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EFFECT OF DEVOLUTION ON HEALTHCARE ADMINISTRATION IN MURANG'A COUNTY, KENYA

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ABSTRACT

The health administration managers play a critical role in healthcare decision-making, and their susceptibility to local and regional politics is noteworthy. This is despite the need for channeling more resources towards the devolution of healthcare in the 47 counties in Kenya. While an expansive body of literature has explored the implications of devolution on certain aspects of an economy, little has been published on the effect it has on healthcare administration. There is a little empirical study on the effect devolution has on the administration of health services in Gatanga Sub-county in Murang'a County despite having a population of 95,601 people. According to the agency theory, an agent ought to serve in the best interest of the principal. By extrapolation, regional healthcare administrators ought to serve better their principals after they are empowered by devolution. To that effect, this study ought to examine the effect of devolution on healthcare administration in Gatanga Sub-county. The study sought to achieve three key objectives, namely (a) to assess the effects of devolution on healthcare financial planning, (b) to examine the effects of devolution on the management of healthcare facilities; and (c) to evaluate the effects of devolution on healthcare human resource management. A randomly selected sample of 91 healthcare practitioners, 46 healthcare beneficiaries, and 19 healthcare administrators in the county was involved in the study. Data was collected using semi-structured questionnaires and analysed using descriptive analysis. It was observed that the county government primarily funds healthcare service with minor support from grants from the national government and donors. They experienced a range of financial challenges, namely unreliable, delayed, and insufficient funding, lack of sufficient equipment. It was also observed that devolution had improved administration through expanding managerial space and improvement in overall service delivery. However, operational challenges, such as poor involvement of stakeholders in day-to-day operations and decision-making, were rampant. Lastly, devolution has allowed healthcare facilities to attract qualified workers, perhaps from local societies, although staff challenges such as staff demotivation and inadequacy of CPD opportunities were observed. This study recommends fostering capacity building for local healthcare facilities to help in bolstering the skills of healthcare administrators and the need for awareness among administrators concerning the welfare of healthcare practitioners.

Key Words: *devolution, healthcare administration, human healthcare resource, healthcare financial planning*

INTRODUCTION

Devolution is a key component of modern-day governance, at least for most countries. It has been pursued not only at the national level as in the cases of the Philippines, Thailand, Nepal, and Indonesia, but at the supranational level as in the case of the European Union (EU) (Tatham, 2011; Lee& Lam, 2017). Definitively, devolution is the transfer of legislative, political, and economic

powers from a central government to the semi-autonomous regional governments (Juma *et al.*, 2014). The provision of health services is one of the economic powers that can be transferred through devolution. The common intention for this transfer has been to enhance economic growth and policymaking agendas of a nation with more efficiency compared to centralized governance (Juma *et al.*, 2014). There has been a growing trend of rising embracement of meritocracy and efficiency in the provision of public services has seen a surge in decentralized units of governments in various forms, including devolution, delegation, deconcentration, and delocalization emerge in Africa.

Devolution in Kenya, empowered by the 2010 constitution, was motivated by the need for more efficiency in the delivery of public services (International Institute for Legislative Affairs, 2015). The ratification of the County Governments Act 2012 provided a better way of promoting accountability, technical equity, and efficiency in the controlling of public resources in Kenya (Murkomen, 2012). Not only does devolution provide communities with a right to manage their social and development affairs, but it also allows for the protection of the interests of the marginalized groups (McCollum *et al.*, 2018). The decentralization of health services is a contentious issue. Some authors find decentralization of health services as vital for enhancing the administrative efficiency healthcare institutions (Tsofa *et al.*, 2017), while others believe that efficiency in healthcare services cannot be achieved without a hand of the central government (Jongudomsuk & Srisasalux, 2012). Haines *et al*. (2009) consider devolution effective if it promotes responsiveness to the needs of the local communities, particularly in health services. In Kenya, the devolution of the health system was anticipated to improve access to health services across the country, eliminate discrimination in the quality of healthcare service between urban areas and 'low potential areas,' and eliminate bureaucracy in the administration of health services, especially in procurement (Murkomen, 2012). It was viewed as a way of promoting efficacy in healthcare service delivery while promoting the quality of healthcare services.

