RECONCILING INDIVIDUAL AND COLLECTIVE
INTERESTS IN KENYA HEALTH CARE: AN ETHICAL
CONCEPTUAL FRAMEWORK

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DECLARATION

This thesis is original and has not been presented in any university or institution for degree or any other award.

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DEDICATION

This thesis is dedicated to my best friends; Agatha, Agatha, Mark and Edith for loving me always. A special dedication to my father, Mburu Muchungi and my Mother, Lucy Mary Wanjiku Mburu. I also dedicate to all my siblings for being there. A heartily dedication to the memory of Geoffrey Griffin.
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DEFINITION OF TERMS

**Autonomy**: Freedom from control or influence of another or others.

**Axiology**: The rational investigation of questions about human values.

**Categorical Imperative**: In the ethical system of Immanuel Kant, an unconditional moral law that applies to all rational beings and is independent of any personal motive or desire.

**Consequentialism**: A moral theory that assesses things by the value of their consequences.

**Deontological Ethic**: A system of ethics that judges actions based on whether they adhere to a rule or a set of rules.

**Ethical Dilemma**: A situation that involves an apparent conflict between moral imperatives, choice of one which would result in transgressing the other.

**Duty**: Moral obligation.

**Egalitarianism**: A social and political philosophy asserting the equality of all men, especially in their access to the rights and privileges of their society.

**Equity**: The quality of being impartial or reasonable; fairness.

**Ethics**: The rules or standards governing the conduct of a person or the members of a community.

**Fairness**: Ability to make judgments free from discrimination.

**Health outcomes**: A result of a medical condition that directly affects the length or quality of a person’s life.

**Instrumentalism**: A pragmatic theory that ideas are instruments that function as guides of action, their validity being determined by the success of the action.

**Justice**: A particular distribution of benefits and burdens fairly in accordance with a particular conception of what are to count as like cases.

**Morality**: Concern with the distinction between good and evil or right and wrong; right or good conduct.

**Neo-liberalism**: A political orientation that blends liberal political views with an emphasis on economic growth.
**Patient:** One who receives medical attention, care or treatment.

**Social Contract:** An agreement, entered into by individuals, that results in the formation of the state or of organized society, the prime motive being the desire for protection, which entails the surrender of some or all personal liberties.

**Society:** A system of human organizations generating distinctive cultural patterns and institutions and usually providing protection, security, continuity, and a national identity for its members

**Utilitarianism:** The ethical theory proposed by Jeremy Bentham and John Stuart Mill that all action should be directed toward achieving the greatest happiness for the greatest number of people.

**Values:** Beliefs of a person or social group in which they have an emotional investment either for or against something.

**Virtue:** The quality or practice of moral excellence or righteousness

**Vision 2030:** The Kenya development program covering the period 2008 to 2030.
ABBREVIATIONS

AIDS : Acquired Immunodeficiency Syndrome
ARV : Antiretroviral
DHE : Department of Health Education
DHMB : District Health Management Board
DHMT : District Health Management Team
HIV : Human Immunodeficiency Virus
HRH : Human Resource for Health
IPAR : Institute of Policy Analysis & Research
KPHF : Kenya Health Policy Framework
MOH : Ministry of Health
NGO : Non-Governmental Organization
NHIF : National Hospital Insurance Fund
PHC : Primary Health Care
WHO : World Health Organization
ABSTRACT

Equity in health care provision is an important goal yet it is hampered by many factors. The competing values of individual and collective interests present a conflict that needs to be addressed if health care has to meet the desired goal of equity. The study argues that pursuit of equity in health care is impeded by the dominance of either individual or collective interests in health care provision. The study seeks to answer the principle question of how individual and collective interests affect health care delivery and uptake. Specifically the study investigates the foundation of individual and collective interests as ethical values in health care, manifestation of the two conflicting values in Kenya health care and suggests a way out of the conflict. Relevant ethical theories are evaluated for their effectiveness in informing health care decisions. Health care in Kenya is evaluated and the two paradigms, population and medical services, are assessed and values inherent interpreted. This study explores the way in which communitarian ideals and practices might be employed in pursuit of equity. The study identifies the health of individuals as shaped by the social and communal environment that they live in. It is observed that communitarians acknowledge the bonds that unite and identify individuals in a community. The study argues that, to achieve equity in health care, these bonds need to be recognized and harnessed rather than discredited and ignored. The notion of individual autonomy in the context of the community is evaluated. Alternative concepts of autonomy – social autonomy and community autonomy – are evaluated in line with both individual and the community values. Moreover, these concepts are viewed as probable means to health care equity goals. The study concludes with recommendations on how equity goal in health care system can be reached within a communitarian vision. Individual and collective interests are discussed throughout as a source of conflict in health care.
CHAPTER ONE

INTRODUCTION

1.1 Background

One of the major concerns of the Kenyan people is how to effectively tackle health problems which increase with the population and social dynamics. This is because health problems constitute the most fundamental threat to human life. The existence and development of any human society is mainly determined by the health of its members.

The health needs of the people of Kenya are numerous and manifold. The government’s effort to solve them has yielded little results due to the manifold problems facing the health sector. New health challenges that seem to be more pronounced are emerging. HIV/AIDS is one of the most devastating of these problems and the government is yet to succeed in combating it. These and many other factors have created serious challenges for the health sector especially the conflict of individual and collective interests (MOH, 2005).

The rural areas of Kenya are most affected by the conflict between individual and collective interests. This is because most health care facilities and qualified personnel are located in the urban areas whereas majority of the population lives in the rural areas. Though the government has made some efforts to improve the
health conditions of the rural people, the conflict is still exemplified in that most rural health facilities rely on the population health paradigm in the form of primary health care. These facilities are run by a low cadre mix constituting mainly of community nurses who are not qualified to handle clinical problems. The few clinicians and physicians are deployed in county hospitals that serve as referral centers to vast geographical areas. The result is that majority of individual patients scramble for the limited clinical services offered by these health workers and facilities on referral basis.

Health care delivery in Kenya thus cannot be discussed without a sound understanding of the national health system. The provision of health services is the responsibility of national and county governments as well as nongovernmental organizations and enterprise entities. This means Kenya relies on a three-tier system towards its health goals.

The first tier which constitutes tertiary health care is in the domain of national government. This level constitutes the two teaching and referral hospitals, Moi and Kenyatta, which are meant to provide highly specialized medical referral services to both the second and third tiers of health system. The second tier is in the domain of the national government but is spread across the nation. It is the secondary health care level and provides specialized medical services to patients referred from the primary health care level. The third tier is the primary health care which is in the domain of the county governments but with the support of the
state Ministry of health. It essentially provides health care for people at the community level in a low cadre skill mix.

In light of the foregoing, health care in Kenya faces a social dilemma in the form of an inherent tension between individual and collective interests in clinical health seeking behavior. Considering the social and economic significance of social dilemmas, an important research question is why social dilemmas in health care often result in undesirable outcomes. This study proposes a solution for this question.

Social dilemmas in health care often result in undesirable outcomes because individuals feel vulnerable to the health seeking behavior of others. The solution to this question is found in taking an actual and practicable approach to social dilemmas in health care. In social dilemmas, practicable options in health care provide the society with opportunity for tradeoffs which enable collective action by reducing perceived vulnerability by individuals in the society. Practicable options allow individuals in social dilemmas to know they can trust other members of the society. If there is mutual cooperation when distributing risk, then this mutual cooperation acts as a win in the tradeoff, and this win increases trust amongst members of the society in a communitarian way. Increasing trust reduces uncertainty about distribution of health benefit, and this decrease in uncertainty reduces perceived vulnerability among individuals in the society. Because of reduced perceptions of vulnerability, individuals are more willing to participate in
the tradeoff and enjoy the resulting benefit. The effect of risk in tradeoffs is moderated by an individual's opportunity for benefit. When risk is high, mutual cooperation is less likely, leading to a trust breach and collective action failure, respectively decreasing an individual’s trust in the other members' intentions and belief in their ability to contribute to collective action. When risk is low, mutual cooperation is most likely; however, without enough vulnerability in tradeoffs, trust and efficiency are less likely to develop. These hypotheses underpin the ethical problems that inhibit both individual and collective good in Kenya health care.

This study provides theoretical elaboration of the conflict between individual and collective interests and uses Kenya health care to exemplify the conflict. The results urge support for the proposed communitarian model and also offer theoretical and policy implications for how practicable options should be used to foster collective action in health care while still protecting individual interests.

1.2 Statement of the Problem

The conflict between individual and collective interests in health care has devastating yet preventable consequences. According to Buck et al, it is characterized by health care being skewed towards either individual or population paradigm in management and delivery. Both individual and societal expectations concerning the management of health care have increased with increase in disease incidence (Buck et al, 1999). Some findings from literature review indicate need
for individual responsibility while others point towards societal welfare thus aggravating the conflict.

One of the main goals of health care is to improve the quality of life for persons through health. The role of health care to improve quality of life highlights the need for additional resources and also restraint for health care consumers. Although new therapies and technology have aided in controlling disease in many individuals, the challenge of balancing individual and society needs is overwhelming for health systems.

Management of disease influences social relationships and creates identity problems that the individual in the society must struggle with. As such, individual patients inherently seek support from fellow members of the society to ease the strain of disease. Participating in common resource is one way that patients can increase the odds for equitable health care for all. For these reasons, the relationship between the individual and the society in regard to health care is examined in this study. The mechanism of support and identification with the society on the setting and achievement of effective health care are the primary relationships that are assessed.

This study examines the role of the community in goal setting for health care management and uptake behaviors and the achievement of such goals. Utilizing communitarian theories as a basis for understanding the relationship between identity and behavior, this study advances the influence of individual identity and
participation in the community on goal setting and goal achievement in health care.

1.3 Research Questions

The principal question of this research is: How do individual and collective interests as ethical values affect health care delivery and uptake? This question contains multiple embedded and overlapping phenomena, which require explicit attention in order to understand and interpret the main research phenomenon as a whole. Therefore, the study investigates the following research sub-questions which are underpinned by assumptions drawn from both the literature review and the methodological framework:

1. What is the foundation of individual and collective interests as ethical values in health care?

2. How do the two conflicting values reflect in Kenya health care?

3. How can the conflict be mediated?

1.4 Assumptions of the Study

1. Individual and collective interests impede quality health care.

2. The conflict between individual and collective interests has manifold manifestations in health care.

3. Moral and ethical inputs can help mitigate the problem.
1.5 Objectives of the Study

The main objective of the study is to review the ethical underpinnings of resource allocation in health care, and then take a first stab at identifying specific factors for ethics consultants and other policy developers to consider as they begin to develop frameworks for analysis in this ethics domain.

Specific Objectives

1. To identify ethical theories and principles that inform health care and show why they have not been effective in guiding policy and practice on the subject.

2. To investigate how gaps in ethical theories, principles and values have affected health care organizational management and aggravated the conflict between individual and collective good with a specific reference to Kenya health system.

3. To establish an appropriate ethical paradigm that can be employed in health care system in order to mediate the conflict between individual and collective interests in health care.

1.6 Justification and Significance of the Study

Quality health for all people is important for national development, yet individuals in the Kenyan society are overburdened by disease. It is important to evaluate the health system and recommend health structures that support the
health of individuals and the population with a view to realizing the goal of health for all through equity. With respect to relevance, the study will benefit policy and legislation in the health care sector where a careful yet effective balance needs to always be struck between individual and collective good in health care. The organizational structures of the health system will find this study particularly valuable in making decisions about resource allocation both for population health and individual medical services. Most importantly, the organizational structures may adopt some of the recommendations regarding priorities in health care provision. Similarly the study will be useful to the health and medical education programs through emphasis on integration of clinical and public health ethics as extra requirements for satisfactory and qualified health professionals up to the task of modern health care dilemma as a result of demographic dynamics.

1.7 Literature Review

1.7.1 Ethical Dilemma in Health Care

According to Lauridsen et al. (2008:192), Ethical dilemma is an ethically controversial situation where health care professionals act as economic gatekeepers and trade-offs are made on economic issues that are viewed as health outcomes for the patient within the health care system. However, this view fails to recognize economic factors as exogenous to health care and limits the scope of dilemma to resource constraints. Husain et al., (2007:11) argue that ethical dilemma is the result of resource allocation within health care sector, where
political, ethical and technical judgments interplay. They too fail to account for the other dilemma involved in health care.

According to Sarikaya and Erbaydar (2007:330), Ethical dilemma is the gap between professional obligations and possibilities of health care professionals, and efficacy of health care system. Thus, as Liegeois and Van Auedhove (2005:452-6) argue, ethical dilemma is the continuous balancing with the need to make decisions on the setting aside of budgetary resources for medical services against the provision of further but substantial resource incentives for community care.

Chipp et al. (2008:532-549), view ethical dilemma as the ethical difficulty that arises concerning principles of patient’s autonomy, which emerge for health care providers in rural and small urban communities. According to them, ethical dilemma is viewed as ethical difficulty in national context with the focus on rural or small communities concerning principles of patient’s autonomy. This difficulty however, emerges both for health care providers in rural and urban communities as a reaction to micro policy procedures.

Berney et al., (2005:620-625) argue that ethical dilemma is an outcome of medical choices based on problem-solving which involves identifying the precise solution to a problem. In health care, however, this requires expertise in patient’s limited role in decision-making which may involve choosing from a number of alternatives possible trade-offs. They argue that ethical dilemma as an outcome of
medical choices is attached to the dominant ideology of health care in Western countries. This idea supports patient autonomy in decision-making but is less accepted in other contexts, for example, in Japan, where physician’s paternalism remains dominant.

To Hurst et al. (2005:7-14), ethical dilemma means the concern about specific interactions that are only for country context. They cite interactions between ethical consultants and physicians as examples. They argue that Ethical dilemma as a concern about specific interactions among specialists means that every country has its unique health system, which includes general and specific aspects. This argument seeks to integrate the classification of specialists and structural infrastructure of health system in a country.

