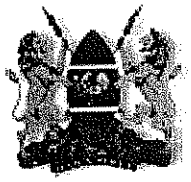


REPUBLIC OF KENYA

SESSIONAL PAPER NO. 13 OF 2012 ON THE ESTABLISHMENT AND GRANTING OF OPERATIONAL AUTONOMY TO NATIONAL HEALTH REFERRAL FACILITIES IN KENYA

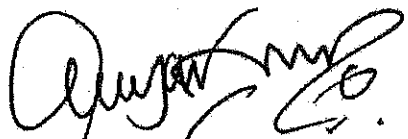
FOREWORD

The Kenyan Constitution states that every Kenyan has a right to quality and affordable health care, including reproductive health; it further states that no Kenyan can be denied access to emergency health services when in need. In addition, the Constitution provides for equity in access to all services provided. The implication of all these is that barriers to health care services of whatever kind will not hinder access and that the resources are distributed in a way that promotes equity in access across all regions or groups in the country.

Although Government has always endeavored to take services to as close as possible where the people are, it has not ben possible. This has been due a number of factors, including expansive nature of some parts of the country, limitations in financial resources and historical circumstances in development. As a result, the total number of public hospitals currently stands at 282, spread across all parts of the country. These hospitals include, two national referral and teaching hospitals, seven Provincial General Hospitals and three specialized hospitals, namely: Mathari, Spinal Injury and Pumwani hospitals – all in Nairobi.

Further, the Constitution of Kenya 2010 assigns the roles of the national and county governments in provision of health services. Amongst the mandates of the national government are health policy, national referral health facilities, and capacity building and technical assistance to counties. As a result, the sector is currently developing policies and structures in the two tier system of government, taking into consideration the government's blueprint- Vision 2030 and the expectations of the Constitution. The Vision 2030 in particular, recognizes that the attainment of provision of equitable and affordable health care at the highest affordable standard to Kenyans will require the current wave of health institutional reforms to be sustained. Reforms through improved governance, decentralization of health facility management, emphasis on preventive services, enhanced collaboration with stakeholders, increased community involvement, as well as by giving operational autonomy to district and provincial hospitals are needed. Besides these, the fast changing morbidity patterns in the country and emergence of non-communicable diseases require that specialized health services should be spread in a more equitable manner.

It is as a result of the foregoing that the Ministries of Health seek to have twenty one strategic public hospitals as semi-autonomous, efficiently and effectively governed and managed offering quality services across all parts of the country. Apart from equitably spreading provision of specialized services as part of the national system, the arrangement will save the counties huge resources that would otherwise expend on health facilities that receive patients beyond the counties. The establishment of the National Referral Health Facilities Management Authority to oversee the referral facilities, will, among other issues, improve the work environment, infrastructure and information management system in hospitals, including the strengthening of their management systems. It is expected that the services provided by the national referral facilities under the proposed arrangement will eventually serve as a benchmark for all public health facilities in the country.



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Contents

1. Introduction and Background

As the government strives to reorganize the delivery of health services and gain alignment with the expectations of the Constitution, the reexamination and repositioning of national health referral facilities is imperative. Leveraging on current initiatives and past experiences offers significant benefits as long as changes are carefully structured and sound regulatory framework created to ensure access, quality and improvements in efficiency are sustained

1.1 Introduction

The Constitution of Kenya 2010 enshrines the roles of the national and county governments in provision of health services. Amongst the mandates of the national government are health policy, national referral health facilities, and capacity building and technical assistance to counties. The ministries of health are currently developing policy directions and structures in the two tier system of government, taking into consideration the government's blueprint- Vision 2030 and the expectations of the Constitution.

Kenya's Vision 2030 recognizes that the attainment of provision of equitable and affordable health care at the highest affordable standard to Kenyans requires the current wave of health institutional reforms must be sustained. Reforms through improved governance, decentralization of health facility management, emphasis on preventive services, enhanced collaboration with stakeholders, increased community involvement, as well as by giving operational autonomy to district and provincial hospitals are needed.

The Ministries of Health seek to have twenty one strategic public hospitals as semi-autonomous, efficiently and effectively governed and managed offering quality services. Providing operational autonomy to tiers 4, 5 and 6 hospitals is considered a flagship project in the first Medium Term Plan under the Vision 2030. In order to realize this goal, the Ministry of Medical Services established a Priority Hospitals Reform initiative with the aims of proposing ways of improving work environment, infrastructure and information management system in hospitals, including the strengthening of the management systems and referral system; and coming up with the implementation plan for a restructured system. This policy paper seeks to align current hospital reform initiatives to the ethos and expectations of the Constitution of Kenya 2010.