Article 235 of the constitution of Kenya states that county governments are responsible for all healthcare delivery functions, including the procurement of medical supplies (Tsofa *et al*., 2017). However, the ability of devolved governments to provide quality healthcare service is mainly dependent on the nature of governance or administrative efficiency of the semi-autonomous healthcare centers (McCollum *et al*., 2018). The role of governance in the performance of the health sector and the achievement of futuristic goals such as Universal Health Coverage (UHC) is widely recognized (Fryatt *et al.*, 2017). County governments are also responsible for handling any challenges relating to healthcare services, including capacity building and overcoming industrial actions (Murkomen, 2012). The constitution empowers county governments to: 'establishing and abolishing offices in its public service,' 'appointing persons to hold and act in those offices' and 'exercising disciplinary control over and removing persons holding or acting in those offices. County governments appoint important positions such as health administrators.

Health administration is a vital facet of the healthcare system, designed to promote efficiency and coordination in the provision of healthcare services and related supplies. This may involve a team of individuals working in liaison to manage different levels of a given healthcare system (Wager *et al.*, 2017). Healthcare administrators make far-reaching decisions that influence the implementation of national health policies in any hospital. Notable is the fact that the coordination, interactions, and decision-making in the complex system of healthcare have political influence (McCollum *et al*., 2018). These activities are designed in a way that they serve the interests, either commercial or political, of certain actors (McCollum *et al*., 2018). This, by extrapolation, suggests that the concepts of devolution and health administration converge at the point of political influence.

STATEMENT OF THE PROBLEM

The role health administration plays in healthcare decision-making makes it highly susceptible to regional politics, the reason for which the effect of devolution on health administration cannot be relegated (McCollum *et al*., 2018). However, the extant body of literature appears to shelve these issues by focusing more on other healthcare aspects such as procurement of medical supplies, than it has on the decision-making and management roles (Tsofa *et al*., 2017). Evidence suggests that the expected outcomes of devolution, such as improved accountability, equity, efficiency, and responsiveness to the provision of health services, are unpredictable (Venugopal & Yilmaz, 2010; Eaton *et al.*, 2011). Their dependence on other factors, such as the political context of the county, creates disparities in administrative efforts of healthcare services, thereby paving the way for undesirable effects on accountability (Eaton, Kaiser, & Smoke, 2011). Extant literature on the implications of devolution on health services has minutely addressed this issue. The significance of this study arises from the underlying healthcare ambitions of Kenya and its 47 counties. The government of Kenya aims at achieving the UHC along with the United Nations (UN), which is concerned with access for all people to preventing, rehabilitative, curative, promotive, and palliative health services (Magnusson, 2017). The third pillar of the Big Four Agenda of the government of Kenya outlines the government's ambition to 'address inequality of access to healthcare and improve health outcomes' (Parliamentary Service Commission, 2018). By the year 2022, the government aims at achieving 100 percent UHC anchored by mass uptake of the National Hospital Insurance Fund (NHIF) services. Achieving this goal requires the national government to scale up services. One of them is the NHIF system to rural areas, an achievement that is largely dependent on the effectiveness and efficiency of the health administration system at community health centers. Past research has shown that the decentralization of authority and resources can affect the provision of health services. In the Philippines, for instance, health centers experienced enormous administrative challenges, including lack of repairs for medical equipment, understaffing, and poor management of resources, barely five years after devolution (Tsofa *et al*., 2017). Similarly, the decentralization of human health resources saw rural districts face staffing challenges that resulted in re-centralization (Tsofa *et al*., 2017).

RESEARCH OBJECTIVE

The purpose of this research was to examine the effect of healthcare devolution on the administration of human healthcare resources, finances, equipment, and facilities.