Warner and Monaghan (2005:21-33) argue that ethical dilemma is the concern about society’s access to health care resources by balancing between the lack of available health care resources and responsibility for quality care. According to them ethical dilemma as a concern about society’s access to health care resources is related to three aspects: access to health care, patient-physician relationship, and management of medical conditions. They argue that overlap between structural and professional roles is perceived and handled differently and, perhaps, is treated in rural than urban areas more adaptively.

The literature review shows that ethical dilemmas concerning decision-making within health care leadership at political level is related to the following aspects:
society’s viewpoints concerning competence of health care workers, formal and informal interactions between health care providers and communities, professional authority of health care experts in society in the context of their interaction with patients, and patients’ access to health care.

1.7.2 Ethical dilemma at Institutional level

Mamhidir et al. (2007:3) define ethical dilemma as being in ethically challenging situations where health workers should balance between loyalty to employers, which forces them to ration, and own professional conviction on the need to provide quality health care to individual patients. They argue that ethical dilemma is experienced when health workers are expected to make decisions that would have negative consequences for patient care by striving to satisfy the society and institutional expectations.

Wienand et al., (2007:73) describe ethical dilemma as need to balance between several decisions concerning the following organizational components: performance contracting and incentives, leadership in the facilities, and patient’s perceived quality of care. The balancing between several decisions as the ethical dilemma emerges in the context of organizational context and loyalty to organizational values. However, they fail to show that these decisions play at the background of professional and normative values.
Torjuul et al., (2005) view ethical dilemma as integral and inclusive of patient’s autonomy, justice, and conflict issues at the same time when the decision is to be made concerning a patient. However they do not explicitly address the relationship between autonomy and justice. They fail to give a convincing justification to show that a concern for autonomy and self respect is a concern for justice in relation to other members of the society.

Saad Bin Saed, (1999:516) views ethical dilemma as emanating from the emerging ethical concern as an imperative to make decisions by health care executives who monitor adherence to medical practice standards at the facilities. According to him, ethical concern is perceived as an ethical dilemma concerning physician’s insensitivity to medical needs of their patients and monitoring of adherence to accepted standards concerning medical practice by all medical personnel.

From this review, it is evident that ethical dilemmas concerning decision-making within health care leadership at institutional level are attached to the following aspects: professional and personal needs of health care personnel, patients’ needs, public interest, human resource development, financial resource allocation, organizational values, interactions between health care professionals and patients, interactions between health care professionals and hospital executives, institutional authority of health care staff, competence of health care staff,
institutional openness to society, and professional obligations of health care personnel.

**1.7.3 Equity in Health care**

Culyer and Wagstaff (1993:431-457) propose equality as the relevant equity principle in health care. They argue that good health is necessary for individuals well being and any view but one which advances equal opportunity is hard to defend. They argue that a just distribution of health is one that is equal whereas an equitable allocation of health care is one that promotes equality in health care. However, they fail to acknowledge that health care is not the only determinant of health thus health care alone does not entail an equal distribution of health. They also fail to account for the notion that ill health is unique to individuals hence health care cannot be distributed equally.

Roemer (1998) and Le Grand (1982) propose an egalitarian concept of equality of opportunity. They argue that discrepancies in health to an extent are due to factors beyond the control of individuals and partly due to individuals’ freely made choices. According to them, health care financing, and not provision should be the criteria to discriminate against individuals who do take up opportunity for health. This would suggest that abusers of lifestyle be charged an overhead tax to cover the expected costs of treatment to continue receiving the same treatment as non abusers; determination of whose criteria would be a hard task.
Conversely, Olsen (1997a:625-639) argues that strong egalitarianism is absurd when employed in health care because it concerns only with the level of inequality between individuals in a society and not with their absolute health status. However, he fails to account for the notion that perfect equality in health requires equality in the health of healthy individuals to optimize the health of the least healthy individual in the society.

Cookson and Dolan (1998: 323-329) suggest a way out of this deadlock by incorporating a social welfare element that accounts for both inequalities in health and the absolute health status of individuals. They argue that social welfare decreases with inequalities in health and increases with the health of individuals. They, however, fail to acknowledge that social welfare also depends on the extent of the society’s dislike of inequality in health and on relative value of the health of an individual or groups of individuals in the society.

Lockwood (1988) argues that health care should be allocated according to need. His principle can be formulated in two ways: horizontal equity which advances same treatment for persons in equal need and vertical equity which advances a differential treatment of persons in need of health care. In this context if the individuals most in need of health care are the same ones who can benefit most from health care, efficiency objective of maximizing health care, equity and efficiency are not in conflict. Allocation of resources advances both efficiency
and equity. However, any other concept of need leads to a conflict between efficiency and equity.

According to Williams & Cookson (2000) most concepts about equity are advanced in the context of decisions about population rather than individuals. At the individual level, rule of rescue is frequently used in decision making. According to Hadorn (1991:2218-2225), the society and each individual are ethically obligated to do all they can to help those in immediate life-threatening health distress. This implies that critical patients with the most serious condition are to be treated first irrespective of the cost implication of treatment. The rule of rescue is therefore identical to the notion of allocation according to need where need is defined as relative severity of illness. Thus, severity of illness of an individual or population establishes priority for health care expenditure regardless of capacity to benefit from treatment. However, Hadorn fails to account for the notion that the benefits of treating an individual suffering from life-threatening illness are inversely proportional to cost. Treatment costs for patients at the end of life are often very high compared to benefits which are very low because death is inevitable. In this context, rule of rescue and maximization of health care are incompatible.

Libertarians are wary of the traditional notions of equity and instead favor distribution of resources according to entitlement (Locke, 1967; Nozick, 1974). According to libertarians an individual is entitled to possessions if justly acquired.
Thus, equity is conceived as procedural rather than redistributive and is valid if private property rights are respected. Libertarianism, however, fails to account for differences in health status emanating from genetic predisposition, income, or living conditions all of which are attached to social ties.

The World Bank proposes the idea of a publicly financed essential package in combination with privately financed services as favorable to policymakers, especially in low-income countries (World Bank, 1993). This, however, does not solve the concerns of libertarians as majority of citizens in low income countries do not meet the private sector threshold for health care.

According to Chuma and Okungu, the Kenyan health system is highly inequitable and policies aimed at promoting “equity and addressing the needs of the poor and vulnerable have not been successful”. Though they acknowledge some progress has been made towards addressing equity challenges, they argue that universal coverage will not be achieved unless the country adopts a systemic approach to health financing reforms (Chuma &Okungu, 2011). However, they fail to show how such an approach can be informed by the wider health system goals of equity and efficiency.

According to Nyarang’o, the last half a century showed an uneven growth in the number of health service providers and health services in the country. The highest growth rate was experienced in Nairobi and Eastern Provinces while Western and Coast had the least growth in health infrastructure. The inequality in health
investment is not only evident for public health provider but cuts across the spectrum of healthcare providers. In 2005, about 50% of hospitals in Nairobi were privately owned compared to less than 4% in Western province (Nyarang’o, 2008).

Nyarang’o argues that poverty defined as deprivation in the core dimensions of health (of economic, human, political, socio-cultural and protective) is un-equally distributed in Kenya. According to him, most economically poor people live in the coast, the Lake Basin, northern and eastern Kenya regions. He observes that in the previous decade, most of the health indicators worsened in the country and more so poverty stricken areas of Kenya (ibid). However, he fails to explicitly account for ethical implications of such a deprivation.

1.7.4 Conclusions

In view of this literature review, it can be suggested that research on ethical dilemmas within health care leadership, management, and administration should integrate factual data about levels at which the ethical dilemmas occur. In addition, it is important to investigate ethical dilemmas not only as a separate, but also as a complex phenomenon, which is attached to decision-making and specific acknowledgement of health care context.

In the literature, there is a lack of focus on ethical dilemmas concerning decision-making within health care leadership in Kenya. Nevertheless, this complex
phenomenon occupies the forefront in the general discourse pertaining to areas of health care management, administration, leadership, and professional ethics in health care and medicine. Generality and inaccuracy of the notion of ethical dilemma concerning decision-making within health care management creates the limitations in research and practice of ethical health care management.

The boundary of this problem encompasses the domains of the decision-makers as leaders and those involved in the conduct of health care management, administration, and leadership. In addition, it includes those who are responsible for decision making at various levels within health care. The research problem, which is presented in this study, requires extensive ethical discussions and empirical research on how to best address the ethical dilemmas concerning decision-making within health care leadership at institutional, national, and political levels in a given context. The review of the literatures shows that there is no fully adequate moral theory that can singly explain and solve all the ethical or moral dilemmas.
1.8 Conceptual framework

Figure 1 A framework is developed from the work of Olsen et al (2003) and Evans and Stoddart (1990) for determining to whom the good should be distributed. Solid arrows show the causes of ill health and consequences of health care. Dotted arrows show claims on the good.

The first step in constructing the conceptual framework for this study is to highlight the character of the competing claims of individual and collective interests. A review of literature suggests that the competing claims are characterized by:

1. The need for health care by individuals and their societal context
2. Whether or not members of the society have personal responsibility in the conditions that have generated their need for health care or their lack of need for care

3. The impact of delivery of health care on the broader health of the society

4. The impact of illness and health care on individuals and the society in general

These claims can be categorized into two. That is, claims based on individual good and those based on the good of the society. Some may belong to both categories. For instance, while the value of equal access for equal need could be viewed as a social benefit, it also benefits the individual. Claims may also be arranged along a continuum from individual interests to societal good.

The way in which claims are structured can take different analytical perspectives. This study builds on claims by Olsen et al. (2003: 1163–72) and Evans and Stoddart (1990: 1347–63) to construct a framework based on the continuum between individual and collective interest. In the resultant framework the indicators for the competing claims as evident in Kenya health care include, but are not limited to; health status, determinants of health, community and health system characteristics, and health system performance. The study evaluates reports on a variety of health indicators for Kenya. It is demonstrated that social context is an important influence on the health of an individual, community or population. The framework acknowledges the increasing emphasis on social
factors in both clinical and population based models of health care. For example the medical paradigm though focused on health services utilization rather than primary prevention, includes societal dimensions of health. The framework establishes a causal link between the societal factors and resulting health care utilization behavior.

The study acknowledges possible criticism of this claim especially in regard to the possibility of an absolute individual status. The first and the second claims are based on need. The word “need” commands a higher moral weight than the word “want”. “Need” in health care usually involves some third party, often a professional, making an assessment while “want” is in the individual patient’s mind as a psychological state.

If need were defined as illness, the more sick patients would be prioritized. But if need was viewed as capacity to benefit, a chance for a collective prognosis for all members of the society would be desired. The conflict between these two principles is of enduring concern for health systems in resource-constrained settings particularly if waiting lists are long and if less than full coverage of care for those in need is realized. Prioritizing the more sick patients first despite their limited capacity to benefit could also be viewed as reflective of the values inherent in the rule of rescue. While there is some potential benefit for those who are rescued, there is also an inherent social benefit in that the society feels better when the health of a constituent member improves. This is again an example of
how varying claims can concurrently reflect the good of the individual and society.

Evans and Stoddart (1990) however, emphasize the individual’s health-related knowledge and the personal feelings of adequacy and self regulation in desire. This study places these considerations more at the level of the community in a communitarian set up. There are many Kenyans who are ignorant of health-related knowledge and who lack adequacy and self control. The shift to the community level makes the tasks of defining these characteristics and of obtaining contextual balance easier.

Accordingly, society should balance personal responsibility with the potential for health care to mitigate the impact of ill-health on the society for the desired social cohesiveness and solidarity. It could be argued that a communal solidarity society should have no room for debate on responsibility for ill health. Differentiating between the blameworthy and the blameless hampers a compassionate response to illness and encourages stigmatization and discrimination of individual victims of ill health.

The impact of widespread curative services on the health of society on the other hand is enormous. In this case it is necessary to consider the opportunity cost of allocating health care resources to curative services as opposed to population health needs, as well as the potential positive or negative externalities associated with curative treatment. There are many positive and negative externalities
associated with curative services and the overall impact on the health of society involves balancing a number of competing interests. On the one hand, the provision of curative services could lead to lower incidence of disease. On the other hand, net incidence could be higher because people live longer.

The challenge in this approach is to develop a rationale for deciding the constituents of claims and their relative strengths. Insights from procedural justice come handy in this regard. Rawls (1971) offers various types of procedural justice. Rawls exemplifies procedural justice by the division of a cake. If the fairest outcome is for everyone to get an equal slice, then one possible criterion would be to ensure that whoever cuts the cake gets the last piece. The key constituent of this kind of claim to procedural justice is that there is criterion for defining a fair division and a process that is guaranteed to lead to it. This is unlike imperfect procedural justice where there is an independent criterion for the right outcome but no process guaranteeing this outcome. However, the problem in this study is one of pure procedural justice where there is no independent criterion for the right result. In other words, reasonable people have valid reasons for divergent views about the constituents and the strengths of claims on health care. If decisions are made through a fair process, however, the outcomes will inevitably be equitable.

If and when people cannot take care of themselves and their own directly or indirectly by pooling resources, the government has a duty to step in and ensure
health care for all. It should be the responsibility of the government to provide health care for all when the communitarian ideals of the society fail. However, this welfarist approach requires immense resource investment not affordable to any state.

With communitarian ideals, the conflict between individual and collective interests is likely to reach a socially beneficial and fair conclusion. Once health care is available to all Kenyans, the question of whether or not Kenyans are entitled to health care as a matter of individual right or as a matter of social responsibility, becomes largely a theoretical one. This way, the debate focuses on the scope of responsibility both for the individual and the community as to what would constitute the package of health benefits. Accordingly, the range of health benefits must be clearly sorted out by principled criteria and through community consultation.

How to go about community involvement in setting benefit claims and their relative strengths remains to be determined but is not within the scope of this study. The study notes, however, that individual communities need to determine the specifics of responsibility and accountability as no universal approach can be prescribed.
1.9 Methodology

The goal of this study was to understand the tension between individual and collective interests and the society’s experiences of this phenomenon. This goal is in line with strategies and intentions of the interpretive research paradigm. According to Higgs, the interpretive research paradigm is based on the epistemology of idealism where knowledge is viewed as a social construction and encompasses a number of methodological approaches with the central goal of seeking to interpret and understand the social world (Higgs, 2001). According to Smith, the investigative approaches of Dilthey (1833-1911) and Weber (1864-1920) focused on interpretive understanding (or Verstehen), to access the meanings of experiences as opposed to explaining or predicting their behavior, which is the goal of quantitative research (Smith, 1983:6-13).

