SHARED HEALTH SERVICES AND COMMUNITY SATISFACTION IN KAMPALA CAPITAL CITY AUTHORITY

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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.

Keywords: Shared health services, Community Satisfaction, KCCA, Uganda

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 clienteles by bringing value to the business.”
Community satisfaction is an assessment of a decision and objective in achieving the needs of the people in a 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, Maq, & Criel, 2011; WHO, 2005), task shifting (Nabudere, Asiimwe, & Mijumbi, 2011), quality and accessibility (McPake et al., 1999; Ssengooba et al., 2007), reproductive health (Kipp, Chacko, Laing, & Kabagambe, 2007; Koenig et al., 2004; Neema, Ahmed, Kibonbo, & 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

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, Makerere II, Bwaise I, 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

<table>
<thead>
<tr>
<th>Variable</th>
<th>Chi-square value</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of drugs</td>
<td>24.794</td>
<td>0.003</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>35.362</td>
<td>0.000</td>
</tr>
<tr>
<td>Distribution of health centers</td>
<td>203.095</td>
<td>0.000</td>
</tr>
<tr>
<td>Level of treatment</td>
<td>103.711</td>
<td>0.000</td>
</tr>
<tr>
<td>Working hours</td>
<td>9.835</td>
<td>0.000</td>
</tr>
<tr>
<td>Medical personnel</td>
<td>214.077</td>
<td>0.000</td>
</tr>
<tr>
<td>Professionalism and care</td>
<td>76.877</td>
<td>0.000</td>
</tr>
</tbody>
</table>

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 ($\rho=0.095^\ast$) 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 ($\rho=0.045^\ast$).

The more the sharing of health services, the lower the level of treatment offered to clients. The health centers are well distributed ($\rho=0.354^{**}$) 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 ($\rho=0.479^{**}$) 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 ($\rho=0.393^{**}$) 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.

<table>
<thead>
<tr>
<th>Spearman's rho</th>
<th>Shared services</th>
<th>Availability of drugs</th>
<th>Medical equipment</th>
<th>Distribution of health centers</th>
<th>Level of treatment</th>
<th>Working hours</th>
<th>Medical personnel</th>
<th>Professionalism &amp; care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared services</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of drugs</td>
<td>.095(*)</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical equipment</td>
<td>.045</td>
<td>-0.036</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distribution of health centers</td>
<td>.354(**)</td>
<td>0.027</td>
<td>-0.314(**)</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of treatment</td>
<td>-.220(**)</td>
<td>-.007</td>
<td>-.232(**)</td>
<td>.628(**)</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working hours</td>
<td>0.069</td>
<td>-.003</td>
<td>0.016</td>
<td>-.032</td>
<td>-.268(**)</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical personnel</td>
<td>-.479(**)</td>
<td>-.104(*)</td>
<td>-.319(**)</td>
<td>.721(*)</td>
<td>.701(*)</td>
<td>-.204(**)</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Professionalism &amp; care</td>
<td>.393(**)</td>
<td>.158(**)</td>
<td>-.239(**)</td>
<td>.435(**)</td>
<td>.450(**)</td>
<td>-.055</td>
<td>.679(**)</td>
<td>1.000</td>
</tr>
</tbody>
</table>

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

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

Conclusion
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 lacking even with sharing, level of treatment needs improvement since the number served also increased 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).

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.

References


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