

**The Effects of Globalization on Health: A Case Study of Kenyatta  
National Hospital (KNH) Referral Healthcare Services**

**Simon Mung'athia Ithai  
BA (Hons.), PGD (PR)**

**A Research project submitted to the Institute of Diplomacy and  
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requirements for the award of Degree of Masters of Arts in International  
Studies**

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## DECLARATION

I SIMON MUNG'ATHIA ITHAI, hereby declare that this work is my own original work and has not previously in its entirety or part been submitted at any university for a degree.

Signed:  \_\_\_\_\_

Date: 21/11/08

This dissertation is submitted for examination with approval as the University Supervisor.

Name: DR. ADAMS OLOO

Signed:  \_\_\_\_\_

Date: 21/11/08

## DEDICATION

This work is dedicated to my wife Nanis Nkatha, my sons; Reagan, Richard and Robin and in memory of my dear and dedicated dad the late Francis M'Ithai M'Mithiaru and my Mum Jerusa Kinanu for their inspiration and encouragement to invest in knowledge.

## ACKNOWLEDGEMENT

From the beginning it was clear to me that this is not about me or what I can do, rather this is about what God wants me to do and how He will enable me to do it.

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Whatever I am and have right now, it all stems from the loving grace and mercy of my Saviour, Friend, Father, Comforter, and Lord, **Jesus Christ**. He alone deserves all praises and glory for without Him, I can do nothing... without Him, I am nothing.

*Psalm 19:14 "May the words of my mouth and the meditation of my heart be pleasing in your sight, O Lord, my Rock and my Redeemer. "*

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## LIST OF ACRONYMS

KNH	Kenyatta National Hospital
MDGS	Millennium Development Goals
MOH	Ministry of Health
UON	University of Nairobi
KMTC	Kenya Medical Training College
CDC	Centre for Diseases Control
FHI	Family Health International
AIDS	Acquired Immune Deficiency Syndrome
ICT	Information Communication Technology
WHO	World Health Organization
WB	World Bank
IMF	International Monetary Funds
SAPs	Structural Adjustment Programs
DCN	Deputy Chief Nurses
HRM	Human Resource Manager
GATT	General Agreement on Tariffs and Trade
FDI	Foreign Direct Investment
WTO	World Trade Organization
GDP	Gross Domestic Product
UN	United Nations
UNDP	UN Development Program
TNCs	Transnational Corporations
NAFFA	North American Free Trade Association

ACEAN	South East Asia Nation
MNCs	Multinational Corporations
GM	General Motors
ENT	Ear, Nose and Throat
MOW	Ministry of Works
DMRD	Diploma in Medical Radiodiagnosis
JICA	Japanese International Cooperation Agency
ICU	Intensive Care Unit
CT scan	Computerized Tomography scan
MRI	Magnetic Resonance Imaging
IAEA	International Atomic Energy Agency
USA	United State of America
MOU	Memorandum of Understanding
EPZ	Export Processing Zone
AMREF	African Medical Research Foundation
USAID	US Agency for International Development
NGOs	Non Governmental Organizations
UNICEF	United Nations Children Fund
NIH	National Institute of Health
DFID	Department of International Development
MEAK	Medical and Education Aid to Kenya
UAE	United Arab Emirate
OS	Operation Smile
EWB	Emirates World Heart

RSNA	Radiological Society of North America
OED	Operation Ear Drop
INS	International Neurological Society
PAAN	Pan African Association of Neurosurgery
LAN	Local Area Network
INCTR	International Network for Cancer Treatment and Research
IUAC	International Union Against Cancer
ARV	Anti Retroviral
PEPFAR	Presidents Emergency Plan for AIDS Relief
UNAIDS	United Nations program on HIV/AIDS
NARESA	Network of AIDS Researchers of Eastern and Southern Africa
TB	Tuberculosis
STIs	Sexual Transmitted Infections
MDRTB	Multidrug Resistance TB
CS	Cost sharing
SHD	social health determinants
NHIF	National Health Insurance Funds



*“The problems of the world cannot possibly be solved by skeptics or cynics whose horizons are limited by the obvious realities. We need men who can dream of things that never were”*

John F. Kennedy

## **Abstract**

The emergence of globalization has cultivated an international consensus that without economic development; it is very unlikely that a country may realize social or political development. It is equally important to note that the economic effect on social development automatically influence the country healthcare services as healthcare systems are improved and adopted.

For decades and before 1980s, the colonial and the Governments of Kenya had pursued a goal to provide free healthcare services to its citizen with minimal success; but as population increased, this endeavor became almost a mirage. The challenge called for a change of strategy with introduction of cost sharing which also could not guarantee sustainability of healthcare services in the country due to increased number of poor people and poverty. An involvement of multisectoral approach to provision of health individual collaboration and adoption of all dimensions through globalization provides a ray of hope to not only economic, political and social development but also guaranteed equitable and reliable healthcare systems in Kenya and specifically referral healthcare services at KNH

With the advent of globalization, KNH has made positive strides that have guaranteed patients with reliable healthcare services. These include increased donor funding, collaboration levels, training and research as well as enhanced the hospital relations with international partners. During this period, the hospital has increased number of local doctors and nurses, enhanced transfer of skills, innovations and technologies which are driving forces to quality and efficient healthcare services. The period has also brought in challenges for the hospital which include increased competition, attraction of qualified nurses and doctors to international are some the issues that have made the hospital to spend more resources in research and development in order to stay afloat. This paper reveals the link between globalization and healthcare and its

influence on institution policy choice. However, the process is not expected to take place automatically without institutional initiatives if KNH is to reap the benefits of globalization. KNH need to make use of the existing infrastructure, human resources and donor confidence, the opportunities that are indeed important in propelling KNH toward Vision 2030 and achieving the desired Millennium Development Goals (MDGs).



# CHAPTER I

## Introduction

Globalization is the flow of information, goods, capital and people across political and economic boundaries<sup>1</sup>. This implies that there is widening, deepening, and spread of worldwide integration as well as interconnection among all aspects of contemporary social life, cultural, financial, trade, investment, technology to spiritual and diseases as well. Indeed globalization of diseases begun in 1892 when the Europeans discovered and inflicted one of the earliest genocide on the American peoples through the importation of smallpox, measles and yellow fever, as the use of force and firearms. Therefore, the potential impacts of globalization also support a broader understanding and practice of public health that embraces a wide range of health determinants such as economic, social and political. According to *Lee, (2000)* globalization is 'the process of closer interaction of human activity across a range of spheres, including the economic, social, political and cultural, experienced along three dimensions: spatial, temporal and cognitive.'<sup>2</sup>

Mobility of people will transmit other multiplier effect in developing countries such as knowledge and skills, integration of culture diversity and flow of new technologies. These are major sources of investment, a conduit for technology transfer and spur growth in other sectors of the economies such as health, transport and communication and other social welfare deliveries. Globalization will bring together public and private enterprises that would be necessary to promote economic integration. An integrated system can often provide a broader

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<sup>1</sup> Daulaire N. *Globalization and Health Development; International Roundtable on 'Responses to Globalization: Rethinking Equity and Health'*, International Development (SID)& the World Health Organization (WHO), Geneva (1999) pp22-24

<sup>2</sup> Lee K. *Globalization and health policy: a review of the literature and proposed research and policy agenda in: health development in the New Global Economy PAHO: Washington (2000) pp 112.*

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range and depth of services not available in a smaller or single service organization as well as reduction in opportunity cost of services<sup>3</sup>.

Good health for all populations has become an international goal and we can state that there have been broad gains in life expectancy over the past century. Health inequalities between the rich and poor persist, while the prospects for future health depend increasingly on the relative new processes of globalization. Public health is broadly focused as a collective health of populations that requires a range of intersectoral activities for it to be realized. It is important to focus public health and globalization in the light of their relationship and impact on effective policy responses by range of public health institutions. The health of the people in the world is greatly influenced by social, economic, cultural, and political factors.

However, the demand for healthcare has not been marched with the expansion of health services infrastructures especially in most developing countries which now view globalization as an opportunity that can help them check their inequalities. Globalization enhances the spread of ideas, culture, values and free flow of goods and services in the world markets and facilitated transfer of neo-liberalism of the 1980s. In addition, the increased movement of people and unrestricted flow of information have made institutions and business firms in both developed and developing countries expand their sphere of operations internationally<sup>4</sup>. Globalization presents opportunities for developing countries to survive the turbulence of economic, social and political competition emerging from developed nations. The degree to which countries have moved toward globalization varies widely due to divergence in skills, market size, and technology development and populations structure among others. In both the industrialized and the developing countries, there is considerable apprehension to globalization.

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<sup>3</sup> M. Rugumamu, *Globalization demystified- Africa's possible development future*. Dar Es Salaam University Press Ltd. Tanzania. (2005) pp5

<sup>4</sup> N. Crafts *Globalization and Growth in the Twentieth Century*, IMF Working Paper, WP/00/04, IMF, Washington D C. (2000) pp 1-4

Some argue that the rising flow of trade, labour and capital has heightened the sense of vulnerability where "Blue" and many white-collar workers in industrial countries fear being displaced by cheap labour from developing countries.<sup>5</sup>

Despite the widespread globalization of state institutions in the North, the South economies is faced with increased crime, mass migration, the spread of deadly diseases and the widening North-South inequality gaps. Africa thus is no exception and according to Rugumamu, (2005) globalization has forced majority of Africans into strategies of no more than survival, denying majority of people even the opportunity to life. It is in this view that such an undertaking would be important to evaluate the effects of globalization at sectoral institutions of the economy especially the health sector which is the anchor of economic growth and development.

### **Background to the Research Problem**

The most important dilemma in the world today – and the most fraught with appalling consequences for the future – arises from the enormous and increasing economic gap between the developed and developing, the rich and the poor world. This central issue of the world politics is likely to dominate political thinking well beyond the 21<sup>st</sup> century, if not longer, and in this connection delivery of healthcare services is a crucial factor.

Poverty and poor healthcare exist in tandem, one leading to the other. Poor healthcare reduces both human activities and mental creativity and may consequently lead to death if not urgently addressed. Studies in the developed economies have show that basic education and good healthcare are among the most powerful forces that propels economic development,

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<sup>5</sup> Ayres Jeffrey M. *The power of the internet in marshalling protest increases the possibility of a backlash. The failure to ratify the multicultural agreement on investment was because of a well-oriented effort mounted by international NGOs using the internet to galvanize widespread support. Similarly the resistance to the meetings in Seattle reflects "the change dynamics of contention in the global age". From the Streets to the Internet. The Cyber-Diffusion of Contention. Annuals (1999) p132-143.*

consumption and consequently economic growth. There have been efforts by the developing countries to strive and reduce the knowledge gaps which separate poor countries from rich countries in order to achieve positive economic growth, healthcare development and social progress<sup>6</sup>. It is anticipated that the panacea for bridge the gap is for the developing countries to engage in the global market so that they can benefits from the trickle down of the developed countries through their goods and services, technology, ideas, skills and capital. While these efforts are being made to access the benefits of globalization in trade and industry, little is known of its effects on delivery of social services in Kenya such as healthcare. It is in this spirit that this study wishes to determine the effects of globalization on delivery of specialized healthcare services by Kenyatta National Hospital (KNH).

KNH was established in 1901 by the colonial government to provide medical services to mostly European settlers. The initial two-ward 45 bed hospital known as “The Native Hospital, expanded its services to cater for Africans and Asians between 1922 and 1937. In 1952 the hospital was renamed King George IV Hospital. Following Kenya’s Independence in 1963, the hospital was named Kenyatta National Hospital in honor of the founding President of the Republic of Kenya, the late Mzee Jomo Kenyatta<sup>7</sup>. KNH became a state corporation in 1987 under the Ministry of Health (MOH) through a Legal Notice Number 109. It is the second largest hospital in Africa with a bed capacity of 1800 out of which 225 beds are in the private wing. The hospital has a staff of 4,955 out of which 220 are doctors and 1700 nurses<sup>8</sup>. According to KNH strategic plan (2005-2010), the hospital is experiencing high turnover of highly skilled personnel (doctors and nurses) who are being attracted by other competitors both local and international. However, in as much as the hospital is lying down strategies to counter the challenge, there is no available information to determine whether this is due to the effects

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<sup>6</sup> Kachienga, O. M., *Health Technology Assessment in Sub-Saharan Africa: Across-National Study of Kenya and South Africa*. University of Cape Town, South Africa (1999)pp2

<sup>7</sup> KNH, *Strategic Plan 2005-2010*, KNH, Nairobi (2006) p viii

<sup>8</sup> *Ibid.* (2006)pp 13

of globalization. KNH medical services are guided by its broad mandate which is “to provide specialized quality healthcare, facilitate medical training, research and participate in national health planning and policy”. KNH is thus the apex of medical referral services in Kenya, Central and Eastern Africa Region offering specialized medical services such as radiology, cardiothoracic surgery, neurosurgery, plastic and reconstructive surgery, critical care services (intensive care services and high dependency services) and kidney transplant among others services. KNH offers healthcare to patients from Namibia, Burundi, Rwanda, Tanzania, and Uganda in addition to supporting these countries in capacity building and technology transfer through training of their medical health personnel. The hospital also provides facilities and resources for training, teaching and research to College of health sciences, University of Nairobi, and other training institutions both local and international.

In order to fulfill its mandate, KNH collaborate far and wide with both local and international institutions that endeavors to improve human health namely; Kenya Medical Training Institute (KMTC), University of Nairobi (UON), Centre for Diseases Control (CDC) of USA, Family Health International (FHI) of USA, Glasgow University, among others. This shows that KNH is a global actor in medical services such that it is important to determine the effects of globalization on its healthcare services. There is need to understand the forces of globalization in order to recognize their benefits and threats to human well-being, and to develop thoughtful and effective responses that would harness and guide them toward supporting healthcare services in Kenya.

### **Statement of the Research Problem**

Understanding globalization as a subject needs certain benchmarks and barometers of its successes and failures. Healthcare is one such barometer. It is one of the markers of social infrastructure and social welfare and as such can be used to either sound an alarm or give a

victory cheer as our interconnectedness hurts and heals the populations we serve. Healthcare is a basic requirement for man's survival and it is therefore of cardinal importance that this service is available to as many people as is practicable and thus the need to evaluate the effect of globalization on this vital services in the developing countries which endeavors to make it a success for their citizen. In as much as globalization can have an effect on healthcare, it is also true that health and diseases have effects on globalization as exemplified by the existence of quarantine laws and the devastating economic effects of the AIDS pandemic. In large measure, disparities in health status of a nation reflect coping practices that are mediated by socio-economic position and ability to access and use health-care opportunities. Globalization is presumed to enable healthcare professionals to identify specific resources in one country to facilitate medical treatment for patients in another country as well as create linkages for consultation among medical professionals whenever they are faced with medical challenges. Globalization also facilitate access to social and healthcare services provided in varying countries, promoting healthcare education and mobility of healthcare personnel across the world thus promoting maintenance of healthcare practices

While much attention has been given to the impact of globalization on economic and social policies, debates on the effects of globalization on national healthcare services has received less attention and predominantly in developing countries. Kenya, like any other developing country participate less in the global arena although the country is indeed being affected by world volatile interconnectivity that is influencing economic, social and political policies. Despite the increasing awareness on globalization, there is no documented evidence on its effects on medical healthcare services in Kenya and especially on referral healthcare services at KNH.

KNH plays a significant role in the provision of quality and specialized healthcare services not only to over 30 million patients in Kenya but also to patients within the central and the East



Africa Region. In order to undertake its responsibilities effectively, KNH interact far and wide within the international arena in search of opportunities that would make healthcare services accessible, efficient, reliable and competitive within the national health sector. The hospital also attracts global attention as the second largest hospital in Africa and a source of data for research and training in tropical diseases as well as an appropriate centre for drugs evaluation. Therefore, KNH interaction in the international arena is highly influenced by the presence of globalization; and since globalization present both negative and positive effects in the general economic growth and development, there is a likelihood of affecting the hospital healthcare services.

This study will therefore seek to determine the effect of globalization on KNH specialized healthcare services after 1980s. That would require a review of variables before and after 1980s that will include technology, human mobility, capital flow (investment, partnerships, and donation); training through the exchange programs, sponsorship, fellowships and information communication technology (ICT), policies, that presents both direct and indirect effect on economic development and growth and consequently health services.

## **Objectives of the study**

### **Broad Objectives**

1. To determine the effects of globalization on KNH medical referral healthcare services.

### **Specific Objective**

1. To compare levels of international involvement and donor support for healthcare services at KNH before and after 1980s
2. To compare the hospital levels of general development before and after 1980s
3. To determine the effects of foreign partnerships for general healthcare services before and after 1980s
4. To determine the number of medical personnel turn over after 1980s

### **Justification of the Study**

Globalization is normally viewed in the economic context whether being discussed at micro or macro levels of the economy. There has been substantial discussion on globalization in the scholarly and popular press, yet there is limited attention on the effects of globalization on health services in Kenya. It is also important to note that the National Health Service in Kenya has been subjected to multiple waves of reform promoting market mechanisms and public private partnerships both in capital investment and service delivery. In addition the government has set standards and encouraged public scrutiny of the public services and has actively promoted a greater role for patients in evaluating and developing healthcare services. That encourages hospitals such as KNH to seek opportunities that would widen their resources base in order to provide competitive and efficient specialized services. The hospital healthcare services have also faced pressures in terms of competition from both local and international investors and such a study provides insight on opportunities that would give it an added advantage.

Likewise, previous studies have focused on the influence of globalization on economy, political and social factors with scanty information on its effects on healthcare, which is central to other levels of society. Since globalization is here to stay, an evaluation of its effects on medical healthcare services especially for the case of KNH is paramount.

### **Policy**

KNH will be able to determine the advantages and disadvantages of globalization on its healthcare delivery services.

### **Academic**

The study will fill academic gaps in the study of globalization and its effects on provision of healthcare services in public health facilities. The study will further shed light on the linkages between globalization and delivery of healthcare service among public health institutions.

## Literature Review

### The Ideological Perspective of Globalization

The ideology associated with globalization is seen in the economic perspectives of “*market forces*” of an “*invisible hand*” of the market mechanism that must be allowed to operate unimpeded<sup>9</sup>. It is important to note that in many poorer countries, ‘market forces’ policies have been introduced as part of structural adjustment programs<sup>10</sup>. This is due to declining international assistance and increasing debt that have forced many governments to accept conditions imposed by the World Bank in return for loans from the International Monetary Fund.

In the past, globalization has often been seen as a more or less an economic process that solely influences the flow of capital, goods and services. Little attention has been made on the effect of globalization on health<sup>11</sup>. Global and national thinking is therefore oriented towards privatization, liberalization, subsidization; regulation and protection of national enterprise are frowned upon. Unburdened by government taxes, intervention and regulations, the argument goes, *a competitive private sector will stimulate trade and attract foreign investment*. In many countries, governments have willingly adopted the ideology of globalization. The big question is whether or not this new level of transnational integration will be strong enough to prevent competition among states for world hegemony<sup>12</sup>.

In any economy, countries are striving to amass wealth as a source of national security. The wealth of a country determines the average level of income per person, which is also an indicator of individual ability to access healthcare, education and other basic welfare facilities. Likewise, the wealth of a country is highly influenced by its role within the world economic

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<sup>9</sup> D' Rourke, K *Globalization and History*. MIT Press, Cambridge, (2000) pp78

<sup>10</sup> Alhrow, M. *The Global Age*. Cambridge, U.K.: Polity Press (1996)pp12

<sup>11</sup> Jon. B., *Mapping the Futures. Local Cultures. Global Change*. London and New York: Routledge (1993) pp56

<sup>12</sup> Amin, S. *Capitalism in the Age of Globalization*. Zed Press, London: (1997) pp112

system<sup>13</sup>. The global economic changes therefore influence a country's economic growth and consequently its ability to provide basics and welfare facilities to its citizens. Health is also a world commodity for everyone on earth and thus is a global public good. Nation-states are working independently to satisfy health needs of their citizen, which in turn brings nations and international institutions together in formal and informal collaborations in order to provide their citizens with better healthcare. The push/pull partnership at the global, regional, national and local levels will not only bring in sharing of resources but will also provide array of solutions to a myriad of healthcare needs especially in the developing countries<sup>14</sup>. Nations that act together can greatly increase chances of providing numerous and sustainable opportunities to their citizens. Provision of healthcare in any nation is highly influenced by the national income that is usually transmitted to per capital income. This study will therefore try to determine the effects of globalization on healthcare services in Kenya and specifically effects on provision of health services at KNH.

### **Globalization and Health**

Although the burden is greatest for the developing world, infectious diseases are a growing, threat to all nations. However, the same globalizing forces that creates such rampant opportunity for pathogens also can provide mechanisms for innovative, global efforts to control infectious diseases. Global governance structures are gaining more and more importance in formulating health (related policies); According to Dodgson *et al.* (2002), the most important organizations in global health governance are the World Health Organization (WHO) and the World Bank (WB)<sup>15</sup>. The latter plays an important role in the field of global health governance, focuses on reaching the Millennium Development Goals<sup>16</sup>. The WB also influences health (related) policies together with the International Monetary Funds (IMF) through the Structural

<sup>13</sup> Richard P Globalization and the Modernization of Canadian Labour Policy Canadian Public Policy, Vol.28, No.1.(Mar.,2002),pp.81-91.

<sup>14</sup> K Douglas Theorizing Globalization Sociological Theory, Vol.20, No.3. (Nov., 2002), pp.285-305.