Within the interpretive paradigm, meanings are derived by human beings in unique ways, depending on their context and personal points of reference as they engage with the world they attempt to understand (Crotty, 1998). This is the notion of multiple constructed domains (Crotty, 1996). In this type of research, findings emerge from the interactions between the study and the subject of phenomena as the research progresses (Creswell, 1998).

Accordingly, this study particularly employed the Max Van Manen’s (1990, pp. 7-8) hermeneutic, phenomenological method of research. Max is a well-known contemporary phenomenologist who has published widely in this area. The
phenomenological, hermeneutic method was employed to interpret the phenomenon being observed from the competing values of individual and collective good. The term phenomenology is derived from the Greek word *phenomenon*, meaning, “to show itself”. In this study, phenomenology was used to highlight the true meaning of human experience as exemplified in existing documented reports. This entailed identifying the problem and describing it both in lay and ethical terms. A value analysis was done of health care, specifically of Kenya system, in respect of the two paradigms. A strong yet pedagogical relation was manipulated in the form of a synthesis reflecting on the essential themes whilst balancing the contextual factors.

According to Gadamer, communication is the universal medium in which understanding occurs, and understanding occurs in interpreting. He views interpretation as a dialectical interaction between the expectation of the interpreter and the meaning of the text. His conception of ‘horizon’ may be viewed as everything seen from a particular vantage point. He argues that questioning is an essential aspect of the interpretive process as it helps make new horizons and understandings possible (1998, p. 389).

Hermeneutic phenomenology proved to be an appropriate methodology to investigate individual and collective interests in health care. The focus that phenomenology provided on lived experience was in agreement with the aim of exploring society’s health care experiences. Hermeneutics allowed for data
abstraction and interpretation to make meaning of the phenomenon in a way that is credible and maintains faithfulness to the society and its prevailing interpretations. Using the interpretive paradigm enabled understanding of the research phenomenon in context from the recorded experiences of the select society.

For the purpose of this study broad range of articles that addressed ethical and governance issues in relation to the practice of health care were collected, read, analyzed and interpreted. These appeared mainly in social science and humanities periodicals, medical journals in which these kinds of articles mainly appeared as opinion pieces, and edited volumes on health systems and biomedical ethics.

Moreover, analysis included texts that have been intensely referenced by academic articles – mainly project reports and statements of regulatory or ethics bodies. Government reports and policy documents were also reviewed and relevant values drawn. The material was gathered through extensive literature searches and has been compiled in the reference section.

An initial analysis showed that issues of individual and collective interests have accompanied health care for many years now. In the reanalysis of the material, emphasis was made on different justifications in the field of health care where these main issues were addressed. An effort was made to highlight patterns of argument that would share core assumptions and would show similar conceptual and normative orientations in Kenya health care. As demonstrated, it was possible
to group the justifications according to three different discursive orders that appeared to be linked to different conceptualizations of the individual and collective good, on the one hand, and to changes in the basic social role or self understanding of the community on the other hand. There is no suggestion that the analysis captures everything that has been published in this domain, but it’s suggested that the analysis, building on the literature, reflects the most relevant lines of the debates the study was interested in.
CHAPTER TWO

ETHICAL THEORIES IN HEALTH CARE PROVISION

This chapter evaluates the predominant ethical theories in health care. The aim is to establish the appropriateness of the existing theories and suggest a framework that can help mediate individual and collective interests in health care. Utilitarianism, deontology and virtue ethics are assessed and a conclusion made that there is need for an ethic that can fit well in Kenya health care.

2.1 Health care Ethics

Medical ethics was initiated by the Greeks and is summarized in the Hippocratic Oath (Miles, 2004). It has guided the moral actions of physicians in health care practice for a long time but recently there has been a profound change in health care. Not only has the basic understanding of the Hippocratic Oath changed, but also who interprets the code. The decision-making role of the physician has been eclipsed by ethical theories and ethical specialists. The Hippocratic tradition of medicine entails not just therapeutic modalities, but also moral dimension of individual oriented decisions that affect the society. It is this latter view of medical profession which has been usurped by non-physicians in the ethics debate, giving medicine a health care dimension.
The operative relationship in medical ethics, the doctor-patient relationship, and the physician’s judgment, are being displaced by exogenous factors not armed with the experiential prudence of the physician. Perhaps the reason for this is the loss of awareness of the distinction between theoretical sciences and applied arts. Medicine, while science oriented, is nonetheless an applied art (Wyngaarden & Smith, 1985). While specialists in general health care may have some knowledge relevant to medicine, that knowledge does not qualify to displace the physician’s expertise in the field of medicine. The lost distinction between the physician and any other health worker only weakens the conditions necessary for a good relationship between physician and the patient. Failure to cultivate this moral bond over the time implies medicine and physicians loss of the ethics battle in the emergent conflict of values.

Throughout the development of human societies including the most primitive there were “medicine men” or doctors. Though there was a religious aspect to the doctor’s role especially in Africa, the main role was to cure disease (Koenig, 2001). This relationship between the doctor and the patient has all along been governed by societal guidelines for the behavior of them both, but particularly the doctor. These guidelines define ethical behavior especially for the doctor.

The guidelines defining ethical behavior in medicine have a close relationship with philosophy. This is perhaps because Greek physicians like Hippocrates were often philosophers and ethics was a branch of philosophy. Aristotle stated that
“human behavior must be in accordance with the natural law” (Aristotle & Sachs, 2002). Consequently medicine and medical ethics preceded and lay the foundation for further philosophical thought.

The Hippocratic Tradition was further exemplified in the Aristotelian thought. The human person is able to derive knowledge of external world through sense of objects. The human mind through intellect and will appreciates the truth and goodness in beings outside of itself. Ethics was the result of acknowledgement of some human acts being concordant with being human while others were not (ibid). It was apparent that life was good and anything contrary was evil. Humans had the innate desire to live according to natural law which was normative and any attempt to frustrate that desire was unethical. The purpose of medicine for the Greeks was to perpetuate human wholeness to individuals who suffered from disease. Anything against promotion of life and health was therefore unethical.

The Hippocratic Oath inherently led to the development of virtue in the physician. Virtues are habits of the will and are cultivated when a person conforms to human nature. Beneficence, non-malfeasance, and confidentiality are virtues that perfect a physician in the medical profession. The Greek tradition was perpetuated by St. Thomas Aquinas (1224-1274) in his further thoughts on "virtue ethics." Virtue ethics is about cultivation of character during the course of moral development such that a good individual chooses the good and avoids evil. This creates the
habit of will to conform to moral tenets. Thus, morality conforms to the moral good and is parallel to medicine which serves health as a physical good.

The doctor-patient relationship was therefore defined in the Hippocratic era. While the doctor bore knowledge and skill relative to the patient, and the patient depended on these skills, the Hippocratic Oath governed their relationship. According to Thom, it was characterized by beneficence and the operative rule was “first, do no harm” (Thom, 2001). In other words, the doctor was to be informed by laws of nature and the virtues he had cultivated. The Hippocratic Oath was dominant for a long time. While modern scientific knowledge had not developed, there was a doctor-patient relationship that helped mitigate both psychological and physical illness for over 2,000 years.

With Enlightenment arose Descartes’ (1596-1650) idealism and a separation of the human mind from nature. Dualism laid the foundation for positivism which means a logical thought based upon empirical observation. By making objective reality the only legitimate concern of enquiry, Descartes advanced natural science through the analytic method. Under the scientific revolution that positivism brought came in the exact science. Scientific method reinforced Descartes’ philosophy and the Cartesian method further and contributed to the belief that scientific method was the only legitimate way to acquire knowledge. This is contentious because disciplines in social sciences may not employ scientific method without distorting the understanding of their subject matter which is the
nature of human beings. By adhering rigidly to the scientific method, the field of medicine has misrepresented its subject matter and absconded the moral responsibility toward the health concerns of human beings.

The shift from realism to idealism that characterizes trendy thought has had profound moral implications. Nominalism which was developed by William of Ockham (1300-1349) prepared the foundation for Descartes' idealism. However it conjointly contributed to the increase of recent science thanks to its emphasis on quantification and precision. The depreciation of objective relation which was the premise of Aristotelian science allowed Bacon and Newton to develop a science that emphasized observation and applied mathematical relationships. Advancement in science has conjointly given the world of medicine exceptional technological innovations like radiology and antibiotics that deeply modified what had been personal medication as envisioned by the Greek, into the present biomedical science. The dualistic conception of human nature and scientific method directed the biomedical model in medicine. Accordingly, human beings are viewed through materialism, to be understood by reductionism using the principles of anatomy and biochemistry. To date disease is viewed as a deviation from the biological plan, caused by some identifiable physical or chemical event and remedy involves corrective physical or chemical agent. Consequently, health is defined as the absence of disease and is associated with doctor’s skills to the extent that medicine has become synonymous with production of health.
The idealist separation of the mind from reality ethically diminishes the central place of virtue. Kant (1724-1804), in the *Critique of Practical Reason* proposed a categorical imperative that set an obligation to individuals to perform their duty. Doctors therefore have a duty, for instance, not to administer euthanasia. Duty ethics therefore is detrimental to the Hippocratic virtue-ethics.

The doctor-patient relationship also was influenced by changes that came with the Enlightenment age. The separation of the mind from reality isolated the individual person and led to the development of the "autonomous self.” This is evident to date. Positivism grew out of empiricism with an emphasis on experience rather than ideas. The positivists relied on empirical facts to build their ethics. Bentham (1748-1832) and Mill (1806-1873) came up with a version of positivism which was referred to as utilitarianism. It translated to “what is useful is good”. Their understanding of human behavior led to the principle of utility which postulates that the ultimate goal of human action is pleasure. This concept was carried on by the pragmatists of United States, especially John Dewey (1859-1952). The pragmatists were instrumental in the development of value theory. The theory advances that values are what is desirable. However, when ethical principles are founded on the pleasure or desire they become relative hence human nature which is based on natural law is subverted.
2.2 Implications of Ethical Theories

Society expects that a person fulfills the obligation to help others in need as they may be in the same position at some point. The question is to what extent this beneficence is required within a given society. The consideration of what an individual’s moral duty is to the rest of humanity; especially regarding issues of health care is a concern that needs to be addressed. Numerous responses have been presented by leading moral theories. Utilitarian, Kantian, and Virtue Ethics each present answers to this dilemma. Utilitarianism advances that actions which maximize net utility are morally necessary, while Kantian Ethics advocates some beneficence though it acknowledges that it is not possible for every context. Virtue Ethics defines virtue by finding the mean between two extremes. Each of these ethical theories encounters criticisms that may discredit their use in response to this dilemma. However, the problem with Virtue Ethics can be mitigated by further consideration of meaning. Therefore, Virtue Ethics provides the most acceptable solution in response to society’s ethical obligation to health care. This is because it can define the middle ground in which trade offs are morally required, but not in excess.

2.2.1 Utilitarianism

Utilitarianism is the first of the three theories suggested to provide a solution to the problem of ethics related to health care in the society. Before exploring the implications of utilitarianism to health care dilemma, utilitarianism as a moral
theory needs to be clearly articulated. Essentially, it claims that the right action can be determined by calculating the maximal net utility. Utility refers to a specific value, and translates to the well-being of all members of the society.

Utilitarianism in medical ethics presents in two areas; situationalism and consequentialism. Situationalism was advanced by Joseph Fletcher (1966) who is one of the pioneers of bioethics. He argues that the rule of "love" supersedes all others and can be used to justify even abortion. On the other hand consequentialism underpins utilitarianism which has dominated the ethical system where the greatest good for the greatest number is a political and ethical maxim.

With the advent of utilitarianism the doctor-patient relationship began experiencing the pressure in moral philosophy. The discomfort with the value of abstract virtues called into scrutiny the principle of beneficence. With the collapse of moral foundations, the physician embarked on scientific technology. Once again, the Hippocratic tradition was heavily dented.

Following the Second World War there was breakdown of the wide assumptions which led to the Enlightenment. Empiricism and skepticism led to postmodernism and the deconstruction of Derrida (1997) and Foucault (1973). Science and technology are no longer revered. Social cohesiveness has eroded and society no longer has a unifying principle.
With this the doctor-patient relationship has continued to undergo profound transformation. Not only has utilitarian ideals superseded beneficence, but exogenous economic factors continue to influence the bond. Parties outside the traditional relationship are involved in clinical decision making that was previously reserved for the doctor and their patient. These include economic austerity and political power. Medical practice has been caught between patient’s ethical autonomy and the bureaucracy of the state policy.

Thus, utilitarianism is consequencialist, and determines what will lead to the best outcome of well-being for the whole society. Utilitarians thus hold that there is generally one morally right action which is the action with the best consequences in any context. There are no supererogatory actions that go beyond the call of duty in this theory.

Public health care programs are founded on utilitarian grounds of the greatest benefit to the greatest numbers. This is in terms of combating the spread of disease and cost effectiveness in delivery of health care. Such programs are considered justifiable when these benefits greatly outweigh perceived risks and potential harms. Consider the following current example.

The HIV virus is a major cause of death in Kenya. HIV is mainly sexually transmitted with about 6.3% of sexually active people living with the virus (NACC &NASCOP, 2012). Kenya has introduced preventive and treatment programs to combat this increasing problem. In public and private places
including colleges and universities are displays of promotional messages and condoms are strategically placed and people encouraged in using them. Some religious groups have opposed this because it is seen as encouraging promiscuity and encouraging sexual immorality.

