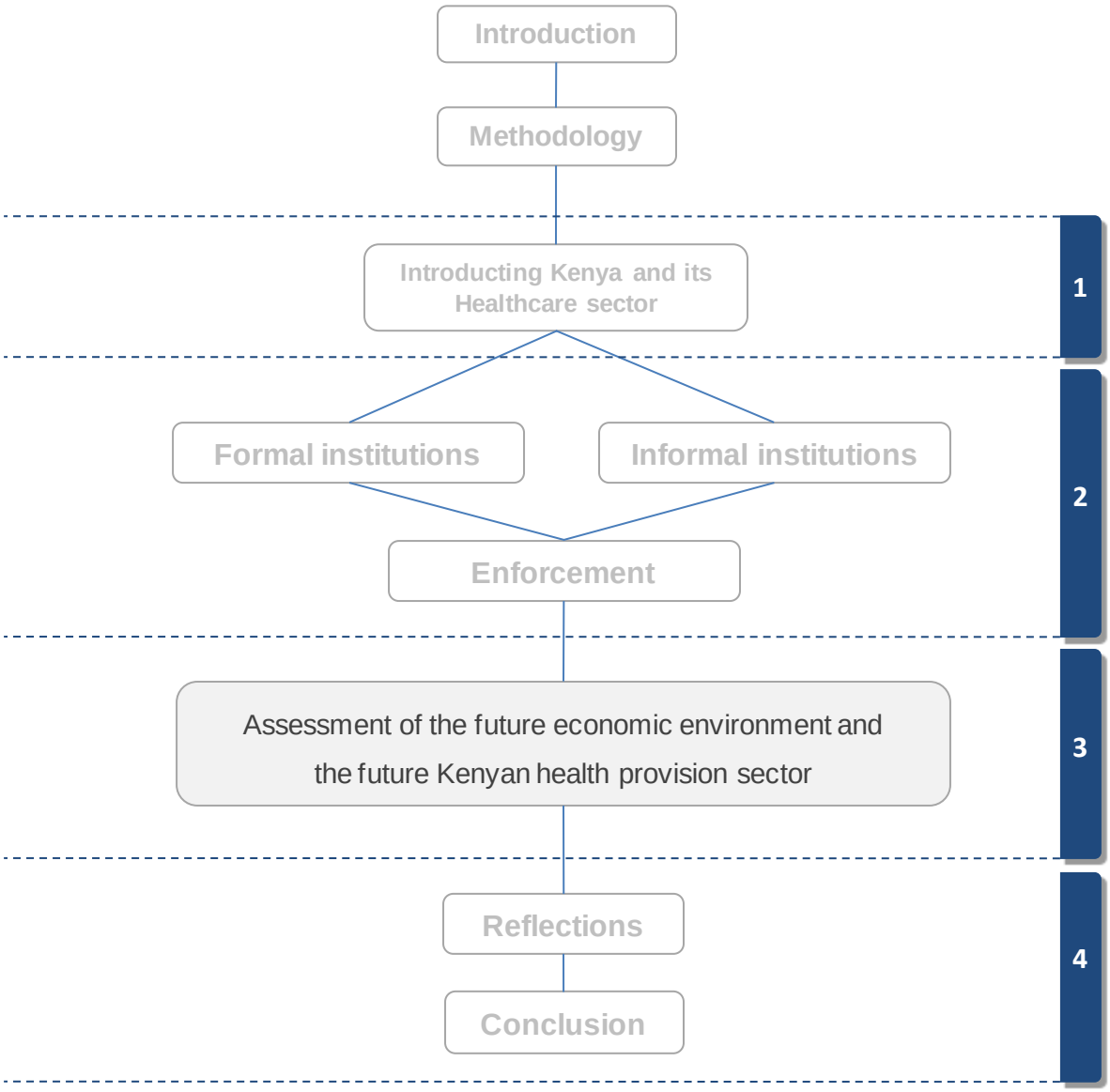
The latest health policy reform, NHSSP II, has recognised this concern and lay out a more transparent distribution of responsibilities throughout the healthcare delivery system. NHSSP II also provides a review of the NHSSP I which point out the shortcomings of the previous health reform, in addition to providing recommendations for the MOH going forward. The recommendations, however, are fairly imprecise and focus on issues such as improved implementation, PPP, preventive care and coordination. The NHSSP II lasting from 2008 - 2012 is to be implemented while the GOK has two MOHs. This has made things more bureaucratic, harder to implement and with smaller budgets as they are split between the two ministries[339]. The NHSSP II will be better enforced, if the constitution is passed and the two ministries gathered in one to enhance enforcement and make the formal institution more effective.

The divide of the MOH into, respectively, MOPH and MOMS was the best solution in the short term, but as many commentators, academics and officials from MOH have expressed it is a negative development. It has resulted in overlapping, shared resources, and uncertainties in responsibilities being some of the handicaps to prevent GOK to reach the health goals. The MOMS has opposed the critics and become more ambitious. It has managed to reach many of its goals, emphasised the importance of PPPs and improved the current referral system. A divided MOH was perhaps not the best solution, but the MOPH and MOMS has, considering the circumstances, been able to address the most urgent issues within the public health sector[340]. The split of the MOH has proven not to be dysfunctional, but would have worked

more efficiently if it was just one institution. Civil servants within the MOPH and MOMS see this as a temporary and insufficient solution and claim that they will merge after the election in 2012.

As described in this section the institutions' interaction will change depending on different factors in particular the EAC and the PC. According to the analysis of these institutions a most likely scenario will be described in the following section to provide a description of Kenya's future economic and health provision environment.

## Structure


Introduction
Methodology
Introducting Kenya and its Healthcare sector
Formal institutions
Informal institutions
Enforcement
Assessment of the future economic environment and the future Kenyan health provision sector
Reflections
Conclusion
1
2
3
4

# 7 THE FUTURE INVESTMENT CLIMATE WITHIN THE HEALTH PROVISION SECTOR

Doing business is particularly a challenge when government regulations and procedures are not facilitating business transactions, but unduly burdensome. Some factors affect investors no matter which industry they are in, but the degree that the industry is affected varies. The PC and the EAC Common Markets will have a large impact on the future economic environment in Kenya. How these are affecting the economy will be elaborated first with respect to the general economic environment and hereafter on their effect on the health provision sector. This will lead to a general assessment of the Kenyan health provision sector, which challenges and opportunities it is facing in the near future and how the future will most likely be. Hence this section postulates an assessment of the most likely scenario of the future economic and health provision sector in Kenya.

The future economic environment is necessary to elaborate on as the economic performance of a country is highly correlated to the size of its health provision sector. In addition are sound macroeconomic policies and the adoption of a liberal democratic regime with focus on improving health and education helping to increase FDI. The two latter factors enhance workers' productivity, which lower the labour cost, hence by adopting better public health policies Kenya will perform better increasing her likelihood of reaching the Vision 2030 and becoming a hospital hub and economic power house of East Africa[341].

## 7.1 FUTURE PROSPECTS FOR THE KENYAN ECONOMY

The previously highlighted weaknesses of the Kenyan economy will be ameliorated largely through the EAC Common Market and with the enactment of a new constitution, events happening in respectively 1st of July and August this year. The implementation and passing of the two will be landmarks for a new, improved business environment in Kenya removing many of the flaws in the current system. The CBK's countercyclical policies have also helped to create the needed liquidity in Kenya through accessible loans with stable interest rates. Going forward their strategy has seemed to be clear with the prospects of changing to inflation target policy to maintain stability, though the monetary policy cannot protect the country from the weather-related shocks it lately has experienced and other force majeure related shocks[342]. These are particularly hard on a country with a large informal sector such as Kenya as this means low export diversification thus a higher vulnerability to such shocks[343].

The following will elaborated the economic prospects particularly with respect to the two landmark events, how they will influence the Kenyan the economy going forward, and how this is reflected in economic growth.

### 7.1.1 The impact of the EAC Common Market

The implementation following the EAC Common Market Protocol enables free movement of i) goods, ii) persons and labour, iii) services and iv) capital in the region. Furthermore does it ensure the protection of cross-border investments and throughout the implementation laws and policies within the EAC will be harmonised[344]. In order to successfully implement these it is important to raise the level of security, through the Inter-State Security Sectoral Council, and enhance political stability in the EAC-countries. The latter and the fact that the decision making will be more decentralised, as many organs now will be EAC based. The statistics will among other things be easier to compare as the countries will have equal definitions and conventions thus enhancing the transparency. The mitigation of trade barriers through the implementation of the protocol will further enhance the intra-EAC trade, which has already sharply increased through the Custom Union Protocol in 2005 and 2007 showing annual increases of more than 10 percent for intra-EAC trade. The harmonisation of laws and tariffs will tighten the competition within EAC as workers and companies are now eligible to choose where to operate more solely based on the ease of doing business, and not due to the constraints applied by the incumbent government[345].

