Republic of Kenya

GUIDELINES FOR THE ESTABLISHMENT AND MANAGAMENT OF AMENITY WARDS IN PUBLIC HOSPITALS IN KENYA

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Foreword

With the National Hospital Insurance Fund (NHIF) as a major source of funding, public hospitals are operating various categories of wards (general, amenity, and private). However, the categorization of the wards has not been clear. In addition, standards in the amenity wards have not been appropriately regulated and coordinated, resulting in different input and output standards throughout the country. The lack of clear guidelines on the establishment and operation of amenity wards has resulted in varying quality of services, staffing levels, equipment, and capacities with disparities across facilities within the same tier in the health system.

These guidelines will facilitate the establishment, operationalization and governance of amenity wards, focusing on financing, standards and quality of care. The main objective will be improved efficiency, effectiveness and transparency in service delivery and resource mobilization in public hospitals in Kenya.

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Acknowledgments

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Abbreviations

AIE	authority to incur expenditure
AWMC	Amenity Ward Management Committee
DHCF	Division of Health Care Financing
EEC	Executive Expenditure Committee
EPI	Expanded Program of Immunization
FIF	Facility Improvement Fund
HAO	health administrative officer
HMB	Health Management Board
HMT	Hospital Management Team
HPI	Health Policy Initiative
IMCI	Integrated Management of Childhood Illness
ICU	intensive care unit
MOH	Ministry of Health
MRI	magnetic resonance imagine
NCK	Nursing Council of Kenya
NHIF	National Hospital Insurance Fund
PGH	provincial general hospital
PMO	provincial medical officer of health
SHI	social health insurance
USAID	United States Agency for International Development
WHO	World Health Organization
VIP	Very Important Person

Chapter 1: Background and Lessons Learned in the Establishment of Amenity Wards

1.1 Introduction and Background

With the National Hospital Insurance Fund (NHIF) as a major source of funding, public hospitals are operating various categories of wards (general, amenity, and private). However, the categorization of the wards has not been clear. Also, many claims submitted by the NHIF accredited hospitals are not paid due to the lack of clear guidelines on staffing levels, charges, costing, standards, and quality of services, among other reasons. Often, it is difficult - if not impossible - to differentiate general wards from amenity wards. As a result, many hospitals place claims for general wards in the category of amenity wards, which attracts higher rebate rates. Also, in some cases, certain services (e.g., lab-tests, x-rays, and drugs) in the amenity wards are outsourced, contrary to the NHIF Accreditation Contract, which emphasizes high-quality care centered on the principle of "value for money." The lack of evidence-based data to treat amenity wards in public hospitals as separate entities from general wards has led to resistance by the NHIF and similar agencies to provide improved rebate rates comparable with those of the private sector. These guidelines detail the establishment, operation, and governance of amenity wards, focusing on financial management, standards of care, and quality improvement. Public hospitals will use the guidelines to effectively negotiate for increased reimbursement rates from the NHIF and similar agencies.

1.2 Healthcare Financing Mechanisms

As in other developing countries, Kenya has had a long tradition of providing free public healthcare services. During the socioeconomic crises in the 1980s, public resources for health could not support the policy of free treatment. Given increasing demand for healthcare, cost sharing was introduced to mobilize additional resources and sustain the national health system goals of equity, efficiency, and improved health status, among others. To enable public hospital managers to make an informed choice on future financing strategies, the following alternative funding options should be explored:

Facility Improvement Fund (FIF). [1] Fees are charged to patients at the time of receiving healthcare services to cover all or part of the cost of a visit or service. The amount paid can differ by patient group (wealthy or poor); services received (preventive, curative, chronic illness, or surgical procedure); or ward (amenity or general); and may cover all or part of the actual cost of service.

Prepayment schemes. These are voluntary lump sum payments by households for services provided by a healthcare provider when a FIF system is in place. The package of benefits and conditions is clearly defined for those who have contributed to the fund.

Social insurance. The insurance can be compulsory and cover an entire population (e.g., social health insurance) or it can be limited to those in the formal and informal employment sectors (e.g., the NHIF), with premiums based on the individual's income. Members receive services free or at a minimal charge at the time of service. The government, as an insurer, pays for the services or owns facilities and employs those providing the services.

Private prepaid insurance. For this type of insurance, members pay a fixed amount for health coverage, and the insurer meets the cost of hospital bills.

Employer-based insurance. If the company is self-insured, the employee pays a fixed amount or percentage of salary to the employer, and the employer pays some or all of the hospital bills. In some

[1] Also referred to as user fees or cost sharing.

cases, the employer pays all the hospital bills without any contribution from the employee. If the company is not self-insured, the employer buys a group policy and both the employer and employee contribute.

Donor funding. Donor financing or development loans pay for earmarked health services, commodities (e.g., pharmaceuticals), or treatment of particular disease conditions.

Health Sector Services Fund. The Ministry of Health established the Health Sector Services Fund on 21st December 2007 with the main objective of enhancing financing flow to health facilities and providing increased financial resources for medical supplies and rehabilitation of health facilities. Establishment of these guidelines will augment implementation of the Health Sector Services Fund particularly in improving the quality of health care services in the health facilities.

1.3 Private Ward/Amenity Ward

The various categories of wards (private, amenity, and general) have co-existed in the public sector since colonial times. A private ward refers to a wing, an annex, or an extension within a hospital where medical and non-medical services are provided to patients at full-cost recovery (that is, no subsidies). On the other hand, the amenity and general wards are partially and fully subsidized by the government, respectively—the patients meet only part of the cost of services. Due to an increased ability to pay, services provided in the private and amenity wards tend to be of relative higher quality compared with the mostly basic services in general wards. Even though all the wards are intended to provide comparable levels of clinical quality of care, the private and amenity wards provide better hotel amenities and services, have a higher degree of privacy and comfort, and accord priority to urgent medical needs, especially in surgical and specialized care. The private and amenity wards may also have a "fast-track" outpatient clinic intended to enable higher fee paying patients to receive services without having to queue.

Due to the government's financial constraints, public hospitals have encouraged increased cost recovery from patients who are able to pay for the services. The amenity wards have therefore been created to generate revenue and operate according to a for-profit private sector model. However, they are expected to only charge modest fees (e.g., for drugs, infrastructure, and staff), as the government is funding part of their costs. For this reason, the NHIF reimbursement rates for public hospitals are not expected to be the same as those for the private sector, which receives no government funding.

As in the case of the FIF in other hospital wards, the revenue generated in the amenity/private wards will be invested in the hospital to improve the quality of services—providing drugs not on the essential drugs list, enhancing cleanliness and efficiency, and improving staff morale. It also offers an opportunity to cross-subsidize the poor from the net financial surplus generated by high-income consumers who normally use the amenity and private wards. Thus, the latter have great potential to leverage gains for improving services in the various departments within the hospitals.

Box 1. The Operation of Private Wards in Other Countries

Countries such as Indonesia, Singapore, and Zambia have systems in which private wards are established within public hospitals to attract fee-paying, high-income patients. In Zambia, many public hospitals have a two-tier charging structure, in which the private or "high-cost" services are offered alongside standard or "low-cost" ones. The private services are expected to offer higher levels of amenity but comparable levels of clinical quality of care. In the two-tier system, the private wards provide amenities such as air-conditioning, television, private bathrooms, cleaner toilets, and additional non-clinical services. Shorter waiting times are also offered for outpatient care.