<sup>15</sup> Dodgson R Global health governance . a conceptual review London , centre on global change and health . London school of hygiene and tropical medicine,(2002)pp23

<sup>16</sup> WHO Annual report, polio free Kneya . WHO , Kenya ( 1994)ppp 31

Adjustment Programs (SAPs). In order to give a more central role to pro poor growth consideration in providing assistance to low-income countries, the IMF and WB introduced the poverty reduction strategy in 1999. Some of these programs have lead to the introduction of cost sharing in public hospital and emergence of competition between private public health services in developing countries<sup>17</sup>

Globalization has also brought in multinational partnerships that are increasingly contributing to health by availing drugs and vaccines, the development of healthcare infrastructures in developing countries, and better public health education programs worldwide. The global proliferation of technology and information has the potential to improve the identification, surveillance, containment, and treatment of disease in both developed and developing countries. Growing international cooperation may also lead to more robust and transparent reporting regarding disease outbreaks and control efforts. Today, no microbe in the world is more than 24 hours away from the gateways of every industrialized country, and what incubates today in the tropical rain forest can emerge tomorrow in a temperate suburb. Studies show that the outbreak of influenza virus pandemic in 1918 – 19 in Europe might have been brought in from China along with the Chinese laborers recruited by the British and French to work on the railway line in France during the World War I<sup>18</sup>. Distance learning, training, and research exchange programs are creating improved access for scientific and medical professionals.

Globalization is causing profound and complex changes in the very nature of our society, bringing new opportunities as well as risks. Despite some empirical research efforts indicating the links between the globalization process and specific health impacts, the present weakness in

<sup>17</sup> WHO Annual report, polio free Kenya, WHO, Kenya (1994) pp 32

<sup>18</sup> Population council, Population and development Review vol3 No. 3: Blackwell Publishing, Kenya (2005) pp 475

empirical evidence on the multiple links between globalization and health is still a problem.<sup>19</sup> In addition, the possible future health impacts of different globalization pathways by means of scenarios analysis could provide a useful contribution to the ongoing discussions on globalization and health.<sup>20</sup> The study would therefore be a useful tool for further studies on the health implications of the globalization process.

### **Electronic and Communication Revolution**

Although the term globalization has been used for a long time with reference to economic phenomenon, there are ripple effects that make the impact of globalization much broader socially and culturally. Ideas, customs, and cultural movements all follow closely after the exchange of goods across national boundaries. Much of the global integration occurs through the channels of technology such as electronic and communication. Communications revolution has heightened and changed our expectations and perception especially the use of internet and superhighway transmission of information. The use of electronic communication such as email has reduced reliance on postal systems. Previously, ideas and technologies took centuries to diffuse across the globe<sup>21</sup>. With electronic communication media, the most novel ideas can reach around the globe, or news of events in one continent can drastically affect financial markets around the world. Because of the electronic media, vast amounts of important information can reach any parts of the globe in no time. Business establishments, whether big or small, are using the Internet in many ways to build or expand their company's growth. With the ever improving technology come new markets, high demand for products, and also greater competition. Making investments in information and communication technology is now a must for any business enterprise. Another form of improved technology is the fusion of the Internet and the fax machine, giving birth to Internet faxing. Internet faxing is faster and more

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<sup>19</sup> Collin, J., *Review of existing empirical research on globalization and health*. WHO, Geneva, (2000)pp56

<sup>20</sup> M. Huynen et al *the health impacts of globalization: a conceptual framework*. Bilthoven. Netherlands Environmental Assessment Agency (2005) pp2

<sup>21</sup> World Bank, *Statement on New Technology*. New York (2000).

economical than traditional faxing. It is a general term which refers to the convenient use of faxing technology over the Internet.

The communication highway has fostered the spread of health systems reform, information and facilities. However, to take advantage of this opportunity, people need to have access to regular electricity, computers, training, and education. Countries and institutions that do not have these facilities risk marginalization. Electronic and communication has also influenced healthcare delivery services through telemedicine. This a practice of medical care by doctors using interactive audio, visual and data communications. Telemedicine provides healthcare where there is none and improves the health care where there is some. It is one way to bring / provide access to quality health care to under-served rural & urban masses. In India, telemedicine networking allows doctors to exchange medical care skills, consultation, diagnosis and treatment, as well as education and the transfer of medical data<sup>22</sup>. The Apollo Group of Hospitals of India, plan to extend telemedicine facilities to cover 125 primary health centers, 25 district hospitals and three tertiary centers in the country<sup>23</sup>. Using special software and hardware, doctors at the telemedicine centre in a hospital can scan, convert and send data images several hundred kilometers away to other interconnected hospitals.

This is indeed a challenge to majority of the developing countries especially in the African continent where communication is at its infancy stage and the few available are left to minority elite and political class. This study will therefore strive to bring out our level of initiative towards making health services accessible via electronic communication.

A major aspect of globalization is that capital moves faster and more easily across national borders. Countries compete more intensively for investment and are driven to converge on the

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<sup>22</sup> Zarril S. *International trade in health services: a development perspective* United Nations and WHO, Geneva: (1998) pp 115

<sup>23</sup> *Ibid* (1998) p 120



most capital-accommodating policy, regardless of local preferences or factor endowments. While capital mobility always induces policy convergence among countries, the level of convergence increases with the number of countries; and convergence is less pronounced among countries with geographical disadvantaged, richer, and less capital-friendly countries<sup>24</sup>. If every country is alike except for tax level, regulation, and public goods, then every country should compete equally vigorously to attract business and capital. However, countries have important differences that affect their attractiveness to firms and investor. Among unequal economic countries, capital mobility is often welfare-improving for the average citizen in less developed country.

Some economic scholars have urged that free movement of capital across national borders, constrains governments to pursue more capital-friendly policies. Any government efforts to redistribute wealth or to restrict its use will be met by "capital flight" and impending economic collapse<sup>25</sup>. Government action and control is now seen as the cause of inflation, debt and economic recession, while the private sector is promoted as the creator of efficiency and growth.<sup>26</sup> Deregulation has however led to financial volatility that has contributed to unemployment, hardship marginalization where low developing countries are hardly part of the global economy (unless they are repaying debts). All these factors are creating greater inequalities between groups, both within and between countries, which are then reflected in health experience.

In the health sector, direct influences have come with deregulation of trade. Reduced overall governments spending means that spending on health falls since governments are the main providers of mother and child health services, AIDS prevention, and other diseases control

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<sup>24</sup> <http://ssrn.com/abstract=1084129>

<sup>25</sup> Smith, B. Capital Market Imperfections. *Inter-national Credit Markets, and Nonconvergence*. *Journal of Economic Theory* 73(2), . (1997)pp 335-364

<sup>26</sup> Sutherland P *Answering Globalization challenges*. *ODC Viewpoint* . Geneva ( 1998) P 22

programs leading to serious reduction on healthcare initiatives<sup>27</sup>. This method of introducing the market mechanism into the provision of healthcare obviously makes healthcare services less available to the poor especially in developing countries.

### **Economic development and Social Services**

“Optimists” of economic benefits of globalization argue that global markets facilitate economic growth and security, which would benefit health. Additionally, it is argued that although other nations or households might become richer, absolute poverty is reduced and that this is beneficial for the health of the poor<sup>28</sup>. While pessimists are worried about the effects of globalization on health, the risk of exclusion from the growth dynamics of economic globalization is significant in the developing world. That notwithstanding, some spectacular growth rates in the 1980’s, especially in East Asia, incomes per capita declined in almost 70 countries during the period<sup>29</sup>.

Joseph Stiglitz notes that the introduction of IMF policies in the developing countries typically were handed out blindly in an effort to adhere to “*market fundamentals*” that later landed these economies in more critical problems than good. In terms of health, services were reduced or removed, and now health care is either unavailable for the poor in many parts of the world, or is too expensive<sup>30</sup>. In Africa, for example, the health care systems inherited by most African states after the colonial era were unevenly weighted toward privileged elites and urban centers. In the 1960s and 1970s, substantial progress was made where most African governments increased spending on the health sector. Their initiatives endeavored to extending primary healthcare that emphasize the development of a holistic public health system to redress the inequalities of the colonial era. This was not realized due to economic crisis of the 1980s that

<sup>27</sup> Dollar D. *Is globalization good for your health?* The World Bank, Washington: (2001) p4

<sup>28</sup> Oman C *The policy challenges of globalization and regionalization* OECD development centre , Paris ( 1996) pg 57

<sup>29</sup> Slight: J *Globalization and its Discontents*, Allen Lane Penguin Books, London: (2002); p45

<sup>30</sup> L. David *Introduction: Globalization and the Humanities*, *Comparative Literature*, Vol.53, No.4. (Autumn, 2001), pp. 275-282.

slowed the economic and social progress of most African countries. This period saw many African governments become clients of the WB and IMF; they forfeited control over their domestic spending priorities. The loan conditions of these institutions caused contraction in government spending on health and other social services. It is in this regard that the study will evaluate government health policies that are driven by the forces of major actors of globalization and their effects on healthcare services in Kenya.

### **Knowledge and Technological know-how**

The knowledge capital within a population is increasingly affected by developments in global communication and global mobility, which contributes to “*globalization of education*” meaning the process of acquiring and getting education far and wide within the globe. Millions of people now acquire part of their knowledge from Tran’s world text books, due to the supra-territoriality in publishing. Because of new technologies, most colleges and universities are able to work together with academics from different countries; students have opportunities to study abroad and ‘virtual campuses’ have been developed. The diffusion of new technologies has enabled researchers to gather and process data in no time resulting in increased amounts of empirical data<sup>31</sup>. Overall, it is expected that these developments improves healthcare training and education.<sup>32</sup>

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<sup>31</sup> J Scholte *Globalization a critical introduction.. New York , Palgarve (2000)p34*

<sup>32</sup> *Ibid* (2000)p37

## Globalization and the Rising Health Inequalities

While the crisis of access to medical care in poor countries has multiple determinants, intellectual property protection leading to high prices of medical equipment and medicine which contribute to the existing critical element of the access gap. Given the current international political climate, systemic, government-driven reform of intellectual property protection seems unlikely in the near future<sup>33</sup>. With the advent of globalization, developing countries can now source for medical supplies from the developed countries online through procurement, collaboration, donations, and inter-institution exchange programs and donor support. These arrangements have not only improved medical supplies in most developing countries but have also enhanced delivery and quality of healthcare services.

Health delivery system in many countries has deteriorated; there is increased limited access to healthcare facilities and low quality of medical care while drugs are not available. In some low income countries, over 70% of the health budget support is from external sources. As public health systems have broken down, so has the spread of infectious diseases become increasingly liable-hitting the poor disproportionately<sup>34</sup>. Emerging and re-emerging of infectious diseases has risen over the past decades, partly because of growing drug resistance, new diseases such as AIDS and partly because of the political ignorance (self interest) promoting corruption into public health instituting system. Low levels of governments commitments in developing countries has also seen re-emerging of diseases challenges include tuberculosis, which was presumed conquered in the industrialized world in the 1950s, bounces back in the late 1980s, and unexpected outbreak Ebola among others<sup>35</sup>. According to the *Red Cross/Red Crescent*, the increased international human movement due to improved transport and reduced cross-border restrictions has enhanced movement of such diseases across nations<sup>36</sup>.

<sup>33</sup> Brundtland G. *poverty and Health Report EB 105/5* by Director General. WHO.: Geneva. (1999) p123

<sup>34</sup> J. Newcob *Biology and border: SARS and the new economics of Bi-security. Bio-economic research associate: Cambridge (2003) p 143*

<sup>35</sup> *Annual report . Polio free Kenya* WHO , Kenya ( 2003) p 77

<sup>36</sup> [www.redcross.int](http://www.redcross.int)

However, some considerable gains have been realized especially considering that at the time of the founding of the World Health Organization (WHO) in 1948, the average global life expectancy was 46 years. Today, life expectancy has risen to 65 years. This can be attributed to the concerted efforts to combat diseases through public-private partnerships which is now being encouraged in most developing countries. In addition, provision of medical healthcare services in most developing countries, ministries of health have contracted out various hospital services such as laundry or cleaning; or contracted private hospital and clinics to provide particular services<sup>37</sup>. In 1980s, the world has witnessed other healthcare major players at the international arena such as multinational pharmaceutical companies as well as philanthropist who have made large contribution towards improving health through financial and research support. Ted Turner and Bill Gates for example have become important players in the global health. In 1999, the Melinda and Bill Gate foundation pledged \$ 6 billion for vaccine development worldwide; WHO annual budget is less than US\$ 1 billion<sup>27</sup>. Transnational corporations are also the key global private-sector actors which market drugs and equipment. Their continued accumulation of profits has partly contributed to poverty in developing countries and reduced access to healthcare services or encourage money for health policy.

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<sup>37</sup> P. Gleick : the worlds water 2002 – 2003 the biennial report on fresh water resources . Washington, DC Island press (2002) P6

## Theoretical Framework

### Functionalism Theory

The Theory of Functionalism is the oldest, and still the dominant theoretical perspective in sociology and many other social sciences. It is a perspective built upon twin emphases; application of the science method to the objective social world, and use of analogy between the individual organism and society<sup>38</sup>.

The emphasis on scientific method affirms the assertion that one can study the social world in the same way as the physical world. Thus, Functionalists see the world as being objectively real and observable with such techniques as social surveys and interviews. They tend to have a positivistic view that assumes that the study of the social world is value-free, in that an investigator values will not necessarily interfere with the disinterested search for social laws governing the behaviour of social systems. According to Sewell (1966)<sup>39</sup>, his major concern was how societies could maintain their integrity and coherence in the modern era, when things such as shared religious and ethnic background could no longer be assumed. He sought to create one of the first scientific approaches to social phenomena that explain the existence of different parts of a society with varying function that keeps the society healthy and balanced “a position that would come to be known as functionalism”.

In his work, Sewell examined how social order was maintained in different types of societies and paid focus to ‘division of labor’ and examined how it differed in traditional societies and modern societies. He argued that traditional societies were ‘mechanical’ and were held together by the fact that everyone was more or less the same, and hence had things in common<sup>40</sup>. That in

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<sup>38</sup> J. Sewell, *Functionalism and world politics a study based on united nations programs financing development*. New jersey, Princeton University Press (1966) p1

<sup>39</sup> *Ibid*, p7

<sup>40</sup> Sewell, J. *Functionalism and world Politics*, Princeton NJ, Princeton University Press (1966) p 359

traditional society, collective consciousness entirely subsumed individual consciousness; social norms are strong and social behavior well-regulated.

Mitraný (1966) also argued that in modern society, the highly complex division of labor resulted in organic solidarity, where different specializations in employment and social roles created dependencies that tied people to one another, since people could no longer count on filling all of their needs by themselves<sup>41</sup>. Functionalists thus explain the importance of globalization process in enhancing filling of technological gaps, divergence in skills as well as health inequalities among others needs between nations and among institutions.

The second emphasis on the organic unity of society leads functionalists to speculate about needs which must be met for a social system to exist, as well as the ways in which social institutions satisfy those needs. Therefore, a functionalist may argue that every society will have a religion because religious institutions have certain functions which contribute to the survival of the social system as a whole, just as the organs of the body have different functions which are necessary for the body's survival. In global perspective, functionalism emphasizes on sectoral and institutions integration of society in order to attain positive economic growth and development. This study will therefore seek to determine how the theory of functionalism fits into explaining the effects of globalization on KNH provision of health services.

### **Neo-liberalism Theory of Globalization**

This "model", theoretically originating from the theories of the liberal classics of Adam Smith and David Ricardo, is being applied in the age of globalization. At the same time, the global neo-liberal order has emerged as the dominant model of economic regulation and ideology. It has imposed new notions of societal, political and economic organization throughout the world,

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<sup>41</sup> Mitraný, D. *A working peace system*. Chicago: Quadrangle Press. (1966) p 221

which are based on certain assumptions about the state, market and society. Neo-liberalism is an adaptation of these views and its ideological ascendancy is linked directly to a particular period in the imperialist stage of capitalism. The benefits of this "globalization," according to the neoliberal argument, are threefold:

- Both the nations comprising the world economy's industrial core and those in the developing periphery benefit massively when the capital-rich core (where interest rates are low) loans to the capital-poor periphery (where interest rates are high).
- Consumers benefit when lower transport costs and reduced tariffs make goods produced far away more affordable. Producers of goods that are exported gain as well because they sell into a wider market. Producers of goods for home consumption do not gain, but there is nothing like competition from abroad to keep them on their toes, alert to ways in which they can improve efficiency and better satisfy their customers.
- The more internationalized the world economy, the more use producers in each country can make of commodities and production processes invented elsewhere. Faster diffusion of knowledge raises the level of productivity and technology worldwide.

Thus globalization leads to a richer world, and to a more vibrant and tolerant world as well. Governments should not fight globalization, neoliberals contend. Instead they should embrace it. Like capitalists, neo-liberalist belief in free trade, deregulation and privatization as the ideal credo for the world.

To a poor country hoping to develop an industrialized economy, neoliberals outline three incentives to embrace the global market.

- In the past it might have made sense to impose tariffs to protect so-called "infant industries" or cushion economic instability. But in the information age, an integrated global marketplace will accelerate the transfer of technology. And it is only by accelerating the transfer of technology that poor countries have a chance of growing rapidly.



- The industrial core has lots of money to lend to the developing periphery. Economies should embrace such inflows of capital, for they provide an opportunity to cut a decade or more off of the half-century process of industrialization.
- Removing trade barriers reduces the scope of the government. That reduction, in turn, reduces the inevitable corruption, stagnation, and bureaucratic obstacles to growth that have beset developing economies for two generations<sup>42</sup>.

Viewed retrospectively, the new century and millennium were perceived to have signaled the beginning of a new world order because neo-liberal economics, bourgeois democracy and Western social values were claimed to have triumphed over all other social systems, particularly communism leading to collapse of the soviet union. Critics of neoliberal insinuate that with the Cold War competition over, the United State leadership hoped to consolidate its hegemonic role and establish cohesion and stability in the world system in order to promote and enhance its vital national interests; and all other people and governments must adapt to the rationality and efficiency requirements of the market. While neo-liberalists view globalization as a process where market forces are allowed to determine flow of goods and services in a deregulated market, functionalism theory advocate effective national and institutions integration of society in order to attain positive economic growth and development. Therefore, functionalism theory is more applicable in this study.

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<sup>42</sup> Sassen S. *Globalization and Its Discontents*, New Press New York (1998)pp57

## **Hypotheses**

1. Globalization is a process and its effects are gradual; thus contributing significantly to quality and efficient delivery of medical healthcare services at KNH after 1980s.
2. Globalization thrives on competition more than co-operation and complementary.

## **Methodology**

### **Study Design**

The study uses both primary and secondary source of information. Secondary data will be sourced from, but not exclusively published and unpublished books, periodicals, medical healthcare reports, medical magazines and KNH reports and journals as well as internet sources. Primary data will be sourced from focus group discussion with key informants in the hospital such as doctors and nurses to determine the opinion, perceptions and views on the effects of globalization on the delivery of medical healthcare services at KNH.

### **Study Population**

Stratified sampling method will be used to get the sample size of 50 senior doctors and 50 Deputy Chief Nurses (DCN) from a target population of 150 (100 senior doctors and 50 senior nursing). The study will also purposively sample three senior officers namely Finance Manager, Human Resource Manager (HRM) and the Chief Executive Officer. These individuals will enrich the survey with additional information on comparative levels and sources of the hospital funding in the period before and after 1980s, level of employees' turnover and the possible global market push and pull within the two periods.

### **Data Analysis**

The study used qualitative data analysis method because the information provided is based on responses from structured interviews and discussions.

## **Scope and Limitations**

### **Scope**

The proposed study will be carried out at KNH, the national referral hospital in Kenya based in Nairobi.

### **Limitations**

1. There may be delays in getting authority to access hospital records due to bureaucracy. However, the university would provide an introduction letter that would minimize delays and facilitate authority for access to required information.
2. The target respondents (doctors and nurses) work in shifts. This would pose difficulties in getting the sampled respondents thus delaying the data collection period. The investigator will however get the schedule for the doctors and nurses in order to allocate time to meet them appropriately.
3. The target respondents are quite busy especially when they are on duty such that the investigator may not get adequate time with them to carry out the survey. However, the investigator will agree with the respondent on the appropriate time to schedule the discussion and interview.

## **Chapter Outline**

Chapter 1: Introduction, and broad context of the research study, statement of the problem, justification, theoretical framework, literature review, hypothesis and methodology.

Chapter 2: History and the importance of globalization across continents.

Chapter 3: KNH before the advent of Globalization.

Chapter 4: KNH after the advent of Globalization.

Chapter 5: Summary, Conclusion and Recommendations.

## CHAPTER II

### History and the importance of Globalization across Continents

#### Introduction

The quest by countries to provide adequate resources to their citizen has not only led to economic evolution but also to social and political integration. This is what is associated with the term *globalization*. The complex and problematic nature of the process of globalization hinder an accurate definition of the term. While the term is of fairly usage, the process has been going on for centuries.<sup>43</sup> It cannot therefore be related entirely on its own without reference to a historical context that has eventually given rise to the process. The process has been labeled as international interdependence, transnationalisation, the new world order and changing international division of labor among others<sup>44</sup>.

Globalization – the growing integration of economies and societies around the world – has been one of the most hotly-debated topics in international economics over the past few years. Rapid growth and poverty reduction in China, India, and other countries that were poor 20 years ago, has been a positive aspect of globalization. But globalization has also generated significant international opposition over concerns that it has increased inequality and environmental degradation.