The three initial members being Tanzania, Uganda and Kenya, representing ca. 85 percent of the population in EAC, all have both English and Swahili as their main language, hence the language barrier that conspicuously has been one of the European Union's greatest barriers[346] does not exist within these three countries. The EAC will therefore enjoy more instant free movement opposed to the frustrating situation the European Union faced with below expected movement in the union after the introduction of the free movement. An important matter for the future is for the EAC to decide whether they will use English or Swahili as the intra-EAC administrative language, even though it is working towards using Swahili there has not been made a final decision and English is used in official documents. The last two countries, Burundi and Rwanda, both have Swahili and French as a vehicular language, but especially Rwanda is changing towards English and has been nominated the most business friendly country in Africa[347]. One of the reasons is her focus on enhancing the cooperation with US and European companies, removing the major constraints and meliorating the business environment. The language barrier in the EAC is not a persisting factor, but there is an ethnic

barrier, often revealed in Africa as an invisible border, this will as earlier described be most prevalent in the rural area, but as Nairobi is multi-ethnic when it comes to representing Kenya's different ethnicity and other East African countries such as Somalis, Ugandans and Tanzanians, it is not proscribed to have a significant impact on Nairobi[348].

Kenya trails Rwanda when it comes to reforming the country, and Rwanda's impressive progression is a frequently discussed topic in Nairobi. The Nairobians are business savvy and want to be frontrunners, not followers of Rwanda. With the enhanced focus on Rwanda through the EAC, Kenya must improve their road, electricity, communication and water infrastructure and bring down bureaucratic processes such as registration of business[349]. These issues are mentioned to be the reason why SSA-countries generally are isolated from both regional and international markets, and if they are properly improved it will entail economic growth and poverty reduction. The current road projects connecting Nairobi to the rest of Africa will is approximated to nonuple the size of inter-East African trade (from $724m, $6,169.8m) and quadruple the size of East-South (from $871.3m to $3,010.3m). Hence the major affect will be particularly apparent for East African countries such as Kenya[350]. Today, traffic accidents are the third-leading cause of death after malaria and HIV/AIDS, presenting major public health problems in disability and healthcare costs. In the early 2000s, nearly 3,000 people were killed on Kenyan roads annually, about 68 deaths per 1,000 registered vehicles, 30 to 40 times the rate in highly motorised countries[351]. The GOK's current initiatives with short term goals will facilitate a better infrastructure to decrease the number of deaths in traffic hence the institution is more effective than it used to be. In general it has been accentuated that an institutional turning point has been reached through the Vision 2030 combined with the short term perspective creating a more durable solution to facilitate high growth[352].

The regulatory interventions initiated both by the incumbents of EAC and the GOK will if properly adopted decrease the informal sector that has been growing in Kenya as a mean of avoiding the bureaucratic matters in the country. Kenya has earlier been characterised as a country that was over-regulated, but has started to realise that this has not been helping the country but instead created barriers to working formally. The current situation tends more towards a deregulation as a part of economic restructurings and liberalisations both with respect to the financial and labour market[353]. This has particularly been through i) a simplification of the tax regulations, which has been accentuated as one of the burdens upon investing in Kenya, ii) better access to loans, e.g. through the prevalence banks as Equity

Bank, iii) and through the increase in international trade as a mean of a more open economy. Both initiatives are negatively correlated with the informal sector[354]. The informal sector is therefore assumed to be decreases vis-à-vis the formal sector, although the formal sector has decreased lately from 63.8 percent in the 1990s to 55.7 percent in the 2000s in Africa[355]. Kenya's biggest constraint of doing business being corruption will likewise decrease as the system becomes more transparent. If Kenya wants to compete with the other EAC-countries where corruption is less widespread the politicians need to address this aggressively to ensure that Kenya remains an attractive location of investments, further pressure from the EAC organs and international organisations located in Nairobi will help to expedite this process.

If each EAC-country adopted the best practice of the most profound indicators for doing business the region would globally rank 12th on ease of doing business instead of 116th[356]. There are therefore plenty of room for improvements for Kenya who is ranked 2nd in EAC to become more business friendly by having less costs going to corruption, lawyers, electricity generators, supplying proper sanitation to employers, accessing affordable internet connections etc. This will reduce the expenditures of doing business, hence increase the efficiency and productivity making Kenya more competitive not only within the EAC, but particularly making it a more interesting investment destination as it will be easier to compete against other emerging markets.

### 7.1.2 THE IMPACT OF THE PROPOSED CONSTITUTION

In the beginning of the twentieth century Kenya and Rwanda both faced the possibility of adopting a new constitution, but it was only Rwanda that ended up adopting a new constitution in 2003. Just like the current draft of the Kenyan constitution recognises the importance of ethnicity, race and religion, and that the citizens are not being maltreated due their ethnical background[357]. It is particularly the matter of ethnicity in Kenyan politics and how this induces phenomena such as clientelism, where the ethnic group with the majority in government abuse other ethnic groups.

The PC is put to National Referendum on the 4th of August 2010, and will according to earlier analysis be passed. Ethnicity has been the mayor subject of discussion due to the post-election crisis, and the PC will enable a more decentralised government, allocating power more regionally. The PC does not affect the incumbent government before the election in December 2012 hence it will be difficult for the GOK to implement substantive reforms. As the election

is already a discussed matter for the Kenyan citizenry the upcoming period will be relative stable, but not many new initiatives besides the aforementioned are believed to be initiated.

The more decentralised government, especially restricting the power of the president, is believed both domestically and internationally to lay a good fundament for less corrupt practices in Kenya. There have been numerous improvements such as the increased focus on investigating MPs and civil servants involved in corruption practices[358]. The US Vice President Biden describes the upcoming constitutional referendum as *"a singular opportunity to put Kenyan governance on a more solid footing that can move beyond ethnic violence, and move beyond corruption, [and] can move the country toward a path of economic prosperity[359]."* He underlines the importance of stability which depends on the separation of power, and that no branch of the government, not even the president, should go unchecked. The PC will accelerate the necessary reforms including reducing executive power to make the government more transparent, accountable and participatory, and ensuring a fertile future for Kenya to obtain future economic prosperity[360].

The incumbent president is not eligible for re-election in 2012, but Prime Minister Odinga is, and if he is elected he will rule under the new constitution where the President is no longer lawmaker and head of state and government. A supreme court is further created to introduce a more efficient and fair court system[361]. The upcoming election will clarify if the constitution is an accepted and functional solution for Kenya's problems, and if it happens under stable circumstances it signals a future of more transparency and stability, and less corruption.

Whether PM Odinga will be elected depends on many factors, but the Kenyan population has realised that parties based on ethnicity will not work as has been evident in the past 3 elections. Recent surveys have shown that Kenyans care more about the political parties' policy such personal economic wellbeing, the performance of the economy, and the policy record in select issue areas[362] than which ethnical orientation the party has. Regrettably to many Kenyans the drafters of the proposed constitution ignored the need for a fair ethnic distribution in politics, but rejected fair systems to ensure a multi-ethnic party state. The problem is that the new constitution still puts the executive power with the president, making it difficult to divide power between all tribes as long as parties are ethnically divided[363]. The citizenry of Kenya have an economically motivated voting behaviour, but due to the ethnical allocation within the parties this creates a prisoner's dilemma for most voters. The voters have in mind that the politicians think more of their own ethnic group than others, hence the

economically motivated behaviour will be reflected in an ethnically biased voting pattern to maximise their own wealth[364]. The latter described scenario is what has been the case for Kenya, and if the PM Odinga wants to win the election it is believed that he has to represent an ethnically diverse party[365]. PM Odinga will face a truly difficult task if the Progressive Democratic Movement (PDM), an umbrella party of the PNU, chooses to stay in the Kikuyu-Kalenjin-Kamba alliance comprising many of the country's voters, but the advantage is that most citizens prefer a non-Kikuyu after the presidency of the incumbent Kibaki[366].

No matter which Kenyan president is elected in 2012, the enactment of the new constitution is one of the cornerstones that have to be adopted to facilitate good governance. The latter is a necessary requirement along with good infrastructure in order for Kenya to achieve and sustain high growth as proposed by the GOK in the Vision 2030[367].

### 7.1.3 FUTURE ECONOMIC PROSPECTS

The economic performance of Kenya is currently limited by the coalition which creates a stable, but restrictive fiscal environment. The EAC region's GDP is expected to grow with 6.2 percent in 2010, and through the Common Market protocol it will help stimulate the Kenyan economy that due to its regional status as a hub and its large share of inter-EAC trade will benefit from the opening of the region. Uganda has lately discovered oil and gas in large quantities, and will attract more foreign investors who will demand more economic freedom, lower corruption and better infrastructure throughout the EAC, as the oil needs to be transported efficiently to the ocean. For Uganda the fastest way is through Nairobi to Port Mombasa, where it is already possible to refine oil[368]. This is just one example of how the region through better infrastructure and more efficient prices will benefit and create more trade for Kenya[369]. A positive effect of improved road infrastructure is less traffic accidents as road safety improves, this is particularly a large problem as they constitute the third-leading cause of death after Malaria and HIV/AIDS, hence representing large public health problem and healthcare cost[370].