Similar to Zambia, private ward arrangements in Indonesia and Singapore offer better hotel amenities to those able to pay for these additional amenities, with the intention of ensuring that clinical quality of care remains the same among the various ward users. The differences among the different classes of private wards include both variations in amenities (from single private rooms with air-conditioning, television, and en suite bathroom facilities to four-bed wards) and in whether a choice of physician is available. A two-tier system based on differences in hotel amenities also exists in the United Kingdom, while in Austria and Finland, senior specialists can treat private patients within public facilities.

The predominant system of pricing includes a combination of bed-charges and physician fees. In Indonesia, prices range from those equaling costs to those exceeding costs, with the VIP and super VIP wards charging 2 and 4 times more, respectively, than the other wards. In Singapore, the charges are also determined by the level of hotel facilities, but they are adjusted periodically and an itemized billing system is used. In Zambia, high-cost ward fees are on average 3.5 times higher than those in low-cost wards, although prices vary among facilities. In these countries, the incentive to generate revenue from private wards is determined by the ability of facilities to retain revenue or at least a portion of it. In Indonesia, the level of revenue retained is reduced by the physician salaries, accounting for 48–60 percent of total revenue. In Singapore and Jamaica, cost-recovery rates vary among facilities, with the higher charging tertiary facilities having higher recovery rates. In the United States, patients have to pay for private rooms themselves, as the room is not covered by insurance unless medically necessary.

Guidelines on the use of revenue generated from the private wards vary across and within countries. In Indonesia, hospital managers have substantial autonomy on the retained revenue, which is used to improve services and facilities through increased expenditure on drugs and medical consumables, recruitment, contracts with private providers, or additional staff incentives. Approximately 40 percent of total retained revenue is used for staff incentives.

Lessons in the establishment of amenity wards in Kenya include the following:

Revenue generation. The main sources of revenue for amenity wards are user fees and government funding. The main payment mechanisms are insurance (NHIF and private insurance) and out-of-pocket payments (user fees). Hospitals with amenity wards have discretion and autonomy in making decisions on revenue generation and use, but must also follow the agreed expenditure guidelines. Managers can use revenue for drugs (not on the essential list), consumables to improve services, the recruitment of staff, staff incentives, and contracts with private providers.

Objectives of implementing user fees (out-of-pocket). User fees from amenity wards could be used to

- *Generate additional revenues.* The revenue could be used to upgrade services in all the wards by improving drug supplies and availability, raising the quality of care, extending service coverage, and ensuring sustainability in health service delivery.

- *Improve equity.* Depending on the population covered and the program design, the revenue could enable cross-subsidization between higher income/healthier and lower income/sicker population groups. The FIF has more potential to achieve higher levels of revenue generation without undermining equity if it is supported by risk-pooling mechanisms that share the risks of the high-cost burdens associated with hospital use among a wider population.

- *Improve efficiency in service delivery.* Public health facilities face critical shortages of medical and non-medical staff due to budgetary constraints. The revenue could be used to bridge this gap by directly covering part of the salaries of amenity ward staff, resulting in efficiency gains. If the revenue is used to enhance financial access to services by the poor through cross-subsidization, equity in service delivery would also improve.

1.4 Human Resource Capacity

Human resource capacity can be defined as the ability of the public health workforce to meet its objectives and perform better. This workforce is the central component of the national public health capacity, which also includes infrastructure components such as resources, facilities, and appropriate technology.

Why is it critical to assess human resource capacity and customer care issues in amenity wards? Building capacity and addressing issues will help to

- Reduce length of stay in hospitals,
- Attend to patients faster,
- Improve actual and clinical quality of care, and
- Improve the effectiveness of service provision.

Strengthened human resource capacity makes an important contribution to the improvement of health system performance. For example, people are more willing to pay for services if a health facility has adequate medical personnel. High human resource capacity is therefore essential for attracting new patients as well as maintaining existing ones.

1.5 Improving Customer Care Including Provider Attitudes

The key to success for amenity wards lies not only in providing high-quality services but also in providing patients with the level and quality of service they desire to create and maintain the public hospitals. When patients have a positive perception of motives, communication, empathy, and clinical judgment, they will respond more positively to care. Good customer care can be used to demonstrate to patients that a practice is focused on quality and improving current patient care. In the end, good customer care will lead to higher quality healthcare and happier and healthier patients.

1.6 What Determines the Amount of Revenue Generated from the Amenity Wards?

The amount of revenue generated from the operation of private or amenity wards depends on the following:

Demand for the services. The more clients who are willing and able to pay for services, the higher the likelihood of raising additional revenue from wards. To this end, emphasis should be placed on establishing affordable fees. Unlike in general wards, the demand for services in amenity wards is likely to be inelastic (more so, if there are no substitutes), indicating a higher likelihood of generating significant revenue from the wards.

Perceived quality of service. The introduction or revision of fees will depend on improvements in the quality of service; patients are willing to pay more for improved quality. For the same reason, if patients perceive the quality of service to be poor, there will likely be a loss in significant revenue to competitors. This, however, depends on the amount of competition, which amenity wards face from private hospitals. The availability of key resources such as nurses, doctors, diagnostic equipment, and drugs is thus critical in amenity and private wards. Other aspects of perceived quality of care such as shorter waiting times and cleanliness are important as well.

Efficiency of fee collection. An efficient system of fee collection must be established to maximize the revenue generated from amenity wards. For example, cash registers would improve not only efficiency in revenue collection but also transparency and accountability.

Policy design and governance structures. Amenity wards are publicly owned, as the government provides the initial capital investment. The private sector is, however, encouraged to invest in the establishment of amenity wards. For amenity wards to deliver high-quality services, attention must be given to the following governance issues:

- The hospital management board must establish managerial incentives and related governance structures that protect and promote public patient interests (e.g., protect patients from being influenced/induced to obtain services from the private wards).
- There must be clear procedures around revenue generation and use in amenity wards.
- The overall financing system must be developed in supportive of cross-subsidization at the population level; management and governance capacity must be strengthened within facilities and health departments.

Actual and clinical quality of care. The hotel facilities in amenity wards will be better than in general wards. The patients in the higher-charging amenity wards (en suites/single self-contained rooms) have a choice of physician. There is also a higher likelihood of having a lower patient-to-nurse ratio—much closer to the World Health Organization (WHO) norm of 6:1. The generation of cost data and knowledge on how to improve patient perceptions of the public sector is critical in making amenity wards an attractive alternative to healthcare provided by the for-profit private sector.

Price setting. Setting charges below those of the for-profit private sector will make amenity wards in public hospitals an attractive healthcare provider option. This notwithstanding, the wards will use private sector billing practices and guidelines. It is critical to note that bed charges and physician fees will differ according to the class of hotel facilities being provided (e.g., there is itemized billing). Amenity wards can charge a combination of bed and physician fees, with the prices ranging from those equaling costs (shared rooms) to those exceeding costs (single), with the VIP and super VIP wards charging 2 to 4 times more than the shared rooms. Costing analyses should be conducted to inform the accurate pricing of services.