#### Definition

According to McGowan and Nel, globalization can, at its core, be defined as a process of change affecting the nature of human interaction as boundaries become eroded across a range of spheres and along three dimensions: spatial, temporal and cognitive<sup>45</sup>. While globalization has perhaps become an over-familiar term it encompasses issues of enduring and profound

<sup>43</sup> Nabudere, D.W. *Globalization, the African post-colonial state, post traditionalism and the New World Order in Nabudere, D. W. (ed), Globalization and the post-colonial African State, AAPS Books, Harare, (2000), pp11-55.*

<sup>44</sup> *Ibid.*, (2000), pp60

<sup>45</sup> McGowan, P. and Nel, P., *The study of International Relations, McGowan and Nel (eds) Power Wealth and Global Order: an International Relations Text Book for Africa, University of Cape Town Press, Rondebosch. (1999), pp2*

significance; the opening of economies, increasing flows across borders, and increasing interdependence between people and places. As a result the distinction between domestic and foreign spheres is becoming more blurred.<sup>46</sup> Therefore issues in the global arena require a more global perspective on foreign affairs in national policies and within those departments dealing with foreign affairs.

The strong case for globalization is the liberal one. Neo-liberals see globalization plainly as being about an increasingly interconnected and inter dependent world: (it is about international trade, investment and finance that have been growing *far faster* than national incomes. It is about technologies that have already transformed our ability to communicate in ways that would have been unimaginable previously... an opportunity to reach *global solutions to national problems*<sup>47</sup>.

Indeed it is about an increasingly interdependent system. However, for a system to exist, McGowan and Nel argue that "it is not necessary that the actor should affect every other actor equally. In case of the global system, some actors are indeed richer and more powerful than others and not all are equally affected by what happens in the system"<sup>48</sup>. The implication of this is that while globalization is increasingly becoming an important determinant of daily existence it does not exclude dependent relations. Michael Dio summarises globalisation in five major components. First the Economic aspects: trade liberalization, deregulation, denationalization of domestic markets, regional economic integration through multilateral trade and free trade agreements, growing mobility of capital and new globalizing division of work<sup>49</sup>.

<sup>46</sup> Lee K: *Globalization and health: an introduction* Palgrave MacMillan: London; 2003(2)

<sup>47</sup> Wolfensohn, D., *the Challenge of globalization: the role of World Bank, 2000*, or Kantai, P., "The Onslaught of Economic Imperialism" in

Plahe, J. K (ed), *MAI: National Sovereignty for Sale? EcoNews Africa, Nairobi, (1999) PP55-71*

<sup>48</sup> McGowan, P. and Nel, P., *The study of International Relations*. McGowan and Nel (eds) *Power Wealth and Global Order an International Relations Text Book for Africa*, University of Cape Town Press, Rondebosch, (1999), pp4

<sup>49</sup> Dion, M. "The Impact of Globalization: Between a Dehumanising Process and a Sense of Togetherness" *Journal of Diplomacy and Foreign relations*, Vol3 no. 1, Institute of Diplomacy and Foreign Relations, Kuala Lumpur, (September 2001pp73).

Secondly, the political aspect that includes increasing reduction of state sovereignty especially in their public policy process with increased democratization.

Thirdly, the social aspect: contributes to the dismantling of social safety nets where social institutions are increasingly being considered as similar business.

Fourthly, the technological aspects, presupposes a great revolution of telecommunication and mechanization, transport and increased digital network leading to globalization of world markets.

Fifthly, the cultural aspect of globalization: Dion noted that on one hand, the hegemony of American culture determines the contents of global mass culture. On the other hand, Dio continues such a cultural homogenization is also due to the fact that economic values (such as efficiency, productivity, competitiveness) have been made absolutes. This is such that the true "ethical values" (such as fairness, justice, and respect for each other) have been annihilated, or have become the servants of economic (profitability-centre) values.

Inevitably, when thinking globalization, foreign policy, the issue of security and the protection of national interests are considered. Crucial policy goals, such as human security, are being reshaped in light of this global influence and issues such as healthcare play a central part in making globalization work. Lee (2000) noted that globalization is also an area of shared mutual concern that offers an opportunity to address some of the world's pressing problems such as providing healthcare services and responding to health crises in regions experiencing or emerging from conflict. Improved healthcare systems can play a role in nation-building and reinforcing world democratic principles. Within these contexts, health can be viewed as a core goal of socio-economic development efforts in the global arena.

Kaplinsky (2006) provides the definition of globalization that is adopted for the purpose of this study. In his definition, Kaplinsky notes that globalization is characterized by systematic reduction in the barriers to the cross – border flow of factors (factors, capital) products, technology and knowledge, information, belief systems, ideas and value<sup>50</sup>. The definition reflects changes in the parameters which governs global flows. It is wide enough to capture a range of globalizing phenomena which includes both primary economic flows and those which are more social in nature. It includes lower barriers to mobility of people as a component of labour force, of physical equipment technology, and finance. It provides more social flows across borders including values, ideas, and people searching to learn more about others culture and technologies. This definition thus provides a fairly summary represents globalization as nature of continual and gradual, rather than abrupt changes process that continues to occur in the world.

### **Historical Perspective of Globalization**

The term "*globalization*" has been used by economists since the 1980s although it was used in social sciences in the 1960s; however, its concepts did not become popular until the latter half of the 1980s and 1990s. The earliest written theoretical concepts of globalization were penned by an American entrepreneur-turned-minister, Charles Taze Russell who coined the term 'corporate giants' in 1897<sup>51</sup>.

Gary Dean (1998), another scholar traces the genesis of globalization shortly before the turn of the 16th century, in Portugal. He noted that the Portugal's global explorations in the 16th century linked continents, economies and cultures as never before<sup>52</sup>. The Portuguese Empire would establish ports, forts and trading posts as far west as Brazil, as far east as Japan and

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<sup>50</sup> Raphael Kaplinsky, *Globalization, poverty and inequality: between a Rock and a hard place*: Cambridge; Polity Press (2006) pp 9.

<sup>51</sup> Bhagwati, J., *In Defense of Globalization*. Oxford, New York: Oxford University Press. (2004) pp67

<sup>52</sup> Dean G., "*Globalization and the National-State*", October 1998, <http://www.okusi.net/garydean/works/globalization.html>



Timor, and along the coasts of Africa, India and China. For the first time in history, a wave of global trade, colonization, and enculturation reached all corners of the world.

Although both scholars differ on the origin of globalization process, they concur on the major events and developments marking the process. We can deduce that globalization is viewed as a centuries long process, tracking the expansion of human population and the growth of civilization, that has accelerated dramatically in the past 50 years. Nabudere also traces the history of globalization to the early forms of globalization that existed during the Roman Empire, the Parthian empire, and the Han Dynasty, when the Silk Road started in China, reached the boundaries of the Parthian empire, and continued onwards towards Rome. The Islamic Golden Age is also an example, when Muslim traders and explorers established an early global economy across the Old World resulting in a globalization of crops, trade, knowledge and technology; and later during the Mongol Empire, when there was greater integration along the Silk Road<sup>53</sup>. He also added that global integration continued through the expansion of European trade in the 16th and 17th centuries, when the Portuguese and Spanish Empires expanded to the Americas. During the 17th century, the world witnessed an increase in globalization business with emergence of multinational companies such as the Dutch East India Company, which is often described as the first multinational corporation.

Basic eighteenth century economic conditions continued well into the nineteenth century, until the railway and steam ship began lower transportation costs significantly, and to create *new circuits of capital accumulation* that focused on sites of industrial production in Europe and the US. But important structural changes in the world economy began in the later decades of the eighteenth century. This was the period of industrial revolution when societies started

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<sup>53</sup> *Ibid.* (2000), 60.

managing their own resources leading to introduction of division of labour that encouraged competitiveness in business transactions.

According to Nabudere, the 18<sup>th</sup> century laid ground that led to the defeat of the European imperial control of the America in the north and then the south<sup>54</sup>. This accelerated the rise of capital and capitalists as a force in the reorganization of nationally defined states; whose purpose was the political representation of the interests of their constituent property owners and entrepreneurs. The independence movements in the Americas and revolutions in Haiti and France produced new kinds of *national territoriality* within the world economy, and states that strove for greater control of resources within their boundaries than any before. Adam Smith and Frederick Hegel were two important theorists of this transitional period -- both of whom took a universal view of national issues, and theorized a great transformation away from an age of kings and emperors toward an age ruled by peoples and nations<sup>55</sup>.

Second, European imperial expansion shifted into Asia, where the use of military power by European national states for the protection of their national interests became a new force in the process of capital accumulation. Chartered companies were criticized by Adam Smith as a state-supported monopoly -- for the English East India Company had a monopoly on the sale of all commodities imported into England from the "East Indies," which included all the land east of Lebanon -- and this early version of the *multi-national corporation* expanded its power base in India with government support but without official permission. Nabudere noted that the industrial revolution facilitated the expansion of the British Empire where the British troops were placed in all its colonies to simply protect the operations of British nationals operating as merchants overseas<sup>56</sup>.

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<sup>54</sup> *Ibid.* (2000) pp17

<sup>55</sup> Goldin I. *Globalization for Development: trade, Finance, Aid, Migration, and Poverty*. Washington DC, Palgrave Macmillan (2006) pp6

<sup>56</sup> *Ibid.* (2000) pp20

The national state thus became both a mechanism for the control of territory within its own borders and for the expansion of national enterprise around the world. The US expanded over land and into Latin America by the expansion of the enterprise of its citizens and expansion of its military power, as the British Empire expanded into Asia and then Africa (scramble for Africa) -- along with the French and Dutch. In the discourse of nationalism, the "nation" and "empire" lived in their opposition to one another; but "economic imperialism" was standard practice for economically expansive nation states, and "gun boat diplomacy" became a typical feature of economic transactions among hostile states.

The 19th century is sometimes called "*The First Era of Globalization*." It was a period characterized by rapid growth in international trade and investment between the European imperial powers, their colonies, and, later, the United States. It was in this period that areas of sub-saharan Africa and the Island Pacific were incorporated into the world system. The "*First Era of Globalization*" began to break down at the beginning of the 20th century with the first World War, and later collapsed during the gold standard crisis in the late 1920s and early 1930s<sup>57</sup>.

In the period after the World War II, the US hegemony was to determine the next phase of international trade through creation of international economic systems. The Americans involved largely the result of planning by economists, business interests, and politicians who recognized the costs associated with protectionism and declining international economic integration. Their work led to the Bretton Woods conference and the founding of several international institutions intended to oversee the renewed processes of globalization, promoting

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<sup>57</sup> Lazarus N. (1999 12) *Modernity, globalization and "the West"* Paper presented at the Graduate School for Humanities and Social Sciences, University of Witwatersrand, WITS, South Africa. (Tuesday, 25<sup>th</sup> May 1999)pp17

growth and managing adverse consequences. According to Nabudere, these systems provided free entry and exit for goods and services from the American TNCs and former colonies were freed from European control in order to create enough raw materials for the American Industries and the market.

The period was also accompanied by a global, economic regime developed by the Breton Woods Conference of 1944 establishing the IMF, International Bank for Reconstruction and Development (what was to become the World Bank), the General Agreement on Tariffs and Trade (GATT). This stage of globalization involved increase in capital flow from the United State, as well as the US founded production system that relied on exploiting economies of scale in manufacturing and the advance of US based multinational enterprises<sup>58</sup>. The stage is also characterized by reduction in trade barriers under the auspices of GATT. Developing countries were not highly involved in this liberalization, but in export of products such as agriculture, textiles, and clothing, in a system of nontariff barriers in rich countries. Also, a set of key developing countries especially those in Latin America, pursued import substitution industrialization with their own trade barriers.<sup>59</sup> Therefore, it is important to note that these developments, along with the Cold war, suppressed the integration of many developing countries into the world trading systems.

In 1970, the world witnessed another stage of globalization with the demise of monetary relations developed at the Bretton Woods and involved the emergence of newly industrialized countries of East Asia, especially Japan, Taiwan (China), and the Republic of Korea<sup>60</sup>. Rapid technological progress, particularly in transportation, communication, and information technology, begun to dramatically lower the costs of moving goods, capital, people and ideas across the globe. Consequently, globalization has been facilitated by the advances in

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<sup>58</sup> This production system is known as "Fordism" or Managerial "Capitalism"

<sup>59</sup> Ibid, (2006)pp7

<sup>60</sup> Dellard, D. *Capitalism in wilben, C., and Jamson K., The political Economy of Development and Underdevelopment. 5<sup>th</sup> Edition, Mc Graw-Hill inc New York (1992) pp85-89*

technology which have reduced the costs of trade, and trade negotiation rounds, originally under the auspices of GATT. Goldin (2006) observed that this stage propelled Japan to emerge as an important, new source of Foreign Direct Investment (FDI): between 1960 and 1995, where its share of global FDI increased from less than 1 per cent to over 10 percent<sup>61</sup>. He further noted that the thawing of Cold War, the entry of China into the world economy, and the general reduction of trade barriers in most developing countries beginning in late 1980s helped to accelerate integration. We can therefore deduce that globalization has been facilitated by advances in technology which have reduced the costs of trade and increased the welfare of the population in most developed countries. It is also important to note the progress towards encouraging cross border trade after World War II; barriers to international trade have been considerably lowered through international agreements - General Agreement on Tariffs and Trade (GATT). Furthermore, the process of globalization was enhanced through the initiatives by GATT and the World Trade Organization (WTO) when they encouraged international trade.

Promotion and restriction of free trade instituted by GATT enhanced the process of globalization due to the institution of systems that motivate reduction or elimination of tariffs; creation of free trade zones with small or no tariffs, reduced transportation costs, especially resulting from development of containerization for ocean shipping; reduction or elimination of capital controls, reduction, elimination, or harmonization of subsidies for local businesses.

Other initiatives to recon include harmonization of intellectual property laws across the majority of states, with more restrictions. Supranational recognition of intellectual property restrictions (e.g. patents granted by China would be recognized in the United States)

The increase in globalization as measured by levels of integration, increased trade and reduction in cross border restrictions for goods, people, capital, technology, ideas and information and communication has been associated with gradual decline in extreme poverty of

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<sup>61</sup> Goldin I. "Globalization for Development: Trade, Finance, Aid, Migration, and Policy. Palgrave Macmillan, Washington DC, (2006) 9-10

the world population. The history of globalization provides a foundation in which to base our future argument for or against the effects of globalization on welfare of mankind and societies.

### **The assumptions of globalization**

The concepts of globalization is discussed in two broad contexts namely of industries and of markets. Within the managerial and populist literature, the globalization of markets is taken to indicate a convergence of customer demands and preferences, with similar needs to be fulfilled by the same product or service. The globalization of industries is taken to indicate a convergence of the form of production of a given product / service, or of companies with similar technologies. Globalization has five primary economic dimensions; trade, finance, aid, migration and ideas. Increasing these dimensions and managed in a way to supports development in all countries, they can help to increase intuitions and governments income and alleviate global poverty<sup>62</sup>. Globalization is characterized by systematic reduction in the barriers to the cross – border flows of factors (factors, capital) products, technologic and knowledge, information, belief systems, ideas and value. It reflects changes in the parameters which governs global flows<sup>63</sup>. It is wide enough to capture a range of globalizing phenomenal which includes both primary economic flows and those which are more social in nature.

According to Adam Smith, “it is not from the benevolence of the best butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own interest” (Cox 1995)<sup>64</sup>.

From the economic point of view, liberals believes that the world welfare is optimally when market forces are allowed to operate freely and goods and investments to flow as free as possible across borders in order to observe the law of comparative advantage. This system will not only allow wealth accumulation but will also mitigate world poverty and improve the

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<sup>62</sup> Ibid. (2006) pp 9

<sup>63</sup> Kaplinsky, R., *Globalization, poverty and inequality: between a Rock and a hard place*:- Cambridge: Polity Press (2006) pp 9.

<sup>64</sup> Cox R. W. “Critical Political Economy” Hettne, B. (ed.), *International Political Economy: Understanding Global Disorder*. Zed Books. London (1995) pp 193.

wellbeing of the people. Gangopadhyay (2005) argued that if technology advances to the point where it support trade across borders, and if people then choose to trade across borders, integrate, and choose it freely, this is good for the society as whole and would facilitate general and spontaneous development and economic growth<sup>65</sup>.

According to *Gangopadhyay*, globalization is neither the manna from heaven nor does it take place in a vacuum. It is a conscious decision of internationalization by multinational firms. Transnational strategy for business requires the combination of a global configuration and coordination of business activities with local responsiveness, and is dependent upon the continuing fragmentation of business processes, whereby the enlarging and converging markets may be served by ever-greater competitive advantages gained by exploitation of lower cost zones of production. It is therefore upon the receiving country to institute regulatory regime that would ensure its citizens reap the benefits from multinational investors to avoid crises, instability and overexploitation of its resources without due benefits. Economic globalization which actually provides the foundation for economic growth and development can be measured in different ways. This center around the four main economic flows that characterize globalization namely;<sup>66</sup>

- Goods and services, e.g. exports plus imports as a proportion of national income or per capita of population
- Labor/people, e.g. net migration rates; inward or outward migration flows, weighted by population
- Capital, e.g. inward or outward direct investment as a proportion of national income or per head of population

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<sup>65</sup> Gangopadhyay P., *Economic of Globalization*. Ashgate Publishing Ltd, MPG Books Ltd, Boamin, Cornwall(2005)pp1

<sup>66</sup> *Ibid.* (2005) pp 58-59

- Technology, e.g. international research & development flows: proportion of populations (and rates of change thereof) using particular inventions (especially 'factor-neutral' technological advances such as the telephone, motorcar, broadband)

In the advent of globalization, considering intra-country income distribution, the evidence is overwhelming that income inequality has worsened. However there is improvement in the global distribution of income arising and access to factors of production and improved welfare of the people. However, in many parts of the world, particularly where incomes are determined by environmental factors (for example weather) or by fluctuating world prices (for example coffee, tea) a major element of poverty is the periodic and repeated nature. There is also low quality and rapid deteriorating environment in low developing countries due to over exploitation and lack of enforcing mechanism of environment protection policies.<sup>67</sup> This indicates that for any nation to reap the benefits of globalization there is need for governance by the respective policy makers to avoid overexploitation and unnecessary labour crisis.

Between 1970 and 1998 income distribution among countries such as India experienced rapid growth in per capita income with some degree of inequality growth, while the USA reflected relatively slow growth of incomes among the poor and more rapid growth among the richest segment of population. In the same period, Japan experienced rapid growth, with heightening of distributional patterns; inequality has been reduced because there has been a process of catch up by the poorest members of society<sup>68</sup>.

China's economy has grown very rapidly and shows widening income disparities, particularly as a result of income growth among the next to richest groups in society. Brazil shows virtually no growth in incomes (except among the poorest segments of society), substantial in equalities

<sup>67</sup> *Ibid.* (1995)pp180

<sup>68</sup> Lawrence, R.Z and M.J. Slaughter, *International Trade: American wages in the 1980s: giant sucking sound or small hiccup?* In M.N. Baily and C. Winston (eds), *Brookings Papers on economic activity: micro-economic* (1993)pp2



with income being increasingly concentrated in two groups; those in the middle and those towards the upper levels of income. Nigeria displays a picture of falling per capita income over time and of rising inequality.

A review of Gross Domestic Product (GDP) in seventy three countries in post-second World War period, found that forty-eight countries inequality fell in the period from 1950 to mid 1970s and then rose sharply in the last two decades of the 20<sup>th</sup> century, distributional pattern remained largely unchanged in 16 countries and improved in only nine (most small economies)<sup>69</sup>.

In high-income economies, income distribution was unequal during the 1980s and 1990s (particularly in the Anglo-Saxon economies), and then stabilize thereafter. While in Europe the distribution of income become more unequal, the distribution of consumption was less adversely affected because of the role played by the welfare state of providing social services to those with low incomes. In Netherlands, real wages fell between 1979 and 1997. While in USA real wages were lower in mid 1990s than they were in the 1960s, and family incomes held up only as a consequence of lower working group.

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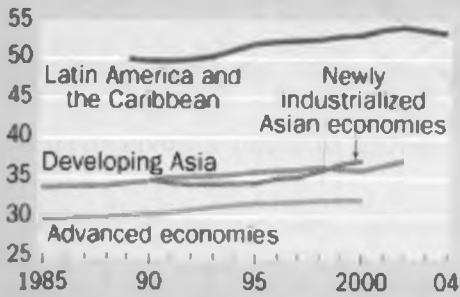
<sup>69</sup> Gu, E., *Labour Market Insecurity in China*. SES Papers 33. Geneva: ILO, (2003)  
[http://www.developmentgoals.org/poverty#poverty\\_levels](http://www.developmentgoals.org/poverty#poverty_levels).

Chart 1

## Rich and poor gap

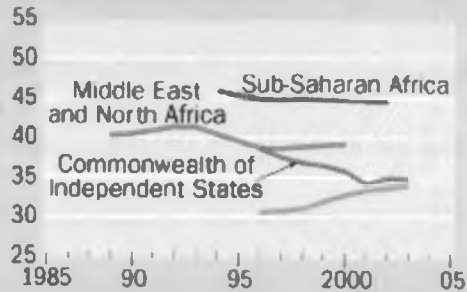
Inequality has increased in all regions . . .

(simple average<sup>1</sup>)



. . . except sub-Saharan Africa and the former Soviet Union.

(simple average<sup>1</sup>)



Sources: Choi (2006); Povcal database; WIDER database; and IMF staff calculations.

<sup>1</sup>Average inequality of countries in each region for which data are available.

The chart shows a rising inequality in income and consumption as measured by the widely used Gini coefficient over the past two decades in most regions of the newly industrialized economies of Asia, such as Nepal and China; while relative inequality has increased sharply in Cambodia, Sri Lanka, Bangladesh and Laos over the past 15 years, as well as in Latin America. In contrast, inequality has declined in Sub-Saharan Africa and the Commonwealth of Independent States. However, the per capita incomes have risen across virtually all regions for all segments of the population, including the poorest. As a result, the poor are now better off in absolute terms, although in most cases incomes have risen at a faster pace for those who are already better off.

