

SHARED HEALTH SERVICES AND COMMUNITY SATISFACTION IN KAMPALA CAPITAL CITY AUTHORITY

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ABSTRACT

The desire for improvement in the performance of delivery of services in Kampala prompted shared health services as a new operational model in KCCA health centers. Though novel methods of work were introduced, the level of community satisfaction remains unknown. This paper analyses the relationship between shared health services and community satisfaction. Using cluster sampling, data was collected from KCCA employees and residents. Results indicate that sharing health services has a significant effect on the availability of drugs, medical equipments, distribution of health centers, level of treatment, working hours, medical personnel, Professionalism and care as seen with p-values less than 0.05. KCCA should encourage shared service model as it is likely to solve society health challenges.

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INTRODUCTION

The change of Administration in KCCA embraced a centralized system of administration that introduced new models of improving health service delivery to the people of Kampala. Health services is one of the mandates of KCCA, with nine health centers in five divisions at the level of health center III and IV respectively. Prior to the KCCA Act 2010, health services had deteriorated in Kampala hence urgent need to improve health services. Shared health services is one of the new model of operation introduced by the current City Administration to solve societal health challenges. In this model, health centers are sharing drugs, health equipments, community health services (family days) and ambulances.

BACKGROUND OF SHARED SERVICES

Shared services started in the United States of America in the early 1900s when corporations like Ford after they decided to decentralize service delivery. Later it became expensive to manage the decentralized centers hence the notion of sharing. Shared services has roots in back office services like informational technology and human resource (Dollery & Grant, 2009). In public service, shared services are progressively revolving into an additional common service delivery tool of choice among governments (Janssen & Joha, 2007).

According to (Schulman, Harmer, Dunleavy, & Lusk, 1999) shared services is, "The concentration of business capital carrying out similar activities, normally spread across through the organization, with the intention to serve several internal partners at a reduced costs, greater service level agreements and with a shared goal of exciting outside clientele by bringing value to the business." Community satisfaction is an assessment of a decision and objective in achieving the needs of the people in given community (Theodori & Luloff, 2000)) and these needs vary considerably depending on what people in a given community prioritize (Brown, 1993).

Theorists argue that, scale leads to provision of experts, technical equipment hence efficiency. Sharing service provision between councils is often seen as a means of improving efficiency without the potential reduction of representation that might, for example, arise through the amalgamation of councils. Participation by councils in shared services delivery arrangement can lead to improved efficiency in their operations and assist councils to achieve financial sustainability, for example councils should examine all possible options available to them for cooperative service arrangements from participation in sector wide arrangements established under

local government authority to informal or formal arrangements with neighboring councils. This was also echoed by (Dollery, Grant, & Akimov, 2010). The principles laid out by Australian government of convenient access to government services and information, responsive services, integrated services will lead over all efficiency hence community satisfaction.

There is a large body of scientific knowledge researched in Uganda in reference to removal of user chargers review indicates a lot of research has been done in Uganda in reference to removal of user chargers (Lucas & Nuwagaba, 1999; Meessen et al., 2011; Orem, Mugisha, Kirunga, Macq, & Criel, 2011; WHO, 2005), task shifting (Nabudere, Asiimwe, & Mijumbi, 2011), quality and accessibility (McPake et al., 1999; Ssenooba et al., 2007), reproductive health (Kipp, Chacko, Laing, & Kabagambe, 2007; Koenig et al., 2004; Neema, Ahmed, Kibombo, & Bankole, 2006). From the literature review, there is deficiency in measurement of performance of the health sector in Uganda. This study sets the initial stage for the platform of operational shared services like health in Uganda.