Chapter 2: Establishment and Management of Amenity Wards

2.1 Guidelines for Establishing Amenity Wards in Public Hospitals

2.1.1 Process of Establishing Amenity Wards

In public hospitals, general and inpatient wards are usually crowded—often characterized by long waiting times for registration and treatment. Even if patients in public hospitals are willing to meet the costs of medical care, they are concerned about service quality and the long lines, the dilapidated appearance of the hospital, insufficient or complete lack of personnel, non-working or absent equipment, and the lack of amenities and other essential supplies in general wards. This contributes to a lack of confidence in most government facilities. To address these issues, amenity wards have been or are being established to provide services to patients who can afford to pay for relatively higher quality services compared with basic services in general wards.

The Hospital Management Team (HMT) should deliberate on the need for establishing an amenity ward. Its establishment will be guided by the number of patients who require services that are more expensive than or superior to those covered by the basic benefits package. The HMT will present recommendations to the Hospital Management Board (HMB), which must endorse them prior to submission to the provincial medical officer of health (PMO) for approval. The board will communicate the approval or disapproval to the respective management team. The PMO will, in turn, communicate the status of approved amenity wards to the Ministry of Health (MOH). The HMT will be responsible for establishing the amenity wards under close supervision by an Amenity Management Committee. In the short term, hospitals can upgrade a ward to an amenity ward that meets the minimum requirements (see 2.1.2). Conversion to an amenity ward is also dependent on the hospital's ability to provide all of the services (see 2.1.2). To start, the hospital or the MOH could establish an amenity ward through a revolving fund.

The HMT and HMB will evaluate how much it would cost to convert or upgrade general wards to amenity wards.

2.1.2 Criteria for Amenity Wards

The hospital or the MOH could provide the initial capital investment for establishing an amenity ward and could also be responsible for maintaining the infrastructure. The revenue generated from user fees could be used to ensure effective equipment maintenance. Regarding staff, the MOH staffing norms would be followed.

An amenity ward must have the following attributes:

- A clear admissions policy that specifies waiting time, admitting doctor, and admission point. Patients should not wait more than 30 minutes before being admitted. The wards should not discriminate against any patient wishing to use the services provided he/she can cover the additional cost not covered by the NHIF card.

- A resident medical doctor or qualified clinician to speed up admission.

- Self-contained single rooms or alternatively separate rooms from the rest of the wards. The beds should be at least 1.5 meters from each other and 1.5 meters from the wall. A maximum of four beds per cubicle is required. Each bed should have a provision for privacy, for instance,

a curtain around it. In malaria prone areas, the use of mosquito nets is encouraged. Patients should not share beds, and they must be able to make emergency calls to staff on duty when they need assistance.

- A variety of foods based on patients' conditions and interests. Also, the availability of appropriate bedding, particularly clean sheets, linens, and towels (these should be changed as necessary).

- Regular cleaning of the toilets and a duty roster for support staff. If possible, facilities such as air-conditioning, television, en suite bathroom facilities with showers or private bathrooms, and a visitors' room with adequate furniture.

- Personalized services and when possible a choice for a doctor and additional non-clinical staff to clean ward on a regular basis. There should be shorter waiting times for surgery and laboratory services.

- A labor ward (one wing to be reserved for maternity).

- A theater for the whole complex, x-ray room (subject to availability of funds).

- A pharmacy specifically for the amenity wards, without stockouts. The facilities may require some seed money for start up and then use of a revolving fund. Drugs not supplied by the Kenya Medical Supplies Agency can be accessed by patients at a fee with a mark-up of not more than 10 percent.
  - o Concentrate on specialist services or routine services and then contract or outsource services. Amenity wards can source services unavailable at the hospital such as CT-scans, laboratory investigations, and drugs. The purchases should be in line with the Public Procurement and Disposal Regulations, 2006.
  - o Have an accounting system with an efficient claims procedure. The hospital should forward all invoices to the NHIF within 30 days of their accrual date, with complete documentation in compliance with the fund's requirements stated in the claims submissions procedure (NHIF Form 41). Normally, the NHIF makes payments on all genuine claims within 30 days from the date of submission. All these costs must be incorporated into the fee charged to patients.

2.1.3 General Wards

There is an urgent need to improve the situation in general wards. More often these wards are crowded and bed sharing has become a norm. This situation can be addressed by the following:

- Improving the services provided in health centers so as to decongest district hospitals. The bed occupancy rate in the health centers is below 10 percent.
- Improving staffing levels at the health centers so as to increase service delivery in these facilities. This should be accompanied by improving the functioning of equipment and the supply of drugs and supplies.
- Improving laboratory services to allow routine tests to be done in health centers.
- Addressing the shortage of nurses in the district hospitals (MOH).
- Improving on support services (e.g., laundry, by buying equipment for all hospitals).
- Enhancing the kitchen in all the hospitals for better cooking, cleaning, and sanitation.
- Improving technology, especially on toilets (the MOH should consider installing toilets that have a censor).
- Improve water provision to enable modern toilet systems to work

2.2 Subcontracting of Non-Clinical Services

To improve service delivery in amenity wards and the hospital in general, the hospital administration should consider outsourcing non-core services/non-clinical services such as catering/food, laundry, cleaning, and security services. The arrangement should be formalized through a contract that specifies the services to be provided and fees to be paid. The non-clinical services should be outsourced without compromising the quality of healthcare. In addition, specialized services, such as CT-scans, could be contracted out and paid for by the patient. Subcontracting of non-clinical services and related services should follow the Public Procurement and Disposal Regulations, 2006.

2.3 Issues to Consider in Contracting Services

- Possible subsidization of catering services or food
- Actual cost of catering services (informed by costing analyses)
- Where to outsource the services
- Setting of quality standards
- Monitoring of the quality of contracted services
- Contractor use of the hospital facilities
- Payment terms (payment can be met from cost-sharing fees and by the MOH)
- Laying off of staff currently involved in providing the proposed contract services

2.4 Operation of Amenity Wards

Professionalism in the management and provision of services is especially important. Unlike general wards, the amenity wards should be run as an enterprise and have, at a minimum, one full-time medical officer. However, the establishment of amenity wards should not lead to a differentiation in the clinical quality of services. This could likely happen, though, as staff and functioning equipment are deployed to amenity wards and the availability of drugs is guaranteed. To ensure that the quality of clinical services is the same across all the wards and that general wards do not suffer due to shifting attention to the amenity and private wards, the below guidelines and preconditions should be followed:

- Amenity ward operations must be governed by existing procedures manuals, such as the Facility Improvement Fund Manual, Facility Improvement Fund Supervision Manual, and the District Health Management Board Guidelines.
- Staff must serve both the general wards and amenity wards in accordance with normal procedures and rotations.
- Consideration must be given to an initial injection of funds to improve basic services in the general wards and amenity wards.

While governed by the hospital's general procedures, the amenity wards should be guided by an Amenity Ward Management Committee (AWMC) of the Hospital Management Board. Currently, amenity wards operate in an ad hoc manner or are loosely managed, with no clear policy on who is in charge. In addition, amenity wards have little administrative autonomy, which they need to make operational decisions.