The adoption of the PC will not have a significant effect before the election of 2012 when it is implemented. Through a more decentralised government, a country with improved infrastructure and laws that are continuously harmonised with the rest of the EAC region, this will initially foster more transparency and accountability which will generate a better business climate and more investments. Kimenyi has shown that in order for Kenya to reach their Vision 2030, they need to reform their institutional infrastructure and obtain good

governance[371]. Good governance is not immediately obtainable but the right initiatives have been made to facilitate this. Good governance is furthermore highly correlated with GDP growth, and it is therefore predicted that Kenya will experience slowly increasing growth towards 2012 from 3.5 to 5 percent[372,373], but as the new government gets in place in 2013 the governance will become more effective, participatory and efficient, and the economy will experience high growth converging to the Vision 2030 goal of double digit growth[374].

Kenya's middle class is growing and it is currently estimated to consist of 10 percent of the urban population being ca. 470,000 in Nairobi and 1.5m in Kenya, ie. the largest in SSA. Over the past 20 years the middle class has reached the quintuple size while the population has doubled. The transformation is partly due to the increase in PPPs that has doubled the past 10 years, but Kenya's current demographic distributions resembles India and Malaysia's in the 1990s, and it is therefore reasonable to assume a similar increase in the proportion of the middle class as a cause of the economic growth[375]. The Nairobian middle class will due to better infrastructure be less fragmented and will have increased to constitute approximately 20 percent of the population in 2025. Hence the middle class will, with a population in Nairobi of 9m in 2025, have grown to 1.8m**.** An advantage of the Kenyan, particularly the Nairobian, middle class is that it is very well educated.

Because of Nairobi's status as a headquarter in the East African region a large number of top management of large companies are located in the city, and together with government officials and other wealthy Nairobians they are estimated to constitute approximately 2 percent of the population in Nairobi. Nairobi is furthermore a popular location for NGOs and embassies were many expatriates work constituting approximately 20,000 people. The upper class, i.e. the proportion of the population who is able to afford high quality health provision, is thus estimated to 80,000 people in Nairobi. The upper class is as the middle class estimated to be increasing, but due to a constant number of top government officials, which is actually likely to decrease because of the new constitution, and a slow increase in expatriates, the only increase will be in top executives. Hence the Nairobian upper class is expected to stagnate proportionally, but still double in absolute numbers to 160,000 in 2025.

| | 2010 | 2025 |
|---|---|---|
| High income | 80,000 | 160,000 |
| Middle class | 470,000 | 1,800,000 |
| Lower income | 4,700,000 | 7,040,000 |

*TABLE 17: NAIROBI'S POPULATION ALLOCATION (2010-2025), SOURCE: OWN PRODUCTION*

Table 17 shows the allocation of Nairobians in the different classes with the largest growth appearing in the middle class, i.e. people with a good wage and typically a higher education. As this class grow they will engage more in politics and influence Kenyan politics. This will entail a shift from ethnically focus to policy focused, as is already expressed and wished by many Kenyans[376]. The country will experience more political stability which will facilitate a lower interest spread, i.e. it will be cheaper to borrow money to finance investments as the market has more trust in the direction of Kenya and where the money are going.

## 7.2 ASSESSMENT OF THE FUTURE POTENTIAL IN THE KENYAN HEALTH PROVISION SECTOR

Kenya`s rapidly increasing population has placed a strain on the health provision system already constrained from soaring rates of AIDS, TB and malaria. Going forward, economic growth in Kenya will fuel greater demand for healthcare, and an increasing need for capital investment within the private health provision sector to meet the demands. The new health reform (NHSSP II) introduces a set of new promising initiatives that will improve the business environment for private healthcare participants. One of the key projects is the SWAp aiming at aligning the health initiatives of donors with the GOK's development agenda through a universal coordination framework. The following chapter will describe the health provision market in general going forward followed by an in-depth analysis of the two segment outpatient and inpatient.

### 7.2.1 THE GENERAL HEALTH PROVISION MARKET

According to the Permanent Secretary of the MOMS, there are two issues in particular that needs to be addressed. First of all, the current referral system needs to be strengthened at all the levels. This involves standardising the services provided at the different levels and increasing awareness among the public on where to go and when. Today, many patients go directly to the national hospital without consulting with the referral hospitals beforehand, and this causes unnecessary pressure on specific levels of the referral system[377]. It will take approximately 5 years to make it work efficiently as particularly the lower levels, i.e. level 4, 5 and 6 needs to be upgraded and standardised with better equipment mainly in the rural areas.

The second issue is healthcare funding. Donors and NGOs provide financial support to selected projects without consulting with the MOH or with stakeholder in the industry. Going forward there has to be a coordinated approach to healthcare financing in order to better allocate capital to the best projects. The SWAp introduced in 2008 aims at pooling funds from Donors and NGOs in order to avoid overlapping, and thereby improving allocation of capital. Although far from a fully functional SWAp, the initiative has received attention among donors and NGOs, and holds the potential to improve the coordination of healthcare funding in the future[378].

The MOH is engaged in changing the current situation with shortage of medical personnel by educating more doctors and nurses, so the respective hospitals do not need their own private educational facilities to avoid personnel shortages. According to Permanent Secretary at the MOMS, the shortage of medical personnel is currently not an issue in Nairobi, but only in rural areas[379]. The situation is also predicted to improve with the EAC Common Market, facilitating easier movement of labour, and as Nairobi is known as a hospital hub and with their hospitals improving in quality it will attract medical personnel from the other EAC countries both due to better quality, higher wages but also as the market has the largest regional attractiveness reaching to neighbouring countries of the EAC. Through the MOH's initiatives to educate more medical staff the shortage of medical staff particularly in Nairobi will disappear and the situation in the rural areas will continue to improve as the infrastructure and living standards improves making it easier to live there.

In the NHSSP II the MOH has stated that it will focus on investments to benefit the poor, and relocate resources from curative to preventive health services. This means that fewer resources will be allocated to traditional curative health facilities, such as hospitals and clinics[380]. The strategy is to focus on general prevention such as improved sanitation and to decrease the proportion of HIV/AIDS.

The GOK hopes to alleviate the growing demand for curative health services for the middle- and upper class through improved cooperation with the private sector, i.e. the private sector will play an even greater role in delivering health services than before. The focus has changed the past years with a prevailing understanding of enhancing the number of PPPs. The issue is that although there is a general agreement that the private health provision sector plays an essential role, it is less clear how the responsibilities should be divided between the public and private sector. According to the Permanent Secretary at the MOMS, the private sector has a

tendency to exploit short term gaps as a result of the dysfunctional health system instead of considering long term business models that complement the public sector[381]. In an effort to resolve the poor coordination between the public and private sector, the GOK has initiated several PPPs in recent years. The MOH has expressed interest in PPPs and wants to cooperate with private companies to let them know where the public sector intends to invest. This will allow the private sector to invest in long term sustainable solutions and complement the general Kenyan healthcare to reach a more efficient and coherent sector that will continuously improve itself[382].

The SWAp and NHSSP II both demands large investments which are primarily focused on the lower class. Because of the large investments and the time consuming process to reach these goals, it is reasonable to conclude that the MOH will not make large investments within healthcare facilities for the middle and upper class - two segments respectively almost quadrupling and doubling in size in Nairobi. Due to the health insurance and the informal institutions in Kenya, this allocation of the lower, middle and upper class is not directly applicable. Private insurance in Kenya covers approximately 600,000 Kenyans and another 600,000 have company insurance. Approximately 400,000 of these are believed to be Nairobians. Currently it is only company insurances that are expected to increase in the future due to inefficiencies and inflexible of the private insurance schemes. As both of these are covering the majority of Kenyans in formal employment earning middle or upper class earnings, it does not change the allocation significantly.

Opposed to normal insurance, the NHIF is covering an increasing number of Kenyans particularly in the informal sector. The higher standard of living and better educated labour force in Nairobi means that a higher proportion of Nairobians have NHIF coverage than in the rest of the country. The total number in Nairobi is estimated at 1.1m in 2010, but will, due to an increasing formal sector vis-à-vis the informal and an increasing coverage of the informal sector and the indigents, cover approximately 4.5m Nairobians in 2025. As the NHIF covers dependents, i.e. family, it is estimated that it will cover almost the entire Nairobian population directly or indirectly, i.e. 95 percent of Nairobians ca. 8.5m. The NHIF will make a larger proportion of the population afford inpatient healthcare, and as it is currently expanding to cover outpatient services it is expected to increase the market for middle class healthcare substantially[383]. This is particularly the case as the NHIF is mandatorily paid for when formal employed, hence it makes the out-of-pocket payment significantly smaller especially for the lower class that is already paying out-of-pocket for most of their healthcare. A large

proportion of the lower class will therefore through the increase of the NHIF coverage act as middle class customer of healthcare. The NHIF is additionally affected by the Kenyans culture of valuing altercentrism and expecting reciprocity. This increases the number of people who can afford middle class healthcare substantially, as both Nairobians from the middle and upper class are prone to pay for their kinship. The NHIF and the Kenyan culture thus have changed the immediate partition of the Kenyan classes transferring a large part of the lower class to afford middle class healthcare. This affect is most significant for the Nairobian inpatient segment which will approximately quadruple as the NHIF decreases the amount of out-of-pocket payments hence makes more Kenyans able to pay for their kinship. The outpatient segment's middle class will approximately triple because of this, and will through the introduction of outpatient coverage from NHIF experience large growth rate the next 2025, particularly since outpatient generally is less expensive than inpatient care[384]. Through more NHIF coverage the organisation has to use its money more efficiently and as the out-of-pocket payment for healthcare will decrease so will the amount that insurance companies are covering. This will entail a decrease in the price of insurance and increase competition hence insurances will be available to a large part of the population.