Consider the arguments for and against this effort. Some parents may discourage their children from using these condoms and may go ahead and withdraw them from such institutions. Others may argue that it should be mandatory for all colleges and universities to provide such services for the benefit of all students. The first argument may stem from the natural law approach whereby condoms may be perceived as doing harm to human dignity. The parents involved may feel that condoms have negative consequences to human life like fornication and the reduction of the woman or man to the status of an object of pleasure. Condoms also have the potential of social abuse. The negative social phenomenon observed in the rise in premarital sex can arguably be attributed to the false security offered by the condom. In this case condoms are rejected because they are not compatible with the laws of nature and therefore their use is an indication of moral decadence in the society. The second argument views sex as relating not only to the social life but also the physical element of the person. Although AIDS affects the social part of life, it is the physical body that is infected and most affected by the virus. It is the individual physical body that is infected by the virus, and as a result of this infection the social person is affected in one way or another. It is therefore
prudent to avoid infection in the first place as much as possible. The utilitarian argument here is that it is a reality that “all are either infected or affected” by the AIDS pandemic. No individual or group has been spared of this pandemic. All people are equally vulnerable to HIV/ AIDS.

In relation to public health care, the utilitarian approach adopts a key principle: when considering one or more alternative courses of action the right action would be that which produces the greatest benefit to the greatest number. This formula based approach is deceptively simple. First identify the benefit and then measure how many people will benefit from a given action. However, a course of action (A) that provides benefit to 90% of people but produces significant harm to 10% is not necessarily better than a course of action (B) which gives benefit to 60% of people but harms only 40%. The extra 30% benefit from action (A) comes with a heavy price; a significantly greater cost of a further 10% that is significantly harmed. It is not possible either to get a simple ethical answer by an arithmetic formula of subtracting harm from benefit such that in (A) the calculation produces 80% and in B 20%. The problem is more complicated if the people harmed are not also the ones receiving the benefit: the benefit to the greater number is here then at the cost to others. If care is not taken, harm to the few for the benefit of the many could easily be justified.

One approach to the problem of harms and benefits is to hold that for utilitarian principles to apply there must be an equal consideration of the interests of all in
the balance of potential benefit and harm. Consider again the problem HIV presented earlier. Provision of ARV treatment is determined on a case by case basis with a clinical assessment of likely outcome. As a consequence a significant number of HIV patients survive longer though with extreme side effects. In contrast, the earlier policy was not to prolong life and promote health well being but rather concentrated on the curative element of HIV which only dealt with opportunistic ailments like TB. It could be argued that the cost of the earlier policy in that many patients would have survived with moderate or no side effects but were by this policy denied a chance of life is enormous. It could equally be argued that the cost for those who survive with little to no side effects is the very profound handicap of those affected by the policy. This demonstrates how difficult it can be to apply the approach of utility to solving such ethical issues and that there is rarely a clear empirical answer to ethical problems. Whilst the actual statistics represent real patients, the extrapolation is that of risk and the potential for harm or benefit.

It is debatable whether it is in the interest of a very sick HIV patient who would die naturally and would not therefore suffer side effects to be kept alive at all costs. But the issue isn’t simply whether it is justified ethically but also who should make the final decision; a question which isn’t readily answered by a utilitarian calculation. The utilitarian approach seeks a relatively dispassionate assessment of the consequences of actions or decisions: that which enhances well-
being is good; that which reduces it by producing suffering or pain is bad. The ethical approach strives to maximize the good by producing the best balance of benefit and harm. It forces one to look at all potential consequences of decisions. A full utilitarian analysis of the HIV problem would also consider consequences not only for the patients but also for families and others in society, although each of these may be given different weights. The utility analysis of HIV management program would consider not just the potential advantage to those infected but also the potential benefits to others in society through reduced demands on scarce health resources and also the increased productivity resulting from a healthier population. It would also weigh the potential harm if as critics claim, a healthy life of HIV patients encourages unsafe sex, hence the spread of HIV. The problem isn’t simply whether ends justify means, but which ends sufficiently justify them.

Medical ethics tends to focus on the individual relationship between physician and patient and emphasizes the autonomy and rights of the patient. From a utilitarian perspective any breach of these rights would be considered harmful but there may be circumstances where an overriding interest for the welfare of others might be considered to justify compromising autonomy, informed consent or confidentiality for example to protect the public from a contagious disease. There may also be a justification where the overriding consideration is to protect the patient where this cannot be achieved without a breach of the patient’s autonomy.
When applied to health care provision, utilitarianism requires the same calculations as it does as a theory to determine what a person’s moral obligation is to the society. This implies maximum utility to determine every choice of action. Consider this example. A man has worked extremely hard and become very wealthy over the course of his career. He could retire and still have plenty for the rest of his life. With all factors considered, he knows that if he gave his entire fortune away to provide basic health care to the millions of Kenyans who can’t afford medical expenses, he could save millions of lives. Assuming this is the utility maximizing option, he also knows that if he does give away his fortune, his children will have no opportunity to receive decent education, health care and luxury they deserve and will struggle the rest of their lives to make ends meet, often suffering disease. This man, according to utilitarianism, would be morally obligated to give out his fortune, in spite of the effect it would have on him and his family, because it brings about a better overall outcome. This is a scenario where an individual is expected to give until it hurts, for the sake of the society.

This analogy is a good example of the objection to utilitarianism and it epitomizes excessive demands that characterize utilitarianism. There are some problems with this kind of reasoning. First, it goes against pre-philosophical system of thought. It is absurd for one to opt to favor others more than his own family, because acting in favor of one’s own cannot be avoided. In such a situation, very few people if any could ever take the “right” action, which ultimately puts morality
beyond the realm of the common person. This requirement is overly demanding and hard to accomplish.

A second problem which accompanies this example has to do with supererogatory actions which go beyond the call of duty. Utilitarianism disregards the existence of such actions. This, once again, beats logic. In contemporary society, any well up individual who gives away his entire fortune would be considered extremely admirable, and would be praised for actions beyond moral duty. But in utilitarianism, since the desired action is one with the best possible consequences, the individual is just like any other citizen fulfilling a moral duty. Since this is not the prevailing response of society, it is a setback to utilitarianism.

Finally, Utilitarianism is overly demanding in its method of finding which action maximizes utility. In the earlier example, the morally right action for the rich man giving his fortune to the sick was required for the sake of illustration. However, in a real situation, the rich man would not know the outcome of his choice of action. In addition, there are diverse opportunities for action at any one time. This makes it difficult to choose the action with maximum utility. It calls for far too many calculations at any one time to suffice as a practical moral theory for beings with limited capabilities. Utilitarianism thus fails to offer the most probable solution to problems of health care provision.
2.2.2 Kantian Ethics

Kantian Ethics may go a step further in trying to solve the problem utilitarianism is unable to resolve. To begin with, Kantian Ethics is centered on what Kant called the Formula of Humanity. This theory is considered as a Categorical Imperative, which implies something must be done, or a call for duty. The Formula of Humanity basically states and advances that one must treat others always as ends and never as mere means to some end (Korsgaard, 1986:108, 110). This requires an elaboration. Treating one as an end entails respect for them, as well as encouragement towards their goals, while still giving room for autonomy of action. On the other hand, treating one as a mere means implies using them as a tool through which one accomplishes their own goal, regardless of their autonomy, or their capacity to make their deliberate choices. It can be interpreted to mean taking advantage of someone. Therefore for an action to be moral it must respect the rationality of other human beings, according to Kant.

This explanation of Kantian Ethics can be helpful in determining how Kant would respond to the problem of health care provision in the society. Kant would regard ill health as a condition which challenges a person’s ability to act autonomously. As morally responsible beings, humans are expected to support autonomy to avoid treating others as mere means, and instead as an end. For this reason, Kant would argue that part of humanity’s moral duty is to “avert, reduce, and correct ill health” (O’Neill, 1975).
Kant, however, also recognizes that humans have physical and fiscal limitations when it comes to solving the problem of health care. So instead of ignoring the problem of the demandingness of the theory, as did utilitarianism, Kant came up with an alternative theory. He argues that there exists both a perfect and an imperfect duty. Perfect duties are those that must be done in all circumstances. Justice is a perfect duty which prevents one from being viewed as a mere means while on the other hand is an imperfect duty (ibid). This implies the need for humans to be benevolent, which is not always possible as benevolence calls for resources, of which the society faces constraints.

The question then arises of how much beneficence is enough to ameliorate an imperfect duty. Defining the extent to which beneficence is required is left to interpretation for each individual, as the definition is vague. One may exercise imperfect duty of beneficence by giving a small amount a year, while another may consider it necessary to give half of their assets. According to O’Neill, “Kantians are required to do what they can to avert, reduce, and remedy … They may not fail to do something” (ibid). The ambiguity here is in the phrase “what they can,” because it is not clear what it entails. Is beneficence accomplishing everything humans possibly can, or is it much less than that? Since the goal is to come up with a theory that can define the extent to which beneficence is required, and since this is the point at which this theory is unclear, it seems that Kantian Ethics is insufficient as a solution to the problem of health care.
2.2.3 Virtue Ethics

A solution to dilemma of health care provision may be found in Aristotle’s Virtue Ethics. Aristotle advances the notion that a person should concentrate more on how to live than they should on concerns of actions. Virtue Ethics is founded on the notion that if one is virtuous in character; they will be inclined to act virtuously. Therefore, most of Aristotle’s arguments focus on how to decide which traits conform to virtue, and how to cultivate them, instead of on good action. According to Aristotle, “A virtue is a habitual disposition about choice, which lies in a mean relative to us, and which is arrived at by reason, by which the person of practical wisdom would determine it” (Aristotle & Sachs, 2002 bk 2:7). This mean that Aristotle refers to is a vital component of his argument. This mean refers to virtue; it is the midpoint between the two extremes; excess and deficiency. These are vital in determining the solution to the problem of health care.

When applied to the problem of health care, Virtue ethics provides an appropriate model to define ethical action. Aristotle employs excess and deficiency to define the mean, in this case which is the virtue. In particular, when considering to what extent beneficence is required, Aristotle argues that stinginess defines deficiency, while extravagance defines excess. The mean between these two is defined by generosity. Inherently borne in this model are the intentions and attitudes of the moral agent. For example, the typical representation of stinginess would be a tax
evading character that hoards every cent wealth from the less fortunate. But being stingy may take other different forms. An individual may give a part of his wealth simply to appear generous. Though his action is generous, his intentions point to his character as being stingy, as he acts out of self-interest.

On the other hand is magnificence which in this sense refers to excessive generosity. For example, a politician may derive great joy from giving to the projects for the poor. Under normal circumstances this would be considered virtuous. But this particular individual is may be so obsessed with giving such that as soon he makes any money he gives it away. Consequently, this individual is unable to meet his personal financial obligations and may be forced to bankruptcy altogether. He may spend the rest of his life miserably, with this obsession putting him in a cycle of debt. This is an illustration of magnificence, which shows that it can be as detrimental as stinginess.

Finally, Aristotle defines the virtue, generosity, as the virtuous “management of one’s property where others are concerned” (ibid, Bk 6:5). Once again, this is more applicable to intention than it is to action. For example, there may be a very poor woman who works hard and makes just enough money to survive. Her small contribution to a health charity for indigent families, while monetarily little, is as a result of extreme generosity. This is because she gives more than she can reasonably afford. She has considered the needs of others and finds them greater than her own, but still takes into account her own needs. This illustrates generosity.
At this point in the argument, Virtue Ethics seems like an extremely plausible solution to the problem of health care dilemma. However, it is not without objections. One objection to Virtue Ethics is that even as it successfully defines the mean in theory, in practice it encounters the same problem as Kantian Ethics; that is, it indistinctly defines the mean in practical situations. It is difficult in practice to determine the mean, or the virtuous action, simply by referring to the extremes. In this case virtue ethics may not be a practical theory to decide the criteria of beneficence in a certain situation, making it unsuitable for solving health care dilemma.

If Aristotle solely defined virtue as a mean between extremes, virtue ethics would be unhelpful. However, there are several other considerations in deciding which action is morally right. Knowledge of a virtue calls for “a habitual disposition” for that virtue, it must “be determined by reason,” and it must be arrived at according to how “the person of practical wisdom would determine it” (ibid, Bk. 6:1). These clauses, together with “a mean relative to us,” describe how a virtuous individual would act in a given situation.

First, a virtue will be characterized by having a habitual disposition. This essentially means that a person is not born with a certain virtue. Instead, it is cultivated through one’s life in the society. Without practice, a person will not be able to acquire the virtue in question. Additionally, a virtue is partially defined by how it conforms to reason. Aristotle argued that reason is an essential component in the discovery of what qualifies as a virtue. This determination of the mean is
heavily influenced by an individual’s perception of the society. It has to do with how well a conclusion about a character trait matches the pre-philosophical notions a person has about daily life. For example, consider a poor man who pays minimal amounts a year in tax. If this man were to only pay minimal amounts in a year, it would seem to be a relative “deficiency” of generosity. However, if this same man gave so much to charity in a given time, it may be too magnificent for him. But with the income that is available to him, he can afford much more than the minimal amounts he gives. According to a person’s pre-philosophical notions, it would mean that this individual has a mean character. This would be a case in which the individual acts contrary to reason; therefore, his idea of generosity must be changed in order to better match what is reasonable.

The final determining factor for a character trait is whether a person of “practical wisdom” would consider the trait to be a virtue. Practical wisdom is to a large extent defined by both experience and understanding. It enhances ability to judge situations and decide the best course of action. This corresponds with Christian notion of discernment. It builds on past experiences to determine virtue, but also gives room for the continual learning for each situation. Practical Wisdom combined with the other clauses in Aristotle’s definition of a virtue, allows Virtue Ethics to determine virtue.

Two notions become apparent when resolving the question of Virtue Ethics as applied to health care. First, the answer is contextual, and must be found through Aristotle’s model on individual case basis. There is no overarching rule that
clearly defines or dictates the extent to which beneficence is required in every situation. Secondly, on objective assessment, it becomes obvious that much of humanity does not envisage generosity. Some give just enough to feel decent about themselves as members of the society, while others show generosity for the wrong motives, thereby negating the virtue in their character. Regardless of any reason, human beings should employ more selfless giving practices, for humanity has fallen short moral duty to those individuals in need.