The NHIF's reimbursements do not match the operational costs of providing services in amenity wards. Claims from public health facilities have been significantly lower than expected because of a lack of follow-up, a weak database for tracking data/claims, and low rebate rates.

All the facilities described earlier will be in place. The AWMC, through the HMB, will be in charge of the amenity wards.

2.4.1 Human Resources

Effective and efficient delivery of healthcare services depends on the availability of adequate and motivated professional staff. An amenity ward will have

- A consultant/consultants to offer guidelines in patient care
- A resident medical officer attending to the patients (the resident medical officer or qualified clinician can speed up admissions);
- 1 nurse to 6 beds as per the WHO norm for general patients (for intensive care or very sick patients, a ratio of 1 to 1 is preferred); and
- Non-clinical staff, as determined by the AWMC, to regularly clean the ward (a duty roster will maximize the productivity of this category of staff).

2.4.2 Management of Amenity Wards

- The amenity wards will not represent a separate independent provider but will remain part of the existing public sector hospital.
- A medical superintendent or hospital administrator will at all times head the management of amenity wards.
- An Amenity Ward Management Committee should be created to provide managerial and advisory functions. The committee should comprise eight persons, including two consultants (one to chair and the other as a member), the matron in charge of the wards, a nutritionist, an administrator, a pharmacist, the laboratory officer in-charge, and an accountant. The committee's deliberations will be forwarded to the hospital's Executive Expenditure Committee (EEC) before further consideration by the hospital management team and hospital boards, respectively.
- Hospital staff will serve the amenity and general wards in accordance with normal procedures and rotations. In the hospitals where there is a nurse shortage, the medical superintendent and the HMB will be allowed to hire additional nurses. The additional staff will be paid with revenue generated from the private wards.

Box 2 provides some tips in operating and managing amenity wards.

Box 2. Tips for Operating Amenity Wards

DOs

- Strive to offer comprehensive care as stipulated in the NHIF Accreditation Contract
- Develop a clear policy on exclusions and advise the patients accordingly
- Develop a clear policy on remuneration of all staff, indicating the percentage of revenue that will be invested to improve services
- Develop an admissions policy that will ensure treatment for all patients in the amenity and private wards as needed
- Undertake independent studies to cost services on a regular basis to inform effective negotiations with the NHIF on reimbursements; in the studies, be cognizant of the level of government subsidies
- Educate patients on their rights (access to bills, print outs) through posters placed in the amenity and private wards to mobilize public support for the hospital

DON'Ts

- Do not establish private and amenity wards with the intent to draw patients from the general wards to obtain additional funds from NHIF claims

- Do not run private and amenity wards as separate entities; they will be integrated as part of the hospital under the same overall administration
- Do not offer special treatment to certain patients within the wards; the specialists within the hospital will be available to all patients as and when need arises (the managers are encouraged to develop a duty roster for all consultants)
- Do not allow the consultants/specialists to run the amenity/private wards as private businesses by using the facilities for referral purposes and drawing all the revenue generated

2.4.3 Financial Control

Management of the revenue generated from amenity wards will follow the general guidelines in the Facility Improvement Fund Operation Manual for Provincial General Hospitals District Hospitals and Sub-District Hospitals. The revenue generated is thus the responsibility of the HMT in collaboration with the EEC, which includes the medical superintendent, hospital matron, health administrative officer (HAO), and pharmacist. The EEC together with the heads of the main departments form the HMT.

Adopt existing FIF manuals/guidelines. Revenue will be managed using the existing FIF manuals and guidelines; however, a separate account will be maintained for the operation of amenity wards. Signatories to the amenity ward account are the medical superintendent/medical officer in-charge, the matron and the hospital administrator; and this will be clearly stated in the policy framework.

Encourage transparency and accountability. An appropriate financial management information and audit system that prevents the misuse of finances needs to be established based on the guidelines in the Exchequer and Audit (Cap. 412) and Paymaster General Act (Cap. 413). The system will ensure transparency and accountability. All financial transactions will be properly recorded in order to check for adverse financial practices such as fraud, wastage, and abuse. The management will put in place a sound financial management system within the framework of the FIF policy guidelines. For effective internal control purposes, payment documents for amenity services will be approved, checked, and batched. This process may require a database for referencing and decision-making.

Aim for self sustenance. The amenity ward will have its own budget and separate accounting system and will support the hospital in general. Profits will be invested back into the hospital as part of the FIF at a rate agreed to by the management board.

2.5 NHIF Billing and Claiming Procedures[2]

The NHIF provides an important source of revenue for the hospitals, and effective collaboration is required among staff in submitting claims (notably, nursing and administrative staff). This notwithstanding, in some cases, clients fail to use NHIF cards, resulting in low revenue collection and the low use of paid beds. Also, some facilities prefer cash rather than the NHIF cards, which can affect FIF implementation in amenity wards. Some NHIF clients and hospital personnel find the processing of NHIF cards to be cumbersome.

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[2] For more details on the NHIF Billing and Claiming Procedures, Accreditation, and Benefits Package for members, refer to the respective contract: Agreement on the Provision of Healthcare Services for NHIF Members (drawn between the NHIF Board of Management and the government hospitals).

Some key interventions include the following:

- Following up with NHIF members or beneficiaries identified at admission is suggested in order to collect and photocopy the necessary documents for the purposes of invoicing the NHIF. NHIF billing officers are supposed to regularly carry out a ward census and interview patients and assist them with completing the claim form and obtaining the necessary supporting documents.

- If the patient is in an amenity ward and additional charges are not covered by the NHIF, the revenue billing officer should prepare a full invoice—that is, including the patient's billing (or co-payment)—and share it with the NHIF. The invoice must show the total amount charged and justification.

- NHIF claims office should be set up within, or close to, the inpatient billing office. Where possible, hospital managers should make requests for advice on billings and claims to avoid delays in processing their reimbursements. A NHIF register must be opened and well maintained.

- In the event that a NHIF card holder fails to provide required documents before being discharged, and the patient continues to stay in the hospital, the patient should be required to meet the cost of days spent in the hospital after discharge.

- The facility must insist on the submission of NHIF remittance slips with reimbursement checks, so that it can match reimbursements with patient debtors to help reconcile the debtors' ledger.

- A billing officer from the amenity ward should liaise with the HAO-FIF to get any additional documentation, file claims, and follow up on pending claims.

- The senior billing officer should be responsible for the NHIF claims unit and will ensure that the other billing officers are working diligently to identify and follow up with all NHIF patients. He/she will keep the NHIF register and prepare the monthly NHIF claims report.

- The HAO-FIF has overall responsibility for all fee collection and NHIF claims. He/she must supervise the NHIF billing officers and ensure that the NHIF register and claims files are properly maintained. The HAO-FIF will check the monthly NHIF claims report and investigate reasons for non-achievement of the claiming target, rejected claims, and delays in reimbursement.

- Funds generated from the amenity wards can be used to assist with making claims if the amount is included in the approved cost-sharing expenditure plan for the facility.