The amount of people who will use upper class will mostly attend a hospital like Karen hospital, but the upper class from Kenya and the region will also travel to Kenya particularly when it comes to tertiary services because of the Nairobian health provision's good reputation. The EAC Common market will not influence the upper class substantially, but as the middle class grows, the infrastructure in the region improves and the quality of the healthcare in Nairobi becomes more renowned in the region, it has the ability to obtain a special status as an East African regional healthcare hub. This will increase the number of patients seeking upper class healthcare, but this segment will still be relatively small compared to the middle class both in absolute numbers and percentage.

Based on the above takeaways the following section will elaborate and quantify the influence of these factors for the Nairobian outpatient and inpatient care market.

### 7.2.2 THE OUTPATIENT AND INPATIENT MARKET

Outpatient care involves healthcare that can be managed without admission to a hospital. Outpatient services are provided by hospitals, single clinics and clinic hubs, but since hospitals also provide inpatient services they will be covered in the next section. Many of the outpatient services provided are "less critical", such as dental care, hearing aids and skin care,

and these health services are more relevant for the middle- and upper class. Seeing as the population in Nairobi is projected to double by 2025, and a large majority of the middle class is situated in the city, the demand for outpatient care will increase considerably in this region. Private outpatient facilities are more frequently used by the wealthiest fifth of the population than any other income bracket. The wealthiest quintile represents 35.5 percent of the total number of outpatient visits compared to 15.7 percent in the poorest bracket[385]. This is not surprising seeing as the wealthiest income group has a higher disposable income, thus it allows them to spend more on healthcare services. The implementation of the NHIF outpatient coverage will entail the other income brackets to follow suit hence increase the market particularly for the lower income brackets in Kenya.

Kenyans with health insurance are twice as likely to use a private outpatient provider and the Permanent Secretary of the MOMS accentuates that the private sector can provide better outpatient services through lowering their costs and improving management[386]. Nairobi has the highest insurance coverage of all provinces[387], with the largest non-hospital outpatient provider being the Upper Hill Medical Centre in Nairobi. It emphasises the value of a strong brand and high quality services to succeed as Kenyans are very quality oriented[388]. This is because the majority of outpatient services provided by private clinics are also available at public hospitals at subsidised prices, but with longer queues and less sophisticated equipment.

In 2007, government hospitals and public health facilities accounted for 56.7 percent of the total number of outpatient visits in Kenya, whereas private clinics and hospitals accounted for 12.7 percent and 6.4 respectively[389]. The remaining patients visited mission hospitals and clinics. Bearing in mind that the Kenyan middle class is mainly situated in urban areas, the market share of private outpatient clinics in Nairobi is believed to be in the range of 25-30 percent. The number of outpatients is expected to grow substantially as the size of the middle class increases with economic growth, the NHIF outpatient coverage and altercentrism. The amount of Nairobians who can actually afford middle class healthcare will because of this be twice as large, i.e. 1m Nairobians, making the current market larger than what one would assume. As the NHIF starts coverage of outpatients it will increase the amount who can afford middle class healthcare substantially and ca. 5m Nairobians are expected to afford middle class healthcare in 2025. The potential population of Nairobi who can afford middle class outpatient care will therefore quintuple over 15 years.

The upper class is expected to double in the same period. This growth in both the middle and upper class will have to be covered mainly by the private sector, as the public sector will not invest considerably in this segment the next 10-15 years as it will focus on accomplishing the NHSSP II.

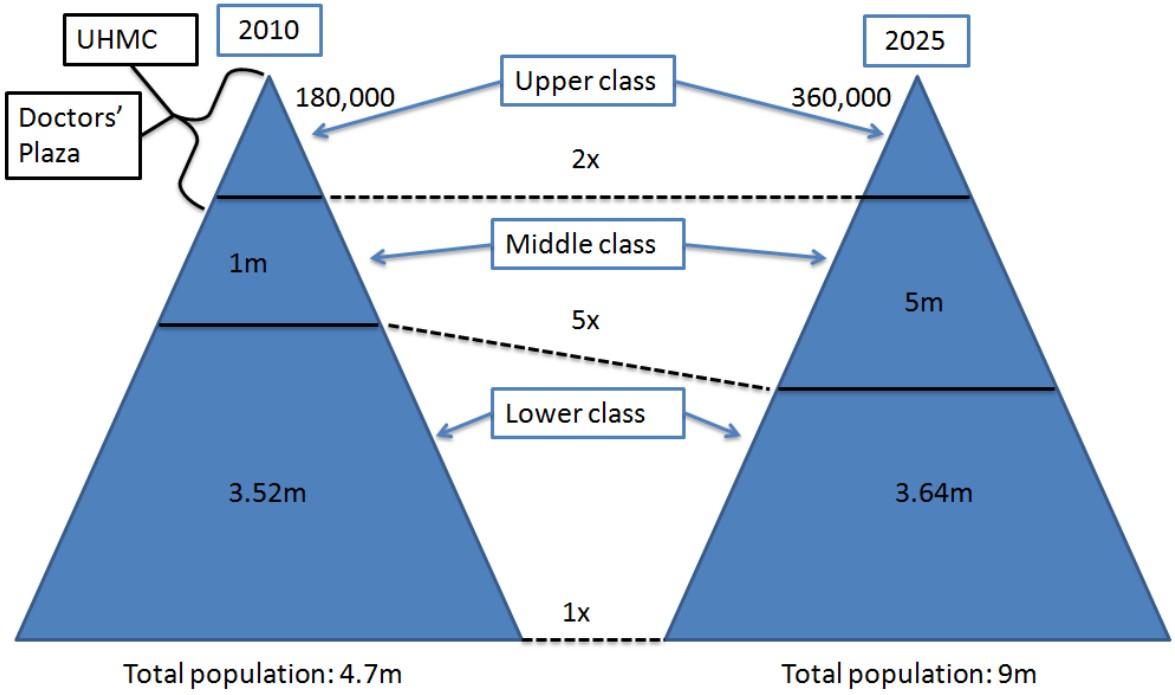



*FIGURE 8: OUTPATIENTS IN NAIROBI BY CLASS 2010-2025, SOURCE: OWN PRODUCTION*

Inpatient services comprise of all health services that require the patient to stay at the facility over a period of at least one night. Hospitals provide both inpatient and outpatient services, but according to the General Manager at the UHMC the outpatient services are generally less specialised at hospitals[390]. As previously discussed the public sector provides 3.767 beds for inpatient care in Nairobi compared to 2.451 provided by the private sector. The majority of private hospitals in Nairobi, and they have continuously expanded their bed capacity to meet the growing demand. The only exceptions are the Nairobi Women's Hospital (NWH) and the Karen Hospital established in respectively 2001 and 2006. Both hospitals have managed to stay profitable since commencement, and due to the increased demand they are planning to expand their bed capacity in the near future. According to the CEO at NWH, strong management, high turnover per bed and the use of technology are key success factors to succeed within inpatient services. Much potential lies for both public and private hospitals to optimise the bed time of patients hence many hospitals have more potential. This potential particularly will be evident in the lower class as this has the highest percentage of public hospitals which have the worst bed time ratios.

The majority of the private hospitals in Nairobi are focusing on the upper middle class, except for NWH which focuses solely on the lowest bracket in the middle class. The poorest population is for the most part served by public hospitals, and in line with the NHSSP II, the public hospitals will continue to focus on this segment. At first sight the part of the population utilising middle class inpatient care seems to be the most promising, and with the effect from the NHIF and altercentrism the market is currently estimated to be 2.5 times the middle class of Nairobi, i.e. 1.25m Nairobians. In the future the NHIF is increasing their coverage and both with the proportionally and absolute middle class increasing this will mean that it is estimated to be twice as large as the Nairobian middle class in 2015 reaching 4.4m. This is a bit smaller than the market for outpatients, which is both cheaper and less necessary than the more expensive inpatient care market. The inpatient market has thus grown by 250 percent, and with a large potential for the private sector to capture most of this growth.