In Chile often thought to be a paradigmatic gainer from globalization there was increased gain in 1971 of 0.46 Gini coefficient to 0.58 in 1989 (*The Gini coefficient calculates to proportion of cumulative income going to the proportion of cumulative population – the higher the Gini the greater the income in equality*). According to Gu (2003), inequality has grown markedly in the transition economies. The Gini coefficients in most of these economies during the late 1980s were in the region of 0.20 – 0.25, rising sharply to 0.37 in Lithuania, 0.47 in Ukraine and

0.48 in Russia. Likewise, inequality between skilled and unskilled wage – earners tended to increase in industrially advanced countries and in Latin America during the 1990s. It is in china that the changing pattern of internal income distribution has been marked and had the greatest impact on global income distribution which indicates high levels of technological invention and adoption. China like India has inflow of foreign technology and investment which have given a boost to growth of industrialization. These investments are encouraged through collaborations and financial-cum-technical assistance as well as reduction in bureaucratic shackles that would not only hinder the growth of internal industries but also prevent investors.

Variation in technological progress explains variation in inequality across countries. This factor alone explains most of the increase in the Gini coefficient from the early 1980s, supporting the view that new technology, in both advanced and developing countries, increases the premium on skills and substitutes for relatively low-skill inputs. Interestingly, among developing countries, the effect of technological progress is stronger in Asia than in Latin America, possibly reflecting the greater share of technology-intensive manufacturing in Asia. Contrary to common belief, trade globalization has helped reduce inequality rather than increase it—particularly for agricultural exports, especially in developing countries where agriculture still employs a large share of the workforce.

Another scholar, Rawski, (2003) indicates that the last Quarter of the 20<sup>th</sup> Century saw an increase in globalization, a reduction in the proportion of the world population living in absolute poverty and a growth in inequality<sup>70</sup>. Whilst according to the World Bank, poverty in the globalizing economy is “residual”<sup>71</sup>. The poor constitute those who have held back from participating in the global economy<sup>71</sup>. This confirms that there are other factors that influence

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<sup>70</sup> Rawski, T.G. *Recent Development in China Labour Economy*. Mimeo, *Development of Economics*, University of Pittsburgh (2003) pp 23.  
<sup>71</sup> World Bank, *Globalization, Growth, and poverty: Building an inclusive World Economy*. Washington, DC World Bank; oxford: oxford university press. (2002) pp 67

the process of globalization because as people change their attitudes, and as globalization deepens, so the poor will be mopped up. And, far from income inequality being caused by globalization, the expansion of labour-intensive exports leads to greater equality. The World Bank argument thus demonstrates that international capital flows are stronger and more stable for countries that clarify and strengthen creditors' rights, corporate governance, investor education, and accounting standards. And there are concomitant benefits that come from improving the financial infrastructure, such as the clearing and settlement process, as well as the supervisory and prudential framework.

Stiglitz, (2002) in *Globalization and Its Discontents*, offers his views both of what has gone wrong and of what to do differently. According to Stiglitz, the story of failed development does have a villain, and the villain is truly detestable: the villain is the IMF<sup>72</sup>.

Stiglitz bases his argument for different economic policies squarely on the themes that his decades of theoretical work have emphasized: namely, what happens when people lack the key information that bears on the decisions they have to make, or when markets for important kinds of transactions are inadequate or don't exist, or when other institutions that standard economic thinking takes for granted are absent or flawed. His views thus set stage for critic of the role by the institutions of governance in a sovereign state. Countries have to have strong political, social and economic institutions for them to be able to participate fully in the global arena.

Williamson (1998) argued that if globalization has caused poverty and inequality, in which case the losers should therefore reduce their participation in the global economy<sup>73</sup>. However, it is not globalization *per se* which has had an adverse poverty impact but the particular way in

<sup>72</sup> Stiglitz, J. *Globalization and its Discontents*. Penguin Books, London. (2002) pp2

<sup>73</sup> Williamson, J. G. *Globalization labour market and policy back lash in the past: journal of economic perspectives* 12, 4 (1998) pp 51-72

which countries have inserted themselves in the global economy. In this case the primary challenge is to refashion a country's insertion into the global economy.

In view of these arguments, globalization has generally supported poverty reduction and would not have been feasible without a wide range of domestic reforms covering governance, the investment climate and social service provisions. Relating to this, ancillary argument that globalization has not just leveraged people out of destitution, but has had a favorable distributional impact and has reduced relative poverty. The argument is that globalization has had many low-income economies to specialize in labour intensive products, a sharp contrast with the capital and technology intensive sectors favoured in previous era of import-substituting industrialization.

Similarly, it can be argued that, for autonomous reasons, recent decades have seen both a deepening of globalization and an increase in income inequality. However, this distributional outcome may have little to do with globalization *per se* but instead due to exogenous factors such as technological change<sup>74</sup>. Other factors which have already been outlined such as new information and communication technologies represent epochal changes in technological regime, with a wide range of impacts on competitiveness, social organization and individual behaviour. The diffusion of this technology simultaneously induces deeper globalization and speed up growth among adopters (but not among non-adopter who fall further behind). At the same time, because the new technology is capital and skill-intensive, its adoption leads to a more unequal pattern of income distribution. In these circumstances the casual link between globalization, growth and poverty is spurious.

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<sup>74</sup> Williamson, J. G. *Globalization labour market and policy back lash in the past: journal of economic perspectives* 12. 4, (1998)pp 51-72

## Forces and Actors of Globalization

One important concrete expression of the optimism with which thinking in the industrialized world addressed the challenge of economic development was the creation of new multinational institutions to further various aspects of the broader development goal. The United Nations (UN) spawned a family of sub-units to this end, most prominently the UN Development Program (UNDP) and the UN Conference on Trade and Development. The Food and Agriculture Organization (founded in 1945, but separately from the UN) and the World Health Organization (1948) had more specific mandates and the World Trade Organization (WTO). The International Bank for Reconstruction and Development (commonly called the World Bank), established in 1944 mostly to help rebuild war-torn Europe, soon shifted its attention to the developing world once that task was largely completed. These are the instruments which play the time of transnational enterprises and help to propel the global process.

The result was not only the creation of regions of the world with their own distinctive economic specializations, integrated into one world system of production; but also the construction of a single world of rules and regulations for the operation of the system. This change did not happen overnight, but it was clearly moving ahead at the start of the nineteenth century and well advanced by the end.

Kaplinsky (2006) argued that these are some of the actors who drive global flow of factors, products, technology, knowledge, information, belief system, ideas and values for the process of globalization to take place. He noted that globalization is the purposeful pursuits of objectives – be they personal economic, social or political which leads individuals, institutions and nations to widen their activities across national boundaries. The key institutions during the global expansion were the transnational corporations (TNC). These TNCs produce in range of countries both the local and the global market where the global shift arises from their purchases, from suppliers in other countries. They serve the global market by sourcing

merchandise form a large variety of geographically dispersed producers including national owned firms<sup>75</sup>. It is in this process that they will equally acquire a global marketing network that will facilitate the flow of goods and services across borders. In that case, they will serve national market with global border products.

Similarly the political expression of economic integration – the European union (EU) , the North American free trade association (NAFTA) and the association of South East Asia Nation (ASEAN) are seen as political alliance which meet the need of global entrepreneurs, defining national and international frameworks to facilitate the expansion of global business. Critics of globalization argue that it is the quest for profits which actively drives the shift across national boundaries not just of goods, capital, labour, technology and ideas. However, the quest for profit will ensure that the income of the people in the receiving economy is uplifted in terms of increased wage, improved welfare, and transfer of technology and development of other social infrastructures.

FDI and Multinational Corporations (MNCs) such as General Motors (GM) Coca-Cola<sup>R</sup>, among others depends on the world market and have had mainly negative effect on the distribution of income. Higher FDI inflows have increased the demand for skilled labor in developing countries, whereas outward FDI in advanced economies has reduced the demand for relatively lower- skilled workers in these countries. In addition, they control world money markets as well as influence transfer of technology across borders<sup>76</sup>.

The other driving force is the power of autonomous political process and the search for influence and hegemony. These include religious fundamentals such as Christianity and Islamic

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<sup>75</sup> Roberts, D., and Kyngé, *How Cheap Labour Foreign Investment and Rapid Industrialization are creating a new workshop of the world* *Financial Times*, 4<sup>th</sup> February (2003) pp45

<sup>76</sup> Adhams, A. M., "Constraint and promises of the Multinational Enterprises upon Development" in K. Ndeti and K. Gray (eds), *The second scramble for Africa: A response and a critical Analysis of the Challenges facing Contemporary Sub-Saharan Africa*, Professors World Peace Academy of Kenya, Nairobi, (1992)pp75-96

as well as idea systems (basic human rights") such as those which promote ethnic and gender equality who have the desire to impose their values on people living in their countries.

And although there is often a correspondence between the spread across borders of profit – oriented economic activities and the search for political hegemony, it is possible to characterize the driving forces for global expansion as being primarily political in nature. That is it arises from autonomous political imperative which are facilitated by the spread of commerce and production rather than being driven by the profit motive with accompanying facilitatory in tow.

Since the 18<sup>th</sup> century, the knowledge content in production and social system has expanded exponentially. Production of goods and services is now highly specialized and requires an extensive social division of labour, not just in knowledge production, but also learning in systems. This requires increasing knowledge that depends on cross border cooperation. The growing cost of technological complexity has meant that it can only be accompanied by profitable utilization if sales are spread over an increasingly range market. Thus the producers of technology are required to widen their global reach in order to sustain their profitability. Transnational corporations have also been prominent in the development and dissemination of new technologies in both the nature of products and methods of productions. These technologies such as microelectronics, biotechnology and raw materials have revolutionized production of both goods and services in developing countries such as China and India<sup>77</sup>. This is the inter weaving between the technological and economical and political dimension of globalization.

The technological progress leads to the advance of global processes in the production of knowledge. Indeed it was a requisite, as it made it possible for the cost of production, storage,

<sup>77</sup> United Nations Centre on Transnational Corporations, *Foreign Direct Investment and Technology transfer in India*, United Nations, New York (1992)pp34-37



marketing, distribution and transport of both goods and ideas to become increasingly lower. However, technology progress was not the only requisite for globalization process to take place. The contribution by entrepreneur is also a force to reckon especially for those who took the risk of exploiting new opportunities to offer technical support were a necessary condition. It was also necessary for the governments around the world to be convinced of its advantage, to allow it or encourage it by gradually liberalizing the flow of goods and services, capital, labour and technology between countries. Hence, globalization will have a period of greater advantage or decline, depending on whether governments' attitudes towards it are more positive or negative in the light of short-term consequences. Technology; however tend to cause greater inequality especially in the short and medium term because scientific discoveries from countries especially those with highest levels of human capital give such countries a huge productive advantage over the others. The other aspect that supports technology is level of education or improved human resources through skills enhancement. Skilled population will be able to adopt the technology, modify or make use of it to reduce cost of production which leads to increased wellbeing of the population.

The critic of technologically induced globalization argues of that "negative" externalities and environmental degradation arising from the increased use of technologies. These results to incidences associated with technological spillover effects across national borders as witnessed in 1986 Chernobyl nuclear power station leakage that lead to adverse effect environmental impact in the United Kingdom. Technology improvement is also associated with the changing weather pattern induced by excessive use of carbon based fuel in North America and Europe which tend to disrupt the ecosystem in the Antarctic.

The spread of global also reflects the natural curiosity of the human species. Technology and communications has helped people to widen their personal and social horizons such that they

acquire the ability to visit and interact with other individuals across borders. This can be seen in growth of tourism between 1990 and 2001 where the number of global tourists doubled from 325 million to 688 million with earning from tourism rising from US 256 billions to 426 billion US Dollars<sup>78</sup>. Each of these tourists carried a few of their own values and ideas across national borders and in turn, absorbed some form of foreign culture from the countries they had visited.

Overall, technological progress and FDI are associated with higher growth, and their disequalizing effect reflects an increase in the returns from acquiring higher skills. The appropriate policy response is therefore not to suppress FDI or technological change, but to make increased access to education an important priority<sup>79</sup>.

Better access to education would allow less-skilled and lower-income groups to capitalize on the opportunities from both technological progress and the ongoing process of globalization. Similarly, broadening access to finance, for instance by improving institutions that promote pro-poor lending, could help improve the overall distribution of income even as financial development broadly continues to support overall growth.

The positive role played by agricultural exports in terms of improving income distribution in developing countries suggests that policymakers should support growth in this sector. At the same time, better access to markets in advanced countries for agricultural exports from developing countries would support a more equal distribution of income in both developing and advanced economies. Policy considerations reforms to increase access to education and training would help ensure that the increase in incomes fostered by globalization is shared more equally.

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<sup>78</sup> World Bank, *World development indicator* Washington, DC World Bank (2004)

<sup>79</sup> Sturgeon, T., *Modular Production Networks: a new American model of industrial organization; industrial and corporate change*, 11, (2002) pp 451-96

## Summary

The discussion has provided an insight on the nature and the process of neo-liberal globalization that is driven by the West and their economic institutions that have evolved since the 15<sup>th</sup> Century. It is also clear that globalization is dominated by the industrial state of the West and the developing countries have no option other than face the global process with appropriate institutions of governance and adoption of technologies that would guarantee them global benefits. However, whether developing nations and their institutions are reaping the benefits or are being reaped of their resources are issues to review in Chapter 4. Consequently, there are other factors of importance that need to be adopted by the low developing countries in order to enjoy the fruits of globalization. These include adoption of liberalization of markets and capital; encourage privatization of public entities and restructuring of public spending as well as integration of the national economy into the global market. These will not only encourage and promote national GDPs and per capita income in the developing nations, but will also enhance the welfare of the people through provision of employment, social services such as healthcare, education, shelter and security.

## CHAPTER III

### **Kenyatta National Hospital before the advent Globalization**

#### **Introduction**

KNH is the oldest hospital in Kenya with a history dating back to 1901. The hospital has undergone four stages of transformation namely *The Native Civil Hospital*, *Nairobi Group Hospital*, *The King George VI Hospital* and finally *KNH*. The hospital provides healthcare services in tandem with the three healthcare services dimensions namely, Curative, Preventive and Promotive. In this chapter, a review will be undertaken to determine KNH efforts in the provision of healthcare services before the advent of globalization. The evaluation will include an assessment of the hospital medical technologies, human resources capacity and development of physical facilities of the hospital during colonial and post colonial era; before and after 1960s.

The concepts of curative and preventive methods are the mankind credo for management of various human diseases and are seen in all traditional medical practice. The modern concept of curative services consists of technology innovations that have evolved over time. Curative concept entails treatment care and management of illness and diseases with the prime aim of curing. The concept is mainly institution based and involves all types of medications administered in modern health facilities. The concept has been perceived in the context of biomedical research and development of pharmaceutical products as well as medical equipment for curative purposes. Services provided include clinical, nursing, physiotherapy, occupational therapy, laboratory, pharmacy, and other hospital based curative services. Curative services are based on the complexity of illness or the diseases. Treatment of ailment is usually graduated from the dispensary level through health centers to district hospitals which handle fairly complicated cases with medical doctors providing medical advice. The next level is provincial general hospitals which are more technical with specialists in medicine, obstetrics and

gynecology, surgery, anaesthesia among others. Complicated cases that cannot be handled at the provincial Hospitals are transferred to Referral Hospital such as Kenyatta National hospital<sup>80</sup>. In the period immediately after Kenya attained independence, curative services was receiving more budgetary allocations than preventive and promotive healthcare services<sup>81</sup>. However, after 1980s, the governments have shifted emphasis to preventive and promotive healthcare services in order to enhance early management of diseases and minimize referral cases.

Few people dispute that healthcare is a basic need and must be available for all. In the colonial years prior to independence, access to modern healthcare services was limited and patients had to pay fees, although very small amounts were involved. After independence, equal opportunity became a goal of the new government, with focus on eradicating illiteracy, poverty and sickness. This chapter presents a view of the oldest referral hospital in Kenya with historical background on colonial ideas that set up the best hospital in East, Central and South of Saharan Africa. Appreciating that the history of KNH dates back to the 18<sup>th</sup> century, this chapter provides an insight on KNH during and after the colonial rule periods. The history of KNH was scanty until 2001 when the first publication on the hospital was put together by a team of scholars involving doctors and other healthcare personnel from KNH and the School of Medicine, University of Nairobi. The establishment of the only hospital that came to be known as KNH was necessitated by the emergence of Nairobi city. Therefore, KNH history is highly intertwined with the history of Nairobi City.

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<sup>80</sup> Ministry of Health (Kenya), *Report on the Organization structure, Operations and Management of the Ministry of Health, part III, Management Consultancy Services Division, Directorate of Personnel management, Office of the President, Nairobi (1993) pp216*

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<sup>81</sup> *Ibid.*, (1993) pp216

## A brief History of Nairobi City

By 1895, Nairobi was unnamed. The only settlement, which existed by then, was a small out-post known as Fort Smith in Kikuyu. Surveying of the railway line, which had begun in 1891, was completed in 1893. In 1898, Nairobi was chosen as the future railway headquarters.

The Maasai were the only local inhabitants who, from time to time, due to their nomadic life, built manyattas on the high grounds. They called it *Nairobi* which is a maasai name that meant *the place of cold waters*. The new growth of Nairobi attracted the transfer of the provincial administration, from Machakos to Nairobi in 1899 and the establishment of Government offices and quarters on the higher ground to the north of Nairobi swamp. The relocation of the government headquarters to Nairobi resulted in the town being under two authorities: the provincial administration and the railway. The influx of settlers seeking opportunities for jobs and business hampered the work of the railway, as the authorities had not anticipated such rapid increase in the population. The understaffed provincial administration was also clamouring for social amenities, which the railway could not provide. Later a shopping area was built east of the government quarters. The first Indian Bazaar situated along Government Road belonged to Mr. A Visram. In March 1901, other Government offices moved from the northern side of the swamp to an area west of the bazaar along Government Road (present day Moi Avenue). By that time, Nairobi town health services were placed under a Medical Officer<sup>82</sup>.

Alastair Matheson (1955) notes that Nairobi which was made a City in 1950, grew up in the early 1900s from a railway construction camp, with an estimated population of 210,000; about 20,000 European, 70,000 Asian while the rest were Kenyan, Goan and Arabs<sup>83</sup>. Around this period, Nairobi had attracted international trade as the link within African European colonies

<sup>82</sup> KNH, *Kenya National Hospital: 1901-2001; A hundred Years of Quality Healthcare*, Sitima Printers & Stationers Ltd, Nairobi (2001)pp5  
<sup>83</sup> Matheson, A. *Kenya: A story of Progress, the Kenya Government and the Central Office of Information (Revised Ed, 1956)*, Stonebridge Press, Great Britain (1955)pp 26

and capitals with a luxury hotel (Norfolk Hotel), three night clubs and several social and sports clubs. Asians came to the hinterland of Kenya in large numbers to work on building the railway and majority ended in commerce working as artisans in industry and other professionals notably medicine and law. By the 1950s, the presence of the Europeans had done much to help the Africans on the road to civilization through technology transfer; education, training and employment. The period also witnessed increased inter-racial education systems with schools for African, European, Asians, Goan and Arab. The higher Education for Africans was provided at Makerere University College of East Africa at Kampala which was supported by the East African Territories while the college of Veterinary Faculty was located in Kenya. The Royal Technical College (now University of Nairobi) provided technical education for all races up to degree level. Bursaries, scholarships and study grants were available to Africans to study in Britain and elsewhere.

In 1955 about 500 students from Kenya were receiving higher education in Britain<sup>84</sup>. Unlike education for European and Asians which was compulsory, for Africans, tradition prejudice hindered their education implementation and progress. Carson (1945) pointed out that in part of the Africa where a great white community existed alongside the natives; there was great economic progress, in health, education and civilization<sup>85</sup>. However, the Europeans facilitation of civilization in Kenya and other parts of Africa was a selfish move meant to protect their economic interest; develop Africans in order to minimize aggression and enhance exploitation of African labour and natural resources.

In the same period, the colonial government in Kenya provided healthcare services for African in 60 hospitals with a total of 6,000 beds (*estimating bed capacity for each one is 100*). These hospitals were supported in the districts by 300 dispensaries and 30 health centres, which also

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<sup>84</sup> *Ibid* (1955)pp32

<sup>85</sup> Carson, J. B., *Administration of Kenya Colony and Protectorate; its history and development*, Ndia Kuu Press, Nairobi (1945)pp8



carried out extensive preventive health campaign. African patients who were able to pay for “special” medical healthcare services were admitted in mission hospitals in the African or “native” areas<sup>86</sup>.

The 1,000-bed King George VI Hospital (now KNH) was ranked the best African hospital in Africa<sup>87</sup>. Attached to it was an 80-bed excellent standard wing for Asians and also a Medical Training School (now Kenya Medical Training School) for African medical auxiliaries training various branches of medicine including radiography.

Between 1930 and 1940, medical work in the *native* areas was at first directed towards the control of epidemic such as plague and small pox. During this period, the Kenya witness separation of healthcare services between the Native areas and the European areas. The district health officers coordinated healthcare services in all native areas while the European officers coordinated healthcare services in non-native areas.

### **The Native Civil Hospital**

According to records, the institution that came to be KNH was first established in 1901 and it was known as the *Native Civil Hospital* meaning a hospital for African who were called by the colonialists “natives”. Natives were confined in specific areas or natives’ reserves. The hospital was located at the junction of Government Road and Kingsway (present day University Way). It was a 2 wards 40-bed hospital. According to Professor Thornton White, L. Silberman and P. Anderson ((1948), the “*The Native Civil Hospital*” was poorly constructed with no drainage and poor sanitation<sup>88</sup>.