- It is in the hospital's interest to submit claims, as it will benefit. The hospital should therefore make it as simple as possible to make a claim by providing easy access to the necessary documents.

2.6 NHIF Accreditation

The NHIF accreditation process accords priority to the elements in Box 3. Accreditation is the process of assessing health facilities against a commonly accepted set of standards or norms. The purpose is to ensure that healthcare providers (both public and private providers) provide high-quality care, centering on the principle "value for money." To achieve this objective, the NHIF uses standards approved by the MOH and has devised a mechanism to survey and assess health facilities against those standards. The NHIF accreditation process is both educational and evaluative, and healthcare providers are expected to learn in an objective manner how they can improve quality.

It is therefore important to consider key issues in designing amenity wards, some of which were outlined in Box 2. A holistic approach is much more likely to give you a better accreditation status than striving for stand alone ventures such as a "revolving drug fund" or a wing purely for the purpose of providing better staff remuneration. Also, hospitals need to provide a clear distinction between amenity and general wards.

Box 3. Requirements for Accreditation, as Required by the NHIF

- Adequate resources, health personnel, equipment, physical structure
- Established quality assurance mechanisms
- Acceptance of NHIF payment basis
- Adoption of referral protocols and sharing of resources
- Acceptance of patient rights

Through the accreditation mechanism, the NHIF also seeks to ensure the maintenance of high-quality health services paid for by fund. Accreditation ensures that all providers conform to NHIF standards and enables the fund to assess health facilities against those standards.

Accreditation is done according to level of facility. The NHIF criterion for accreditation at each level (1–6) is shown in Appendix A and will be studied carefully, as it is the prime mechanism for contracting hospitals.

2.7 Quality of Care in the Amenity Wards

2.7.1 What Is Quality of Care?

The generic term quality of care refers to the technical aspects of quality, such as the provider's behavior and skill in making interventions and applying technology. These interpersonal elements of quality are judged as good or bad according to how the care complies with social norms, ethical standards, clients' expectations, and amenities. There are also social elements of quality that are non-clinical in nature. These non-technical aspects include the accessibility of services, the efficiency with which they are delivered, and the convenience of using the services.

2.7.2 Dimensions of Quality

The dimensions of quality are interrelated, and although not all are of equal importance, each has a bearing on quality. Some commonly accepted dimensions are excellence and appropriateness of the clinical care provided, as judged by professional and societal norms; access; interpersonal relations or patient satisfaction; efficiency; continuity of care; consistency of care; and effectiveness of care. Box 4 provides a typology under the broad headings of technical and interpersonal aspects of quality of care. As a rule of thumb, all patients will get acceptable standards of care according to the MOH policy.

In addition, the following minimum quality measures for operating a private/amenity ward are recommended. For example, the minimum number of beds for facilities at Level III, IV, V, and VI must be 5, 10, 20, and 30, respectively. Note that the technical aspects in the quality of care provided in amenity wards should cover those being provided in the general wards, at a minimum.

All amenity ward patients will get acceptable standards of care in line with the MOH Kenya Quality Model, which is reinforced under the NHIF accreditation process. Comprehensive care includes

Box 4. Technical and Interpersonal Aspects Determining the Quality of Care in Amenity Wards

Technical aspects
- Accuracy of diagnosis
- Efficacy of treatment
- Excellence according to professional standards
- Necessity of care
- Appropriateness of treatment
- Continuity of care
- Consistency

Interpersonal aspects
- Patient satisfaction
- Acceptability of care
- Time spent with provider
- Attitudes of provider and treatment by staff

basic high-quality healthcare, except for stated exclusions, without having to pay extra fees delivered by a particular health institution (based on the levels set by the Kenya Essential Package for Health). Comprehensive care is tied to quality of care and comprises a single bed, reasonable sanitation facilities, reasonable food, a standard lab test, an x-ray, essential drugs, and clean wards. Under NHIF Contract B, where the amenity wards fall, patients are allowed to top-up payments to an agreed ceiling dependent on the hospital's categorization by the NHIF.

Whereas admissions to the wards in public hospitals depend on the patient's choice, ability to pay, and availability of beds, the NHIF members will not necessarily be admitted to an amenity ward if the fee is above and beyond reimbursements by the NHIF. Such patients can be taken care of comprehensively in the general ward.

2.8 Minimum Specialized Services to be offered

The comprehensive healthcare package covered under the NHIF includes both in-patient and out-patient services. NHIF cardholders, including patients in the private wards, will be entitled to the following services:

- Medical consultation with a doctor, clinical officer, or nurse
- Specialized care in hospitals for inpatient care
- Laboratory investigations, dental care, and radiological examinations
- Drugs and essential medical supplies
- Surgical procedures, terminal care, and physiotherapy, including rehabilitative therapy
- Hospitalization and occupational therapy

Exclusions to the services will depend on the nature and type of the accreditation contract with the NHIF, as specified in the Agreement on the Provision of Healthcare Services to NHIF Members (drawn between the NHIF Board of Management and the government hospitals). Patient co-payments will be necessary in the case of the exclusions. At the moment, the following services are excluded from the benefit package and shall be paid for by the NHIF member: open heart surgery, renal transplant, intervention cardiology, magnetic resonance imaging (MRI), dental prosthesis/appliances, optical devices, cosmetic surgery, orthopedic appliances, transplant surgery, vitreoretinal eye surgery, lipo

suction, hearing aids and appliances, mortuary charges, some laboratory services (hormonal profiles, fertility tests), gamma camera operations, radiology treatment, CT-scans, haemodialysis, peritoneal dialysis, circumcision, and tubal ligation.

2.9 Co-Payment for Specialized/Chronic Conditions and Exclusions from NHIF Contract

Exclusions and co-payments for amenity wards shall be reviewed regularly and clearly stated in the NHIF Contract B. Hospitals are expected to abide by the guidelines, and those submitting claims to the NHIF will be required to reflect the co-payments in the claims.

Chapter 3: Pricing and Costing Issues

3.1 Introduction

The private sector marks up the cost of services to generate profit. To inform the price-setting strategy in public hospitals, the NHIF, in collaboration with public providers, must conduct detailed cost analyses of the services routinely offered. However, in the meantime, hospitals can use private sector billing practices and guidelines to set the fees for amenity wards. A key criterion is to set the fees below those in the private sector so as to make the amenity wards an attractive alternative option to private hospitals.

3.2 Setting Amenity Ward Fees

Setting fees is challenging because a hospital must anticipate both changes in their costs as well as changes to payments. Hospitals must estimate the costs of purchasing pharmaceuticals, medical devices, and other supplies. These products are continually changing, and new drugs and technologies are often significantly more expensive than those they replace. While the medical benefits are often substantial, these products increase costs in ways that are hard to predict and are often not accounted for in fees set in advance or fixed by the government. Note that while attention might be paid to setting affordable fees, certain categories of patients will still accrue bills beyond their ability to pay. These patients should be referred to the AWMC for a waiver consideration.