MATERIAL AND METHODS

Methodology

The researcher distributed questionnaires in the selected parishes. Using (Krejcie & Morgan, 1970) table a sample was drawn from the estimated populated of Kampala two million people to arrive to a sampling size of 700. The different parishes selected; Kampala Central 3, Industrial area, Kisenyi and Nakasero; Kawempe 6, MakerereII, BwaiseI, Mulago, Wandegeya, KawempeII and Kazo – Angola; Makindye 8, Kibuye, Kibuli, Kisugu, Kansanga, Bunga, Katwe, Monitor publication and Namuwongo; Nakawa 6, BukotoI, Luzira, Mbuya, Banda, Nakawa, and Naguru and Rubaga 7, Mengo, Katwe, Ndeba, Nalukolongo, Natette, Wakaliga, Kisenyi III. and Cluster sampling was used to generate the parishes and head of household. The interviews were also conducted in 2 villages per division to allow focus group discussion at the health centers and also interview the Public Health Inspectors and head of business in the five divisions of KCCA.

Analysis

723 people were requested to participate and 446 (64.5%) accepted, majority where male. The questionnaire data was coded, entered and analyzed using Statistical Package for Social Science (SPSS) 18.0 software.

Results

To analyze the impact of shared Health services on community satisfaction in KCCA. Community satisfaction was measured in terms of availability of drugs, medical equipments, distribution of health centers, level of treatment, working hours, medical personnel. Professionalism and care as illustrated in table 1 below. Results indicate that sharing health services has significant effects on the availability of drugs, medical equipments, distribution of health centers, level of treatment, working hours, medical personnel. Professionalism and care as seen with p-values less than 0.05 in table 1 below

TABLE: 1 CHI-SQUARE TEST RESULTS FOR THE IMPACT OF SHARED HEALTH SERVICES ON COMMUNITY SATISFACTION IN KCCA

Variable	Chi-square value	P-value
Availability of drugs	24.794	0.003
Medical equipment	35.362	0.000
Distribution of health centers	203.095	0.000
Level of treatment	103.711	0.000
Working hours	9.835	0.000
Medical personnel	214.077	0.000
Professionalism and care	76.877	0.000

The correlation analysis revealed that sharing health services has a significant positive effect on community satisfaction. It is indicated in table 2 that sharing health services has a positive relationship ($\rho=0.095^*$) with the availability of the drugs. This implies that the drugs are somewhat enough to serve all the communities in all the divisions. The equipments are enough as a result of sharing health services ($\rho=0.045$). The more the sharing of health services, the lower the level of treatment offered to clients. The health centers are well distributed ($\rho=.354^{**}$) and health services are uniform across the different divisions as a result of sharing the services. Due to the increase in the number of clients as a result of sharing services, the medical officers ($\rho=-.479^{**}$) are few to serve the clients and as a result of sharing the medical officers are forced to work extra hours. It is also revealed that sharing health services is positively ($\rho=.393^{**}$) related to the level of professionalism and care given to the patients as seen in table 2 below.

TABLE 2. CORRELATION RESULTS BETWEEN SHARED HEALTH SERVICES AND COMMUNITY SATISFACTION

		Shared services	Availability of drugs	Medical equipment	Distribution of health centers	Level of treatment	Working hours	Medical personnel	Professionalism & care
Spearman's rho	Shared services	1.000							
	Availability of drugs	.095(*)	1.000						
	Medical equipments	.045	-0.036	1.000					
	Distribution of health centers	.354(**)	0.027	-.314(**)	1.000				
	Level of treatment	-.220(**)	-0.007	-.232(**)	.628(**)	1.000			
	Working hours	0.069	-0.003	0.016	-0.032	-.268(**)	1.000		
	Medical personnel	-.479(**)	-.104(*)	-.319(**)	.721(**)	.701(**)	-.204(**)	1.000	
	Professionalism & care	.393(**)	.158(**)	-.239(**)	.435(**)	.450(**)	-0.055	.679(**)	1.000

Notes: *. Correlation is significant at the 0.05 level (2-tailed).

** . Correlation is significant at the 0.01 level (2-tailed).

Hierarchical regression analysis between sharing health services and community satisfaction. Hypothesis testing of the effect of sharing health services on community satisfaction was examined.