THEORETICAL LITERATURE REVIEW

This study was guided by the agency and stakeholder theories. The agency theory explores the association between the owners or stakeholders (Principal) and managers (Agent) in an organization, and it has been touted as a reliable basis for examining the decentralization of powers in a society (Wagana *et al.*, 2015). The key tenet of the agency theory is the idea of the delegation of responsibility from the principal to the agent, which is the basis for evaluating devolution. Citizens, who are the principals of a society, delegate the functioning and management of their society to agents through a political process. Regarding that, the agents are expected to make decisions or act in the best interest of the principals (Wagana et al., 2015). This was ideally the basis for the massive adoption of the new constitution of Kenya in 2020. The principals were interested in assigning agents responsibilities that would yield them better rewards in their respective constituents (Buluma & Obande, 2015). The agents would be better stewards of the principals' resources in a manner yielding the best interest to the principal.

Freeman (1994) proposed the Stakeholder theory under the premise that the conceptualization of organizational affairs should be conducted with the consideration of all stakeholders. The theory suggests that leaders should manage an organization not only to the benefits of its stockholders but also that of the stakeholders (Freeman, 1994). Stakeholders are viewed the groups or individuals such as employees, members of a local community, shareholders, distributors, and suppliers who are key to the success or survival of an organization. The lack of support or goodwill from these individuals or groups would be detrimental to the progress of an organization or project, which is the basis for their consideration (Freeman, 2004). From the perspective of public service, the stakeholders' theory implies that the managers of public resources ought to have the interest of all people and should be considerate of the role of stakeholders in the management of those resources. This befits the concept of devolution in which political and economic resources are decentralized for more inclusion in the development agenda of a county (McCollum *et al.*, 2018). The basis of devolution should be to promote the involvement of all stakeholders in the administration of the resources, the result of which can be better determined through empirical assessment as in the proposed study. The assumption is that when leaders at lower levels are given more decision-making power, they embrace the inclusion of stakeholders in the conduct of daily affairs.