2.3 Conclusion

From the above discussion, utilitarianism, which is the dominant theory in health care provision, is insufficient to balance individual and collective interests as it is too extreme in demanding for optional acts. Kantian ethics can be rejected due to the fact that the excess is defined (we cannot complete all beneficent actions at all times) and the deficiency is defined (we cannot just do nothing), but the mean remains undefined hence it is not possible to determine the necessary beneficence. Virtue ethics, however, defines the mean, or the virtue, by adopting Aristotle’s definition of a virtue. This includes virtue being acquired versus inherent, determinable by reason, and being sensitive to criticism of practicable wisdom. This kind of virtue is indispensable to ethical life; for once the virtue is discovered it is possible to develop it into a character trait. Once this happens, the person is inclined to act virtuously in any situation. With this, Virtue Ethics albeit with a
consideration of contextual factors, makes determining ethical action in regards to beneficence achievable.

It is clear then that of the three theories so far discussed, Virtue Ethics is closest to giving a practical model to determine the extent to which beneficence is required in when individual and collective interests are in tension. However, integrating it with contextual factors still remains a challenge.

Analysis and evaluation of theories which dominate health care provision shows levels of insufficiency that could lead to the many problems in the health system including the competing interests of individuals and the population. A situational analysis of health care may reveal instances where individual and collective interests are in conflict yet the dominant theories have not been able to mitigate.
CHAPTER THREE

INDIVIDUAL AND COLLECTIVE INTERESTS IN HEALTH CARE PROVISION IN KENYA

3.1 Introduction

This chapter is a qualitative content analysis of health documents and related research reports with a view to highlight the tension between individual and collective interests in Kenya health care. It is found from this that health system in Kenya exhibits a variety of instances where individual interests are in tension with collective interests. These instances include: the health system itself, health states of individuals, equity, access, economic viability and social relationships. Few documents reflect on the meaning or definition of the ethical values inherent in either individual or collective good; and the tension between the two. However, most do invoke underlying values which are found to exacerbate the tension.

3.2 Evolution of the Health System in Independent Kenya

The first public health institutions in Kenya appeared in 1953, a decade before independence as the department of health education (DHE). Their principal activities included health education to pregnant women, young mothers and school children. However, the program did not take off immediately as the formal training and deployment of public health officers was delayed until 1976 (Republic of Kenya 1998:2). In a shift of attention to population concerns, the
policy instituted a family planning campaign with an aim to reduce fertility rate which stood at 60% in 1960s.

Kenya adopted the National Hospital Insurance Fund Act in 1966 (Wamai, 2004). The National Hospital Insurance Fund (NHIF) is a compulsory scheme targeting all salaried formal sector employees whose income exceeds certain set minimum in a contributory structure. From the onset, the fund has covered the contributor’s spouse and children under 18 regardless of the type of ailment or number of children. This is a case of conflict of values between individuals and groups within a larger population as risk is equitable whereas benefits are inequitable.

The conflict starts with the premise that health care benefit ought to be distributed according to need rather than willingness and ability to pay risk premiums. In this case an equitable distribution of health care benefit is where the amount of health care benefit correlates with need and is independent of other factors such as income, which are irrelevant to need. Thus uptake of health care benefit should depend on need and not on social and economic status.

The concern with NHIF has been how far health care benefit is distributed unequally, especially across socioeconomic groups such as those stratified by income. Emphasis on equity in financing of health care, by contrast, tends to take as the starting point the premise that health care ought to be financed according to ability to pay. It appears that the NHIF builds on an egalitarian viewpoint, where reducing inequity in health outcomes is regarded as the equity goal. However, risk
equity is silent hence the conflict. Risk equity would be in line with the aspirations of individual patient well being as opposed to the more population based government health care and would imply the notion of individual responsibility to health.

In 1998 NHIF was made a statutory body after an amendment to the 1966 Act and is currently fully autonomous. It is managed by a wide sector board of directors drawn mainly from all the health care sectors though it is not funded by the state. In 2003 a new policy for NHIF was drawn which sought to radically transform the fund into a social insurance scheme. However, the new policy has been met with a lot of hostility by employers, employees and clinical professionals for lack of sufficient structures alongside other external factors (Ndavi et al, 2009).

The fund covers about 26% of the population which is far below the prospects of a universal health care. As of June 2012, the NHIF system coverage comprised 645 health institutions, 150 of which were run by government while the rest are run by non- state actors. Considering the problem of gate keeping and the emphasis on Primary Health care, the 150 facilities run by the government play referral role and only for the working class. This epitomizes the gap between clinical and population health care with individual responsibility determining the type and quality of clinical care.

With the creation of the District Health Management Boards (DHMB), hospital units under separate administrative management were also established and local
community health service centers were proposed to dispense both clinical and public health services (MOH, 1994). Their mission was to assume responsibility for public health in their designated administrative units and take action regarding preventive interventions in their host hospitals. Creation of public health units seemed to be a solution to the problem of integrating public health functions within hospitals. Given the central place accorded to hospitals in the health system, their responsibilities and population catchment, these institutions were viewed as the best avenue to bring public health closer to clinical services. However, the department of public health did not meet this objective because the integration of clinical and preventive services did not occur. On the contrary, the incorporation of public health departments in the hospitals took the responsibility for prevention away from the public health professionals, hence a deeper isolation of the paradigm.

In the late 1990s, the health system was reorganized once again in the *Kenya Health Policy Framework Paper* (KPHF) which emphasized a clear departure from the public health care system organization model by seeking to transfer the provision of curative services to the NGO/private sector (Oyaya and Rifkin 2003:115). This shift in policy was expected to free more government resources to be allocated to preventive health services in order to reduce burden of diseases (Republic of Kenya 2003c:4) In addition, the Kenya government sought to strengthen the regional health management teams and boards. Their mandate was
to coordinate service delivery in their regions and to allocate resources to institutions and community organizations in their administrative units. The government also delegated to health teams and management boards the task of managing regional public health programs and establishing public health departments. During this period, the government undertook a vast operation to merge institutions, reducing the number of clinical facilities to a minimal referral level. Lower level clinical facilities were transformed into community health centers with public health roles.

In 2003, the Kenya government once again undertook a major reorganization of its health system. Regional boards were strengthened further, and their mandate was redefined to support the development of local health service networks on a geographic basis while continuing to allocate funds to facilities in their regions. Moreover, the Kenya government added a local level to the formal integration of public health into health care decision-making structures. Although local community health service centers were partly responsible for providing the bulk of direct services to the population on a local level, the new reform added a further responsibility for them to develop and maintain local public health care plans. This reorganization introduced the mandate of population-based responsibility to clinical health organization and, in most cases, a clinical facility. The objective was to confer to clinical facilities the responsibility of developing integrated health care adapted to the needs of a geographically defined population.
DHMB and DHMT are responsible for creating and piloting local intersectoral engagements, with an aim of acting on health determinants and improving service delivery to the population. Moreover, an officer in charge of public health in the locality is included in each team. By crafting these unique local institutions, the government formally integrated public health into health care governance structures. Assignment of a dual responsibility (delivery of care and services, and public health) to health facilities, however, requires broadening service provision by adopting a population-based clinical plan and integrating public health into its activities which is a goal yet to be realized.

Attempts have been made to articulate population health and health care issues in a more formal manner within a single governance structure. For instance, Kenya had earlier tried out a clinical model that integrates clinical prevention into the production of high-quality health care at the best cost (MOH, 1986). However, the success of this model cannot be evaluated since it was abandoned under pressure from donor and development partners who advocated for individual responsibility through market economy. Another example is the primary health care (PHC), the integrated public health care system. PHC concept may have been borrowed from the United States where it is the largest health care plan (Perlin et al. 2005). Its organizational model is centered on patients, and is coordinated through different levels of care within delimited geographical areas. The PHC is an example of a shift from a clinical model to population based care. PHC services organizational
model comes closest to a community care model as community representatives join clinical professionals in decisions for provision of health care services to the population. However, this remains just a model as policy decisions are made at the MOH headquarters in disregard of recommendations from DHMBs and DHMTs. These examples nevertheless illustrate models that have been adopted by the government in an attempt to integrate both paradigms to varying degrees.

Health system in Kenya is currently undergoing significant shifts. These shifts are mainly as a result of the influence of demographic and epidemiological dynamics associated with a huge population growth and an increasing social and economic burden of chronic diseases. In addition, higher uptake of modern technology and pharmacological advances has enhanced the health system's capacity for clinical intervention. The government is thus continuously engaged in devising ways to improve the organization and management of health services to maximize collective resources invested in the goal of health for all.

In 1994 the government published the Kenya Health Policy Framework Paper – NHSPP (MOH, 1994), with a goal to provide “quality health care that is acceptable, affordable, and accessible to all” in Kenya by 2010. With decentralization as the central strategy for managing the provision of health care, the policy framework has been implemented on five-year plans. The first NHSPP covered the period from 1999-2004, and the second covered the period from 2005-2010 but was extended to 2012. The current plan started in 2012 and is
expected to complete in 2017. Under the framework the country’s health system is organized in a hierarchical pyramid. Community dispensaries comprise the largest – and lowest – level of the pyramid. County and regional hospitals are fewer and are placed higher on the pyramid. The Kenyatta National Hospital and Moi Teaching and Referral Hospital sit at the top.

The Ministry of Health develops policies, formulates standards, and makes allocations for health care resources. However, in accordance with the decentralization, the county is the level at which most management takes place with boards and management teams charged with oversight responsibilities. The 2008/2009 Kenya Demographic Health Survey reports that there are more than 5,000 health facilities in Kenya. It oversees about 41% of health centers, NGOs run 15%, and the private sector operates about 44%. The government operates majority of hospitals, health centers, and dispensaries. The private sector mainly operates nursing homes and maternity facilities targeting the higher income population.

This effort has been accompanied by re-evaluation of the past performance of the country’s health system and the implementation of reforms, the scope of which varies in each cycle of policies since independence. NHSSP frameworks receive mid-term reviews and final evaluation (MOH, 2007). Overall, a consensus emerges concerning the lack of preventive action, problems of access to clinical care, lack of coordination and ineffective use of health care thereby aggravating
the conflict between individual and collective interests. These reviews suggest necessary changes, and the government has launched significant cycles of reforms.

Health care reforms have involved gradual integration of population health, a sector that includes collective health interventions, into clinical care which in contrast is concerned with diagnostic, curative and rehabilitative interventions at the individual level. These reforms have been well received by various stakeholders including development partners. However, ethical issues emerge regarding the contribution of one sector to the activities of the other. The issues associated with the integration of the two services are described with somewhat contradictory objectives. Moreover, previous efforts to integrate public health into the clinical system through introduction of community health departments into clinical facilities have had limited success in Kenya (Oyaya & Rifkin, 2003).

### 3.3 Population Health Services

The World Health Organization (WHO) has identified two paradigms of health service delivery that enable health systems to meet the health needs of populations (WHO, 2008). These include clinical and population health services. Clinical services include diagnostic, therapeutic and rehabilitative care consumed by the individual patient. Population health involves collective services. It involves health promotion and disease prevention activities targeted at groups and the population (Murray & Frenk, 2000). In this view, population health and clinical
care delivery coexist within the health system. However, in Kenya the functional interactions between these two paradigms vary. Traditionally, population health interventions are viewed from the angle of public health and are rarely integrated into the health system. An attempt to integrate public health interventions bring about tensions with the health system which is traditionally dominated by clinical interventions.

According to Acheson, population health is the science and art of preventing disease and promoting health through the organized efforts of society (Acheson, 1998). Such collective efforts thus are not limited to specific services or interventions. The current trend in Kenya is to give a comprehensive functional definition of population health and advocate for organized efforts of state in realizing the meaning of population health. The goal is to have an impact on human health in the broadest sense (MOH, 2008). The collective action is through a series of functions derived from public health that cover a wide range of interventions. These include such functions as survey and analysis of population health and well-being status and its determinants (Wamai, 2004). It also involves control of risks and diseases such as infectious diseases, injuries and social problems like substance abuse. Another function is the formulation of regulations, legislation and public policies for health.

Studies show significant variations in health among individuals within the population in relation to social determinants of health (WHO, 2007; MOH, 2009).
The health of an individual is influenced by many factors such as social status, level of education and occupation. Individual lifestyle habits, especially smoking and alcohol use also affect the state of health and well-being. For example, some studies estimate that in Kenya smoking is responsible for at least 3% of all deaths in adults aged 35 to 84 (Eriksen et al, 2012). There is growing acknowledgement that lifestyle habits of individuals are largely influenced by the social and economic environments in which people live.

Understanding of the concept of health determinants has led researchers to develop population health models that attempt to comprehend the various determinants (Evans and Stoddart, 1990). Health status results from multiple determinants hence none of them is overriding. For example, in Kenya unemployment causes social isolation and poverty (IPAR, 1997). These then affect an individual's psychological health and capacity to adapt to new situations. Moreover, factors that influence the health of an individual are not necessarily the same as those influencing the health of the population. This is because health determinants act at both individual and collective levels. This notion is in agreement with Rose's observation that the causes of individual cases are not the same as the causes of overall incidence (Rose, 1985)), hence the divergent values.

Public health adopts a comprehensive approach, focusing its actions on many health determinants to improve and maintain population health (WHO, 1986). While this perspective includes clinical care delivery in determinants of health, it
is not restricted to clinical function and has allocated it limited space the result being a conflict of values in the clinical setup. Thus clinical care in Kenya has a limited positive impact on population health compared to other determinants such as lifestyle habits.

Public health interventions in Kenya health system are broad and involve prevention and promotion initiatives (Muga et al, 2005). Disease prevention thus includes risk reduction and refers to interventions whose goal is to forestall an event or particular health condition either to an individual or population. This approach targets individuals and groups that face identifiable risk factors and mainly focuses on disease.

There is no simple framework available for dealing with ethical conflicts in population health in spite of the tendency of ethical principles to infringe upon each other. Some formulators of the public health frameworks agree that the principles cannot be ordered according to priority but must be weighed in concrete circumstances. Kass and Childress et al. identify criteria for this weighing process (Kass, 2001:1776-1782; Chilress et al, 2002:170-178). They argue that the burdens of a population health program should be proportionate to accruing benefits to constituent members. They further refer to the 'harm principle', which implies that restrictions to personal freedom should be minimized and that they can only be justified if necessitated by a clear population health requirement. The framework by Childress et al. puts ethical conflicts at the
centre, rather than merely highlighting out ethical values. They advance five justificatory conditions for population health programs that infringe moral principles: effectiveness, proportionality, necessity, least infringement, and public justification.