Ho: Sharing health services does not lead to community satisfaction

H1: Sharing health services leads to community satisfaction.

The results in Table 3 shows a hierarchical regression analysis to test whether sharing health services can lead to community satisfaction. Controlling variables were included to examine whether the results of the regression are affected by these variables. The control variables were entered together with the independent variable as shown below. In model 1, model 2 and model 3, it is clearly revealed that sharing health services has a significant positive effect on community satisfaction. For health, shared services should be encouraged because of it improves basic equipments and operational working hours hence positively impacting on community satisfaction. The respondents' education level was revealed to have significant negative effects on community satisfaction in all the models as seen in Table 3 below.

In model 1, gender ($\beta=0.060$, $p>0.05$), age ($\beta=0.044$, $p>0.05$) were revealed to have positive effects on community satisfaction but however their effects were not significant. It is further indicated in model 1 that the health facilities ($\beta=-0.017$, $p>0.05$), level of treatment ($\beta=-0.077$, $p>0.05$) have insignificant negative impacts on community satisfaction. Implying that shared services have not impacted on health facilities and the treatment levels are still lacking this could be due to limited government funding in the health sector in Uganda since health infrastructure needs government commitment and a lot of resources. The study revealed that the percentage of variance in community satisfaction explained by sharing health services is 13.2% as seen below. The hierarchical model is well specified as the F-values in all the models are significant as seen in Table 3 below.

TABLE 3. HIERARCHICAL REGRESSION ANALYSIS BETWEEN SHARING HEALTH SERVICES AND COMMUNITY SATISFACTION

	Model 1	Model 2	Model 2
	β	β	β
(Constant)	2.564*	2.547*	2.404*
Sharing health services	0.293*	0.287*	0.293*
Gender	0.062	0.060	0.050
Married status	0.113*	0.115*	0.116*
Age	0.044	0.045*	0.052*
Educational level	-0.066*	-0.066*	-0.072*
Equipments health facilities	0.075*	0.073*	0.071*
level of treatment	-0.017	-	-
working hours	-0.077	-0.084	-
	0.103*	0.106*	0.091*

medical personnel	-0.080	-0.088*	-0.117*
R-squared	0.132	0.132	0.128
F-Value	6.060*	6.732*	7.301*

* implies that p value is less than 0.05

CONCLUSIONS

Generally Uganda has registered modest improvement in the health services in Kampala although there are still a lot of grey areas that need to be addressed especially in availability of drugs, health equipments are still not enough even with sharing, level of treatment needs improvement since the number served also increased as a result of working beyond boundaries and therefore urgent need of additional health staff to handle the increased number of patients. Qualitative data indicated that KCCA health centers are open during weekends and public holidays as a result of sharing model that encourages divisions work beyond boundaries in order to achieve community satisfaction and the study is in line with Taylor (1983).

The new novel arrangement of sharing that Kampala Capital City Authority (KCCA) replaced as a method of delivery seems to be yielding positive results though the model works well with increased supervision, total change management of the organization, government commitment, financial support and change in processes and methods of work. The study also revealed that health centers share drugs, basic equipment and transportation i.e., the ambulances are five and being shared among the 10 (ten) health centers in Kampala under KCCA. Shared services model plays a great part in explaining the registered improvement in the health sector in Uganda for the last three years. The development is still modest and community satisfaction has not reached its optimal level, drafting a policy on shared services in Uganda will guide systematic improvement in health services in the country.

Shared services has a number of drawbacks since its success is dependent on how well it is implemented (Dollery, et.al, 2010) and it is not easily generalizable therefore it treated as a case by case basis. Before replicating the model, further research is needed to establish whether shared services improve quality health care and general health improvement. Since this study was done only in Kampala and limited to 10 (ten) health centers, the findings can't be generalized though they act as a quick fix to the initiation stage of improving health sector challenges in Uganda.

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