CONCEPTUAL FRAMEWORK

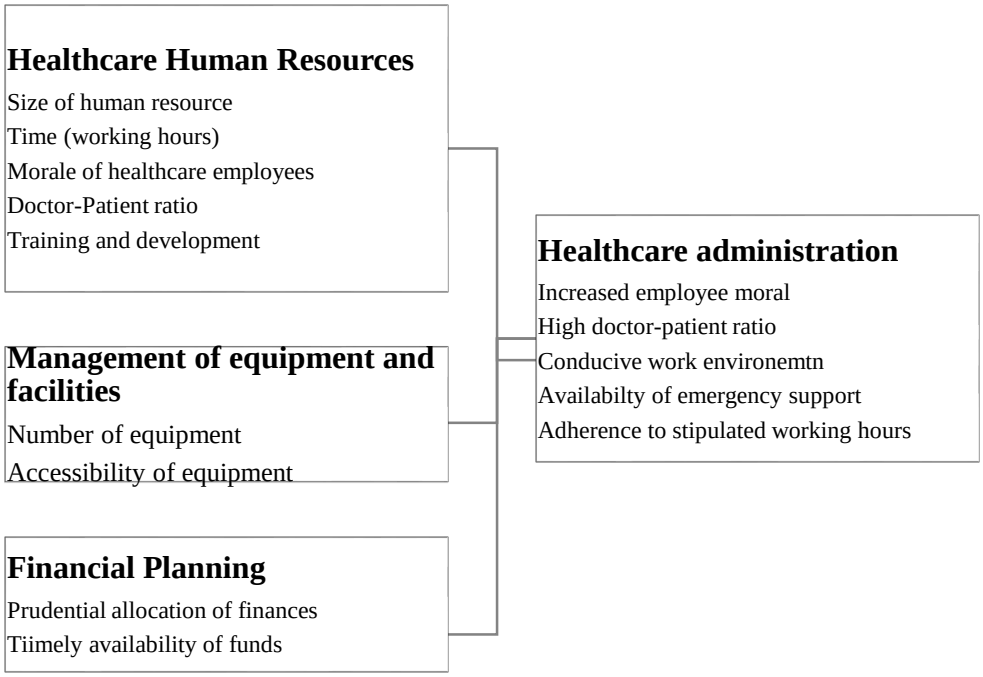

Figure 1: Conceptual Framework

Some of the core functions of healthcare administrators lean of human resource management, financial planning and reporting, and the management of healthcare facilities and equipment at a healthcare facility. For the management of the human healthcare resource, the decisions made by the administrators can affect the size of the labour force available in a given healthcare center, the working hours of the staff, and the morale of the staff. These choices can also influence the conduciveness of the healthcare workplace besides influencing the doctor-patient ratio, whose effect is felt in the quality of care delivered to patients. The healthcare administrators are also responsible for ensuring that essential facilities and equipment for providing healthcare are available and accessible to the society they are meant to serve. This includes making the necessary financial plans for making sure that vital services are always running to the benefit of society. These areas align with the propositions of both the stakeholders' theory and agency theory. On the one hand, these considerations ensure that healthcare services prioritize not only accessibility but also quality to the benefit of society. On the other hand, they ensure that a given hospital does not prioritize the healthcare needs of the patients while neglecting the team mandated to deliver those services.

RESEARCH METHODOLOGY

This study was guided by descriptive research design. This design allows a researcher to describe the characteristics of a population or a phenomenon and does not necessitate statistical

measurements (Lewis, 2015). This method was considered ideal for the proposed research because it provided the basis for using both quantitative and qualitative approaches in the collection of research information. The sub-county has a population of 95,601 and covers approximately 603.0 square kilometres (KNBS, 2019). The sub-county has 49 healthcare facilities, 24 of which are owned and operated by religious institutions (Kimani *et al.*, 2019). This means that only 25 healthcare units are registered under the health docket of Murang'a County for the sub-county. This study was focused on these healthcare facilities. These hospital facilities provide a range of medical services, including antenatal care, antiretroviral care, HIV counselling and testing, curative care, family planning, growth monitoring, immunization, and x-ray services.

Table 1: Demographic characteristics of respondents

Category		**Practitioners**		**Administrators**		**Beneficiaries**		**Total**	
	Variable	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Gender	Male	25	27.5	15	78.9	13	28.3	53	8.3
	Female	66	72.5	4	21.1	33	71.7	103	21.2
	Total	**91**	**100**	19	100	46	100	156	29.5
Age	18-24 Years	3	3.3	0	0	1	2.2	4	0.6
	25-34 Years	15	16.5	0	0	9	19.6	24	5.8
	35-44 Years	15	16.5	5	26.3	19	41.3	29	5.8
	45-54 Years	44	48.4	11	57.9	9	19.6	74	12.2
	55 Years and above	14	15.3	3	15.8	8	17.3	25	5.1
	Total	**91**	**100**	**19**	**100**	**46**	**100**	156	29.5
Service Experience	Less than two years	7	7.7	2	10.5	-	-	9	5.8
	3 to 6 years	21	23.1	8	42.1	-	-	29	18.6
	7 to 10 years	23	25.3	3	15.8	-	-	26	16.7
	11 to 14 years	24	26.4	5	26.3	-	-	29	18.6
	15 years and above	16	17.5	1	5.3	-	-	17	10.9
	Total	**91**	**100**	**19**	**100**	**-**	**-**	**110**	**70.5**
Expertise	Clinical Officer	25	27.5	-	-	-	-	25	16
	Pharmacist	13	14.3	-	-	-	-	13	8.3
	Nurse	39	42.9	-	-	-	-	39	25
	Doctor	7	7.7	-	-	-	-	7	4.5
	Others	7	7.7	-	-	-	-	7	4.5
	Total	**91**	**100**	**-**	**-**	**-**	**-**	**91**	**58.3**