Health promotion thus operates within group dynamics and the goal is the health and well-being of the population as a whole. Health promotion interventions not only target changes in individual characteristics but are now touching on ecological approaches that involve community and policy initiatives, hence the need for greater synergies.

### 3.4 Clinical Services

Clinical care in the Kenya health system involves relationship between an individual patient and various care providers in a unique skill mix (MOH, 2006). Clinical resources are mobilized within this framework to correct or maintain the individual’s state of health. Various clinical diagnostics and therapies are mobilized to solve a particular health problem. The clinical system's key functions are to restore a state of health and preserve an individual person's autonomy and dignity. Therefore, clinical interventions are patient centered and should maintain health or restore absence of disease in the life of an individual.

Disease is conceived as any poor biological functioning that appears as quantitative disturbances of physiological phenomena (Canguilhem, 1966). To
solve a clinical problem, the cause is identified and eliminated or its symptoms corrected by use of an appropriate clinical intervention. Most clinical interventions are curative and target individuals, not populations. Clinical interventions in Kenya are more often directed towards diagnosis and treatment, and are performed in upper level health care facilities.

The clinical sector is composed of human resources for health (HRH) alongside institutional and financial resources. However, these are structured to provide goods and services to the population, with a goal of improved health for all. Conversely, the main concern of the clinical paradigm is to meet the demands of individual patients seeking care. It involves planning according to the non-economic model of supply and demand. As clinical care in Kenya health system is disproportionate to demand (Nyanjom, 2006), uptake is influenced by an ineffective supply of services. This makes clinical care a complicated enterprise and the resultant scenario is characteristic of rationing and insufficient care. State clinical system is managed in line with maximal efficiency and administrative power vested in policy action. The institutional approach is dominant and planning of services has mainly targeted maximal utility by the population. Thus, the needs of non-direct users have been inadequately addressed, and population-based planning for clinical care has not been prominent.

Clinical ethics emphasizes autonomy over institutional obligations if the two are in conflict. However, the need for autonomy brings unprecedented challenges to
clinical practice. If patients insist on decision-making authority, it is tempting to go by them. However, this submission approach by health workers can be a form of abandonment to the patient in a resource constrained context. The clinician feels that without full authority to make decisions, they should not be held accountable for outcomes. The physician may fail to deliberate on the right course of action and assume the patient will make a decision, anyway. When physicians take more responsibility for decisions, they also have more opportunities to practice beneficence. They bear the burden of making difficult decisions, for example, when they are responsible for telling a patient when to withdraw futile care to spare resources for more favorable outcomes.

If autonomy is to be more relevant to Kenya’s clinical challenges then there must be appropriate principles to complement it, especially when it conflicts with other values or is inapplicable. The problem with autonomy principally is that of overuse, especially of scarce resources. The Kenya health system approach to autonomy for individual patients could be described as paternalistic. Beyond the politically loaded term lies the concept of beneficence. The sense that medicine is a profession that, at its core, is devoted to helping others may by extension mean helping each other too.

Both paternalism and autonomy are invaluable guiding principles in clinical ethics. The more universal principle of beneficence should be restored to prominence in Kenya health care for the good of health for all. However, the
danger of any attempt to ease paternalism in Kenya health care may be the possibility of discarding the good of the patient, which is the greatest value in medicine. The government provides health care to the population; most of whom are indigent. The government therefore decides for the patient how much care they can get out of the available resources. Under the circumstances, beneficence should complement autonomy, rather than compete with it. Success of clinical practice therefore will only be achieved when attempt is made to balance patient autonomy with beneficence, nonmaleficence, and justice in a resource constrained context.

3.5 Convergence between Public Health and Clinical Services

Public health and clinical services are often perceived as in tension with each other. Over the last few decades, the context in which the two sectors operate in Kenya health system has changed. Influenced by pressures from several fronts like Bretton Woods Institutions and guidelines from other external partners, the government has been forced to integrate them to a greater extent. Reasons of convenience have brought them closer; with each paradigm requiring the expertise the other can provide to address complex health problems such as chronic diseases, alcoholism and road accidents. There are various contextually unique transitional factors that have allowed greater interplay between these two paradigms.
In Kenya, public health and clinical care have evolved in parallel, with little interaction. Influenced by pressures from several sources, these two sectors tend to be closer despite deeply divergent perspectives. Three transitions seem to influence this convergence: the epidemiological dynamics, the technological advancement and the organizational transformation.

### 3.5.1 Epidemiological transition

The profile of major causes of disease and death in Kenya has changed significantly over the past few decades. Chronic diseases are now the principal cause of morbidity and mortality worldwide (WHO 2005). As such, they have become priority issues for the health care system. Almost 40% of adults in Kenya are at risk for reported chronic health conditions such as diabetes and hypertension (Mathenge et al, 2010). Thus, these conditions have become priority issues for health care system in Kenya, as they represent a significant societal burden yet they are largely preventable.

This epidemiological transition has changed the nature of health problems that public health and clinical sectors have to address. First, for people living with chronic diseases, health promotion should include clinical services that help them live better with their disease as is the case with ARVs for HIV patients. Moreover, prevention should be carried out through clinical screening programs. Thus, prevention and treatment of health problems are no longer the sole prerogatives of a specific paradigm. Screening and health promotion in clinical settings, through
promotion of self-care, are conducted on an individual basis and work towards treatment as well as health promotion among people with chronic diseases. This calls for synergies between the divergent paradigms.

3.5.2 Technological transition

Technological and scientific advances are making rapid penetration into the Kenya health care. High-tech diagnostic capacities, ongoing development of investigative technologies, pharmacotherapy and biochemistry allow for effective treatment of an ever-increasing number of diseases. They also enable more and longer interventions for each individual patient. These include increasingly sophisticated techniques for resuscitation, organ transplantation, assisted reproduction and medical imaging. Moreover, recent advances in technology are making it possible to focus more on disease screening and prevention. Examples of these advances include ARV treatments that lower the incidence of HIV related deaths and Pap smears that reduce cervical cancers both of which are public health initiatives with strong clinical components.

With global medical technology transfer catching up with Kenya (Republic of Kenya, 2011), it is clear that the anticipated innovative therapy will have an impact not only on public health practice but also on curative medicine and health services management. Indeed, uptake of advanced medical technology will improve the targeting of public health interventions. The ensuing screening activities will not only affect costs but will most likely raise further ethical issues
(Collins 1999). This anticipation and the existing ethical pressures call for collaborations between the clinical and public health paradigms.

3.5.3 Organizational Transition

The higher prevalence of chronic diseases and the complexity of patients' needs require a variety of health services as well as concerted action by health professionals and other stakeholders. These patients require regular and more intensive contacts with various health care providers and interventions that are better coordinated. They need better integrated care and continuity among different service delivery facilities. Health care organization is complex and covers a broad spectrum of interventions that ranges from prevention to treatment and from follow-up to convalescence. Change in patient management logically leads to integrated organization, and new organizational models add complexity to health care processes.

High-performance health systems are those in which information concerning prevalent health problems is available and utilized. It is where preventive interventions are planned across the continuum of care delivery and where provision of care is a source of health promotion. Conversely, health care interventions in Kenya health system are planned according to maximal utility rather than their impacts on targeted populations. Oyaya and Rifkin (2003) cite this as an attempt to conform to the policy goal of health for all. Though the era is gone when all that was required was to offer the best treatment available on an
individual basis, public health approaches and clinical expertise need to work in synergy for population-based planning in health care.

### 3.6 Divergence between Public Health and Clinical Services

According to Wamai, recent reforms have facilitated greater convergence between public health and clinical health in Kenya though the two sectors are driven by relatively distinct visions that are even contradictory in some areas (Wamai, 2004). For instance, when it comes to interventions, public health is interested in the population as a whole, whereas clinical health targets individuals. Moreover, the interventions' temporal scales are different. The results of environmental interventions may not become visible for years. Conversely, if the intention is immediate reduction of pain or anxiety caused by disease, results are easy to observe in the short term and the causal relationships are more direct.

Tensions between population and clinical health create significant challenges in the formal integration of public health into health care structures. These challenges play on two levels: (a) the development of population-based planning within organizations that deliver clinical services and (b) the expression of public health and clinical concerns at the community level.

#### 3.6.1 Population-Based Planning Within Clinical Setup

The result for the population health initiatives has been challenging. Not only has population health had to bear its ongoing responsibilities for monitoring and
protecting the population against threats to health and safety, but it also has had to take on new responsibilities for promotion of healthier lifestyles. It is also charged with the provision of safety-net health care services for those unable to afford the growing expense of care, and a role as a watchdog to ensure the quality and effectiveness for a rapidly expanding clinical care enterprise. It is, however, hampered by a shrinking share of the health care budgetary allocation as noted elsewhere. Medicine, in the meanwhile, content with growth in its science and therapeutic base, tends to be more specialized, narrowly focused, and less aware of the work of population health.

The assignment of geographically defined population responsibility to Health facilities thus undoubtedly poses new challenges. Three issues complicate population-based planning within health care organizations in Kenya. They are changes in the planning process from individual-level to community-level planning, service planning based on foreseeable needs and critical-mass planning. Critical mass is closer to majority consensus in policy, where the most effective position is more often than not held by the majority of people in society.

The most critical of these issues is to change the policy from one based on delivery of individual clinical services to one geared towards community-based health services. This new mandate introduces the notion of territory into the planning process. Planning must not only respond to the needs of immediate service users but must also consider the needs of individuals or groups who, for a
variety of reasons, do not currently consult health care providers to meet their health care need. This includes the need for training of clinicians and other health workers whose resources are skewed towards urban and affluent areas leading to marginalization. This view differs from traditional management of health care organizations, which is based on response to service demands and is in line with the clinical paradigm. Such a policy process is more complex in urban areas, where an organization's catchment area may not correspond to geographical territories and where individuals living in different neighborhoods sometimes use services located far from where they reside.

According to Pineault and Daveluy, adopting a purely population-based perspective to policy process is naive and ineffective because it does not take into consideration organizational reality (Pineault and Daveluy, 1995). This is so in Kenya where the existing complement of resources, their organization and accompanying constraints are unique. The most appropriate model thus would be a compromise between a population-based and clinical planning process based on users and resources. The challenge, however, is to build on available resources to increase the impact on population health. Therefore, within the context of such challenges, policy makers are compelled to think not only about clinical effectiveness linked to service utilization, but also and especially about population-based effectiveness or maximal efficiency. This is because the
government and partners have to know whether the resources that have been mobilized are producing the expected outcomes within the community.

For all its potential to improve health care, population-based care still remains a concern for the clinical paradigm. It undermines the doctor-patient relationship and advocacy for individual patients. Indeed, population based care adds new ethical issues on to those already in clinical practice. The need for change, however, and the benefits of this approach are too important to abandon. Challenges in the health system sometimes lead to undesirable outcomes for individual patients and the population as a whole. As a result, health workers may sometimes be faced with situations whose best course is to manipulate the challenges for the benefit of an individual patient and the population, instead of striving to improve the delivery of care for all. Such manipulation of the system produces more ethical issues and the challenges become more complicated.

Care for individual patients is at the center of health system but must be delivered within the context of the goal of generating health for all. By adopting this approach as a guiding principle and applying the tools of population health care, health system can improve the delivery of care for the benefit of all patients. However, new ethical challenges must be anticipated.

Apart from resources invested in these respective fields of delivery, almost the entire health budget is based on a collective vision of health for all. Resources should thus be geared towards achieving greater population-based effectiveness
through health care. Indeed, by advancing a population-based approach, public health encourages the health care sector to strive for such effectiveness in line with efficiency and maximization. In this regard, the clinical sector would constitute a powerful medium for preventive efforts because of the significant percentage of individuals who use services in a year. This is particularly so for primary care services. Clinical prevention thus is an example of a growing and effective population-based response to non-expressed needs though the government seems not to have realized this hence the emphasis on public and community health initiatives. This is contrary to the actual situation where more than 41.6% of health budget goes to curative care compared to 23.5% for population health initiatives according to 2009/2010 budget analysis by GTZ.

The current health system was designed to address acute problems in a timely manner as the prevalence of chronic diseases was low. However, change in the epidemiological profile to a greater prevalence of chronic diseases (UNAIDS, 2012) has a significant impact on the nature of health problems faced by the health care sector in Kenya. Chronic diseases evolve in a more predictable trend as opposed to acute diseases. At the same time, their evolution can be altered by preventive measures whose objectives are to maintain autonomy and quality of life while respecting human dignity as exemplified in palliative care (Malloy et al, 2011). This approach ensures that services are planned in a more predictable and sequential manner. For instance, having a certain number of cancer patients
enables an organization to plan appropriate oncologists for the upcoming year. However, due to policy and implementation discrepancies, this kind of an efficient arrangement cannot be realized in Kenya.

Finally, integrating public health into clinical health can change the logic of health planning at the local level. But are the health management teams the right agents for integration? DHMTS have close relationships with most of the population that uses such services as consultations, hospitalizations or services in the lower levels (Ndavi et al, 2009). As a result, on an annual basis, services fail to reach several clientele that receive most of their services in privately run clinics and hospitals (Muthaka et al, 2004). If community networks are not implemented, population based health services will have difficulty reaching the population. DHMTs also face several challenges in developing partnerships with service providers in their areas. A promising avenue is to develop partnerships with primary care clinical organizations within an area, an approach that would facilitate managing the area’s population needs. Indeed, almost 65% of the population seeks health services mostly from private health care providers.

These perspectives reflect divergent lenses through which health priorities can be viewed. Compounding the conflict is the resentment developed on the part of clinical health by the perception that population health and state too often meddle in their prerogatives, and on the part of population health that resources and public attention are skewed towards clinical health, to the detriment of support for
population health. These perceptions do not make for easy coexistence of the two paradigms in a health care set up.