1.2 Strategic focus of this policy paper

The strategic focus of this paper is to secure approval for establishment of twenty one (21) functioning National Health Referral Facilities that are accessible, efficient and affordable, with improved regulation and management, towards progressive realization of the national standards and values in line with the constitution

2. Rationale and Motivation

2.1 *Rationale for establishment of additional national referral health facilities*

The Government of Kenya seeks to establish national referral facilities across the country in order to expand the scope of medical services of high technology or specialization. The National Referral Hospitals are: Marsabit, Isiolo, Wajir, Lodwar, Garissa, Kakamega, Mombasa, Kisumu, Kisii, Embu, Nyeri, Machakos, Nakuru, Bungoma, Thika, Kitale, Malindi, Meru, Spinal Injury Hospital, Pumwani Hospital and Mathari Hospital.

Highly specialized health care should be accessible albeit requiring significant investment and funding

Owing to the changing morbidity pattern in Kenya and the development of increasing specialty in the medical field, there is indeed a need for high technology services and specialized institutions spread across the country. Acknowledging that such investments are capital intensive and costly, the Ministry of Health deems it fit to limit the number of national health referral facilities while ensuring that they are strategically dispersed to address the accessibility and equity challenges.

These national health referral facilities will assume and enhance the functions that are currently undertaken by the existing provincial and high volume hospitals for which a significant investment has been made. For the purposes of ensuring that the Northern Kenya is adequately served, three selected facilities that are currently classified as Level 4 facilities (Lodwar, Marsabit and Wajir) will be elevated to national referral hospitals. It is anticipated that the hospitals will function as the national regional referral hospitals for all the counties in the region, but at the same time also as the complement county hospital for the county in which it is located (second level of referral) and as the local hospital for the population in its immediate vicinity. A specific attention will thus be paid to safeguard the access of the population from the entire region to the highly specialized services and limit direct access, especially for the population in the immediate vicinity of the hospital. The provision of primary health care and walk in ambulatory services (emergency and general outpatients) in physically distinct facilities sited immediately next to the national referral health facility in order to enable triage and filtering and rigorous enforcement of referral policies will be considered.

The national referral health facilities will harness subspecialties aligned to local circumstances and economies of scale

The training of specialists depends on the existence and proper functioning of referral hospitals. Recognizing that the national government is responsible for training institutions, universities and research centers, the selected national health referral facilities will play the role of teaching hospitals across the country. It is anticipated that a detailed assessment of sub specialties for each of the national referral health facility will be undertaken taking into consideration the local circumstances and practical experience.

Recent assessments of the two national referral facilities highlight the need for decongestion and effective utilization of high concentration of specialized staff

Currently there are two national referral and teaching hospitals in Kenya – Kenyatta National Hospital and Moi Teaching and Referral Hospital. These institutions while enjoying an enviable concentration of specialized medical staff continue to experience congestion in terms of service demand ranging from patient care, teaching and research. The establishment of the additional national referral health centers will contribute to decongesting the two institutions and at the same time ensure that the health care specialists are optimally utilized. Additionally, there is an increased need to expand the capacity to handle disasters and emergencies including those that are cross border.

2.2 *Rationale for increasing autonomy of the selected national health referral facilities*

Optimal governance system

Reduce overdependence on central government for resource allocation and decision making

The Ministry of Medical Services recognizes that public hospital reforms is a pivotal element of the health system reform and that consideration of a completely revised governance and management structure is required to advance devolution as envisaged under the Constitution of Kenya 2010, Vision 2030 and various ministerial pronouncements.

Findings from an array of hospital assessments undertaken by the Ministry of Medical Services in collaboration with partners have consistently suggested that the current regulation and governance and management structure of Level 4 and 5 public hospitals is in several aspects inconsistent with existing reforms such as those relating to devolution of health services delivery, and health financing. The structure also hampers effective implementation of hospital strategic and operational plans and thus the overall service delivery. Specifically, the issues highlighted include the following: Firstly, there is a sub-

Improved accountability and efficiency

Professionalize management functions

Enable national level to concentrate and deliver on its mandate

optimal governance system, specifically with regards to selection of board/committee members and their capacity to provide oversight to the hospital management in delivery of services. Secondly, the public hospitals continue to rely heavily on the central headquarters for resource allocation and decision making. Thirdly, there have been financing mechanism hurdles. Although the public hospitals in Kenya do currently enjoy some level of autonomy in their use of revenues, governance is still significantly influenced by the government. Funds from government budgets are still allocated and controlled by the government hierarchy. Personnel management is still subject to central government controls over staffing structures and grades. Fourthly, infrastructure and equipment capacity remains below expected norms and standards for the corresponding levels of delivery. There have also been tendencies by public hospitals to expanded infrastructure and high-technology equipment in a fragmented manner. Imbalance in the growth and distribution of hospital facilities remains unaddressed. Fifthly, utilization of amenity facilities remains suboptimal. Social capital investment in the private units of public hospitals has weakened management control over the staff who have invested and work in them. Self-financing has not created incentives for efficiency. Irrational over-provision of high-end services for more affluent patients and over-prescribing of drugs have led to uncontrolled growth in hospital expenditure.