The target population for this study was composed of healthcare providers in the hospital facilities and the recipients of healthcare services. The citizens were targeted for their perspectives on the quality of healthcare services they receive from the healthcare centers controlled by the County Government of Murang'a. Healthcare providers who were targeted in this study included doctors, pharmacists, nurses, healthcare administrators, laboratory technologists, and clinical officers. A simple random sampling method was used in targeting the participants for this study. The study targeted 203 participants to assist in collecting information concerning certain aspects of the

healthcare services delivery in the sub-county. The data for this study was collected through semi-structured questionnaires and interviews, which were administered remotely because of mobility limitations emanating from COVID-19 barriers. The collected data was analysed using descriptive analysis and partial correlation analysis. The descriptive analysis allowed for the use of descriptive statistics such as measures of central tendency, frequencies, and percentages using the Statistical Package for Social Sciences (SPSS). One hundred and fifty-six participants agreed to take part in the study against a targeted number of 203 participants. This number represents a 76.85% response rate from the healthcare administrators, practitioners, and healthcare beneficiaries who were the target participants in this study. The demographic characteristics of the respondents were as showed in Table 1. The study focused on four medical expertise, namely doctor, pharmacist, nurse, and clinical officer. Any other profession among the practitioners was captured under the 'others' cohort. The respondents of this study included 19 healthcare administrators, 91 healthcare practitioners, and 46 beneficiaries. While 8% of these participants were male and 21.2% females, their proportionality across the different categories of respondents varied, as showed in Table 2. Most of the practitioners and administrators fell within the 45-54 years cohort, and beneficiaries were largely in 35-44 years cohorts.

RESEARCH RESULTS

The results of this study are presented subject to the overarching aim. First, the perceived effect of healthcare devolution on financial planning is presented, followed by the management of facilities and human healthcare resources.

Financial Planning

Effective financial planning and management in healthcare are vital for achieving the quality delivery of services. According to Dong (2015)**,** such financial metrics as liquidity, the profitability of a hospital, operational efficiency, and cost optimizations strongly correlate with healthcare outcomes. Several financial elements were examined among the respondents. These factors include the reliability of funding from the country government, delayed funding, inadequate liquidity characterized by insufficient funding, and the autonomy of financial management.

A higher percentage of the surveyed administrators indicated discontent with the assessed elements of financial planning about their hospitals. For instance, 89.5% indicated that the funding they were receiving in their hospitals was unreliable, although this was contrasted by 10.5% of the respondents. About 79% of the surveyed respondents noted a delay in funding, contrary to the belief of 21.1% of the surveyed respondents. Besides that, 84.2% indicated that the funding they received was not sufficient for their operations. In comparison, 43.2% of the surveyed respondents highlighted a lack of autonomy in the management of finances in their hospital. The study expected financial challenges to be evident from the assessment made among healthcare workers and beneficiaries. The availability of essential healthcare services and equipment is one of the benefits

of optimal financial management, according to Dong (2015)**.** Their absence may suggest financial challenges in a particular healthcare facility.

While the administrators suggested financial challenges based on the above-highlighted responses, they indicated that the equipment available in their hospitals was sufficient to provide medical services to their target population. A similar observation was made from the healthcare practitioners, 63.2% of whom indicated that they believed the equipment available in their healthcare centers was sufficient for the number of patients they served. The availability of specific equipment and special healthcare services such as theatre, dental, emergency, and optical services in the sampled healthcare facilities were also examined based on the knowledge of the respondents.

Regarding that, 12% of the respondents suggested the availability of emergency services in the facilities they served; 22% suggested the availability of x-ray services, while 21% indicated the availability of pharmacy services. Other available equipment and services included theatre services (2%), laboratory facilities (21%), dental and optical services (22%). The purview of the healthcare administrators concerning the sources of funds for managing hospital operations was also examined. The respondents were to choose whether they financed their operations from revenue earned from the services they provided, from donor funds, county government budget, or grants from the national government, if any. In that regard, 49% indicated that their funding largely came from the country government, 14% from the national government, 24% from revenue generated from services, and 13% from donor funds. This finding was consistent with Kimathi (2017), who observed that county health services were mainly financed through public finances, private funds through consumers, and donors. However, for Kimathi, consumers contribute the largest portion of the financing, up to 35.9%, while donors provided up to 30% of the healthcare funding.

A partial correlation was performed to examine whether the purview of the administrators concerning the funding challenges was associated with their overall belief about the value of devolution to their work. The partial correlation was preferred because the select variables were rather random, which, according to Wetzels and Wagenmakers (2012), is an ideal ground for partial computing correlation. This methodology measures the degree of association of two variables and examines whether the association is statistically significant. Through this correlation, the study would establish whether the overall belief of the administrators concerning the effectiveness or value of devolution to healthcare was associated with the financing challenges they were experiencing.