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<sup>86</sup> *Ibid.* (2001)pp3

<sup>87</sup> *Ibid* (1955) pp3-4

<sup>88</sup> KNH, *Kenya National Hospital: 1901-2001: A hundred Years of Quality Healthcare*, Siama Printers & Stationers Ltd, Nairobi (2001)pp2

The Hospital had a treatment room, two different waiting areas for Africans and Asians respectively. By 1908, the Hospital had expanded its bed capacity to 45. The feared diseases then were malaria, tuberculosis and major outbreaks. The first epidemic to be managed at the Hospital was a plague (*Bubonic Plague*) which broke out in Nairobi in 1902 due to poor sanitation at the Indian Bazaar (*"the shopping mall then"*) that claimed 19 deaths. Unlike nowadays, when doctors are abundant, then there were only three medical European officers namely; Drs. Haran, Radford and Spurrier, who were primarily responsible with the suppression of the disease. Major diseases that are now the talk of every medical practitioner such as HIV/AIDS and all forms of cancers were either rare or were not being reported due to constraint in information dissemination. The period 1905 – 1912 witnessed outbreaks of plague, malaria and tuberculosis in Nairobi. The numbers of deaths recorded for this period were as follows: -

Diseases	1905	1907	1908	1909	1910	1911	1912
Plague	26	0	0	0	0	22	5
Malaria	0	198	200	123	203	189	171
Tuberculosis	0	176	198	183	235	216	205

The hospital facilities were limited in Nairobi with a population of 817 both Africans and Indians in the period 1913 – 1914, such that a disease outbreak would cause overwhelmed congestion in the hospital. During the same period, a total of 2,419 outpatients (Asians and Europeans) were attended at the Hospital. Between the same period, the In-patient statistics were: -

Total No. of sick days	11,988
Average No. of sick days per person	13
Average No. of patients per month	76

This number was high and above the hospital capacity which was as a result of increased population of Nairobi. By the time the Hospital was constructed, Nairobi had a population of approximately 6,000. In 1921, the population of Nairobi had reached approximately 23,428 exerting pressure for a bigger hospital with good drainage and isolation facility to handle infectious diseases.

There were limited financial resources, technical skills and equipment in addition to conflict of interest for the colonial government hampered any initiative to put up appropriate hospital facilities. During this period conditions at the Native Civil Hospital continued to deteriorate as confirmed by the Medical staff in the Hospital who expressed concern over the inadequate facilities: -*“There is no proper waiting room for African patients, open verandahs are being used ... medical, surgical, infectious, slightly ill and seriously ill are all mixed up together. Dental extractions are performed on the verandah... One room is available for the examination and treatment of all cases...sterilizing facilities...storage facilities for drugs are totally inadequate*<sup>89</sup>.

Proposals for a suitable site for a new Native Civil Hospital were provided by Heads of Departments and the Municipal Committee of Nairobi and they agreed on Railway Hill (later referred to as Hospital Hill) off Ngong Road. In 1951, the New Native Hospital was put in operation with a bed capacity of 423 beds for Africans and 41 beds for Asians. It was constructed of *cramped corrugated iron walled huts, wooden floors and canvas-sided wards.* The Hospital offered in-patient services only. All admission cases were referred to this Hospital from the Nairobi General Dispensary.

With the expansion of the city due to influx of people coming to seek for jobs, the Nairobi authority felt there was need to centralize hospital activities in order to reduce the

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<sup>89</sup> *Ibid.* (2001)pp5

administrative costs and enhance economies of scale in equipment and staff. In a memorandum on Nairobi hospitals presented by the Nairobi Town Planning Authority to the Colonial Administration, it was noted that there was need to consider putting up a hospitals for the population of Nairobi in order to cope with the rising population. The idea was to be considered not only with regard to that time, but also with long-sighted vision of the needs of the future.

### **The Nairobi Group Hospital**

Despite the resistance of the idea for a combined hospital by some of the colonialist such as Lord Delamere who fought to maintain segregation of the European and the African, the Nairobi Group Hospital Scheme kicked off in 1937 with the laying of the foundation stone for the medical block for the Africans Wing with 380 beds. The medical block was completed and opened on 11<sup>th</sup> March 1947 immediately after the end of World War II which had slowed the construction. Later expansion included the surgery block and an X-ray Department and 24 wards as well as six operating theatres two for orthopaedic and one for general operation, gynaecological, ENT and Emergency theatre. In addition, the Asian Wing Ismail Rahimtullah named after the partial sponsor Ismail Rahimtullah Waljee Hirjee Trust was completed in November 1952 with 123-beds with a separate operating theatre. The Old Native Civil Hospital was converted into a Nairobi General Dispensary to serve as the principal Outpatient Department for Nairobi. (The buildings that housed that dispensary were later taken over by the Central Police Station).

### **The Nairobi Group Hospital Staff Establishment**

In an effort by the colonial government to prevent Natives from the control of the national resources, a limited number of Kenyans were enrolled for specific professions such as medicine, law and engineers. In this view, majority of the doctors and nursing team who were

in the list of staff establishment to run the Nairobi Group Hospital were fourteen European who included medical staff such as surgeons (**4**), pharmacist and compounder (**one each**) and six nurses. The **Native Staff** included **four** dressers for the wards, **three** dressers for Casualty, One laboratory & X-ray attendant, **one** mortuary attendant, **eight** ambulance attendants, **two** office boys & messengers, **five** sweepers, **one** night porter for messages in emergency. **Kitchen Staff** included **one** Goanese cook, **one** Hindu cook, **two** African Mohammedans. The hospital staff establishment was 42.

Before the Second World War, there were few specialists and medical officers. Reports show that in 1944, the whole of the British colony had 51 doctors and 47 nurses who were all Europeans. During this time, nurses used to perform clinical duties such as diagnosing, dressing and administrative duties. That painted a gloomy future for the colonial government and the report outlines some of the immediate challenges in the medical field which included:

1. How to meet the ever growing demands and needs of African people for in-door and out-door medical relief.
2. How to obtain adequate and timely medical intelligence with regard to unspectacular diseases.
3. How to take advantage of the ever-increasing opportunities of spreading knowledge of hygiene, improving domestic environment, etc.
4. How to arrange for training of Africans.

These challenges necessitated the drawing up of a development plan in the late 1950s emphasizing the maintenance of European standards, raising those of Asians and creating African standards. Unlike the European and the Asians who were taught in English, for the Africans, English was introduced much later, Eshiwani, (1993)<sup>90</sup>.

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<sup>90</sup>Eshiwani, G., S., *Education in Kenya Since Independence*. Printpak, Nairobi. (1993)pp25

During the late 1950s, the pace of development was accelerated with more training for Africans, provision of equipment and better social services such as healthcare with a view to water down clamour for independence. The standard of diagnosis and treatment at the Nairobi Group Hospital continued to rise. The then Director of Medical Services (DMS), noted that *“an increased number of electrocardiograms were done in 1952 and gastroscopy was added to the list of investigations undertaken. Seldom before the last two years has such a high degree of surgical skill been available for African Cripples. Orthopaedic disabilities, bone and marrow tuberculosis, 32 cases of vesico-vaginal fistula were operated this year”*. However, theatre operations were mostly carried out by the Europeans with limited training being imparted to local people.

### **Nairobi Group Hospital Renamed King George VI Hospital**

The need to change the name Nairobi Group Hospital was expressed by the Director of Medical and Sanitary Services who felt that: -

*“... the Group Hospital name is no longer strictly appropriate as the Group Hospital was originally intended to be a Hospital containing Wings of the three races. As now envisaged, it will be a Hospital containing Wings of Africans and Indians. The European Wing is to be built elsewhere”*.

Later around 1955, the Nairobi Group Hospital was renamed King George IV Hospital which was an indication by the British towards relenting colonial rule in Kenya. According to the then Director of Medical services, *“the change of name was to emphasize the uniqueness of the Hospital and reflect its professional origin of the United Kingdom (UK); and also supposed to get rid of the unpopular word “native”<sup>91</sup>”*.

In 1953, King George VI Hospital had 225 medical beds, 281 Surgical Beds, 79 Children Cots and 46 Cots. Interestingly, the increased number of patients in the only referral hospital was not

<sup>91</sup> *Ibid.* (2001)pp10

in line with the number of doctors especially Africans of Kenyan origin. In the same period, medical and other general staff were 8 European doctors, 3 African doctors, 27 European nurses, and 462 African staff.

The European doctors were placed in specialists category and included senior surgical specialist, surgical specialist (General), surgical specialist (orthopaedics), ophthalmic specialist, specialist anaesthetist, two medical specialists, medical officer (gynaecology) and medical officer (paediatrics). These were assisted by medical officers and resident interns who were basically African and who were to learn and gain skills on the job after completion of basic training in the UK. This was a big challenge for Kenyans who were struggling for independence. However, the Europeans had a grand vision for the only referral hospital as well as the district hospital for the Nairobi area and the principal medical centre for Kenya. It was reported in the East African Standard (1953) that "*when planning King George VI Hospital, the colonial Government envisaged a Hospital equipped to cope with the most difficult cases which the country's centres might send*"<sup>92</sup>. The Hospital received complicated cases, both medical and surgical, which were "beyond the range of experience of the provincial physician or surgeon". Cases that also required more detailed investigation than was possible at the provincial centres were referred to this Hospital.

The expansion of the hospital was seen in this period culminating to setting up of Infectious Diseases Hospital (IDH) in 1956, and an Orthopaedic Centre in 1961 for rehabilitation of soldiers ("*Askaris*") who were involved in the World War II both which were sections of King George VI Hospital. This was an effort towards specialization of healthcare services as stated by the Deputy Director of Medical Services during the opening of outpatients' clinics "... *the*

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<sup>92</sup> *Ibid* (2001)pp15

*clinics will be treating patients on appointment ... not on a queue basis... by a panel of the country's foremost medical and surgical specialists".*

However, majority of these specialists were from UK and India with few practising doctors from Kenya who were on strict supervision by the European. Other outpatients' clinics which were opened with the colonial support include ENT, Eye, Dental, and physiotherapy services. Other extensions introduced at the King George Hospital were casualty with resuscitation and recovery room, minor theatre, instrument and bowl sterilization room, plaster room and casualty ward for twelve patients as well as a permanent mortuary (*currently KNH Post Office*). Laboratory services for clinical examination in the hospital were carried out at the Medical Research Laboratory.<sup>93</sup>

According to KNH (2001), in 1956, medical personnel of consultancy status who were engaged in private practice in Nairobi were appointed as honorary physicians and surgeons by the DMS to provide services at the King George VI Hospital. Some were allotted few beds<sup>94</sup>. This arrangement fostered a spirit of professional co-operation between the public medical services and the private medical practitioners as well as enhanced transfer of skills, knowhow and technology in healthcare delivery in the hospital. In 1958, there were only 45 Kenyan medical students at Makerere University while in the subsequent year, there were 500 registered medical practitioners serving a population of about 8 million. The number included registered missionary doctors trained elsewhere. In 1960 the doctor-population ration was 1:10,000 which Kenyan doctors felt will never change with the rate of training Kenyan doctors placed in Makerere, Uganda and demand the need to establish a medical school in Kenya for the training of Kenyan doctors.

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<sup>93</sup> *Ibid.* (2001)pp13  
<sup>94</sup> *Ibid.* (2001)pp12



## **Healthcare Financing**

Funding for healthcare services at King George VI Hospital was undertaken by the UK with minimal funding from India. In addition little funding came from cost sharing where patients were expected to pay KES 10 per week in the first week and 5/= in the subsequent weeks for adults and one shilling for children. According to the Deputy Director of Medical Services, *“these charges were only a small fraction of the cost of maintaining a patient in hospital for a week ...* The increased demand by Africans for more and better medical services, made the colonial government to charge fees in order to support healthcare services for all. There was no collaboration for financial or technical support from any other country except training for technical medical officers that was facilitated by the UK Government.

## **KNH in the Post-Independence Period**

### **King George VI Hospital Renamed Kenyatta National Hospital**

Like in the colonial period, the management of the newly independent Kenya was poised to propel the country into its future nationhood in literally all sectors, including health, and the land mark political strides that ushered in self rule in 1962, independence in 1963 and republican status in 1964.

On 17<sup>th</sup> April 1964, King George VI Hospital was renamed Kenyatta National Hospital in honour of the first President of Kenya, the late Mzee Jomo Kenyatta. Dr. Njoro Mungai, the then Minister for Health said in his speech during the renaming ceremony that: -

*“Hospitals in Kenya had been named after Kings and Queens of England, as the British respected their Kings and Queens, we too must respect the Father of our Nation*

Like in any other sector of the young independence and economic state, skilled human resources was scarce in the newly established KNH. The new management of the hospital had

to adopt a management skill through a number of formal and ad-hoc committees to assist in management, co-ordination, planning and development of the Hospital. The idea to constitute the committees would have been likely out of the clarion coined from the national motto of “harambee”. It was a call and clamour for change, centred on elimination of ignorance, poverty and eradication of diseases orchestrated by massive political will and steadfast regional and international support and goodwill. The Committee represented members from the ministry of Health, Nairobi City Council, university of Nairobi, two members of KNH and a laboratory consultant. The committee was responsible to the Ministry of Health for the general management and development of the Hospital and had authority to make decisions and take such action as within the general policy and financial resources of the Ministry.

The new Government quest to provide comprehensive healthcare services to its citizens increased pressure on the limited resources. The increased population coupled with free comprehensive healthcare services tremendously overstretched the capacity of the healthcare facilities and this effect indeed were felt at KNH because the public were familiar with its historical quality healthcare services. Available data on the number of patients who attended KNH for the first time without being referred from a Nairobi City Council dispensary or health centre was as follows: -

1963	133,991
1964	128,807
1965	110,456
1966	156,623
1968	457,489

As the number of out-patients continued to increase, the problem of lack of physical space to work in arose. The situation was further aggravated by the shortage of staff and drugs. This scenario is confirmed by the catering supervisor who noted that ... *there were shortages of staff and supervisors; a lot of money is used repair to boiler which has reached a stage where it is uneconomical to repair. Catering Manager (1974)*<sup>95</sup>. Consequently, complaints against the Hospital persisted mainly due to congestion and long queues. In order to shorten the long queues, more clinics were opened by the end of 1968.

According to a statement by one of the hospital staff, shortage of clerical staff to record names of patients in each clinic made it difficult to obtain actual figures of patients treated. ... *"the only recorded data were nothing but the total number of patients the doctors attends in the clinics"*. In 1967 and the subsequent year, KNH recorded the highest number of patients especially in the hospital clinics. Paediatric clinic and Eye clinic recorded the highest number of patients in 1968 with a total of 61,170 and 40,000 patients respectively.

New disease conditions emerged such as Kwashiorkor as a result of malnutrition among children while hygiene was a real challenge due to increased eye problems. An increasing number of patients were booked for diagnosis services such as X-ray, Echocardiogram for heart and plastic surgeries<sup>96</sup>. This was an indication of improved knowledge and skills despite the existed challenges of limited equipment. According to a report forwarded to the hospital management committee by a pharmacist (1970), *"...bottles washing machine and filter pump were manual, ...we have an old fashioned autoclave, unreliable and dangerous to operate .. already has caused some accidents... majority of the equipment have been condemned by the Ministry of Works (MOW)"*<sup>97</sup>.

<sup>95</sup> KNH/DIR/43, min. 34, Minutes of the catering department, KNH (1974)

<sup>96</sup> *Ibid* (2001) pp31

<sup>97</sup> KNH/C.1, KNH management Committee: report on Sterilization Preparation Unit (SPU), KNH (1970)

The increasing number of patients exerted pressure on old equipment causing frequent breakdown. The situation was compounded by limited human resources and skills for servicing, maintenance and repair.

According to unpublished report, a review of the X-ray department by the hospital management committee shows that the general radiography equipment were old and semi automated "... *the one which is over 20 years old is operated manually and serves way over 100 patients per day*"<sup>98</sup>. In addition, most of the radiographic services were carried out by expatriate Radiographers. The hospital radiology department was also faced with lack of supplies for consumables such as films, chemical and contrast media during and immediately after independence. In the 70s Kenya had only the chief radiologist specialist and Chief radiographer who were placed at KNH.

In an effort to alleviate shortage of radiographers, formal training on radiology which was being conducted at Port Florence (Kisumu) was transferred to King George Hospital (KNH) in 1956. In 1962 the first two local doctors enrolled for a Diploma in Medical Radiodiagnosis (DMRD). The hospital also acquired new imaging equipment such as ultrasonography, cardiac catheterization, mammography and the computerized tomography among others. The expansion and equipping of the radiology department was also extended to include Radiotherapy Department. In 1974, an intracavitary caesium 137 was introduced in radiotherapy department as well as a human scanner in 1979.

However, despite these initiatives, the major challenges in the provision of healthcare after independence was lack of technical skills to facilitate maintenance and repair as indicated by

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<sup>98</sup> Ibid (1970)

However, despite these initiatives, the major challenges in the provision of healthcare after independence was lack of technical skills to facilitate maintenance and repair as indicated by one of the staff in his report to the hospital management committee... *one of the expensive machines in ultrasound room is not working...the other may develop problem due to overworking ... no expert to repair or services; ...room is also leaking and could create moisture that can cause short circuit ...that could be dangerous to patients*<sup>99</sup>.

The shortage of staff in the colonial days and immediately after independence was also experienced in dental services. Dental services in Kenya were provided by the Europeans dentists and the only dental service that a Kenyan would perform was tooth extraction which was done by an upgraded nurse at KNH. In 1964, the first Kenyan dentist graduated from Glasgow University in UK and was stationed at KNH to work under minimal supervision from European Specialists. The dentist was expected to offer limited dental services such as teeth extractions. However, later in 1970, KNH established a fully pledged Dental Services Unit at Kabete, (later came to be known as 'Kabete Meno'). The Unit was also faced with challenges among them lack of skilled human resources, equipment and inadequate supplies. In 1971, eight (8) more dentists joined the profession leading to the establishment of other dental units in Nyeri, Nakuru, Mombasa and Kakamega; where the government provided each unit with a dental chair and a dentist<sup>100</sup>.

Soon after Kenya attained independence, donor funding was limited and Britain was the only source of foreign aid to all sectors of the Kenyan economy. Consequently, majority of the equipment that had been provided to KNH by the colonial government were unserviceable and required urgent replacement in late 1970s.

<sup>99</sup> KNH, *Kenya National Hospital 1901-2001: A Hundred Years of Quality Healthcare*. Sitima Printers & Stationers Ltd. Nairobi (2001)

<sup>100</sup> Ibid (1993), pp218

In 1973, KNH got donor funding from the Japanese International Cooperation Agency (JICA) to procure new equipments and facilitate training of staff. The rare support made it possible for the establishment and equipping of KNH Intensive Care Unit (ICU) with semi automated respirators monitors and one dialysis machine. The equipments made it possible for doctors at KNH to perform the first kidney transplant to a Turkana female patient in 1978. The government of Belgium provided KNH with telecommunication equipments leading to the installation of the hospital switchboard. Communication was essential in establishing linkages between KNH and the rest of the world. Initially the hospital was linked to unreliable erratic post and telegraph<sup>101</sup>.

Records show that the first heart operation was performed in April 1957. Due to limited human resources and lack of appropriate equipment, KNH was not able to carry out open heart surgery until later in 1975. The first operation was pericardiectomy. This is the stripping of the bag that normally contains the heart. It is done when it becomes involved in disease and prevents the heart from filling with blood. As the heart is not opened, this by definition is a closed heart surgery as opposed to open-heart surgery in which the heart is opened usually involving stopping the pumping function of the heart temporarily<sup>102</sup>.

Major improvement in KNH Cardiology department in terms of physical facilities and equipment occurred in 1975. In this year the governments of Japan and Holland in collaboration with the Kenya Government made a major investment. These donations brought in transformation in heart disease diagnosis, treatment and management. The hospital acquired ICU monitors, heart and lung diagnosis machines and established cardiac catheterization laboratory. The improved equipments made it possible for KNH to undertake the first open

<sup>101</sup> KNH, KNH/DIR/43/1974  
<sup>102</sup> *Ibid.* (2001), pp41

heart operation by Kenyan surgeons in 1979<sup>103</sup>. Previous open heart operations were carried out by visiting surgeons from UK.

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<sup>103</sup> *Ibid* (2001)pp 41

## Summary

The colonial period provides a historical overview of KNH healthcare services with the advent of medical equipments that enabled major healthcare task to be carried out electronically with ease and efficiently. Before the advent of globalization, there was limited use of sophisticated medical equipment and skilled human resources among Kenyans. This period has also seen KNH through the transformation stages; Native Civil Hospital, to King George Hospital and finally KNH. Medical services at KNH were provided by foreigners before, during and immediately after the colonial period. There was also limited access to quality healthcare due to lack of diagnosis services for various disease ailments. The colonial period and the advent of medical equipments brought in new dawn in Kenyan and especially in KNH healthcare delivery system.

The study has also established that Britain was the only source of funding and specialized labour for KNH. According to Solly, (1953) *...there were no research stations, limited doctors and labour was hard to get due to limited schools and institution of higher learning...*<sup>104</sup>. There was limited collaboration between KNH and the rest of the world except with institutions in the UK. There was literally no promotion of cooperation using information technologies such as internet and telecommunications.