3.3 Frequency of and Factors in Determining Fee Adjustments

Hospitals must periodically adjust their charges in order to maintain financial viability. Fee adjustments are justified when the cost of providing healthcare increases, the inflation rate increases, and the quality of care improves (e.g., through updates in technology). Failure to adjust fees in these cases will mean a reduction in the actual proportion of costs recovered and, hence, serious implications for healthcare provision in the amenity wards. The HMB, in consultation with the AWMC, should adjust the fees when deemed necessary. Any adjustments that will have implications on NHIF rebate rates must be negotiated with the NHIF and the DHCF.

The following factors should be considered to guide the process of adjusting fees:

- **Overall inflation**
  - Adjust for past inflation to bring fees back to original levels in real terms
  - Adjust fees for future inflation until next fee increase to maintain revenues in real terms

  As the fees are contingent on the inflation rate, there will be no increase in fees in real terms.

- **Changes in cost of specific services/procedures** (e.g., price increases in drugs, technology, etc.)
  - Conduct a costing study to determine the actual cost of providing services—which could be used to negotiate for increased reimbursement rebates. The NHIF and MOH should jointly conduct the study, which will be done at all levels of healthcare (levels 2–6).

- **Competitive forces** (e.g., the cost of services provided by the private sector)
  - Adjust fees according to market conditions
  - Compare fees with mission facilities and private sector
  - Review practice of private sector in adjusting fees
  - Adjust or base fees on prevailing market conditions and fees of comparable private health facilities

- **Quality of services** (e.g., waiting time, personnel, availability of drugs and diagnostic services)

- **Bed charges and physician fees** (charges will differ according to type of facility and non-medical services available)

- **Administration costs** (of running amenity wards)

- **Level of hotel (ward) facilities/variation in amenities** (e.g., single, private rooms, televisions, four-bed wards, and choice of physician)

The cost of providing services must be estimated periodically to ensure that fee adjustments adequately account for any cost increases. The costing information will also provide the basis for monitoring the management and efficiency of amenity wards. A Fee Adjustment Committee will provide the costing and related information (see Box 5).

Box 5. Responsibilities of the Fee Adjustment Committee

- Making recommendations on services to be levied and corresponding charges
- Setting revenue collection targets based on service use
- Receiving all cost-sharing expenditure proposals for review and recommendation
- Receiving and forwarding operational budgets to the HMB
- Monitoring and supervising expenditures
- Handling disciplinary cases, such as fraud or abuse of FIF
- Making decisions on the frequency of fee adjustments
- Reviewing reports on collections, reimbursements, and service use
- Forwarding reimbursement claims to the NHIF
- Arranging for the annual audit of revenue generated from private wards

3.4 Process of Setting/Adjusting Fees

The AWMC has the overall responsibility for setting the fee levels. The committee will then submit its fee recommendations to the HMB for review, revision (as necessary), and approval. The board will then forward the proposed fees to the PMO for final approval. The NHIF branch officers should be co-opted in the HMB and involved in the fee-setting process. The changes in guidelines and policies must then be communicated to facilities prior to implementation. Once the hospital has endorsed the approved fees, no consultant, medical officer, clinician, or other staff person will be allowed to levy additional charges (e.g., development, weekly fees). See Box 6 for a checklist of the steps involved in adjusting fees, which is similar to the process of setting new fees.

Box 6. Steps for Approving Fee Adjustments

- The chairman of the AWMC convenes a meeting to deliberate on the need for fee adjustments.
- The committee presents the proposed adjusted fees to the HMB for further discussion, amendments, and approval.
- The DHCF make decisions about the proposed fee adjustments and have the authority to grant final approval.
- After the fees are approved, the HMB and respective committee sensitize staff on the new charges.
- The new fees should be displayed in all waiting rooms and in the cash register office.

To facilitate fee implementation, the MOH should be proactive in announcing the changes. To show that the proposed fee adjustments were justifiable and explainable, the PMO will release a circular to service providers about the fee adjustments.

Co-payments

- In facilities where the revenue collected from the FIF does not entirely cover the cost of delivering care, the facility will need to introduce a co-payment as agreed on in the respective Contract B.
- The costs not covered by the NHIF must be met by the patient.
- The costs that exceed the NHIF rebates will also be met by the patient.

Chapter 4: Financial Management

4.1 Collections and Banking of Revenue

The following recommendations are useful in the collection of fees:

- Issue receipts for all chargeable services upon payment (one copy for the patient and one for the records).
- Maintain a register at the cashier, indicating details of the fees charged and receipt number.
- Issue a charge sheet—indicating the patient number, services rendered, and fees to be charged—to the patient for presentation to the cashier at the time of payment.
- Itemize billing for regular monitoring of charges and frequently update the patients (twice a week) on the cumulative charges.
- Retain the charge sheet where the service was rendered if the whole process involved more than one area.
- Submit a monthly report accounting for all fees collected by the source to the accounting officer (medical officer in charge of the amenity ward) for reconciliation with the cash collected.
- Display fees posters in all waiting areas in the amenity wards and in the cash office. The poster will show the fees chargeable for each service and will advise patients to obtain and keep receipts for all payments.
- Maintain separate cash registers for fees generated from amenity wards and that from laboratory or surgical services.
- Maintain a daily fee summary sheet for use in calculating the monthly totals.
- Establish automated systems, as opposed to manual ones, to enhance efficiency in revenue generation.
- Bank daily in the hospital account all the revenue generated.

4.2 Use of FIF Revenue

Facilities can use the revenue from private/amenity wards to reach/cover more clients—including NHIF cardholders and those from the private sector—and to improve the quality of healthcare services.

4.3 Guidelines on Revenue Use

The EEC under the chairmanship of the med. Supt./med. Officer i/c of the hospital (not the Amenity Ward) medical officer of health in charge of the amenity ward and the respective committee will be responsible for determining revenue use, which may include increasing the quality of services and facilities through improved drugs and medical consumables or additional staff incentives.

Expenditures will be determined in accordance with government procedures and guided by good planning that entails proper priority setting. To minimize fraud and the misuse of funds, an appropriate system of recording, compiling, accounting, and reporting financial information system must be established. To enhance the effective and efficient use of revenue, the following guidelines are recommended:

- Ensure that planned expenditures fall within the available funds collected.
- Ensure (the committee) that only expenditure requests that fall within the available funds are approved.

- Compare the reported expenditures with the approved plans.
- Spend revenue from amenity wards in ways that contribute to visible improvement in the quality of patient care.
- Do not accept unauthorized deviations.
- Use expenditures on priority areas identified in monthly, quarterly, and annual plans.
- Clearly define the appropriate management structure, spelling out who collects, verifies, and uses the funds.

The process for planning expenditures is as follows:

- The AWMC prepares the quarterly and annual plans and then forwards them to the HMB for review.
- After the plans are approved, the medical officer confirms the availability of uncommitted funds.
- The HMB then authorizes the approved expenditure request, plans, and authority to incur expenditure (AIE).

4.4 Staff Honoraria and Salaries

Improving client coverage and the quality of care for patients are top priorities, listed before increasing staff motivation. As touched on earlier, revenue will be used to invest in more resources for the hospital to expand the breadth of services and improve quality in a way that is obvious to patients (e.g., through an increased supply of drugs or bed linens).