The opinion of the administrators concerning the healthcare progress amid devolution was partially correlated with their responses about different aspects of funding, as showed in Table2. A weak to moderate correlation between the opinion of the administrators about the progressive effect of devolution on healthcare and the funding experience was observed. Notable, however, is that none

Table 2: Partial correlation of perceived effect of devolution and funding experience

Control Variables		Unreliable funding	Funding delays	Insufficient funding	No autonomy in financial management	Budgeting challenges
Unreliable funding	Correlation	1.000	-.185	-.183	-.255	-.224
	Significance		.463	.468	.307	.372
Funding delays	Correlation	-.185	1.000	-.231	.411	-.071
	Significance	.463		.357	.090	.778
Insufficient funding	Correlation	-.183	-.231	1.000	-.021	.344
	Significance	.468	.357		.933	.162
No autonomy in financial management	Correlation	-.255	.411	-.021	1.000	-.290
	Significance	.307	.090	.933		.242
Budgeting challenges	Correlation	-.224	-.071	.344	-.290	1.000
	Significance	.372	.778	.162	.242	

Management of Healthcare Facilities

Effective management in healthcare necessitates sound decision-making among leaders, empathy, and democracy through the involvement of all stakeholders. In the same token, it was expected that with the powers that come through devolution, healthcare administrators had more room to exercise their management, especially independently in a manner that served the best interest of the individuals below them in the hierarchy. Only 42.1% of the administrators agreed that they had decision-making autonomy, akin to little or no external influence. Twenty-six percent of the administrators suggested that their decision-making had some level of external influence, while 31.6% of the respondents were indifferent concerning the level of decision-making autonomy. An equal number of administrators indicated that they were in contact with other executives concerning healthcare matters either always or very often.

Concerning healthcare practitioners, 56.20% indicated that they were not involved in decision-making regarding their healthcare institution. Only 21.17% of these respondents strongly agreed that their leaders were always up to the task in management affairs. Moreover, only 15.33% of the respondents agreed that their leaders constantly communicated with the team to keep them updated over institutional affairs. This means that the other respondents either disagreed or were not sure concerning constant communication from their leaders or their leaders being up to task concerning responsibilities.

Management efficiency was also examined from the perspective of the surveyed healthcare beneficiaries. Considering the obtained responses, 76.74% indicated that they believe there was an improvement in services in the local health center. However, 77.68% indicated that there were delays in healthcare services delivery. An equally high number of beneficiaries (74.40%) indicated that doctors and nurses were polite, a quality that is attributable to efficient management. Another aspect of management was the autonomy for decision-making and the subsequent satisfaction with the space for making managerial decisions.

The study examined the perspective of the healthcare administrators concerning whether or not they had the managerial to make decisions in their respective hospitals. Considering the survey, 42.1% strongly agreed that they had this freedom, 26.3% only agreed, while 31.6% indicated indifference. In addition, 68.4% indicated that they were satisfied with the space they were given for making decisions in their hospitals. In comparison, 31.6% indicated that they were not satisfied with the decision-making space.

Lastly, the study examined the opinion of the healthcare administrators concerning the impact of the country's government and the national government in the operations of their hospitals. Concerning that, 63.2% of the surveyed respondents indicated that the country's government had the most impact. However, 21.1% indicated that the ministry of health had a large influence in their hospitals. In addition, 10.5% of the respondents indicated that the impact between the two arms of government was equal, and a meagre 5.3% could differentiate.

Healthcare Human Resource Management

Published literature underscores the vitality of human resources in achieving quality healthcare. Human resources are at the center of effective and efficient medical services through which patient satisfaction is achieved (Alhassan *et al*., 2013; Mosadeghrad, 2014). This vitality is part of the reason healthcare policies around the world are formulated in a manner that seeks to remove workload and pressure from healthcare practitioners to ensure productivity (Gerolamo & Roemer, 2010). Nonetheless, one of the human resource elements assessed among the surveyed institutions is the size of the workforce.