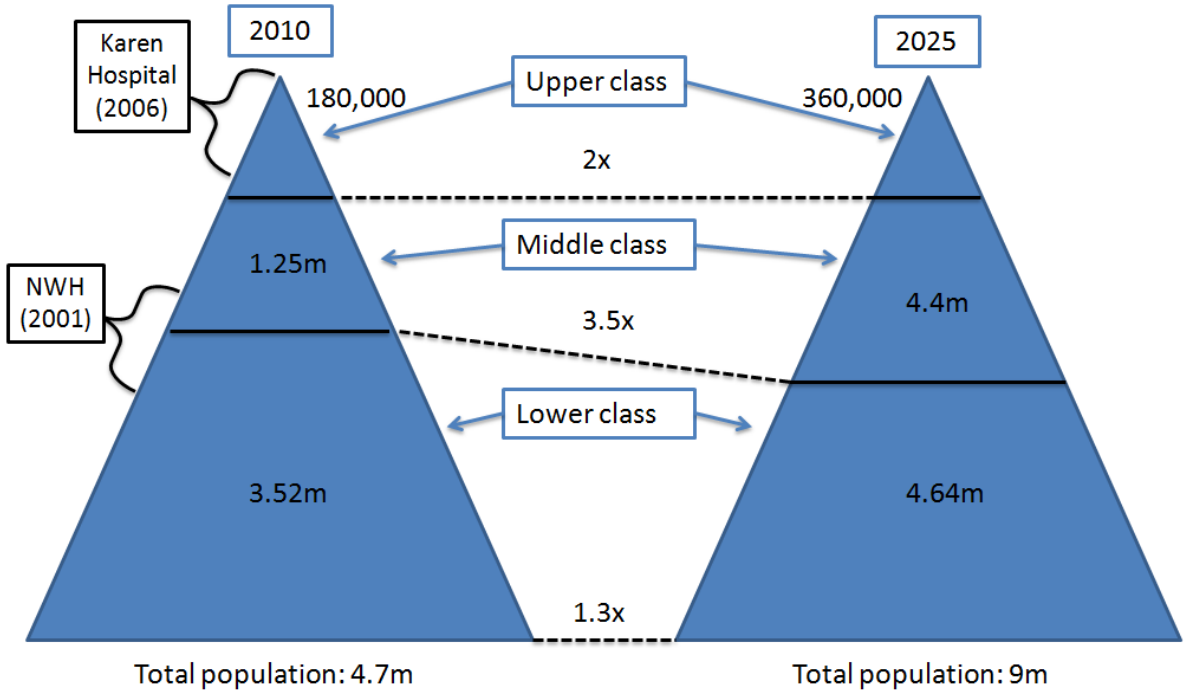
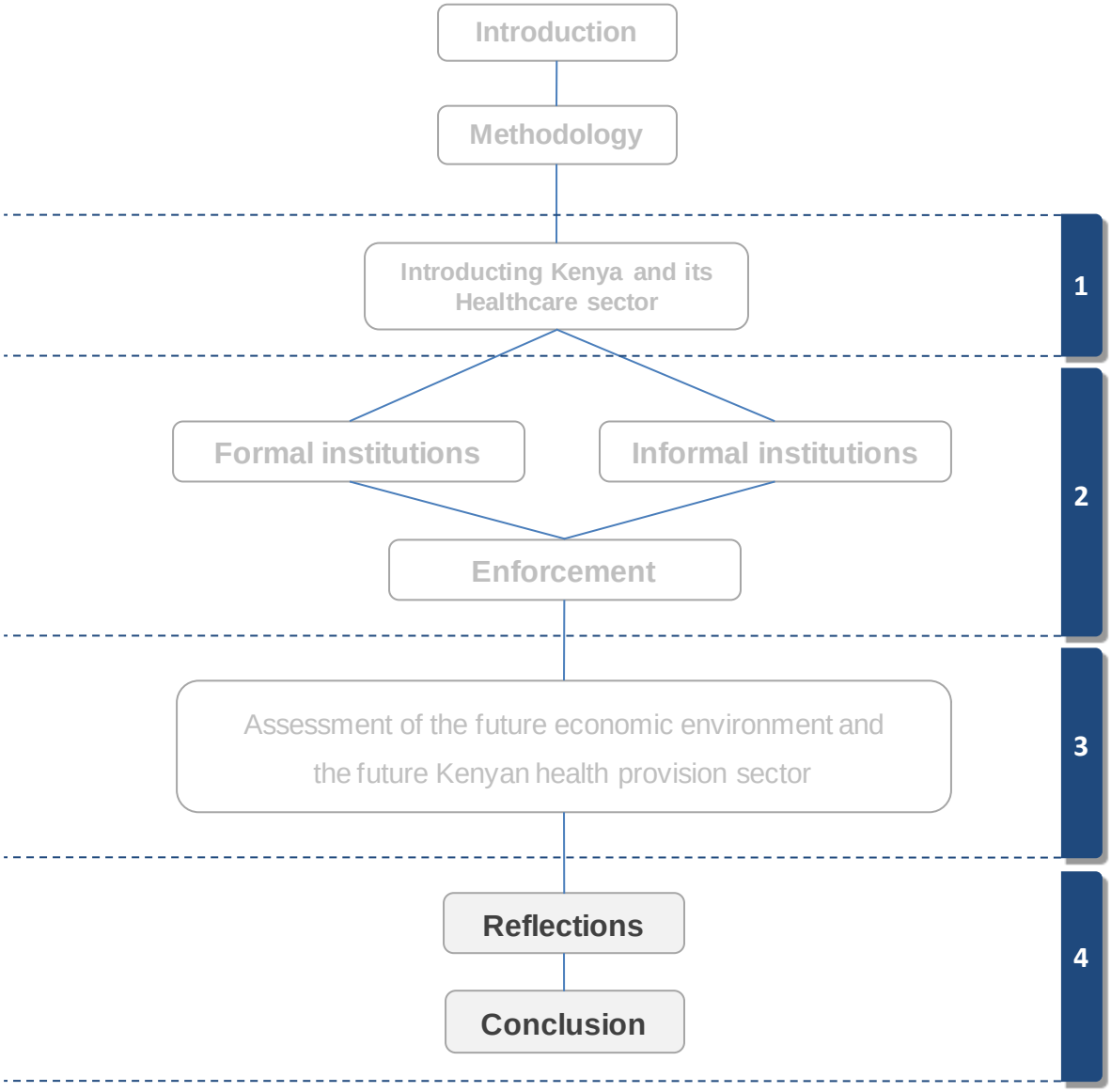



*FIGURE 9: INPATIENTS IN NAIROBI BY CLASS 2010-2025, SOURCE: OWN PRODUCTION*

Both the outpatient and inpatient care market for upper class healthcare will double, but as this market is very attractive and just had a recent addition in the Karen hospital there will not be much demand in the near future for more "high-end" hospitals in this category.

As the institutional infrastructure in Kenya becomes more established it creates opportunities to integrate mobile phones and internet especially within outpatient care. There has recently been focus on the possibilities of satellite clinics attached to larger hospitals or clinics in Nairobi with well educated staff. Through mobiles and the internet they are able to advice the

respective persons at the site, who are usually nurses or staff with short medical training. AMREF has used this to educate nurses and to educate medical staff through more updated and accessible training, i.e. addressing some of the problems of the past. This will be one of the means that hospitals can use to decrease the inpatient time which has been a problem especially for Kenyatta hospital. As mobile phones are now more widespread used in Kenya, patient contact can be sustained through e.g. mobile phones. The CEO at NWH stated that "We never discharge our patients completely, because we stay in contact with them through telephone, skype or sms". The use of basic technology therefore enables the hospitals to increase the turnover rate per bed reducing costs and increasing the number of patients treated. The improved road and electricity infrastructure will bring down the costs of doing business, but as most hospitals and outpatient clinics will still need an electricity generator because of mistrust to the government to build up the system immediately, it is only the better roads that will increase the amount of patients coming from outside Nairobi.


Introduction
Methodology
Introducting Kenya and its Healthcare sector
1
Formal institutions
Informal institutions
Enforcement
2
Assessment of the future economic environment and the future Kenyan health provision sector
3
Reflections
Conclusion
4

# 8 REFLECTIONS

The purpose of this thesis is to analyse the future potential for foreign investors in the Kenyan health provision sector with special focus on how institutions shape the business environment. When choosing this topic for the thesis we were conscious of the challenges we could stumble upon seeing as the thesis focuses on a country, industry, and theory that neither of us had acquainted with prior to commencement. Today, six months later, we can with certainty say that the thesis has been very challenging, but likewise rewarding. In the upcoming paragraphs we discuss the challenges we faced in the process of writing, and what we could have done different in hindsight.

In the institutional analysis it has been difficult to say something specific about how the various institutions influence the health provision sector in Nairobi, and which in certain cases has led to that not all institutions have been discussed with respect to the health provision sector, but only the most relevant and some simply on a general level. Weak legal institutions for instance are obviously national institutions that affect different types of investors countrywide, but they too influence investors focusing specifically on the health provision sector in Nairobi. The sector specific information about how informal factors such as corruption and crime influence private participants in the health provision sector have not been obtainable, and in general much information on the Kenyan health provision sector is limited.