## Chapter IV

### Kenyatta National Hospital after the Advent of Globalization

#### Introduction

Before the KNH gained autonomy in the early 1980s, the hospital operated as a department of the Ministry of Health (MOH) for effective management. The bureaucracy through the MOH resulted in delays in decision making and implementation of programs and activities. The hospital received severe criticism from every quarter of the Kenyan society, and especially from the ordinary citizens who depended on the hospital for their everyday medical needs. The massive shortages and deteriorating conditions that was almost wrestling the hospital to its knees, also attracted the attention of the mass media who described the situation in the hospital using all kinds of headlines “*Hospital of Shame*”, “*Massive Shortages Strangling KNH*” among others. The hospital staff was also blamed of corruption practices and slow procurement process. However, majority of these issues were compounded by lack of skilled manpower, increased demand for specialized services due to increased population in Nairobi and deterioration of tertiary healthcare services at the district and provincial levels. KNH was almost a ghost hospital with run down equipment, massive shortage of essential drugs and medicines, lack of basic items, congestion, squalid and stinking wards, corruption and demoralised staff<sup>105</sup>.

In 1984, the Government decided to address the problems affecting health care services in the country, and those of KNH in particular as the only National Referral and Teaching hospital. The report by the Government review committee recommended the need for KNH to be managed in a different style with a view to rendering efficient and effective referral healthcare services and enhance medical teaching and research services in Kenya. The report further led to

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<sup>105</sup> *Ibid.* (2001)pp23

the establishment of KNH as a state Corporation under the State Corporations Act via a Legal Notice No.109 (Kenya Gazette Supplement No. 23 of 10<sup>th</sup> April 1987)<sup>106</sup>.

The Hospital is run by a Statutory Board that is responsible for proper execution of policies and effective management with the Director as the executive officer assisted by two Deputy Directors; Deputy Director Clinical Services and Deputy Director Finance and Administrative Services. The Hospital Organizational structure has been changing with the establishment of new functions and departments/units. During the transition to parastatal status, KNH had way over thirty departments including more than ten clinical departments. The increased demand for specialized healthcare services coupled with emergence of new diseases has pushed the number of department to over forty.

### **Human Resources and capacity building**

Following Kenya independence and in the late 1970s Kenyans replaced expatriates at KNH with the staff establishment growing exponentially from less than 1000 to now over 4,000 employees consisting of specialized doctors and nurses. In the 1960s, development of staff was focusing mainly on training of doctors. In the later years as the number of staff in various cadres began to rise; KNH embarked on continuous staff training programs aimed at developing an efficient workforce at all levels. This has gone a long way in making the staff more effective and productive in various services. However, arising from the challenges of the 1980s, low levels of specialized human resources in the country, the Government trust on its own citizens on the management of KNH was low and some of the policy makers believed that Europeans are the best managers.

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In November 1991, the Government attempted to employ services of a team of expatriates, the International Hospital Group of Britain, to manage the hospital with the aim of improving the "administrative skills of the local staff". A British expatriate, Mr. Bob Wilcox, took over the running of the Hospital as the Chief Executive following the signing of a 3-year contract between the Government and the International Hospital Group of the United Kingdom<sup>107</sup>. Local doctors resented hindsight and rejected the recruitment of the expatriates on high salaries without adequate consultations. Consequently, in 1992 the team was replaced by Prof. Julius Meme, who assumed overall authority of the Hospital. This was an assumption that "local experts" might understand healthcare problems facing a Kenyan institution like KNH than an expatriate. KNH was able to make positive strides and according to staff, during this period, the hospital even gained trust of most donors partners such as the World Bank (WB) and the United State of America (USA) who provided financial and technical support.

The hospital has over 200 specialized doctors and employs over 2000 nurses. Majority of these staff have trained in Kenya, at the University of Nairobi with a limited number training in UK, US, South Africa, Botswana, Japan, Israel, German and parts of Asia among others. The increased human resources capacity has been made possible through exchange programs between KNH and health institutions and other institutions of higher. Other personnel have acquired training through scholarships from the Kenya Government as well as bilateral and multilateral aid for technical assistance or human resources capacity building. In the early 1990s, there was also an increased private capital flow to Kenya in all sectors including healthcare services by corporate and non-governmental institutions which helped in the transfer of technologies, skills, ideas and training which were also instrumental in impacting KNH with skilled manpower. This confirms what *Goldin (2006)* had indicated that foreign aid remains a vital resource for developing countries because it can finance investment in infrastructure and

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<sup>107</sup> *Ibid.*, (2001)pp29

services, supplement capability in health and education, and provide access to new ideas in the realm of policy. The availability of specialized medical personnel indeed accelerated the pace of the hospital healthcare services and placed KNH on the competitive edge in the local and international healthcare systems. This progress has not only assured patients of reliable and efficient referral healthcare services; but has also widened the scope of its core business as a reputable training and research institutions attracting medical students from all over the world especially those undertaking studies in tropical medicine. The realization of these opportunities by KNH reaffirms *Scholte, J., (2000)* argument that globalization facilitates development through mobility of knowledge from developed to developing economies. He adds that because of new technologies, "*most colleges and universities are able to work together with academics from different countries; students have opportunities to study abroad and 'virtual campuses' have been developed*". A growing body of evidence also confirms that it is not simply higher growth, but higher shared growth that is more effective in accelerating social and economic development and growth. These observations also confirms that globalization facilitate sharing of information, technology and ideas.

The study shows that while majority of the staff running KNH are full time employees, the College of Health Sciences, University of Nairobi and the KMTC provide highly qualified clinicians who take an equal load of clinical work in the wards and in the various clinics and nursing and technical services during their practical training in various areas within the hospital respectively.

### **Physical Facilities and Equipment**

The completion of the Tower Block in 1981 not only provided KNH with an identity but also increased the hospital bed capacity to 1,209. However, due to the increased number of inpatients, the hospital provided additional beds in the wards, giving a total bed complement of

between 1,890–2000 in 50 wards. Unlike the countable clinics and less than five theatres in the 1970s, KNH now has 20 outpatients' clinics and 24 theatres. The expansion of inpatients facilities was not the end of the hospital challenges because between 1983 and 1990, the number of outpatients increased from 121,620 to 170,000 respectively with daily turnover of 400-600 patients. The situation called for the expansion of other general facilities such as Accident and Emergency, theater, pharmacy, clinics as well as increase personnel among others. The technical skills of the doctors, nurses and other technical staff who had gained experience from hospitals in the developed countries, redesigned KNH facilities to meet the challenges of the time.

With funding from the JICA, the Government of Holland, the WB and the Government of Kenya, KNH healthcare services improved with the acquisition of ultramodern equipment and expansion of physical facilities among them Department Medicine, Occupational Therapy, operating theatres, ICU, X-ray and Accident and Emergency. In 1993, the Dental and Orthopaedic Units were transferred to KNH from the old site in Kabete in an effort to centralize specialized services. These initiatives meant that the hospital was able to expand and offer new healthcare services such as open heart surgery, ICU and kidney transplant.

Unlike in the late 1970s when the first kidney transplant was done, in 1990s KNH recorded an increase in kidney transplant in the hospital to over hundred patients following the improvement of equipment, technology and skilled medical specialists. In addition, the old single and unreliable Mera Coil Canister type of Dialysis machine that used to dialyze a single case in a day has been replaced with over 20 ultramodern dialysis machines from Japan that are capable of dialyzing four patients each in a day. The number of Nephrologists and Urologists (renal specialists) has also increased to more than five who provide medical support to patients with renal ailments before kidney transplant. The improvement in renal services also meant a

reduction in renal patients seeking overseas kidney transplant as well as dialysis services from private healthcare facilities which also translate to saving not only for the poor patients but also for the country. The growth of the Renal Unit, the only fully functioning government run unit in sub-Saharan Africa with the exception of South Africa has seen patients' attendance increase from one in 1974, 50 in 1980s and now over 200 patients.

Likewise, ICU which is equally a life saving facility has indeed improved comparatively over time from a ward of less than ten beds and respirators monitors in 1973, to the current state of the arts department with thirty beds and ultramodern respirators from Netherlands. This is in addition to satellite ICU rooms equipped with respirators for new born children. According to a senior medical doctor at the hospital, *ICU has greatly improved its capacity and quality of services in handling critically ill patients who require support of ultramodern machines with three beds reserved for emergency cases.* Unlike the old technology in ICU where each bed had individual monitor forcing a nurse to be stationed at each bed, the new technology from Philips Pharmaceuticals of Holland ensures that all the beds monitors are connected to a central monitor unit where an individual trained nurse can monitor patients parameters for each bed at the central monitoring unit without necessarily moving from one bed to another. The Japanese support also has helped the department to set up a maintenance workshop within the department and facilitate training of technical staff who maintains the equipment and ensure sustainability of ICU services.

Over the years since 1980s, KNH has made great strides towards enhancing diagnosis services through introduction of new imaging modalities of ultrasonography, cardiac catheterization, mammography and the computerized tomography and extra image intensifiers among others. KNH is currently in a position to carry out advanced investigation such as mammography, Computerized Tomography (CT) scan, and ultrasound guided biopsies, digital Subtraction

Angiography Fluoroscopic Unit which augments interventional radiology practice, ultrasonography and angiographic work.

Further, the funding through a bilateral loan from the Kingdom of Spain, KNH has been able to acquire an ultramodern spiral CT scan and Gamma Camera to enhance diagnosis of various types of cancers and a state of the art Magnetic Resonance Imaging (MRI) and Doppler ultrasonography machines which has greatly improved radiological investigations. The equipments are capable of providing all kind of internal images (both tissue and orthopaedic) for patients of all ages. Radiology makes it easier for doctors to diagnose ailment and advance early treatment interventions with the most desired accuracy.

The equipment have not only guaranteed patients with accurate, timely and effective treatment to a array of ailments, but have also facilitated training of post-graduate course in Masters of Medicine Degree in Diagnostic Radiology offered by the University of Nairobi. In addition, these improvements meant a reduction in patients' morbidity and mortality arising from efficient fast tracking patients' ailments.

However, despite the tremendous improvement in acquisition of equipment some staff feels that the increasing number of patients outweighs available equipment leading to their overworking and frequent breakdowns. They further add that the hospital is still faced with a limited number of technical staff to operate and maintain the new equipment. The acquisition of new Cobalt 60 unit cancer machine for Radiotherapy department through the support from the International Atomic Energy Agency (IAEA), and a simulator in 1983 was a big boost and a relief to cancer patients who depended on expensive services from private hospitals.



In the early 1980s, KNH acquired cardiology equipment with the funding and technical assistance from developed countries such as UK, United State of America (USA), Holland and Belgium. The hospital was therefore facilitated such that in 1998, 51 open heart surgeries were carried out and 25 were children. These kind of surgeries were rare before 1980s due to lack of equipments and trained cardiologists. This trend has improved with time and in 2006, the hospital carried out heart surgery for a three-day old baby. In collaboration with scientists from other developed countries, KNH cardiologists are now focusing on interventional cardiology which is the process of performing certain operations on the heart by use of remote techniques without necessarily opening the heart and the chest. Doctors agree with *Goldin (2006)* that foreign direct investment can contribute to poverty alleviation when it supports the generation of new employment, promotes competition, improves the education and training of host-country workers, and transfers new technologies.

However, the Quality control becomes a special problem where optimal number of operations is not done. It is a well-established fact that a team needs to perform a given minimum number of operations to maintain acceptable level of competence and to develop new methods. Although patients are available, the costs for such specialized venture in addition to kidney transplant are quite a challenge to majority of low income group of patients. It cost between KES 70,000 – 200,000 for open heart and between 500,000 -1million for kidney transplant. The other limitation noted in the adoption of western technologies was shortage of spare parts, especially for equipments purchased from companies that do not have local distributor (suppliers). In an event where such equipment breaks down, repair work is delayed before the spare part is imported. This equally led to delayed services to increasing number of patients.

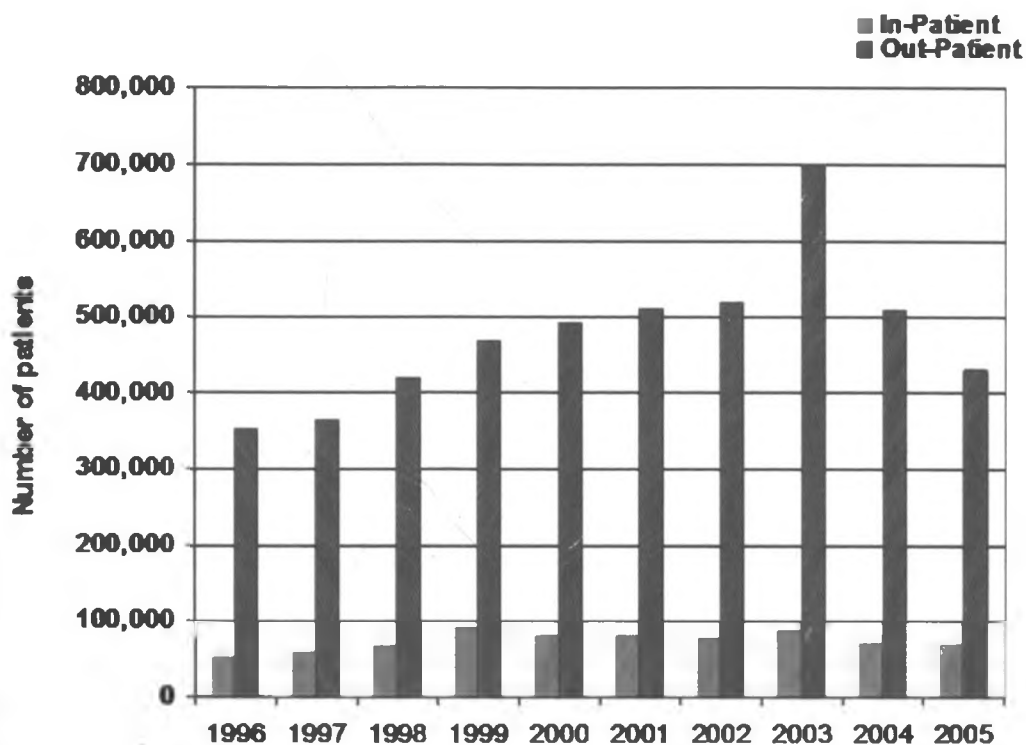
## **Emergence of Healthcare Hub in Africa for Patients Care, Research and Training**

Since inception, KNH has been at level six of the hospitals category which provides referral and teaching healthcare services. This was confirmed by the East African Standard Newspaper (1953) where it was reported that *"when planning King George VI Hospital, the colonial Government envisaged a Hospital equipped to cope with the most difficult cases which the country's centres might send"*<sup>108</sup>. The same view is also contained in the current hospital philosophy that ... *KNH being a national referral hospital and premier health institution in the region, its activities have multiplier effects in terms of health status of Kenyans and people in the region...* The improved facilities, human resources skills and equipment at the hospital have provided a pull for patients from various countries in Africa, students and research scientist from across the globe. The number of in and out-patients at the hospital has increased with time. Unlike in the late 1970s when the annual turnover of inpatient was low, to-date the bed occupancy in general wards is between 100% and 300% in a hospital with 50 wards and 2000 beds. On average patients range from 2000 to 3000. ***See graph 1***

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<sup>108</sup> *Ibid* (2001)pp15

Figure 1: IN-PATIENT/OUT-PATIENT ATTENDANCE 1996-2005



Source: KNH, Annual Report 2005/2006, KNH, Nairobi (2007)pp13

Unlike before the 1980s, globalizations has opened hospitals gates such that KNH has continued to receive patients from Zaire, Uganda, Tanzania, Burundi, Namibia, Somali, Rwanda, Nigeria and Sudan among others. The number of foreign patients has grown from a single patient to an average of 20 annually. Majority are inpatients admitted for specialized services such as heart surgery, renal failure management, and cancer treatment. In addition, the hospital is also instrumental in enhancing medical tourism where specialized medical services are provided to tourists and business people on transits or within the country. KNH also maintains linkages with multinational corporations operating in the Export Processing Zone (EPZ) and transport companies with memorandum of Understanding (MOU) in the provision of specialized healthcare to staff either on transit or operating in their companies. KNH is also a hospital of choice not only to Kenyans but also foreign citizens due to its capacity to handle disasters. The hospital's capacity to handle mass disasters was put to test on August 7<sup>th</sup> 1998

during the bomb blast at the American Embassy. 250 people died and over 5,000 were injured. A total number of 1,134 patients were at the hospital on the day of the bomb blast and a total of 1,482 including referrals from other hospitals underwent corrective surgery. KNH in collaboration with the African Medical Research Foundation (AMREF), US Agency for International Development (USAID), and the MOH carried out the emergency services and meeting cost for those who required reconstructive surgeries. According to KNH staff "...for the first time Kenyans were grateful that the country has a health facility of KNH's calibre..."

While the Government of Kenya expects KNH to generate funds through cost sharing, the management notes that majority of the patients who receive treat at the hospital are from low social economic background and hardly do they afford medical fees. In an effort to complement its income, KNH operate an amenity with 225 beds. The competitive charges for the amenity are subsidized and attract majority of the corporate patients. The hospital also undertakes strategic alliances and partnership with Non Governmental Organizations (NGOs), private sector, development partners and other relevant organizations for the provision of quality healthcare services and training. The period after the 1980s has also seen the hospital enhance collaboration and association with other hospitals, health institutions, institutions of higher learning and research organizations within and outside the country. In research components, CDC, USAID and United Nations Children Fund (UNICEF) are among international institutions with both local and international student carrying out research on HIV/AIDS and Tuberculosis. The increased demand for healthcare in the country has also seen increased demand for trained personnel. According the Head of Radiology Department of KNH, the process of globalization has made KNH a healthcare hub in facilitating training of medical doctors and other health professionals at diploma, undergraduate levels from the University of Nairobi, KMTC and other health institutions in Kenya in addition to mentorship of Government and private hospitals. These arrangements provide service to KNH and

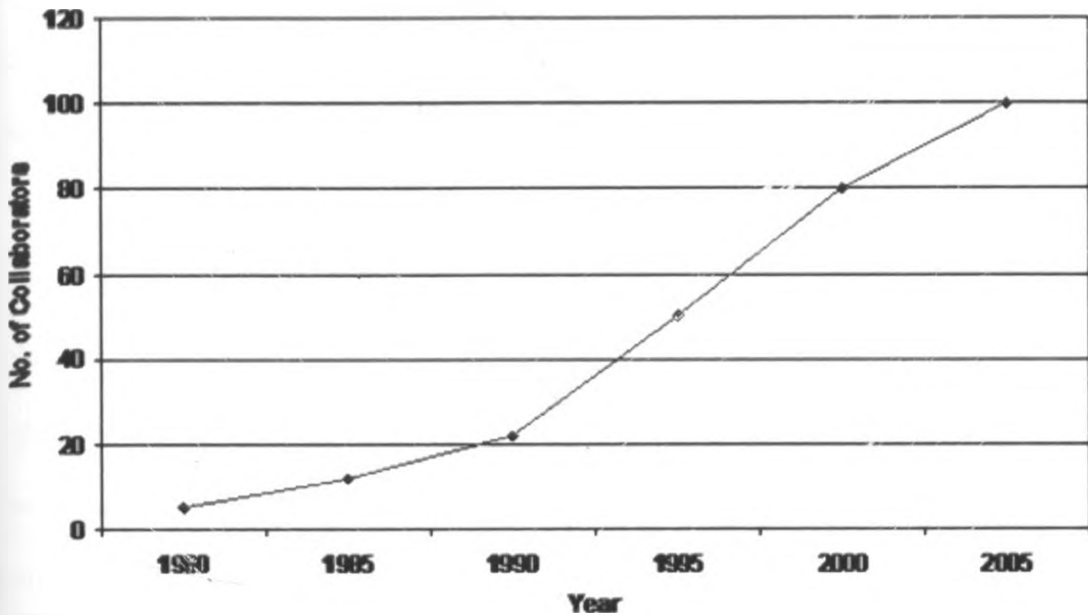
offer students an opportunity to advance their search for medical knowledge because KNH receives very complicated and challenging cases. However, the biggest challenge pointed out includes pressure on limited hospital resources for training due to increased demand. That means KNH resources especially training facilities are not increasing at the same rate of demand.

### **Increased Level of Collaboration**

Globalization has also opened gateways for KNH to extend its realm through partnership with both local and international institutions with a view to facilitate training, provide reliable and affordable healthcare services to poor patients as well as to acquire innovation and modern technologies. The study shows that in the cardiology clinic, more than 400 Kenyan patients requiring urgent open-heart surgery are poor citizens who cannot afford the subsidized cost of KES 300,000. In an effort to address such problems, KNH has established collaborations with doctors from reputable health institutions, multinational companies and countries who occasionally extend free healthcare services to low income group of patients. Such collaborations also facilitate transfer of technologies, innovation and training for local healthcare personnel. These partnerships constitute over 30 humanitarian medical programs run by the hospital. Some of these partners include U.S. Government agencies, principally USAID, the National Institute of Health (NIH), and the Centers for Disease Control and Prevention (CDC), remain important benefactors. Other major sponsors include the U.K. Department of International Development (DFID) and the Bill and Melinda Gates Foundation. Increasingly, other governments' development agencies, private foundations, and the private sector are contributing to KNH growth and diversification. The Heart Foundation mission of UK is dedicated to increasing awareness of heart disease in addition to facilitating research on heart diseases. The UK non-Government Organization Medical and Education Aid to Kenya

(MEAK) visits KNH twice annually to conduct heart operations on children with complicated case and from low social economic group<sup>109</sup>.