Staff working in amenity wards will be given modest honoraria as a special consideration for working in these wards. The honoraria should be paid at the end of each quarter through the district accountant. The hospital staff will prepare the payment vouchers, and the PMO will grant the AIE. Through the permanent secretary, Ministry of Health, the Amenity ward managers will also obtain authority from the Directorate of Personnel Management to allow payments of salaries/emoluments to staff that are already on payroll.

The AWMC should determine the criteria for staff payments—which will be based on the hospital's projected costs and revenue—and establish a pooled fund for this purpose. The medical officer and registered clinical officer should be paid a professional fee over and above the regular salary. For surgical cases, honoraria should be made to the surgeon and his/her assistant, anesthetist, and theater team on a case-by-case basis. Nurses, paramedical staff, and support staff would be paid at a flat rate drawn from the pooled fund. The AWMC should standardize all compensation rates for staff and daily fees paid by the patients to the hospitals. The proposed rates and charges for the amenity wards are shown in Table 1.

Table 1. Compensation Rates and Fees for Amenity Wards

Consultation (professional fee)	400/= for consultation, 300/= for MO/DO, 200/= for RCO (in emergency) per patient, per day
Professional Surgical Fees *(NB: Hospital maintains 65% of revenue, while the remaining revenue is shared with staff as honoraria)*	
Professional fee (Assistant to the Surgeon)	500/= (per case)
Minor surgery (under local Anesthesia)	3,500/= (per case) split as follows, 1,500/= (hospital theatre fee), 500/= (theatre nurses), 1,500/= (surgeon)
Major surgery (under general Anesthesia)	15,500/= (per case) split as follows: 5,000/= hospital theatre fee, surgeon 6,000/=, NC 2,000/=, Anesthesia 2,000/= and all 500/=
Anesthesia	2,000/= (per case)
Theatre team	2,000/= (per case) if minor, major cases 2000/=
Nursing Procedures	
Nurses	200/= per day
Other Charges	
Bed charges	400/= per day
Drugs (if bought out of the hospital)	(cost price +15% mark-up)

The above fees notwithstanding, the MOH will review the pricing policy annually and communicate the updated prices to the hospitals through government circulars forwarded by the PMO. The latter will, in turn, maintain constant supervision of the health facilities to ensure that the approved rates are implemented per the policy guidelines. The HMB will monitor implementation of the approved rates and/or reviews based on reports presented to them in board meetings.

Amenity wards should not operate at the expense of general wards but rather operate in accordance with professional ethics. Monitoring and supervision mechanisms must be established to ensure that there is no abuse of the system. All staff should share the professional fee from the amenity wards, including committee members as advised by the AWMC. From the total revenue, 65 percent will be invested in improvements to the quality of care and 35 percent will be paid as professional fees. A separate accounting system, including bank accounts, should be kept for the respective amounts.

4.5 Eligibility for Staff Honoraria

Only staff directly involved in the provision of services in amenity wards will be eligible for the respective payments.

4.6 Working relationship between the NHIF and the MOH

Key MOH departments—the Department of Standards and Regulatory Services, DHCF, and selected provincial general hospitals and high-volume district hospitals—and the NHIF will meet quarterly to

deliberate on issues related to the operations of amenity and private wards.

Various subcommittees should be established to meet more regularly on the issues and decisions related to the operation of the amenity and private wards (e.g., fee adjustments, quality assurance, and infrastructural developments).

The NHIF and MOH should ensure that the quality of service is not only maintained but also improved. Because of the scarcity of resources, the various entities responsible for inspecting the health facilities, especially the MOH, should work with the NHIF to share tasks and costs in support of maintaining consistent standards across all facilities.

Appendix A: Standard Benefits Packages for NHIF Accredited Hospitals

Accredited health facilities will be expected to provide the following standard benefits packages.

Level I— COMMUNITY, foundation of service delivery priorities. NHIF does NOT accredit facilities at this level as the interventions focus on the villages, facilities, households, and individuals.

Level II— DISPENSARY

First referral level for traditional health practitioner clinic and community health workers. First contact with established formal health facility network. Must hold a registration certificate to operate as a dispensary and a land registration certificate, among other statutory requirements.

Infrastructure
Compound of one hectare or equivalent and four rooms including a waiting area. Must meet public health standards including adequate supply of clean water, sanitation, and safe waste disposal; and provide staff houses with amenities for eight families, three observation beds, and a generator.

Equipment
Two blood pressure machines, six thermometers sets, two stethoscopes, two sets of screens, a waiting desk, a cupboard, a confidential records system, emergency trays part 1 and part 2, and two refrigerators (one electric and one gas).

Governance
The Dispensary Health Committee, under the leadership of an enrolled community nurse, includes the public health technician responsible for environmental health and health education, subordinate staff, and security personnel; the nurse is the secretary of the committee.

Services
- Services provided must comprise professional consultation by a nurse, which would include clinical assessment, diagnosis, treatments, follow-up and referral where applicable, family planning, diagnosis and treatment of common ailments, and basic surgical services as approved by the Nursing Council of Kenya (NCK).
- Telephone and standard nursing care procedures, including radio call services to support patient referrals.
- Transport services, including one motorbike and two bicycles.
- Range of services, including the priority essential health package (HIV/AIDS, tuberculosis, malaria, reproductive health, expanded program of immunization (EPI), Integrated Management of Childhood Illness (IMCI), food safety, and control of communicable diseases) and interventions limited to basic curative and preventive services.
- Provision of essential drugs and medical supplies, including prescription services to social health insurance (SHI)-approved drug stores. Essential drug list for Level II, as approved by the Pharmacy and Poisons Board.
- Functional suggestion box.

Level III— HEALTH CENTER

Services
- Services provided must include professional consultation by a clinical officer and a nurse, which would include clinical assessment, diagnosis, treatment, follow-up and referral where applicable,

and nursing and midwifery services.

- Laboratory services, including all lab tests, the priority essential health packages (HIV/AIDS, tuberculosis, malaria, reproductive health, EPI, IMCI, food safety and control of communicable disease) and interventions, which include curative and preventive services.
- Provision of essential drugs and medical supplies, including prescription services to SHI-approved drug stores.
- Dental services.

Level IV— DISTRICT HOSPITAL

- Has all the components of a Level III health facility, receives referral from health centers, dispensaries, private clinics, traditional health practitioner clinics, and community-own resource persons.
- Out-patient care and in-patient care.
- Registration certificate to operate a hospital in place, as well as land registration certificate and other statutory requirements.
- Minimum bed capacity for a hospital is 200. Range of services, including comprehensive obstetric care, functional casualty/accident and emergency department, diagnostic laboratory with blood transfusion services, theater services, physiotherapy services, mortuary services, dental services, general surgery, orthopedic surgery, and intensive care (ICU) services.

Infrastructure

- Compound of four hectares of land or equivalent; sufficient building to provide for consultation clinic, casualty, admissions, and records, pharmacy, laboratory, x-ray, operating theater, intensive care, delivery room with equipment, sterilization room with equipment, kitchen, laundry, central store, boiler room, generator house, maintenance workshop, and incinerator. Staff changing rooms with amenities, adequate staff houses with essential amenities, and a mortuary.
- Adequate public health standards, including clean water supply, sanitation, and safe waste disposal, 200 beds minimum, and a functional generator.