Other theoretical angles to the thesis could be to apply Porter's diamond model which analyses the competitive advantage of nations. This works excellent particularly in a developed market, but due to the strong influence of the informal institution and that our focus has been Nairobi, and not Kenya as a nation, it would entail a different result. It could furthermore have been chosen to solely look at the country's competitiveness and how the EAC Common Market affects the investment climate, and improves the business climate.

When discussing how formal and informal institutions interact we have attempted to use Helmke and Levitsky's (2004) theoretical framework. Although the theoretical framework seems fairly straight-forward at first sight, the actual classification of how the various institutions interact has been cumbersome. It has been difficult in particular as it has been pursued to investigate how formal and informal institutions interact in a specific sector and region.

The fact that we solely focuses on private for-profit investors has posed challenges. In Nairobi, where there is a substantive need for health services, an investor needs to consider the impact he has on the health provision development, and not solely profit. A strictly for-profit motive is difficult because there are numerous non-profit health providers in Nairobi which distorts the competition among private health providers. Moreover, individuals are usually sceptical towards for-profit businesses operating within health due to evident conflict of interest.

With respect to the collected data to estimate the market size of respectively the inpatient and outpatient care segment, one should bear in mind that these numbers are particularly based on the conducted interview throughout the 3 weeks of intensive interviewing in Nairobi. As Kenya is yet to have a recognised and national conventions on much of its collected statistics and furthermore lack to have Western standards much of the expressed perception of the market has been based on these interviews. In the hindsight particularly the interviews with the first secretary of the MOPHS, the CEO of NHIF and the Health Management Systems Specialist from the US Embassy have shown to be particularly vital to attain a high validity and reliability of the thesis and to make the proposed estimates.

Keeping the above mentioned reflections and the analysis in mind the thesis has now shed light on what is thought to be the most relevant thoughts in order to conclude on the initially presented research question. This will be pursued to be answered in the following conclusion though remembering that due to the complexity of the thesis only the most relevant and simplified conclusions of this rather delicate subject can be clarified thus a more exhaustive picture will be obtained by reading the thesis in its entirety.

# 9 CONCLUSION

The thesis' research question was to understand the formal and informal institutions that shape the business environment for foreign investors investing in the Nairobian health provision sector. To conclude how this has been investigated and analysed in the thesis the IFC's report, "The Business of Health in Africa", is used to commence on this conclusion. The report has identified five main imperatives that together can facilitate the development of the private sector healthcare in Sub-Saharan Africa; i) Develop and enforce quality standards, ii) foster risk pooling programmes, iii) mobilise public and donor money to the private sector, iv) improve access to capital, and v) modify local policies and regulations to foster the role of the private sector. The MOH government has addressed the first through more control on

health facilities to enhance the general quality. The NHIF is addressing the second slowly, but steadily, to include more Kenyans in the healthcare scheme and will expand the coverage to include more Kenyans. The third have not been addressed by the MOH, but it is possible to obtain funding through NGOs and Donors and with the vast selection of these in Nairobi and the presence of UNON, investors can apply for funds such as the DANIDA programme that supporting partnerships between Danish and Kenyan companies. Private funding has accelerated the past year with the Kenya Commercial Bank giving a loan to build the Karen Hospital, and Aureos, with the World Bank as the initiator, acquiring NWH with plans to expand heavily.

The primary institutional obstacles when conducting business in Kenya is the high level of corruption and crime, the political and economic instability, and the complex tax system. Two landmarks event, being the EAC Common Market and the new constitution, will accommodate these and make future investment easier. With respect to the health provision sector, it is particularly the economic instability that has affected its potential, as it is attractive for a foreign investor that a large bracket of the population can afford middle class healthcare.

In the context of the health provision sector, the MOH is viewed as the most important political institution, but the ministries responsible for energy, water, roads and public works are also relevant for investors as they provide the basic infrastructure necessary to conduct business. The unstable supply of electricity for example is a major cost component for businesses in Kenya, whereas poor roads and congestion hinder patients to visit health facilities. The MOH has endeavoured to reach the goals accentuated by IFC through NHSSP I. It is now trying to build up a system that had failed to correspond to the needs of the Kenyans not working according to its formal structure making it inefficient. Through the NHSSP II and the SWAp the MOH is focusing on re-establishing the formal structure, i.e. the referral system, and having it enforced. This means that a large proportion of the budget will be used on administrative costs, repairing and strengthening level 1-3 health facilities particularly in the rural areas, thus little expansion will be done on the public health facilities to the growing middle and upper class. Another vital area is to prevent diseases through improved sanitation to ensure better health. This is addressed with an increased focus on preventive care, but will also improve as the water supply and coverage increases to reach a large amount of Kenyans to ameliorate their general sanitation. Many of these initiatives are helping to improve the standards making it easier to build on the system as a private investor.

The MOH knows that it cannot satisfy the need of health provision in Kenya on its own and has thus emphasised PPPs to achieve a high-quality, comprehensive, well-functioning and sustainable health provision system. Hence, in order for investors to succeed in the long term, they need to understand how the referral system works and complement in cooperation with the MOH rather than compete with the public health provision system. This is vital to understand for a foreign investor upon investing in Nairobi and Kenya to ensure a sustainable profitable business.

Corruption is a major obstacle when doing business in Nairobi, and the healthcare sector is no exception. If an investor decides to start up a private health facility, he has to be conscious of the problems related to bribery. Although corruption in the healthcare sector is less frequent today than four years ago, investors are still likely to face bribery and fraud when cooperating with the public sector where it is more prevalent. Crime is another major problem affecting the business environment in Kenya, and investors should be prepared to slice of 10 percent of sales due to theft, legal and illegal security. In the health provision sector the largest crime related problem is counterfeits, and close to 30 percent of the drugs in circulation are counterfeits particularly due to insufficient public procurement and lack of control.

Kenya's cultural diversity with more than 40 different tribes has been and is still a bottleneck for the ease of doing business for foreign investors. Ethnicity is deeply embedded in the Kenyan society and it has been the root for many violent conflicts since independence, the latest being the post-election violence in 2007 which was mainly between the large tribes Kikuyu and Luo. However, for foreigners considering investing in the health provision sector in Nairobi, ethnical differences do not pose a direct threat, but is more widespread in the rural areas. Historically ethnical clashes have been among the tribes exclusively and these conflicts have taken place outside Nairobi. Ethnical differences may however cause problems during the upcoming 2012 election, and thus affect the political and economic stability in Kenya. With the enactment of the new constitution and the international pressure to ensure peaceful election the chance for a repetition of the 2007 election is seen as a very unlikely scenario. Gender roles are another cultural issue that investors need to bear in mind. Discrimination against women is widespread, and women are often hindered to seek healthcare as a result of strict working hours or other chores. When females do seek healthcare, the husband, family or community are typically chosen as decision makers, especially in the case of maternity care. Language is deemed as a less important factor for investors, as English widespread in Nairobi, especially in the context of business, but knowledge of Swahili is recommended as it

is the Lingua Franca in East Africa receiving increasing popularity and vital in the rural areas of Kenya. This is also the case for religion since close to 80 percent of the Kenyan population is Christian. Although Christianity is widespread, nearly 25 percent of the population believe in witchcraft and regularly consult traditional healers. In rural areas, close to 50 percent of the population believe in witchcraft or other supernatural beliefs, called traditional medicine. In Nairobi, however, traditional medicine is rare, but has gained among Kenyans since independence as they have more trust to traditional medicine than Western medicine. Thus it poses, particularly in the rural areas, the potential for investors to include this to increase the trust in the used medicine through combining the traditional and Western medicine.

Kenyans are particularly family and kinship oriented valuing altercentrism and expectation of reciprocity. This means that the family will pay for their family members, relatives and close friends in order to sustain the future economic income flow of the clan and they expect that if they pay for someone they will be willing to pay back later if needed. It corresponds to a tontine agreement within the clan thus the allocation of the population with respect to using health provision is per se different. The phenomenon of altercentrism and expectation of reciprocity therefore increase the number of individuals that can afford middle class health provision. The middle class segment is the most interesting for a for-profit foreign investor as it is the proportionally fastest increasing in Nairobi and is number of patients who can afford this is due to these phenomena and the NHIF's increasing coverage surprisingly large segments. The private sector needs to assess which part of the referral system they belong to, and how they can complement the referral system. The new referral system introduced in the NHSSP II is a step in the right direction, but the system will not succeed as long as the private health provision sector chooses not to participate and cooperate with the MOH.

Issues related to trust also influences the business environment for foreign investors. Many patients choose private instead of public health providers as a result of mistrust, especially for HIV/AIDS consultation. Patients often suspect that nurses and doctors at public health facilities hospitals are more likely to tell others about their diagnosis, and therefore they choose private providers to preserve discretion.