3.6.2 Population and Clinical Health Concerns

Integrating key population health concerns with issues related to clinical care is not necessarily obvious. According to Acheson (1998) difficulties arise in terms of two fundamental differences: the limits of each sector and their respective targets. Although the context in Kenya fosters convergence between the two service delivery areas regarding preventive clinical practices role in screening and choice of interventions based on the needs of the population (Ministry of Health, 2005), some population health interventions remain outside the clinical domain. Population health is concerned with broader and more diversified areas that are not covered under clinical health care, such as the environment, public infrastructures and occupational safety, which incidentally are pressing issues in Kenya. Population health may therefore be short-changed in a health system where health care delivery is the central concern. So is it appropriate to integrate population health concerns into a system that predominantly provides clinical services? Such an approach elicits reservations as many population health initiatives are macro and the local level has relatively little control and leverage to plan and implement such initiatives. Most macro level population health initiatives are sponsored by donors and development partners through bilateral negotiations; a task too huge for local participation.
Local integration contrasts with a much more comprehensive national view of the scope of population health intervention to influence health. In this context, one population health issue is the definition of the limits of its interventions within the health system. Health care delivery is an excellent avenue to complement the more traditional intervention approaches to population health. However, it is imperative to elaborate and clearly define the place of clinical health and population health within the concept of health care. For example, Kenya’s public health department implemented health education centers in various health facilities in the country. These units sought to improve nutrition which has an impact on chronic diseases (Ndavi, op. cit.). This strategy supplemented and supported preventive clinical practices in private and public clinical facilities in their respective areas.

Second, the main targets of both sectors often pull in opposite directions, creating conflicts that are difficult to mediate. The rationale behind clinicians' and organizations’ search for solutions is to maximize individual clinical services by advocating for their patients to receive the best possible interventions. However, the rationale guiding population health is to maximize health for the population as a whole. This population-based perspective affects large groups of individuals and its goal is to ensure mediation on a population scale. This leaves out the more critical factor of diseases that affect individuals yet take up enormous resources
that can effectively be utilized for easier to treat but equally fatal ailments that affect many people.

These differences could be difficult to reconcile in the context of health care delivery at the community level. This paradox has existed for long (Gostin & Powers, 2006) and it reflects the realities of service delivery in Kenya. The contrasting roles could reduce the reach of population health interventions carried out by the health care sector in general.

3.7 Conclusion

In Kenya, like any other nation, resources for health have always been scarce, such that health must compete with other equally desirable social goals like education and national security for budgetary allocations. It is not possible to provide all the required resources to the health system without undesirable sacrifices in other social goods. It follows from scarcity of resources that some form of health care rationing is unavoidable. Rationing implies denying some individuals potentially beneficial health care. The policy direction in Kenya is such that resources are allocated so as to maximize the health benefits as measured by either the aggregate health status of individuals or disease burden of the whole population. Cost effectiveness is the standard analytic tool and compares the aggregate health benefits from a given resource expenditure. This tool determines how to maximize the health benefits from limited health care
resources. This maximization standard assumes a utilitarian moral tenet with distributive justice as its most problematic feature.

The quest for greater efficiency in health system demands that the government merges and integrates various activities that are likely to improve health for all. The reforms currently underway in Kenya present a unique opportunity for the public health and health care sectors to develop more concerted and convergent activities. It has the potential to transform health services by developing services that are better adapted to the needs of the population. This strategy calls for management based on medium and long term visions, through building on interventions that will potentially have greater impacts on the population as a whole. Moreover, to be truly effective, such convergence must target public organizations as well as the private network, and especially primary care services, to create local health service networks. It is important to direct actions not only at the organizational level but also towards the training of professionals. It would be relevant to integrate a range of possible strategies to improve population health in professional training. The success of reform depends on acknowledging the issues and challenges inherent in the juxtaposition of sectors that have not easily integrated in the past. This requires conceptualization, careful evaluation and mediation of the inevitable ethical tensions between individual and collective interests that often accompany the two paradigms.
CHAPTER FOUR

COMMUNITARIANISM AS A SYNTHESIS FOR INDIVIDUAL AND COLLECTIVE INTERESTS IN HEALTH CARE PROVISION IN KENYA

4.1 Introduction
This chapter explores the ways in which a communitarian conceptual approach can be employed in pursuit of equity in health care provision. A brief overview of the communitarian philosophy is given. Reference is made to the features of communitarian philosophy that are useful in the pursuit of health equity goals. A discussion on the question of individual autonomy in the society is advanced in the context of health care provision. Capabilities and their relevance in health care are then discussed. Finally, some thoughts are given to how equity in health system can reasonably progress within a communitarian vision.

4.2 Communitarianism
Many of the philosophical claims to communitarianism date back many years ago, for example in the value of social relations as endorsed by Aristotle (MacIntyre, 1992; Weiss, 1995a). Communitarianism includes a variety of normative, conceptual and moral assertions. It follows then that attempting a concise definition of communitarianism is a difficult task. Some communitarians base their arguments on the concept of autonomy while others base it on alternate concepts of self (Avineri and de-Shalit, 1992; Weiss, 1995a). Some conceive it as
a democratic collective, while others have a much richer understanding of the
nature, value and processes involved (Weiss, 1995a; Frazer, 1999). Further, some
communitarians are classified as liberal while others are seen as social
communitarians (Etzioni, 1991; Taylor, 1992). What is common, however, is the
recognition and value of community and social relations. In particular,
communitarians aim to create a “good” society that encourages and balances the
social values of the community with individual good – a balance rather than
maximization of either (Etzioni, 1991).

The term community itself is problematic. It is often based on vague assumptions
and Hillery (1955: 111–123) identified many definitions of community. For many
of communitarians, the concept of community is more than a mere collective
association of people (Anderson, 1990). The term community suggests a group of
people with a bond such as shared language, culture or history. It can be inferred
then that some or all of the common values, norms and goals of the community
are by extension goals of the individual. The individual is at least in part
connected to the community (Schlesinger, 1997: 937–992).

Most individuals in Kenya view themselves as part of a number of communities.
Consequently, the nature of bonds between some individuals is multifaceted.
Feminists argue that communitarians have a narrow conception of what amounts
to community, with thought skewed on traditional forms of community such as
family or tribe (Weiss, 1995a). They argue that communitarians neglect “communities of choice”, such as friendships or fraternities. In this study, however, community refers to a group of people united by citizenship.

Communitarianism fits uneasily between individual and collective interests. It appears relevant to social problems including ill health and indigence among other problems (Baum, 1998). Moreover, there are some conceptual and practical themes to communitarianism which make it well suited for goals of social justice and equity, including in health care. Conceptually, communitarians argue that individualistic views of self and social relations disregard the role of community in forming and sustaining identities (Weiss, 1995a). Such identities are shaped by many social influences. Understanding oneself thus can only be realised in the context of community, where individual experience converges with those of others (Avineri and De-Shalit, 1992).

Communitarians argue that individual interests tend to inhibit and compromise mutual understanding, and the discovery of common good. As Sandel (1992) states: “Allegiances are more than values I happen to have and to hold at a certain distance. They allow that to some I owe more than justice requires or even permits, not by reason of agreements I have made, but instead in virtue of those more or less enduring attachments and commitments that, taken together, partly define the person that I am.” Historically it has been communities that have pioneered movements for civil rights and heightened awareness of issues of
liberation, tolerance, social justice and ecological or environmental concerns. Clearly equity is relevant in this context. Communities are well placed to foster ideas about what is equitable in health care; about who shall have access and to what extent. Such ideas are shaped by the community and social relations inherent in it.

At the same time communitarianism remains mindful of the individual therein. Communitarians are concerned about an over emphasis on individuals and individual rights as much as they are critical of community institutions that are authoritarian and restrictive, and that cannot pass scrutiny within a larger framework of human rights and equal opportunities (Etzioni, 1991; MacIntyre, 1992).

Individualistic autonomy assumes that one can escape social conditioning and make rational choices irrespective of such conditioning (Barclay, 1999). Increasingly however there has been support from philosophers and others of a social concept of autonomy. According to Mackenzie and Stoljar (1999), such concepts recognize that an individual cannot escape social conditioning altogether. Social structures influence the likelihood of an individual developing autonomy. It is not the case that community in itself is not compatible with individual autonomy, but rather that a certain type of community is not compatible. Social autonomy allows that all nurture the others in their weakness. Illnesses, social problems and other needs all undermine autonomy. Social
autonomy thus is about the support from members of the society who have it in their power to assist and liberate from suffering. Therefore autonomy is able to exist in relationships of interdependence and dependence within the society.

Traditional communities in Africa lived and continue to live in a form of social autonomy. As Chirayath et al. write: “Communal decisions about their preferred lifestyles were, in part, based on the traditional ethic of accountability to others. Social accountability is required by their commitment that autonomy, at a personal and group level, will be exercised so as to ensure that what is done contributes to the care and nurture of others with whom they are related; so that personal behavior remains socially grounded” (Chirayath et al., 2005).

In practice individuals need a community to develop skills for relational autonomy. Where that occurs, autonomy can flourish. Social autonomy necessitates a circular process: just as community is necessary for autonomy, autonomous individuals are necessary to create the kind of community that fosters that autonomy.

4.3 Communitarian Framework for Health Care

The implications of the above analysis of communitarian health care equity goals are potentially profound. There are a number of factors that influence the likelihood of individuals or communities using health services. Some of these include opportunity costs and welfare costs (Ivers et al., 1997; Houston, 2001). Additionally, there are characteristics of individuals and communities themselves
that influence their uptake of health care (Laila, 1999; 475–482). As Schafer describes when considering differences in access to health care services between the rich and the poor, “the rich are usually much better informed than the poor about the availability of potentially beneficial health care services. Even when the poor possess the requisite knowledge, they typically lack a strong sense of control and autonomy in their lives to seek needed care and attention with the same vigor and sense of entitlement as someone whose personal efficacy has been nurtured” (Schafer, 1994; 373-375)

In highlighting the importance of capabilities, including autonomy, Shafer argues that where people in greater need of health care have limited capabilities, health care equity goals are less likely to be met Differentials in wealth and power within a society create different opportunities for education, the development of skills and the ability to cope with daily life (Shaw et al., 1999). This relationship has been discussed extensively in relation to health and well-being more generally. Sen (1993) in particular has proposed that fairness or justice in society is about attempting to foster equal capabilities across individuals or communities. In this context he defines an individual’s functionality as what an individual manages to do or be (Sen, 1985). Capabilities refer to an individual’s freedom of choice between different functionalities. Both of these issues are relevant to access of health care. Capabilities approach captures the theoretical and conceptual work on these functionalities, while at the same time being applicable to real life scenarios
and actual practice. Founded on development ethics and economics, the capability approach is well suited to health policy-making and promotion.

These views on capabilities and functionality are similar to those on relational autonomy, in particular substantive autonomy which emphasizes the formation of a moral agent’s desires, beliefs and emotional attitudes; including attitudes and beliefs about themselves. If interest is in provision of equity in health care, it becomes important to establish structures and practices that strengthen individual and community capabilities to use services. The process of protecting both the individual and the community in a communitarian approach at least presents an opportunity for communities and individuals to develop equal capabilities. This is particularly important for those communities that lag behind in terms of capabilities for historical reasons or because of governance and social structures.

Further, it has been shown that attitudes and beliefs about oneself can influence the development of ill-health per se, not just one’s ability to access health care (Shaw et al., 1999; Yen and Syme, 1999; 287–308). Marginalized individuals and communities can internalize negative processes into their beings. Not only are those who are marginalized more likely to develop ill-health but further, once they do, they are less likely to have the capabilities to use health care.

The ability to have freedom and choice, and the ability to function relevant to well-being, are central to equity in health care. The full development of individuals is difficult if not impossible to realize on one’s own. Communitarian
approaches would take into account the community determinants of equal access. If the aim is to provide health care in a holistic sense, health care services, mechanisms and processes which enable feelings of self-worth must be in place. This will foster pride and trust at both community and individual levels.

4.4 Community Autonomy

Community involvement is clearly not unique to communitarianism (Schlesinger, 1997). The key feature for communitarians, however, is the level at which community is involved in decision-making, with community autonomy giving power and choice over to the community, such as resource allocation (Kenny, 1994). This involves incorporating the community’s values into the health system. Habermas (1994) uses the analogy that the community sees itself as the author.

The authority of physicians and the broader trend towards scientific knowledge and professional training have put community autonomy in an uncomfortable position with health care policy developers and managers (Schlesinger, 1997). Indeed, it was professionalism that historically moved health care control away from communities. It was communities which traditionally supplied health care. Communitarians propose that community control be re-established in health care. This should not be interpreted as necessarily resulting in lesser involvement of the State to supply care, but rather as greater involvement of the community in governing the nature of that care. Moving the emphasis back to community, however, can be unsettling for medical authorities, experts and professionals.
It has been argued that citizens do not have the knowledge to make decisions about health care. This is a valid argument, but not one that necessarily curtails the governance of community in health care delivery. According to Waitiki, majority of Kenyans are not well placed to form judgments about the benefits and costs of different types and forms of health care, either for specific interventions or for health care institutions (Waitiki, 2010: 60-74). This implies that they rely on the health care policy decision makers to help make decisions for them about the merits of different procedures, interventions and organisational structures.

Thus, for health system it may imply that the people want to take an active role in running it, while some prefer to leave decisions with experts. However, in a representative setup where citizens would rather have policy specialists make decisions for them, these specialists should base their decisions on the broad community values, not their own elitist values. Thus health care legislation should be established, which clarifies and elicits the community’s values regarding health care. Communitarians propose that public reflections and critical scrutiny lead to solutions which are just (Taylor, 1992).

What communitarianism must then address is establishment of processes which inform public judgement and encourage deliberative civic engagement instead of authoritative expert knowledge. Approaches are needed which allow participants time to deliberate, ask questions of experts and spend time formulating considered responses. There is a risk that minority groups or individuals within a community
will not have their voices heard by the majority as is always the case in a democratic setup. In these instances, social autonomy will recognize that the community has a responsibility to the weaker members.

Community autonomy thus has manifold effect. First, there are the benefits from self-governance. Second, there are increased bonds and connectedness among community members. Kenny argues that when people share an impetus towards common goals and resolution of decisions, they start to trust one another and form strong connections (Kenny, 1994). Shared interests and shared meanings ensure that stronger communities are created and can be sustained. Individuals start to develop and foster dual utilities where the utility of others becomes important. Thus individuals start to act for others not according to their own values but to the values of these others.