Graph 2 **KNH level of Collaboration from 1980**



Doctors at KNH show that such collaborations are eye openers for the local physicians in terms of professionalism and use of new technologies. *"Over the years we have seen a gradual improvement in equipment in Kenya and a genuine willingness on the part of local staff to learn and do better. It is rewarding to see the direct impact of our efforts in the improved health of the patients on whom we operate. And on a personal level we learn a huge amount and see things we have never seen before and it is a fantastic team building exercise."* These partnerships provide both parties with something to learn from each other both in research, innovation and technologies. According to an unpublished statement by a visiting surgeon from UK *"The local medical team appreciates that we can be role models to increase their knowledge and bring very simple but effective technique to help them treat patients"*.

<sup>109</sup> KNH, Kenyatta National Hospital; Strategic Plan 2005-2010, KNH, Nairobi. (2006)pp36

Others include collaboration with doctors from the Emirates World Heart (EWH) foundation through the United Arab Emirate (UAE) Red Crescent and the Kenya Red Cross. The partnerships of these institutions facilitate free open heart surgery for patients who cannot afford. EWH is a global network of specialized surgeons who visit KNH to offer free heart surgery and donate equipment. The Radiological Society of North America (RSNA) also provides training on radiology and radiotherapy.

For more than ten years, Operation Smile (OS) an organization founded in USA with volunteers from more than 30 Medical Mission sites in 26 countries visit KNH twice annually to provide free medical operation on patients with facial deformities and cleft lip and palates. The organization has benefited over 2000 patients at KNH since it started its missions to Kenya. OS provides a framework for its partner countries to come together to share knowledge, technology and skills through the use of programs customized to each country's specific medical infrastructure. The KNH and the UON partnerships also offer Operation Smile medical volunteers training in advanced techniques and provide opportunities including fellowships, and exchange program for career development visiting professorship programs. In addition, KNH is also running Operation Ear Drop (OED) program in collaboration with surgeons from Netherlands. Since the inception of the program in 1999, more than 2000 patients benefited. The hospital has also received donation of modern equipment worth over KES 10 million for Ears, Nose and Throat (ENT) department, in addition to training of students from the UON and KMTC.

The International Neurological Society (INS) through the Neurological Society of Kenya (NSK) and Pan African Association of Neurosurgery (PAAN) brings together renowned neurologists from Saint Louis and Washington Universities respectively who visit KNH annually to carry out operations on complicated neurological cases in an effort to exchange

ideas, skills and identify new approaches to disease diagnosis and treatment. The study reveals that patients' population includes the spectrum of neurological abnormalities, head and spinal cord trauma, hydrocephalus and congenital anomalies and spinal tumors among others.

The KNH neurosurgery program is of paramount importance especially realizing that in Kenya there is only eight neurosurgeons; six are at KNH while two are in full time private practice. This present a sympathetic situation for patients with neurological conditions who have to wait for several months before they are attended. Currently, no formal training program in Neurosurgery exists in Kenya. The NSK in collaboration with KNH, the Aga Khan Hospital, the Nairobi and Gertrude Children's Hospitals plans to start a training program on neurosurgery. Certificates of competence will be awarded by the University of Nairobi and the Neurological Society of Kenya through centers of excellence abroad.

However, among the challenges facing KNH initiatives to provision of efficient healthcare is lacks an established ICT. According to Doctors, ICT is important during this era of globalization and the MDGs. The hospital is currently operating with limited Local Area Network (LAN), where there is no website and is linked to a very slow dialup internet connection which limits international collaboration and use of telemedicine that would boost exchange of skills and ideas.

KNH also collaborate closely with the International Network for Cancer Treatment and Research (INCTR), a non-governmental organization founded by the International Union against Cancer (IUAC) and the Institute Pasteur in Brussels with branches in the USA, France, Brazil, Egypt and Nepal and offices in the UK, India and Tanzania. The INCTR, assists developing countries through a structured program of research collaboration, education and training, to develop an increased understanding of the causes and predisposition to regionally



important cancers, and to increase survival rates and the quality of life in patients with cancer. Other support arising from this partnership includes capacity building for cancer treatment and research through long term collaborative projects, training and education. This confirms *Dehesa, G. (2003)* argument that adoption of new technologies improves human resources and enhances productivity when they are applied due to increased volume output for each unit added to the input factor.

KNH has also well established linkages that have promised a concerted war against HIV/AIDS in the country. The FHI support provision of Anti Retroviral (ARV) drugs, training of staff and equipping and refurbishing of the hospital facilities. Other notable international institutions supporting HIV/AIDS at KNH are President's Emergency Plan for AIDS Relief (PEPFAR)-USA, Global Fund to Fight AIDS, TB and Malaria, United Nations program on HIV/AIDS (UNAIDS), WHO, Network of AIDS Researchers of Eastern and Southern Africa (NARESA), Centre for Disease Control and Prevention (CDC) among others.

Doctors admit that collaborations are not only beneficial to KNH, but also to patients and the country through the reduction of the disease burden and lower cost of medical treatment. However, some donations provided to KNH especially medical equipment are obsolete and cannot be used in Kenya due to lack of spare parts or have been overtaken by new technologies. Some donations are also made but do not address the priority of the hospital especially for those that require installation or consumables as accompaniment. Such equipment may end up not being used and if they are used, they end up diverting resources from the intended purposes because the hospital will incur cost of installation or providing accompaniment. While the international volunteers are committed to provide the most needed

assistance, KNH is faced with staff constraint especially nurses, technical staff and lacks modern equipment equivalent to those of the visiting teams.

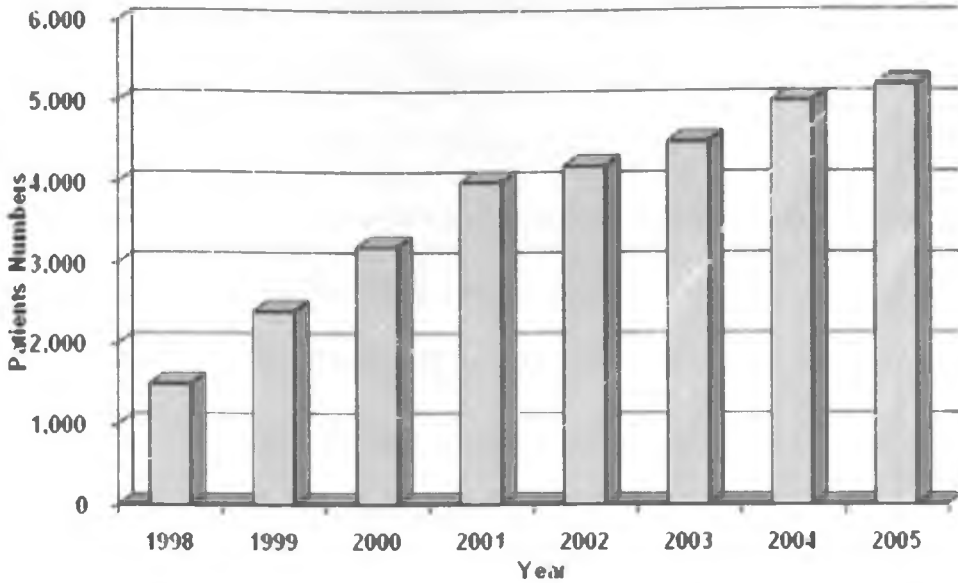
### **Emergence of New Diseases and Health Conditions**

In the 1980s, when the world witnessed the emergence of HIV/AIDS, KNH was no exception and in the preceding years, cases of HIV increased accounting to 60% of all the hospital clinical care. In the 1990s, 30% of the bed occupancy were HIV patients and the number has kept on increasing with time. Doctors attribute the emergence and increase of HIV patients to the increased mobility of people across borders. The emergence of the HIV affected KNH resource allocation and distribution. Some resources for other clinical care were diverted to provision of comprehensive care services such as screening, diagnosis and treatment for other opportunistic diseases such as Sexual Transmitted Infections (STIs) and Tuberculosis (TB).

In the year 2000, drugs for the management of HIV cases accounted for over 10% of the hospital drug budget. Records show that TB cases in KNH have increased tremendously from less than 2000 patients in 1998 to over 5000 in 2005. HIV has also increased the cost of TB treatment due to emergence of cases of Multidrug Resistance TB (MDRTB). The overcrowding in medical wards (*a 30 ward capacity admit 100 patients*) has also worsened the spread of TB in the hospital among both patients and healthcare personnel. In the year 2002, 93 members of staff were diagnosed with TB which doctors attribute to overcrowding and lack of isolation facilities for patients affected by infectious diseases.

Graph 3

## TB cases



Globalization has also facilitated cross boarder diseases transmission such as Bird Flu, Ebola, Smallpox, Measles and other hemorrhagic fevers. These highly contagious diseases have made KNH to divert resources for the common killer diseases like malaria and diarrhea in order to enhance their control. *Daulaire, (2006)* recognizes that globalization has enhanced human mobility leading to the spread of previously isolated diseases through the four transmission modes; airborne, waterborne, by direct contact, and through vector (insects or other creatures that carry germs from one species to another). The *Red Cross/Red Crescent (2007)* also confirms that the increased international human movement due to improved transport and reduced cross-border restrictions has enhanced movement of such diseases across nations.

Preparedness to counter international scare of infectious pandemics calls for a broad based strategy involving players outside government public health because the impact is usually felt beyond the health sector. Such scares have made KNH to extend its linkages far and beyond the African border in search of partnerships for support and access to appropriate information on such diseases.

After the 1980s, KNH has also experienced an increase in lifestyle disease incidences such as diabetes, hypertension, renal disorders, obesity, gout, skin diseases and cancer among others. Majority of lifestyle diseases have increased due to the adoption of Western culture that has influenced the eating habits of the Kenyan population. The changes in diseases epidemiological pattern and emergence of new ones necessitate the need to allocate and divert resources by the hospital from the known common diseases and adoption of prevention measures. According to *Dehesa, G. (2003)*, the growth of cross-cultural contacts have facilitated cultural diffusion through the desire to consume and enjoy foreign products, ideas and adopt new technology and practices.

KNH also plays a major role in the treatment and management of orthopaedic patients arising from the increasing number of traffic accidents and other emergencies, in addition to receiving referral patients from all over the country. These cases have increased due to human mobility and Western means of transport that have been adopted without improving transport infrastructure and adoption of appropriate policies for management and control. Treatment and management of orthopaedic patients and correction of other physical deformities is expensive. In most cases patients are expected to buy implants and pay for cost of the prolonged hospital stay (minimum average 36 days).

Globalization has also subjected KNH to managing patients affected by manmade disasters and human conflicts. In 1998, the hospital was faced with the worst disaster affecting over 5000 casualties from terrorist bomb blasts of the American Embassy in Nairobi. More than 2000 patients received treated at KNH and majority had injuries that were done reconstructive surgeries.

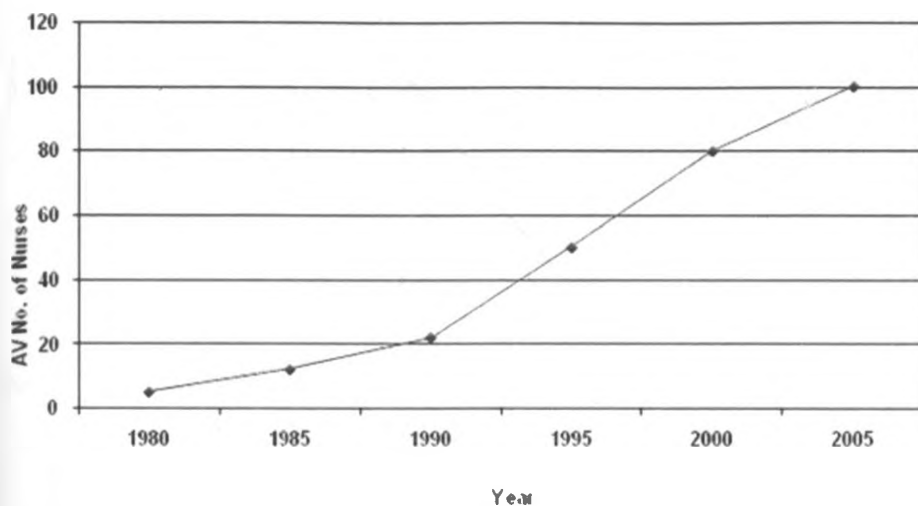
## **Increased level of Competition**

The effect of globalization after 1980s subjected KNH to increased level of competition. This is as a result of increased private medical services and emergence of hospitals owned by non-governmental organization and mission Christian institutions. Notable institutions that were set up in Nairobi include the Aga Khan Health Services with 280-bed facility, the Nairobi Hospital, 200-bed and Gertrude Garden Children's Hospital with 120-bed among other diagnostic services institutions such as X-Ray and Nairobi Dialysis Centres. The private competitors handle fewer customers and therefore the quality of service may appear more appealing than that of KNH. Therefore, consumers had the opportunity to subject KNH services to competitive scrutiny because they had an array of other services from private hospitals to compare with. Realizing that KNH specialized services are deliberately priced to be affordable, this influenced market prices for various services in majority of private hospitals. KNH also provided a yardstick for setting up and equipping private hospitals.

The demand for doctors and nurses by private hospitals affected services delivery at KNH because of the shared loyalty as the cream of medical personnel got an opportunity to sell part-time services to the private hospitals. In addition, the hospital witnessed an increase in migration of specialized nurses to countries in the North especially Britain, USA, Australia, Canada and a few in other African countries such as Rwanda, Botswana, Namibia and South Africa. Majority of these nurses have been trained and gained marketable experience at KNH in specialized areas such as ICU, Renal and theater among others.

Graph 4

Average annual No. of Nurses from KNH Taking International Jobs



Some of the push factors to other countries are overworking due to fewer nurses (*nurse/patients ratio is 1:30 in general wards and 1:3 in critical care against WHO recommended 1:1*), lack of supplies and corporate governance, low wages at KNH, lack of innovation and new technologies, lack of motivational factors as well as corruption levels in the country. KNH has also witnessed increase in cases of delayed and mismanaged disease that end up at the hospital due to emergence of *money-for-medical services* type of medical care that has been infiltrated by quack doctors and nurses. Such cases lead to increasing cost burden for treatment and sometimes mortality at the hospital. This period also witnessed a reduction on reliance in KNH healthcare services as patients seek alternative services abroad. This is due to the increased information on available hospitals abroad and reduction in cross border restrictions.

In an effort to stay afloat in the competitive world, KNH set up 225 bed capacity private wing to attract local corporate clients and international patients. The wing is also meant to boost the hospital financial capacity owing to the increased number of low social economic patients who are not able to pay for their healthcare services. KNH has also built offices/clinics (Doctors Plaza) within the hospital compound to accommodate doctors (consultants) for their private practice in order to retain them within easy reach whenever they are called upon to attend to

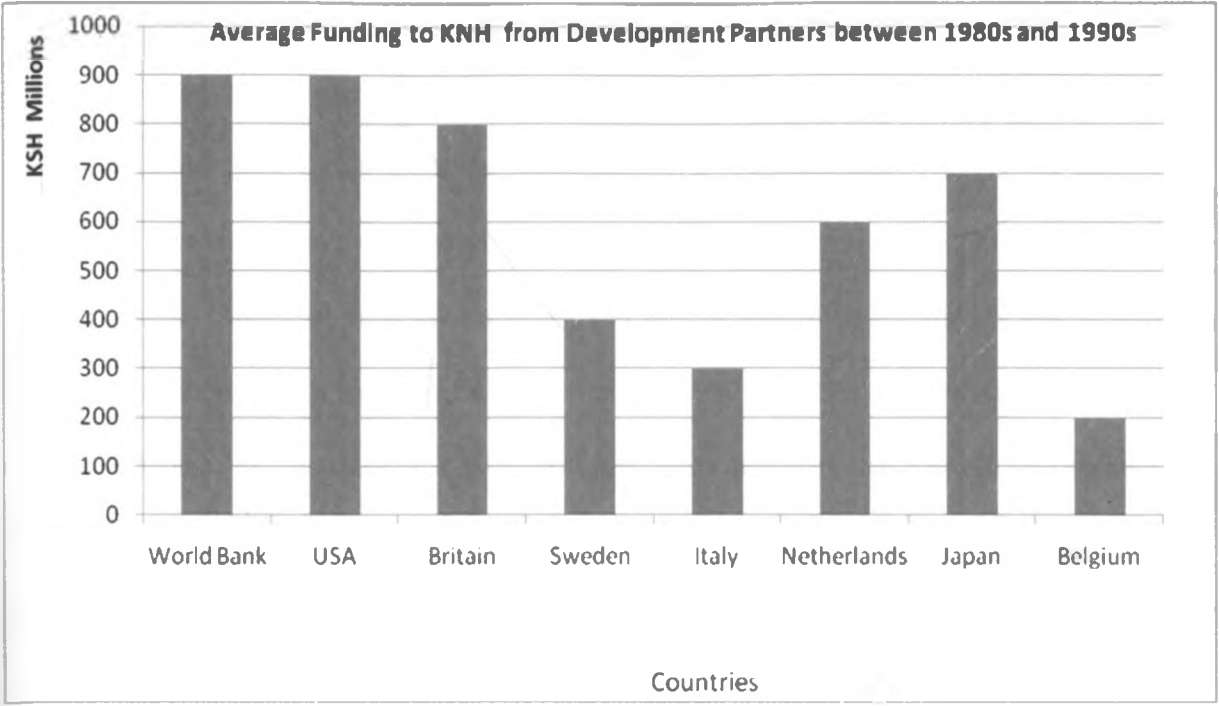
patients in the general hospital. The Private Wing provided an opportunity for them to admit their patients. However, some of the consultants have been accused of neglecting general patients for their private patients where they accumulate financial gain at the expense of their employer. Some staff thus feels that the arrangement creates an internal competition other than helping KNH to compete at both local and international levels.

### **Donor and Aid Influence**

In the 1990s, KNH attracted donor funding in form of loans and for technical assistance or capacity building. Much of the funding came from countries in the North such as USA, Britain, Netherlands, Japan, World Bank, Sweden, and Italy. These donations have made it possible for the hospital to initiate rehabilitation of physical facilities, procure and replace old medical equipment which greatly improved the provision of services. In the early 1990s, the World Bank funding of 600 million helped in the rehabilitation and acquisition of new equipment while the Japanese Government donated equipment worth KES 670 million. The funding supported the upgrading of diagnostic equipment in order to strengthen KNH capacity to offer specialized treatment which hitherto was lacking.

In the 1990s, KNH also received funding from friendly organization, institutions of higher learning and individuals to facilitate training, upgrading of water supplies and electricity, procurement of drugs, reagents and to facilitate war against HIV/AIDS. The study also show that a good amount of donation and training came from partners in form of funding for medical mission projects. KNH in collaboration with international healthcare institutions, pharmaceutical companies and hospitals are running over ten free and subsidized medical projects annually.

Graph 5



While Aid and donations have made positive impact on provision of healthcare services by KNH, the World Bank funding will be remembered for the introduction of cost sharing in hospitals where patients are expected to pay fees for healthcare services. This was a move towards entrenching SAPs in education and healthcare delivery in Kenya. Cost sharing (CS) contributes to 20% of the total KNH recurrent budget.

Charging for medical services limits access by the poor, undermined their standard of living and contributes to low quality of healthcare. The introduction of CS show that patients from low social economic groups cannot afford KNH specialized healthcare services unless if they are bailed out by the government. While the Government is not committed to provision of free healthcare services, KNH limited resources cannot withstand the pressure from the increased demand and the declining donor funding. This situation confirms Rugumamu, (2005) view that globalization has forced majority of Africans into strategies of no more than survival, denying majority of people even the opportunity to life.



## Summary

With the advent of globalization, KNH has recorded an increase in level of funding from the development partners. In addition, the increased level of collaboration, KNH has been able to provide free or subsidized services to patients from low socio-economic group. The improved donor funding, collaboration levels, training and research have contributed to the provision of quality healthcare by KNH. After the 1980s, local doctors and nurses have acquired appropriate skills to undertake some of the complicated surgeries that used to be referred to the Western hospitals during the period before the 1980s. The availability skills, innovations and technologies are forces that guarantee KNH the benefits of globalization and efficient healthcare services for the patients.

Globalization has also brought in challenges for the hospital which include increased competition and "*brain drain*" as qualified nurses and doctors leave KNH for international employments. These challenges have made the hospital to set aside funding for research and development in order to determine opportunities that would guarantee its competitiveness.

However, there is potential in KNH reaping the benefits of globalization due to the existing infrastructure such as physical facilities, human resource capacity and donor confidence. These opportunities are indeed important in helping KNH to enhance its healthcare services in the global market.

## CHAPTER V

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

#### Summary

The emergence of globalization has cultivated an international consensus that without economic development; it is very unlikely that a country may realize social or political development. History and the recent experience have also taught us that global integration can indeed be powerful forces for reducing poverty and empowering people. Poor people are less likely to remain poor in a country that is exchanging its goods, services, and ideas with the rest of the world although the reach and impact of globalization remains uneven<sup>110</sup>. It is equally important to note that the economic effect on social development automatically influence the country healthcare services as healthcare systems are improved and adopted. Globalization is therefore a continual and gradual rather than an abrupt changes process that continues to occur and affects social health determinants (SHD) in the world.

For several decades, before the 1980s, the colonial government and later after Kenya attained independence, the Kenya Government, both had pursued a goal to provide free healthcare services to its citizen with minimal success; and the efforts were became more elusive as population increased. The challenge called for a change of strategy with introduction of WB strategy of cost sharing in healthcare services which also could not guarantee sustainability of healthcare services in Kenya due to increased number of poor people and poverty. An involvement of a multisector approach to provision of healthcare services which include individuals, public private partnerships, collaborations and adoption of varying ideas, skills and technology through continuous research and development are possible options that would guarantee sustainable healthcare.