The population in Nairobi is doubling over the next 15 years, but as the institutional environment is continuously improving and strengthening, the middle class will experience the highest growth. In absolute numbers the Nairobian middle class will grow from 470,000 to 1.8m. The MOH will instead of satisfying this market ensure that the lower class will be

able to obtain descent healthcare through ensuring the basic needs such as sanitation and simple healthcare are widely available. One of its means to do this is the NHIF which will cover an increasing part of the population. Its coverage is expected to reach ca. 95 percent of the population in 2025 either directly or through family that has NHIF-coverage. Its coverage will additionally increase from solely inpatient to outpatient entailing a large increase in this market.

The outpatient segment, mostly covering primary and secondary care, is the segment that is expected to grow the most in Nairobi. This is due to improved living standards and that the NHIF is going to expand it coverage to outpatients, and will result in the market to quintuple the next 15 years, as seen in figure 8. The majority of the increase in the middle class segment has to be covered by the private sector hence posing a large potential segment to invest in. The two large players on the market, i.e. UHMC and Doctor's Plaza, can either be used as a place to start the business, as they are both in the healthcare hub of Nairobi or to get a quick overview of the current players in the market. The segment is both interesting because of the increase in the segment, but furthermore as it is possible to invest both as a small or large investor, i.e. one can settle with a small clinic or make a large investment covering many parts of the outpatient segment. The IFC recommends investing in high-end clinics that target the growing middle- and upper class population in urban areas, and estimates that it is possible to deliver net profits of up to 30 percent[391].

The potential business models within outpatient health provision range from single clinics to large scale clinic hubs that rent out facilities to doctors and other health practitioners. Investors should target the middle class by providing high quality services seeing as the public sector is increasing its focus on the poorest part of the population. The largest outpatient provider in Nairobi, the UHMC, is primarily focusing on the upper class by providing outpatient care for company employees. According to the general manager at the Upper Hill Medical Centre in Nairobi, there is a growing need for outpatient clinics in order to meet the demand from the middle class that is expected to have grown to 5m in 2025 in Nairobi representing an interesting segment, and the current providers will not be able to fulfil this increasing demand unless large investments are undertaken.

Inpatient care, covering mainly secondary and tertiary care, is currently larger than outpatient, but will not grow as fast towards 2025 though still increasing with 250 percent. It demands larger initial investment, but has lately shown signs that there is an unmet supply within this

care. The newly built Karen Hospital has been a great success, and although it is yet to be fully filled with patients, it has performed above expectations. The willingness of the Kenya Commercial Bank to loan money to the project showed to be good business, and draw the attention of other banks, that this segment has future potential. As the Karen Hospital is covering the upper class, and still has room for patients, the upper class is not seen as a potential area to make a capital intensive investment, and the attention will again be drawn to middle class health provision. The private equity fund, Aureos' investment in the NWH underlines the fact that of all segments, it is the middle class that has the best risk-return relationship and potential. The NWH focuses on the lower middle class, leaving an unfulfilled need of inpatient care in the middle and upper middle class. The hospital has expressed plans of expanding in this segment, and with Aureos' helping it to be profitable this area will be difficult to enter.

Although the NWH and the Karen Hospital have managed to run their operations profitably, investing in a full-fledged hospital is deemed as risky due to its high entry barriers such as building the hospital. Considering inpatient care from a foreign investor's perspective, investing in a hospital will require local presence for a long period of time seeing as the investor will have to hire, train and coordinate a large base of employees. However, the MOH's increased interest in forming partnerships with the private sector should make it easier for foreign investors to secure financing, obtain information and hire staff. Access to finance can be facilitated partly through i) local banks, who are showing increasing willingness to invest in healthcare, ii) local NGOs, or iii) government B2B programmes. Prof. James Ole Kiyiapi has accentuated a need in Nairobi for specialised services. This can also be done by with smaller inpatient hospitals in Nairobi that through PPPs can reach both the middle and lower class. With a profitability and sustainable business solution in mind a foreign investor should focus on the middle class segment that is expected to grow to 4.4m Nairobians by 2025 which can hardly be covered especially as the MOH is not planning to invest in new hospitals and is ready to do PPPs make the health provision system more comprehensive and ensure high-quality.

The improved institutional conditions in Kenya are presenting new opportunities for a foreign investor seeking to invest in the Nairobian health provision sector. The outpatient health provision sector is more promising for foreign investors compared to inpatient due the growing middle class and the low start-up costs. But both segments increasing substantially represent a respectively more inexpensive investment opportunity for the outpatient segment

and a more capital intensive solution within the outpatient segment. Examples of the improved institutional environment is the governments increased focus on the private sector through PPPs and the new referral system, which both encourage private sector participation. The late sound macroeconomic policy, the city's status as a hub for international organisations, decreasing threat of new ethnic riots through the new constitution and international pressure, and the increasing middle class all emphasise the new era Kenya is entering. Corruption and crime which has been seen as some of the most severe constraints are become less prevailing as enforcement has improved. The government's willingness is a vital brick to make this happen, and can, as has been seen in Rwanda, achieve double digit growth rates.

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## 11 APPENDICES

All interviews consisting of 43 pages may be found on the attached CD in the back of the thesis. The three most relevant interviews are also given below due to their central importance the thesis.

### 11.1 11.03.2010 – NATIONAL HEALTH INSURANCE FUND

- **Richard Kerich, Chief Executive Officer**

Demography of the Kenyan population: 40 million

| | | |
|---|---|---|
| Group A: | Formal sector: | 2m |
| Group B: | Informal sector: | 30m |
| Group C: | Poor: | 7m |
| Group D: | Very poor: | 1m |

**National Health Insurance Funds:**

- Statutory requirement in the formal sector
- Most universities pay through tuition fee, but not regulated
  - NHIF are working to get more organisations in.
- It doesn't cover the first 2 months
- No insurance if you get fired after the year ends (employer always pay for a year)
- Have opened for voluntary memberships
  - 500.000 from group B
  - All 30m from group B are able to pay for the NHIF
    - About 3m families who are able to pay, but not currently doing it.
  - Increased benefits to do it, if a part of the informal sector to make them declare what they earn.
  - They are encouraged to pay per year, but can also pay per month, and soon pr. week or day!
- There has been strong growth in the insurance pool.
- Private insurance: 600.000 members, which are mainly in formal employment, group A
- 70-80 % of Kenyans are currently uninsured => great potential. The real reason is lack of awareness/ignorance
  - Marketing in TV, mosques, newspapers

**NHIF accrediation**

- NHIF accredit hospitals and give them certifications.
  - Currently about 570 hospitals all over Kenya
    - 215 public/governmental hospitals
    - 71 mission hospitals
    - 290 private hospitals
- Can only be accredited if the hospitals apply, but they also check public hospitals, as they often forget to apply

**NHIF contracts**

- NHIF have three different contracts, depending on the cost level of the hospital
    - Comprehensive A, covers everything and is usually government hospitals
    - Comprehensive B, covers everything but surgical
    - Comprehensive C, Covers a fixed amount and the client has to pay the residual itself or through further insurance

**Healthcare industry:**

1. **Public hospitals**, mostly oversubsidise
2. **Mission hospitals** (Christian hospitals), which used to get a lot of donor aid, but are now almost non-profit (selfrunning), and doing more busines then before.

**The HC market:**

71 mission hospitals (quite large)
Ca. 200 small Healthcentres
Ca. 7000 hospitals (ca. 4000 public and ca. 3000 private hospitals)

**Political:**

- No reforms/initiatives to decrease the informal sector, which is the faster growing than the formal. Believed to hold the economy from growing even more!
- Must follow the SAP.
- EAC is opening the boarders.
    - Kenya has a competitive advantage fo being a regional hub.
    - Kenyan has a well functioning NHIF
    - ECASSA - East and Central African Social Security Association
    - HC in **Uganda** is almost non-existing
    - HC in **Tanzania** is very small

11.2 16.03.2010 – AMERICAN EMBASSY

- **Dr. Bedan Gichanga. Health Management Systems Specialist.**

**We saw that you had worked at Aga Khan Hospital - tell us about it.**

- Is it non-profit? No, not directly. It is owned by an Indian trust or fund, and runs on its own resources.
- It was funded by the government before, but now it does not need the support.

**The role of the National Hospital Insurance Fund**

- The NHIF gets the majority of its revenue from statutory tax, i.e. the legally imposed tax paid by the formal sector.
    - The "luxury" of being national.

- It is correct that the NHIF is increasing its focus on the informal sector, and the initial interest was quite high but the rate of renewals` was is low.
- It is safe to say that the insurance market "drives the healthcare sector". The logic is simple: when the size of the HC insurance market increases, the visible market size for healthcare services increase, and the feasibility of HC investments increases.