Minimum Equipment

- Two blood pressure machines per ward/clinical areas, four thermometer sets per ward/clinical area, four stethoscopes per ward/clinical area, 12 fetoscopes, three screens per ward/clinical area, operating theater equipment, and surgical sets.
- Laboratory equipment for basic tests, health education kit (12 televisions, three LCD projectors, six laptops, three screens, three portable small generators, three heavy duty photocopy machine, three overhead projectors, 24 radio-cassette recorder with CD, three mobile public speaking sets), and two waiting desks per services area.
- 12 cupboards (at least one cupboard per ward and one per clinical area), confidential records system in place, 12 sets of emergency tray part 1 and 2 (at least one set per ward and per clinical area), and 12 refrigerators (10 electric, two gas).

Governance

The HMT, led by the medical superintendent, includes all heads of departments. The medical superintendent is also a member of the HMB, comprising opinion leaders from the local community serviced by the district hospital.

Services

- Services provided must include professional consultation by a doctor, clinical officer, and nurse, which would include clinical assessment, diagnosis, treatment, follow-up and referral where applicable.

- Nursing and midwifery services.
- All laboratory services including specialized tests (e.g., CD4 counts, immunological tests, hormone measurements, etc.).
- Telephone and radio call services to support patient referrals and management.
- Transport services, including two ambulance vehicles, two staff vans, two saloon cars, two 4-wheel drive vehicles, and five motorbikes.
- Range of services, including the priority essential health package (HIV/AIDS, tuberculosis, malaria, reproductive health, EPI, IMCI, food safety, and control of communicable diseases) and interventions including curative and preventive services.
- Provision of essential drugs and medical supplies, including prescription services to SHI-approved drug stores. Essential drug list for Level IV.
- Functional patient/client feedback structure; district hospital may also provide clinical training facilities for Kenya Medical Training College.

Level V & VI —PROVINCIAL GENERAL HOSPITALS / REFERRAL HOSPITALS

- All the standard services of a hospital in Level IV. Classified as a regional, or national, referral hospital with up to 600 beds.
- Specialist services in internal medicine, obstetrics/gynecology, general surgery, neurosurgery, dentistry, psychiatry, ophthalmology, ear nose and throat, orthopedics, cancer care, forensic medicine, burns management, intensive care management, and advanced neonatal care.
- Training facilities for Kenya Medical Training College; internship training for medical doctors, dentists, and other related graduates from medical schools.
- Research and training services for regional health services.

Basic Staffing Norms for key services delivery cadres, by level of care

Level	Population	Level of function	Minimum human resources			
			Service deliver staff	**No.**	**Support staff**	**No.**
1	5,000	Level 1	CORPS	50		
2	10,000	Level 2	Nursing staff (RCNs)	2	General attendants	2
			Community Health Extension Worker	2	Watchman	1
3	30,000	Level 3	Clinical officers	2	Statistical clerks	2
			Outpatient support	1	Clerk/cashier	1
			Management support	1		
			Nursing staff	14	General attendants	2
			Outpatients	3	Cook	1
			Delivery/inpatients	4	Watchmen	2
			MCH activities	4		
			Dressing room	2		
			coordination	1		
			Overall coordination	1		
			Community oral health officer	1		
			Laboratory technician	1		
			Pharmaceutical technologist	1		
4	100,000	Level 3 function	Clinical officers (outpatient filtering)	2		
			Nursing staff	8		
			General outpatients	2		
			Delivery/MCH activities	6		
			Laboratory technician	2		
			Pharmaceutical technologist	2		
			Medical officers	6		
			Outpatients	2		
			Inpatients	3		
		Level 4 (core) function	Management	1		
			Dentist	1		
			Pharmacist	1	Statistical clerks	2
			Clinical officers	5	Clerk/cashier	1
			Specialized clinics	4	General attendants	10
			Anesthesiologists	2	Drivers	2
			Nursing staff	60	Cooks	4
			In charge	1	Watchmen	3
			Specialized outpatient clinics	8	Store attendant	1
			Wards	30	Health Admin.	1
			Theatre	10	Officer	
			Nursery	3		
			Radiographer	1		
			Dental technologist	1		
			Laboratory technologist	1		
5	1,000,000	Level 3 function	Clinical officers (outpatient filtering)	4		
			Nursing staff	22		
			General outpatients	10		
			Delivery/MCH activities	12		
			Laboratory technicians	4		
			Pharmaceutical technologist	4		

Level 4 (core) function	Medical Officers	15		
	Outpatients	4		
	Wards	8		
	Maternity	2		
	Management	1		
	Dentists	2		
	Pharmacists	2		
	Specialized clinical officers	12		
	Anesthesiologists	4		
	Pediatric clinical officer	1		
	Psychiatrist clinical officer	2		
	Dermatology clinical officer	1		
	ENT clinical officer	1		
	Ophthalmology clinical officer	3		
	Nursing staff	178		
	Management	4		
	Specialized outpatient clinics	10		
	Wards	120		
	Theatre	40		
	Nursery	4		
	Radiographers	3		
	Dental technologists	4		
	Laboratory technologists	3		
Level 5 (core) function	Medical specialists	24		
	Physicians	3		
	Obstetricians/Gynecologists	4		
	Pediatricians	3	Statistical clerks	2
	Surgeons	3	Clerk/cashier	2
	Psychiatrists	1	General attendants	20
	Ophthalmologists	2	Drivers	2
	ENT specialist	1	Cooks	4
	Dermatologist	1	Watchmen	3
	Anesthetist	3	Health Admin.	
	Pathologist	1	Officer	2
	Radiologist	1	Accountants	2
	Orthopedic surgeon	1	Store attendants	2
	Rehabilitative therapists	4	Medical engineer	1
	Physiotherapist	1		
	Occupational therapist	1		
	Orthopedic technologist	1		
	Social worker	1		
	Medical officers (intensive care unit)	1		
	Nursing staff (intensive care unit)	12		
	Clinical pharmacist	1		

Source: Ministry of Health (2006), Norms and Standards for Health Service Delivery, MoH: Health Sector Reform Secretariat, June

Appendix B: Task Force Participants

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Glossary

Sustainability: Achieving the capacity to generate, over time, sufficient, reliable resources to deliver continued and improved healthcare for a growing population with minimum external support. Sustainability requires sufficient inputs into the health system, the effective and efficient use of resources, and the delivery of services on a continued basis.

Efficiency improvements: The provision of services at a higher level of quality using the same amount or fewer resources.

Equity: Access to basic, high-quality healthcare based on the need for those services and not on the ability to pay or the geographic location.

Elasticity of demand: The degree of change in demand of a commodity as a result of changes in the price for that commodity. If demand is elastic, it means that a small change in price will lead to a large decrease in the demand for that commodity. Likewise, if the demand is inelastic, an increase in price will have little or no effect in the demand for the commodity.

Private agents: Private for-profit and not-for-profit healthcare providers, the suppliers of non-clinical services necessary in the provision of healthcare (e.g., cleaning, laundry, food, security), and private insurance companies and patients willing and able to make out-of-pocket payments for healthcare.

Resources

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