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<sup>110</sup> Goldin, I. *Globalization for development: Trade, Finance, Aid, Migration, and Policy*. Palgrave Macmillan, USA (2006)pp16

## Conclusion

This chapter is the last lap of this study and contains conclusion and recommendations. The market mechanism, technology and interdependence issues are the forces of globalization occasionally manipulated, designed and driven by developed economies and through TNCs for their benefits. The economic factors certainly constitute the most important dimension to be altered if meaningful achievement is to be made on global benefits while we adopt collaboration. KNH has been forced to adopt and accept policies that are not pro-poor interests or even protect the institution against emerging global challenges such new and re-emerging diseases that are influenced by mobility of people across borders. With the use of air travel, people are able to go to foreign lands, contract a disease and not have any symptoms of illness until they get home, having exposed others to the disease along the way. World-wide migration and the other interconnected associated with transborder processes that constitute the heart of globalization *"are mixing people and microorganisms on an unprecedented scale"*.

Although KNH stand to gain through partnership with institutions from developed economies of the North, the hospital need to develop appropriate policies that would minimize dumping of obsolete equipment arising from donations. Institutions and countries that have had benefits of globalization have indeed embraced good governance and kept abreast with the emerging technologies. But there is need to deal with the related issues of political will, governance and enhanced sectoral delivery of healthcare systems with adoption of referral systems. Under such circumstances, KNH need to invest in good Governance and accountability which are the global force that attracts partnerships and technologies from developed economies. These forces would enhance efficiency; facilitate the transfer of technologies, skills and ideas to developing economies.

Globalisation contributes in various ways to the migration of health professionals. This migration is asymmetrical – from poor countries to rich ones – with the poorest countries unable to attract replacement workers. The result is diminished health care access and services. The absence of an adequate density of health workers, in turn, correlates with increased in workload for the few who are left, limited healthcare services and mortality.

Globalization is however a reality and it is indeed here to stay. However, the effects and its extents differ and depend on whether one is in the global North or South. It is indeed here to stay. The study did not therefore seek to imply that it is unworkable, unbeneficial and that the world market vision should be abandoned. The mandate was in the challenges. Among the opportunities are the virtues of market openness and public–sector efficiency. KNH ought to treat the process cautiously, to take its time so that only positive aspects are embraced.

The process of globalization advocate for competitiveness and adoption of liberalized but integrated market. Certainly, these are qualities that KNH need to embraces in order to enhance its competitiveness, retention and attract specialized staff and guarantee sustainable income. In addition, the increased level of patients` awareness on quality care and their medical rights, the hospital need to adopt a customer retention strategies; these are the dictates of globalization to keep institutions on their toes, alert to ways in which they can improve efficiency and better satisfy their customers. An integrated global marketplace will equally accelerate the transfer of technology. And it is only by accelerating the transfer of technology that poor countries have a chance of growing rapidly. Removing trade barriers reduces the scope of the government. That reduction, in turn, reduces the inevitable corruption, stagnation, and bureaucratic obstacles to growth that have beset developing economies for two generations.

The more internationalized the world economy, the more use producers in each country can make of commodities and production processes invented elsewhere. Faster diffusion of knowledge raises the level of productivity and technology worldwide.

The ideological, political and economic interest of the rich countries and individuals dictate global policies because power is mainly defined in economic terms. Therefore, while emancipation, the poor are often powerless to influence the social, political and economic factors that determine their wellbeing or poor being.

Globalization provides strong, active government to build infrastructure and redistribute wealth to ensure that growth benefits all. The process seems to be bent more towards wealth creation for already wealthy than towards distributional justice in favour of the poor. In order to benefit, the poor must be able to open the door (to harness the benefits) to active participation in globalization from home.

The economic benefits of recent globalisation have been largely asymmetrical, creating winners, losers and growing inequalities between the two. Globalisation's enlarged and deepened markets reward more efficiently countries that already have productive assets (financial, land, physical, institutional and human capital) than they do countries that lack them (typically low- and some middle-income nations).

The functionalism theory increasingly appreciates that health is a global public good. The distribution of this good remains vastly unequal; however, the disparity gap can be narrowed through adoption of the process of integration between the developed and developing economies.

## Recommendations

In an effort to realize the benefits of globalization by developing countries, there is need to strengthen economic foundation by strengthening local human resources capacity. That would enhance the adoption of technologies, skills and ideas which are important SDH.

KNH need to encourage and attract support from both local and international partnership such as healthcare institutions, faith base and NGOs, Civil Society, and pharmaceutical companies. Such partnerships will enhance transfer of skills, good governance, management control of resources and decision making. In an effort to attract goodwill from corporate partners and individuals, the hospital needs to make use of the mass media to create awareness on its healthcare activities in order to cultivate public confidence. In the Information age this will be boosted by free and objective countrywide electronic media coverage, use of internet, website, e-mails and publicity campaign.

Given the diverse, changing, and trans-generational nature of contemporary patient populations, KNH need to ensure that clinician are equipped with appropriate skills for identifying the special circumstances that surround and define individual's health. Therefore, there is need for universal training as an imperative to reduction in inter-institutional gap amid globalization. Others initiative should include instituting multidisciplinary involvement of the institutional departments in harnessing global benefits.

There is also need to institute and review appropriate policies that may hinder free flow of goods, technologies, ideas and services across borders in order to reduce inter-institutional and countries barriers.

Furthermore, KNH need to support and encourage individual development for its employees to acquire necessary skills that would enhance provision of healthcare services and improve the hospital competitiveness in the global market.

Realizing the increased income inequalities levels among Kenyan population and appreciating that globalization process thrives in a liberalized market, the Government need to strengthen National Health Insurance Funds (NHIF) that would support poor patients to get access to referral healthcare services. Strengthening access to public healthcare will not only guarantee quality services but will equally protect the poor from exploitation by private healthcare givers. KNH need to encourage research and development in order to develop home grown innovations that would address local problems. Such efforts should include enlightened institutional stewardship, planning, resources allocation and management and enforcing performance contracting among others.

### **Encouraging Local and Regional Partnerships**

KNH need to strengthen regional and local collaborations through Inter-local institution linkages (through MOU), conducting joint research and conferences in order to create forums for exchanging local and regional innovations, technologies, ideas and skills. Such partnerships should include individual and departmental levels. These initiatives may be strengthened through establishing strong linkages between KNH and its development partners and adoption of current information and communication network via internet, E-Medicine and telemedicine.

In an effort to reduce cost of medical treatment, KNH need to provide the lead for the country to make use of the extensive body of alternative medicine. With the help of the UON research, KNH and the Government need to document, scientifically study, and validate these

modalities from varying sources. The alternative treatments can be offered to patients with end-stage diseases like cancer, HIV/AIDS or diabetes. KNH and the UON can therefore set in place an accreditation process for alternative medicine that comply with the WHO standards.

KNH cannot hope to do anything for the people if the people are not part of the process. Each community's problems are best understood by them and the solutions therefore lie with them. The hospital must talk with communities and learn how to move its agenda forward with them. In addition, the increased patients' awareness on their medical rights, there is need for KNH to adopt caring for patients within an *eco-friendly environment* focused on patient care – placing patients and families first.

### **Global Actors Strategic Inclusion**

Among the key objectives of economic policy should be the creation of an economic environment which generates livelihoods for all people, providing stable incomes at a level consistent with their physical, mental and social well-being; and social protection for those unable to attain or sustain such a livelihood. Therefore the influence of the process of globalization cannot continue with the IMF, WB and WTO in the forefront undermining the gradual process in favour of the rich individuals, multinationals and economies. These institutions need to urgently seek to overcome narrow national and self interest of the rich if the poor are to benefit. The World Trade must be equitable and predictable through fairness to developing countries. The Developed countries should always contribute to healthcare systems under IMF-WB pollutions and health hazard. Furthermore, developing countries expect to see a strong and more coherence WHO that is capable of negotiating and make appropriate recommendations against the drugs patents rights of the multinationals in favour of the poor populations and the developing countries.



Realizing that globalization is a process that is occurring every second in our life, this study is not exhaustive. More research is therefore recommended to complement the small part I have managed to cover. It would be desirable to determine the effects of economic globalization on provision of healthcare services in Kenya. This is because we cannot rule out the existence of new and more striking findings.

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Appendix A: King George IV Hospital



KNH formerly King George Hospital before the advent of globalization in the late 1950s

Appendix B: Surgical Ward -1954



A surgical patient's ward at KNH in 1954 before the advent of globalization

## Appendix C: Native Education



*Pupils in one of the native school, 1950s*

## Appendix D: European Education

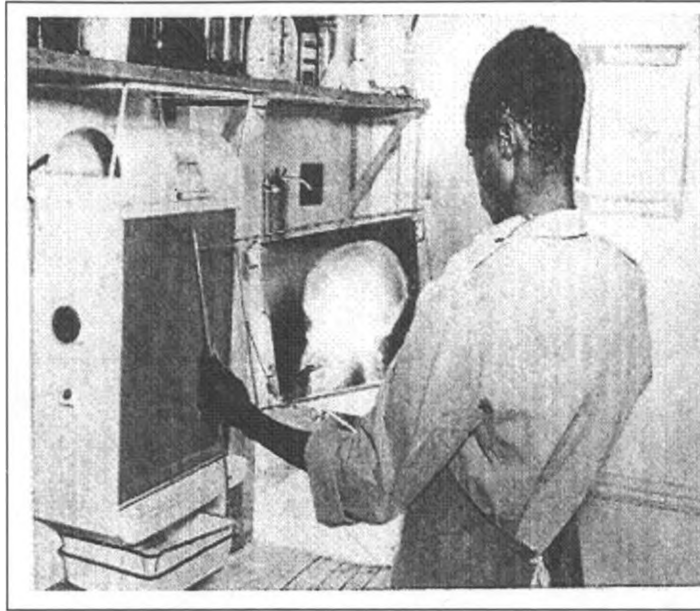


*Pupils in one colonial school, 1950s*

Note the diversity in the education setup which might have contributed to slow or delayed uptake of technologies and skills and dissemination of ideas.



## Appendix E: Less Developed Diagnostic Technology



A radiologist trained at King George Hospital Technology was not well developed as witnessed by this radiologist reading x-ray film manually. Uptake of technology by the African was slow.

## Appendix F: Blood Donation Process



*Source: Kenyatta National Hospital, 1901-2001: a hundred year of quality healthcare (2001) pp45*

A donor giving blood (left), note the bottle which used to collect and store blood. These could be recycled in order to minimize cost and serve many patients.

## Appendix G: An Ambulance before 1980s



Patient (right) arrive at the hospital using a lorry which was an ambulance then, note also bare footed porters who were performing nursing roles in 1950s

## Appendix H: Pharmacy in 1950s, King George IV Hospital



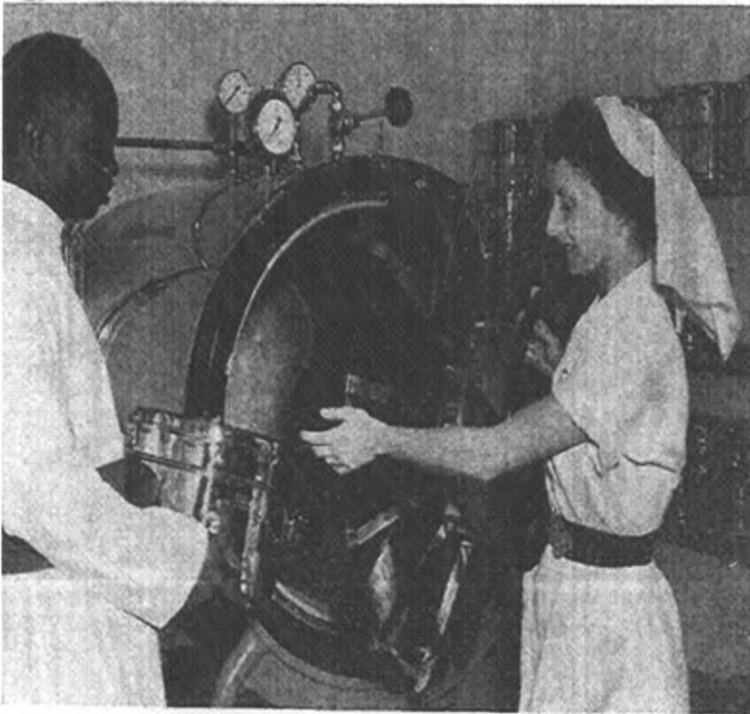
A compounder in a pharmacy of King Gorge VI hospital 1958, majority of the activities were carried out manually due to limited technology and skills. However, there was high level of care in order to yield the desired results. Pharmacy services included preparation of drugs

## Appendix I: Local Anesthetists



*In the late 1950s and early 1960s, KNH (King George VI Hospital) was training and experiencing services of highly skilled Africans such as this anesthetist who were trained at the hospital's school.*

## Appendix J: On-Job Training of Local Skilled Staff



*Source: Kenya History in Outline, The Eagle Press, Nairobi (1953) pp77*

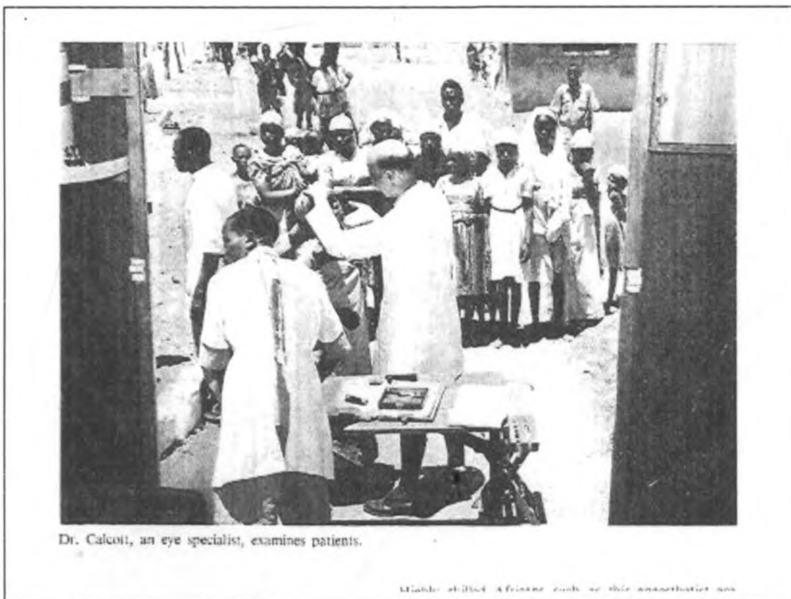
*A manual sterilization machine (left) and theatre operation (right). Note that the Africans were allowed to learn on the job. Otherwise major tasks were done by the Europeans.*

## Appendix K: European Specialists in the Theater



Theater operation was specialized service that was left to European Doctors during the period before the advent of globalization, before 1980s.

## Appendix L: European Conducting an Outreach medical Camp



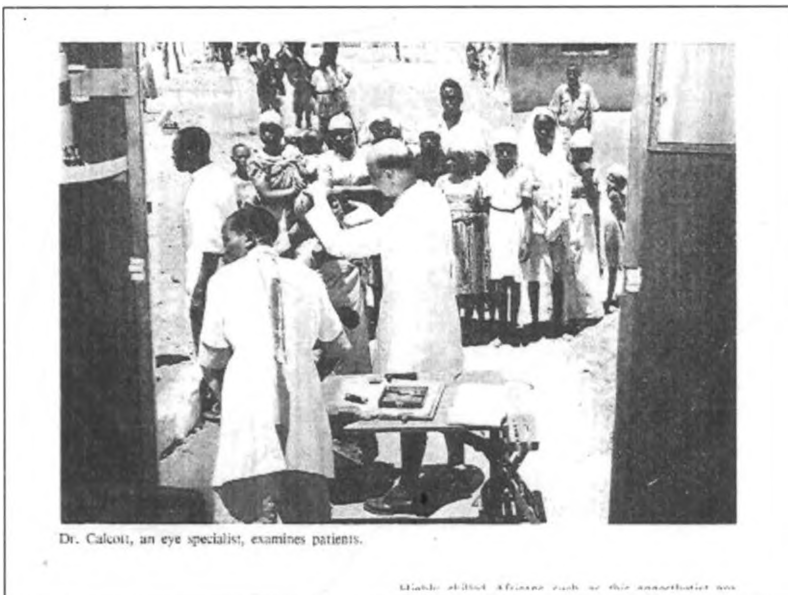
Some of the European Doctors carrying eyes check up during a medical camp organized by the colonial government to minimize referral cases. This was the period before the advent of globalization

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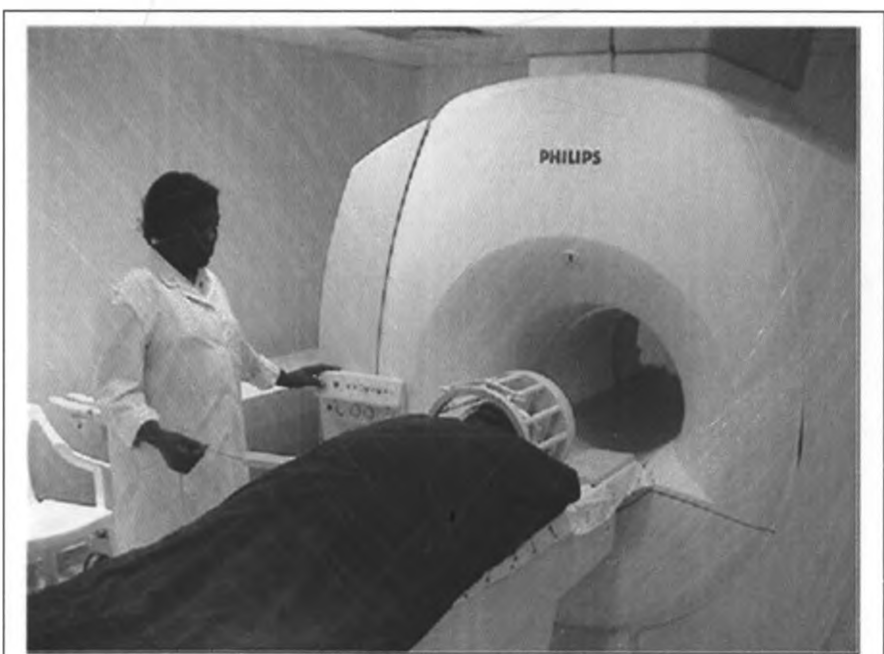
Some of the European Doctors carrying eyes check up during a medical camp organized by the colonial government to minimize referral cases. This was the period before the advent of globalization

**Appendix M: The modern KNH facility**



The new look of KNH (tower block) after the advent of globalization that accommodate over 2500 inpatients and provide outpatients to over 25,000 patients

**Appendix N: MRI machine, one of the Modern Equipment after globalization**



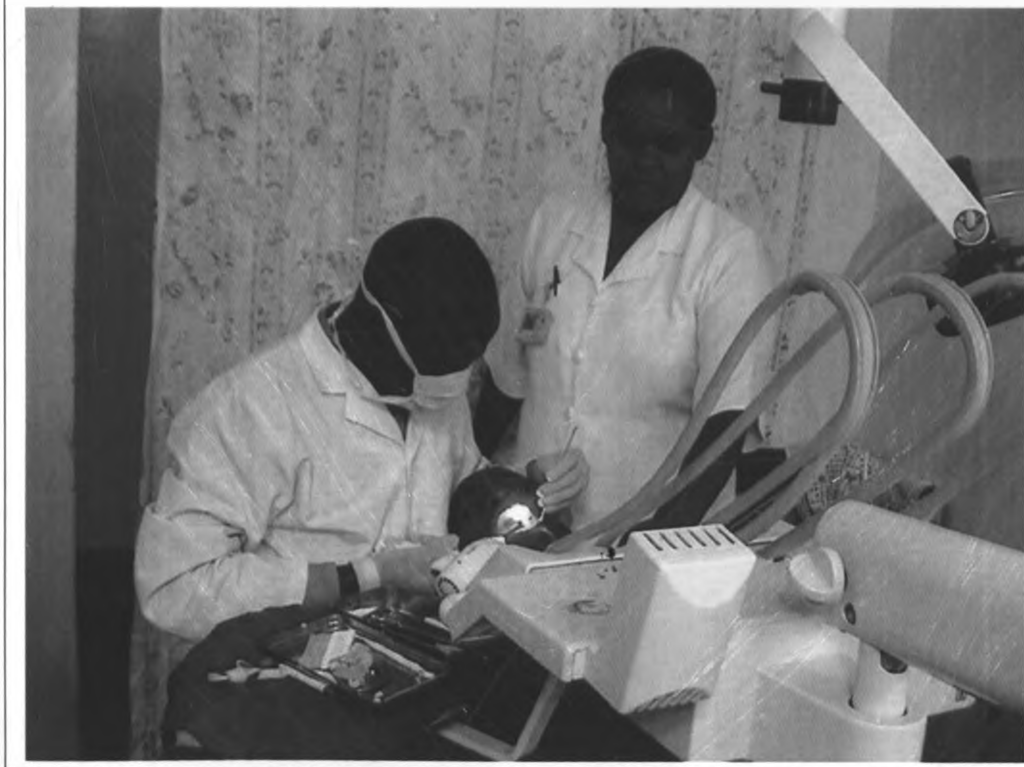
*A patient being prepared to undergo diagnosis using the a ultra modern MRI machine at KNH acquired from Netherlands through a grant from the Government of Spain in the year 2008*

## Appendix O: The Modern KNH Theater Facility



A modern theater at KNH after the advent of globalization where patients are being attended by specialized local doctors (specialists)

## Appendix P: A modern Dental facility at KNH



A Dental Unit at KNH fully equipped with ultra modern equipment for handling specialized referral cases after the advent of globalization