In a scenario where different communities in a multicultural society like Kenya have different concepts of health, and as a result, different notions about ideal health care, Wiseman proposes that these differing concepts be recognized and the cross cutting element be fostered (Wiseman, 1999: 207–223). This calls for explicit and acceptable national values. Health care from a majority perspective necessitates that the values of the communities receiving these services align with the majority perspective. Where they do not align, minority individuals or communities may have to change aspects of their values. Given the history of
coerced social change in minority communities this is an ethically difficult position.

Community control provides an opportunity for these differing concepts to be incorporated into health care. It allows health care to be tailored to various notions of health, and to differing values around the way health care is provided. A communitarian philosophy would maintain that there is no universal health care equity goal that will suit all communities. The choice of health care equity goal should be left with each autonomous community. Having said that, as health care system goals are often established at an international level, it may be that one among the many goals is more likely to be respectful of diversity and differences. Equal access for equal need entails the recognition that individuals may vary in their preferences for health and health care and that social policy should interfere minimally with such preferences. Equality of use of health care does not allow this especially in a state where social policy operates in resource constraints.

Health care equity goals in Kenya, however, tend to stop at horizontal equity (GOK 2007d: 104), how equals are treated in relation to one another. Providing equitable health care may require a step beyond horizontal equity goals towards vertical equity, which is concerned with the unequal but equitable treatment of unequals in the society. According to Kenya Health Sector Strategic & Investment Plan (KHSSIP) health care funding for public health in Kenya is lower than that of curative services (MOH, 2012). This impedes health equity as defined in the
vision 2030. Such discrepancy in funding poorly compensates for the vast differentials in need and in access to health care for all the citizens. If greater emphasis were placed on vertical equity, and how people in different positions are to be treated relative to one another, there would be greater possibility of achieving equity in health care.

The Community may formulate a feasible way to approach vertical equity, particularly for poor members of the community. Communitarian approach would form an ethical basis on which resources can be distributed within the health care system (Mooney, 1998; 1171–1180). Communitarian approach deals with how different people within society should be treated relative to one another. In a communitarian approach, the community may wish to allocate resources according to a standard conventional concept of need. Other external factors however may become important, like disadvantage in other spheres, positive discrimination and getting it right through affirmative action. A communitarian approach can take into account a wide set of values and goals that are potentially relevant to the community in achieving equity in health care.

It is worth noting also that communal interests help realize not only equity but also efficiency. The community is able to direct resources where it wants them to be efficiently used. One of the key points in communitarian approach is that the interests are arbitrated by the wider community. This achieves a number of things. First, it removes the barrier of dependence on what people individually or
communally desire (Sen, 1985). That is, interests are not dependent on the individual’s or community’s ability to feel harmed or to desire. This is very much in line with socialization processes. As Sen observes, the idea that resource distribution should be based on this is one of the most limiting aspects of utilitarian ethics. Second, arbitration by the wider community is not just instrumental but bestows benefit in itself. Thus it is not only those who receive who benefit but also those who arbitrate over and honor the claims – i.e., the community at large, that benefit.

Communitarian approach can also allow one to overcome some of the potential problems identified by Houtepen and Meulen in their critique of communitarian notions of solidarity. They see a failure of communitarian ideas in the Dutch Committee on Choices in Health care. The first criterion there was “necessary care” which was defined as “care which enables the individual to function normally in society”. They suggest that the main criticism against the report “was the lack of clarity of this criterion” and ask: “Who determines what is normal functioning in a pluralistic society?” (Houtepen and Meulen, 2000; 355–376). One can readily argue using communitarian claims that defining normal is not necessary. All one needs is characteristics of individuals (e.g., health status, age, etc.) which are then deemed to be the basis of claims or not and those which are then weighted according to the strengths of these claims as judged by the community. The issue here is not as Houtepen and Meulen state it to be i.e., “an
appeal to a return to shared values” but rather an acceptance that such shared values first already exist and second may be fostered yet more by such a process.

4.5 Implications of a Communitarian Approach in Health care Provision for Kenya

Communitarianism would appear to help in shifting the emphasis in health care towards equity. While the goals of equity seem to conflict with those of efficiency, a communitarian approach does not necessarily entail restrictions to efficiency, unless the community desires that. Health care is then broadly conceived as a community good – health care as a social institution – rather than the narrow perspective of individuals. This re-framing of the health care perspective leaves communitarians with the difficult task of thinking about how their ideals can be enacted within the health care system. Are such ideals overly idyllic: the notion of well functioning communities under the banner of a national community, operating in social autonomy, nurturing both individuals and communities? Putting these communitarian theories into practices and structures, with all the explicit communitarian tensions, cannot be easy.

While there is an over-riding dominance of individualistic ideologies in most health systems, there are also examples of communitarian ideals. In particular, there is an extensive literature around community development and empowerment in Australia (Kenny, 1994). There are also some efforts at incorporating community values into treatment, delivery, policy and social welfare (Wiseman, 2000).
4.6 Conclusion

A communitarian approach to health care in Kenya is promising. It allows for differing concepts of health and fosters relevant, value laden and efficient form of health care. It informs decisions about health equity goals, while taking into account the pluralistic nature of the modern Kenyan society. It provides a process that would promote individual autonomy and other valued capabilities. It moves concerns for inequities back on to the health care agenda – and Kenyans are concerned with equity in health care.

Based on a communitarian philosophy it is possible that there can be a health care system that gives individuals greater opportunity to harness respect, self-worth and autonomy. It would be a mistake to look for a simple solution for health care inequities. Vertical approaches are limited. Modern communities may face difficulty in balancing many tensions in Kenya particularly individual and collective interests in health care. However, these divergent positions are not very difficult when viewed from a communitarian perspective.
CHAPTER FIVE

RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

The primary concern of this research was to highlight the conflict between individual and collective good in Kenya health care and to suggest a suitable mediation framework. A mere categorization of public health and clinical services functions in health care is insufficient for the goal of health for all.

5.2 Summary

Findings of this research indicate that maximal utilization of health care in Kenya has gained momentum in recent years. Social and economic considerations have been the driving force in health care and this has had broad implications for the nature of clinical practice. Two different ethical orientations are relevant to this enterprise and both require a synthesis. Clinical ethics has traditionally dealt with individual moral questions of modern clinical practice, while public health ethics has been concerned with how governance can incorporate an ethical perspective in public health care. Clinical ethics employs an individualistic tact, emphasizing autonomy and entitlement. This however, has failed to anticipate the development of a population approach to health care delivery.

The rapid development of population based health care results in a compelling need and opportunity for a greater interplay between these two paradigms.
Clinical ethics must deal with both the theoretical and practical aspects of health care without turning all decisions into matters of individual preference. Individual preferences are unsustainable in a system in which individual and societal interests sometimes conflict. Public health care ethics must be informed by the principles of ethics in clinical practice if it strives to deal with health care issues in a decisive manner. What is lacking is a substantive social ethic to power the process of synthesizing a new code of mutual responsibilities between health system and patients. In Kenya where economic values predominate, there is need for a renewed articulation of the core health care values of beneficence and access.

Moreover, these values need substantive means in order to engender new policies that protect the vital interests of patients and the health system. However, given the power-dominated legislative process in Kenya, a different mode of consensus building is needed to create ethical codes of health care to guide this process. Competing interests will always conflict, and difficult choices will have to be made. The hardest part involves formulation of policies that moot a balance so that all interests can thrive even amidst compromises that may not have been preferred. For example, the health system may need to forego economic considerations in order to provide beneficial clinical interventions. Doctors may need to yield autonomy and moderate consequential gains in order to make health care more efficient.
Consequently, patients may need to cultivate autonomy to even demand nonbeneficial or marginally beneficial interventions. Collaboration of bioethicists, physicians, patients and the health system will be necessary. A deliberative process could serve as a useful model of how to incorporate the perspectives of competing interests.

Clinical decisions concerning marginally beneficial treatments will adversely challenge the mediation process. Yet, a new consensus on the nature of responsibilities in this area will need to be worked out for a fiscally and ethically sound future for health care delivery through state health system. These responsibilities must be founded on ethical values and not merely economic ones. Cost efficiency and sufficient health care must meet in a morally sensitive framework for health care. There have been many changes in the history of health care delivery in Kenya; each yielding reorganization. For each change there is a new hierarchy of values. Any reorganization in future, however, needs to be guided by the fundamental values of beneficent care giving and not dominated by market values. This will require a new synthesis of clinical ethics and economic analysis that produces a practical yet principled code of health care management and delivery in the country. This process must take place at societal, professional and legislative levels in order to realize the goal of acceptable health care for all Kenyans.
For this synthetic process to be truly meaningful, health care leaders need to engage political leaders and other stakeholders in a serious and issue based dialogue. Carefully focused ethical analysis should be the basis of any policy changes. Even finely deliberated and well-intentioned tradeoffs may have implicit consequences that emerge as negative outcomes. Transformation has taken place very rapidly in health care delivery, and Kenya has not had time to analyze and comprehend fully its implication. The very essence of clinical professionalism is at issue, and should be of concern for parties both inside and outside of the clinical profession. There is need to clarify and articulate these issues before they are communicated to clinicians in training as a yardstick for accounting of their profession for the future directions. When it’s communicated to them, it must be fully integrated into the well-established systems of clinical education including case rounds in the wards and clinical setups. The challenges to ethical health system are substantial, but many stakeholders working collaboratively can create the needed solutions.

5.3 Recommendations

5.3.1 Collaborative Leadership

For public health, no partnership is more important than with clinical care; for clinical care, none is more important than with public health. The tone for collaboration of these two paradigms is set at an all time top. With the public keenly interested in health issues, and with the popular media eager to report on
them, many opportunities exist for visible and acceptable collaboration. If public health and clinical leaders at the local, county, and national levels can work side by side as a matter of routine in the establishment of a shared vision for health important signals can be sent throughout their respective communities and new approaches on engaging key issues can emerge.

### 5.3.2 Insurance Frameworks

Health insurance for all as enshrined in the concept of National Social Health Insurance Fund is a good model for comprehensive health care. All the stakeholders must work together to resolve the issue of financing which has dogged the implementation of the system. However, the government must come up with proper legislation to balance the risks and benefits for all without making some section of the population feel like they are overburdened with the responsibility of caring for other people’s well being. This will resolve the conflict between individual and collective interests whereby indigent citizens can access a minimum but decent health care while those who are capable can pay insurance premiums in the market to supplement any further care necessary. This will also solve the problem of free ridding which is a cause of discontent among some sections of contributors opposed to universal health insurance.

### 5.3.3 Efficiency Monitoring and Performance Contracts

Performance measures that gauge the effectiveness of health care professionals should reflect their effectiveness in linking to societal and public health resources,
in accordance to the needs of their individual patients. Infectious disease surveillance, containment initiatives, comprehensive management of chronic conditions all require relationships and referrals outside the clinical setup that should be grounded on standards. At the organization level, performance measures for health care systems should include components that characterize engagement with public health responsibilities. They should also foster community linkages and reward relevant health care provider activities directed at the wider society. Public health system performance should similarly be measured according to parameters that reveal the degree and effectiveness of the working relationships with the health care provider community on public health priorities. These parameters should range from health policy planning, preventive measures, and health status assessment to meeting the needs of the underserved in the society.

5.3.4 Collaborative Professional Training

Attitudes and practices are shaped early in any system of training. Until professional education in health and health care adopts a philosophy that supports and underscores the centrality of the relationship between individual and societal interests, the tendency to operate in divergent ways will prevail. Training in clinical professions generally has had little content on the public health and community resources that can be useful in the effective management of many health conditions. The same is the case for ways in which health care
professionals can play leadership roles in population health initiatives. Similarly, training in public health generally contains little about the practical challenges of individual patient care. Greater familiarity in the initial stages of professional training should improve the working levels of the relationships.

5.3.5 Attractive Incentive Structures

Money might not be the only motivational incentive, but it can help especially in a country like Kenya where health workers peg their services to remuneration. Traditionally people join the caring professions because they want to help and have passion for it. Nonetheless, structuring financial incentives to encourage positive action can foster desired outcomes. Public health programs funded from public coffers should forge collaborations with the health provider community and be rewarded for doing so. Health care reimbursement to private providers should be structured not only to encourage and ensure the delivery of preventive clinical services, but also to emphasize the need to maximize value for health care. Maximal value for health care should include the value of a population health paradigm and engagement with the public health community as partner in health promotion and disease prevention. Pay for performance should therefore include pay for better community health.
5.3.6 Collaborative financing

As long as the budgetary support for the public health system continues to shrink, both in absolute terms and relative to its expanded demands, the health security of Kenya will continue to be weak. Success for a healthy population is dependent on public health leadership and initiative. Thus a sustained and sufficient budgetary support is needed. It would make sense to tie that support to the overall allocation for health care. A sufficient funding, dedicated and set aside from clinical services spending could establish the working principle, the fact and the soundness of the relationship between public health and clinical services in a resource constrained setup.

The reforms and challenges ahead of health and health care in Kenya are substantial. Some are intimidating; others are exciting while all are formidable. If they are to be effectively dealt with, the enduring tendency of public health and clinical services to operate in a loosely connected and sometimes unrelated way is not acceptable. The public interest in health care can be served only if collaboration is forged. However, this will require strong and determined leadership and political will alongside associations far closer and more sustained than has been the case. The result will be brighter, more affordable health prospects for all Kenyans.
5.4 Conclusion

This research made several observations that need to be acted on if health care is to be balanced against the conflict of individual and collective interests:

1. That the conflict between individual and collective good in health care provision inhibits the smooth provision and uptake of health care both to individuals and the population thereby eclipsing the vision of health for all.

2. That bold measures need to be taken urgently to mitigate the effects of the conflict on health care in Kenya.

3. That all Kenyans need to embrace any reforms, and ensuing tradeoffs, geared towards realizing the vision of health for all Kenyans including those on financing and human resource for health.

4. That a complimentary code of ethics needs to be developed to incorporate both components of public and clinical health. This code should then be incorporated in the training of health professionals who on internalizing will express it in their performance.
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