Regarding the obtained responses, 70.8% believed that the healthcare centers in which they served were sufficiently staffed, which was contrary to the belief of 29.2% of the surveyed practitioners. The perspective of the practitioners concerning the influence of the staff number on the efficiency of service delivery in the assigned centers was also examined. Twelve percent of the participants believed that the size had a lot of influence on the quality of service delivery. Other responses indicated partial influence (7.3%), a little influence (62.8%), although 17.5% believed that the size did not influence the quality of service delivery. The work environment for the human healthcare resource was also examined. This allowed assessment of critical elements such as the level of staff motivation, remuneration, and compensation, and perceived staff quality.

Only 3.6% of the practitioners indicated strong satisfaction with their remuneration. A higher number of practitioners either disagreed (18.2%) or strongly disagreed (27.7%) that they were satisfied with the remuneration they received for their services. When assessed about the quality of staff in their assigned healthcare centers regarding skills and competence, responses varied from very high quality (4.4%), high quality (4.4%), average quality (28.5%), low quality (18.2%), and very low quality (4.4%). The level of motivation at work also varied among the respondents. On average, the healthcare workers were highly motivated at work (47.4%) compared to those who indicated low motivation levels (25.6%).

An important element of human resource management in healthcare examined in this study concerning training and development. This influences competency and proficiency levels among medical service providers besides their preparedness in addressing different healthcare challenges. The surveyed healthcare administrators indicated that training and development for healthcare practitioners had significantly benefitted from devolution. Concerning that, 53% of the administrators suggested that there were more training opportunities for healthcare workers than there were before devolution. However, 47% of the surveyed administrators did not hold a similar view.

A similar assessment was conducted among practitioners. Concerning that, 63.5% of the participants indicated that they had participated in professional training in the previous year. Moreover, 5.8% strongly agreed that they received support to further their professional ambitions, although 4.4% strongly disagreed that their workplaces offered support for professional growth. A further assessment concerning the frequency with which training and development were made, as shown in **Error! Reference source not found.**. Only 68.2% agreed that their workplaces provided regular training for professional growth. Another 10.1% were not sure concerning the availability of regular training services in their workplaces. In addition, 13.9% indicated that the training was very often. Others indicated that training and development activities in their workplaces were either often (25.5%), sometimes (30.7%), or hardly (29.9%).

DISCUSSION

The outcomes of this study align in part with the findings of other published studies around the same research domain. For instance, disruptions in salaries, political influence in human resource management, poor morale among staff, resignations, and lack of essential drugs were attributed to healthcare devolution in Tsofa *et al*. (2017). Miriti (2016) observed that insufficient and delayed funding by the country government led to surveyed hospitals in Meru to rely on funding from the national government in spite of devolved healthcare. The study also established improvement in staff training in the surveyed hospital besides improved service delivery to the target population. However, unlike in this research, Miriti observed that the doctor-patient ratio was largely affected by devolution. Staffing has also been found to influence the delivery of healthcare services in other case studies (Mehta, 2011; Gupta *et al.*, 2014).

The overarching effect of devolution appears to be increased room for decision-making among healthcare administrators. According to Tsofa *et al*. (2017), this space is important for promoting the management of essential medical supplies and services. This key benefit of healthcare devolution has been repeatedly observed in related studies such as Mitchell and Bossert (2010) as well as Mohammed *et al.* (2016). Although decision-making autonomy among healthcare administrators was a challenge during the initial stages of devolution, it has gradually improved owing to the development of custom structures of management at country levels (Tsofa *et al*., 2017). However, taking full advantage of this space among administrators necessitates individuals to have the capacity to undertake their assigned duties. In Pakistan, for instance, Bossert and Mitchell (2011) observed that the lack of individual and institutional capacities to undertake decentralized functions influenced the management of the health sector. It is imperative for the healthcare administrator to have the capacity and skill to include all stakeholders in decision-making. For the most part, decision-making space emanating from devolution ought to provide the opportunity for all stakeholders to take part in influencing the direction of their institutions.