**AAR**

- One of the biggest "pure health" insurance companies.
- According to Bedan the health insurance market is actually declining, as we have been told by others.
    - What is the reason for this decline?
        - The insurance companies have failed to offer so-called "downstream insurance schemes" which captures the potential from the BOP.¨

**What is you general perception about the market for healthcare in Kenya?**

- The healthcare market is actually not expanding that much because the majority of "new" hospital are just a re-branding/re-structuring of old hospitals.
- However, private equity companies such as Aureos and the World Banks private investment vehicle, the IFC, believes that there is growth potential in the Sub-Saharan healthcare market.
- **Nairobi Womens Hospital** looks really promising. The management is strong and moves fast.

**Untapping the BOP potetial**

- Equity Bank has shown that it is possible to earn money by attracting customers from the BOP population.

**Now let`s talk about the market size of the healthcare industry in Kenya.**

- First of all, it is very difficult to accurately estimate the market size due a number of factors. (One factor is competition - which other factors are important?

**The potential for investing in the Kenyan Healthcare sector**

- Bedan would not recommend anyone to invest in hospitals, because there are apparently enough beds (inpatient healthcare).
- Organised outpatient healthcare, however, has GREAT POTENTIAL.
    - After a while you will need a capitative (uniform tax) package. (Simon: I am not quite sure what he was referring to here?)
    - **Problem**: Today, there are very few **outpatient** insurance schemes.
- Bedan thinks the AAR model is very good business as a result of a unique business model.

**Potential for investing the "secondary outpatient" service**

- Approximately 50% is inpatient.
- The healthcare insurance does not cover hearing-aid and so on.
    - The insurance scheme is KEY in order to succeed in the "secondary outpatient" market.
- The potential will grow over time when the middle class increases.

**Kenya undersea optical cable in Kenya**

- This new optical cable will enable high definition TV, peer to peer networks, IPTV and surging internet demand.
- Great business opportunities related to the service sector.
    - Call-centeres
    - Large english speaking population
    - The time difference is not that bad.

**Why are there less FDI in Kenya compared to Tanzania and Uganda?**

- Politics one of the main reasons. Hopefully the new constitution can create a better environment for FDI and improve the business procedures through a "one-stop shop".

IMPORTANT! **High energy costs are one of the main barriers to business in Kenya**

- One solution would be to link up with Ehtiopia.
- Electricity solutions being considered:
    - Wind (Quite costly)
    - Hydro (Cheap)
    - Nuclear (Even cheaper)
- The cost of electricity is more than three times as costly as the electricity in South Africa.

**Corruption:**

- According to Bedan the challenges related to corruption are "not that bad", at least not when compared to Tanzania and Uganda.

**Legal framwork:**

- The legal framework is not the problem - we have enough rules and regulations, but the issue is that the rules are not necessarily enforced.
    - We need a better judiciary system.
- According to Bedan cases can be postponed for a very long time before they are treated in court.

**The role of the EAC:**

- This will increase the size of the market, and thus create new business opportunities.
- It will probably take quite a while before we see common politics such as one EAC president.

- Kenyans are completely different from the Tanzanians, and might be a possibility that the Kenyan people will override the TZ.

**Kenya as a EAC hub or cluster?**

- Bedan says that there has a decentralising trend the last years, and this may impede the formation of a cluster in Kenya.

### 11.3 25.03.2010 - MINISTRY OF MEDICAL SERVICES

- **Prof. James Ole Kiyiapi, Permanent Secretary**

**<u>Challenges with the current public HC system</u>**

- High demand
  - There hasn't been any systematic investment in the HC infrastructure
  - The increasing growth doesn't match the expansion
  - Which means that there are high need for improvements

**<u>Critical areas moving forward</u>**

1) HC system needs to be strengthen from level 1 all the way to level 6

- The referral system needs to improve.
  - The system currently doesn't function whatsoever, many go straight to Kenyatta National Hospital (KNH), but it is only suppose to be a referral hospital and not a direct.
- Level 4 districts hospitals are not standardised, some are very poor, and some in decent standard
- Next 5-10 years the infrastructure needs to be at a basic level,
  - Which means having staff, theatres, kitchen
- Standardisation

2) Human resources are very inadequate

- 38.000 nurses required, currently available are ca. 17.000
  - 2-3.000 needs to be hired a year
  - Mainly lacking in the rural areas
- Needs to increase the number of staff
- Increase service
  - needs to make it more attractive to work in the rural areas
    - Create pull factors to get people to move there, like in South Africa where they have people doing a it for maybe half a year or less on rotation

3) Issue of the medical commodities

- Are trying, but there needs to be done a lot more
- Shortage right now,

- Improve supply chain
- Use local manufacturing
    - Improve system, planning, storage
    - increase budget
    - impower local manufacturing
        - needs electricity, roads, water to enable this, which is not currently there
- Prevention needed
    - Environment improvement
    - Infrastructure improvement
    - Community involvement
        - Wash hands etc.*If people are poor options are very scarce

4) Commodity supply

- Pharmaceutical industry in Kenya needs to be regulated
- Quality insurance

5) Financing

- Kenya currently use only 7% of budget on HC, the goal is 15% for African countries

<u>How to fund HC:</u>

1. Direct charge
2. Health insurance, NHIF expansion
3. Funding from Treasury, i.e. taxes, especially on the top
4. Partnership with organisations, such as DANIDA

<u>HC in Kenya:</u>
Health Care sector currently use 90 bn KSH, but the public sector only accounts for 45 bn KSH, the other 45 bn goes through others

1. Interventions are minimilistic
2. Is inefficient
3. Can't prioritise

=> So the money used is not very focused as things are now. The public sector there for needs to work together with the private and have a focused strategy.
* Addressing through sectorial approach, trying to cooperate, keeping things in one basket and one goal

<u>Attain sustainability</u>

- strengthen the current system
- less programmes, more more buildups, so the programmes instead can be effective through better infrastructure
- more efficient system, *so we can deliver better service tomorrow than today!*
- more efficient use of money
- build infrastructure

    - Standardise
    - Build referal system
- get fundamentals right
    - so they can respond quickly and robustly
    - E-Health can only work when the infrastructure is there - not yet, but in the future
    - poor coordination

**MAKE HC**

1. **ACCESIABLE**
2. **AFFORDABLE**
3. **TRANSPARENT**

PPP

- At present time it is difficult.
- Private is threatened by the public
- Not an hornest platform for PPP
- NHIF are not sure what they want to do (He spoke with Richard, and he was not able to say what their strategy currently is)
    - not interested in a strong and efficient NHIF (unfortunately) - they need to get back to basics
    - They currently use ca. 40 % of their income for administrative costs - too high, should be around 18-20 %
- The private sector knows that the 6 level referral system is not working, but also that the Min. of Health wants to bring it back
    - A large part of the private sector is most likely not ready for this
    - The private sector is very short short term/or lack belief in a functional referal system
    - If the want to invest long term, they need to assume a functional referal system, and figure out where it is possible to build profitable on the public referal system.
- The public sector need to get back to their initial platform
    - The private sector has exploited openings/dysfunctionalities that were temporary. E.g. were there a short period when a hospital in Rift Valley was not working probably, and a private less equipped hospital opened and did great business/lots of patients. But when the public better equipped hospital opened again, the private hospital most of their patients and blamed the Min. of Health.
- **Private hospitals need to do specialised services that complement and adds to the public sector**

*Many private investments were driven by a dysfunctional system

**Potential in the out-patient business**, as they can do this better, by better management. They might be outsourced by the public to the private sector

The future of HC in Kenya

- HC can't be ignored by the government, so they need to do something, why we most likely will see large improvements already. Already gone far the past years.
- Public HC sector is improving, paradigm shift to system approach, now more holistic approach

1. Functional referal system
2. Well spread facilities in the country
    1. In South Africa a basic clinic with room for doctors for a short period and a few beds (mobile hospitals)
        1. maybe just a truck that has everything inside, no reason to have small hospitals everywhere if it is not neccesary
        2. dispensaries have many things, even small room for surgery
3. Funding should be properly leveraged
4. Repair staff shortage
    1. About 1.500 health workers have been hired every year in the past. In the future hope to get 3.000 to fulfil the current need after 5 years
    2. About 500-600 doctors should be hired a year in the future, currently about 200. If this is kept at 500-600 a year for ten years, then the services could be doubled

<u>Infrastructure needs to be built! Standardisation of the quality</u>.

- some referral hospitals have good equipment, but they need to perform
- Go basic, not high tech, more efficient use of money
- Health workers are already doing a lot, and with little more than can do so much more

<u>Constitution</u>

- It will improve governance and take it to a new level
- Create a new thinking and be more efficient

<u>HC in Kenya</u>

- Kenya can be a leading HC country in Sub-Saharan Africa
- The country is more optimistic this year than last. Need to sustain the current effort

<u>Doctors</u>

- Many medical schools are opening up for more doctors (South Africa has 8 medical schools, we don't know how they are in size)
    - Kenyatte University (2008)
    - University of Nairobi (1967)
    - Moi University (1980s)
- in 2-3 years (probably more 5 years ) there will be more than a sufficient number of doctors

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