The identified challenges of healthcare devolution are also consistent with the published literature. For instance, the World Health Organization (2010) highlights the idea that most healthcare workers around the world are not sufficiently paid, which can help explain the level of dissatisfaction among the surveyed practitioners concerning their remuneration. The gaps in healthcare delivery in a particular case study may be attributed to staffing and morale issues among workers. For instance, Mehta (2011) observed that staffing challenges in human healthcare resources contributed to poor delivery of healthcare services and led to poor satisfaction levels among healthcare beneficiaries. Tsofa, Molyneux, Gilson, and Goodman (2017) observed that healthcare devolution in some counties was marred by the re-centralization of financial planning from the health-facility level to the county-level, which complicated healthcare administration at the lowest levels.

Some of the operational challenges in the healthcare sector, such as lack of adequate equipment, insufficient CPD programs, and poor remunerations, could be attributed to consistent budget cuts, in which the sector receives far fewer finances than needed to guarantee quality delivery. Since the onset of devolution, county governments in Kenya have been allocating a meager 5% of their total budgets to healthcare, which is expected to be meet all needs, including staff remuneration, equipment purchases, medical supplies, healthcare infrastructure, and miscellaneous expenses (Kimathi, 2017). This practice is undesirably inconsistent with Kenya's commitment to the Abuja Declaration to which the country (and other counterparts) pledged to commit at least 14% of the national budget to healthcare. While Kenya signed to this declaration before devolution, it would be expected that the mandate is passed on to the county government. The outcome of insufficient allocation to the healthcare sector is lack of essential equipment, poor service delivery, and poor remuneration practices among staff, among other challenges, some of which were evident in this research (Kimathi, 2017).

CONCLUSION

Several conclusions were arrived at subject to the underlying research objectives. Healthcare services in the sub-county are funded mainly by the county government with minor support from grants from the national government and donors. Healthcare facilities have been experiencing financing challenges characterized by unreliable, delayed, and insufficient funding, which has resulted in such challenges as lack of sufficient equipment and the inability of facilities to provide certain services, including dental and optical services. The surveyed administrators also cite corruption as one of the challenges facing the delivery of healthcare services in the target case study. Second, devolution has provided healthcare administrators with expanded space for making localized decisions besides improving the communication between administrators and other healthcare executives at the county level.

However, there are challenges in operational management characterized by poor involvement of stakeholders in day-to-day operations through regular communication and involvement in decision-making. Nonetheless, there have been improvements in the overall delivery of healthcare services, according to healthcare beneficiaries. Lastly, devolution has allowed healthcare facilities to attract qualified workers, perhaps from local societies. The surveyed respondents believed that the available human resources were competent and adequately skilled to meet the predominant healthcare challenges. There are mixed reactions concerning the effect that devolution has had on the doctor-patient ratio. Other effects of devolution on human healthcare resources include demotivation for workers out of management shortcomings, the inadequacy of training and development opportunities for workers, remuneration lamentations.

This study recommends fostering capacity building for local healthcare facilities and skills for healthcare administrators in improving the overall management of these facilities. The documented literature does not demonstrate efforts made by county and national governments in promoting capacity building. This could be part of the reasons behind the management loopholes identified in this study, such as lack of stakeholder involvement in the management of healthcare centers and insufficient communication. Second, there is a need to develop a framework for fostering continued professional development for healthcare practitioners. Promoting professional development for healthcare workers may help in improving both their morale and prospects of quality care delivery going forward. This may require the county healthcare executives to understand the changing healthcare needs of our society and therefore preparing human resources to meet these needs.

One of the core strengths of this study is the idea that it was narrowly focused on one sub-county, which allowed the study to involve as many participants as possible. This allowed a deeper and more detailed assessment of the primary aim of the study for the consideration of future research and the subsequent policy implications. Nonetheless, the focus of this one study on one sub-county can be considered a limiting factor in the attempt to generalize the observations made herein.

Kenya has 47 counties, with each boasting of at least five sub-counties. As such, it might not be statistically coherent to extrapolate the findings of one sub-county to represent over 200 other counties. Notably, each county government has unique approaches to healthcare services and healthcare administration, which means the findings herein might be inapplicable in another setting.

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