The above issues have been attributed to financing, human resources, provider payment policies, and the governance and regulatory environment in which public hospitals are operating. These issues have created conflicts in the goals of the hospital managers and those of the government and created incentives that operate at odds with rational, cost-effective use of hospital resources.

Notably, the government budget subsidies have been decreasing as a share of total hospital revenues over the last decade. New forms of public financing such as reimbursements from the National Hospital Insurance Fund; development partners support, and compensation for designated programs, teaching, and research have been available but with minimal effect. At the hospitals, out of pocket payments remain the largest source of hospitals discretionary revenue.

Over the last decade attempts have been made to delegate certain operational responsibilities to hospital managers with reasonable success. Such efforts include the retention of revenue collected by public hospitals under the Facility Improvement Fund mechanism and the attendant empowerment of hospital management to plan and budget for utilization of such funds/collections. Public hospitals have also been receiving block grants under the Hospital Management Services Fund and therefore have been

granted the responsibility of determining what to spend the funds on.
Perhaps the most daunting challenge facing the public hospitals has been that of human resources capacity both in numbers and mix. Delegation of authority related to human resources decisions to hospital management is still very limited.

The overarching reason for moving toward greater autonomy for public hospitals in Kenya is the desire to decentralize the health system and reduce the financial burden hospitals imposed on the Ministry of Health budget. The government intends to significantly make public hospitals responsible for generating the resources needed for their operation by making the institutions parastatal or autonomous and really turning over all financial responsibilities and decision-making for its resources to the institution. The increased autonomy will also reduce inefficiencies by promptly providing improved information to decision-makers about resource decisions; providing hospital managers with increased control of the factors affecting their efficiency; as well as providing stakeholders with increased accountability and responsiveness. It is also envisaged that the increased autonomy will accord hospitals increased opportunities to exploit public private partnerships. Finally, the increased autonomy will ensure that that there is commensurate authority for resource decisions and therefore enhance accountability.

3. Policy Options Considered

3.1 Values, principles and essential elements

Several options were considered in determining how the national health referral facilities selected would be anchored in the public health care system in Kenya. In examining the possible feasible options, careful attention was paid to the following key values, principles and elements:

a) Suitability in meeting health care principles of equity, affordability, accessibility, quality of care, effectiveness and responsiveness

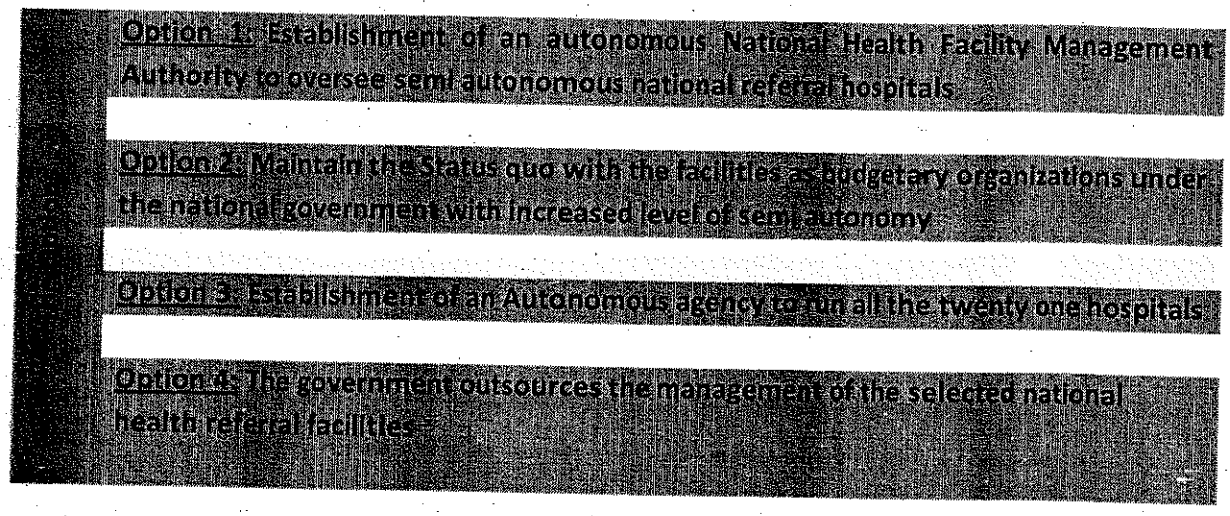
b) Need to leverage current initiatives and consolidate gains from ongoing support to the selected facilities

c) Alignment to the devolved structures based on the expectations of the Constitution of Kenya 2010 and Kenya's Blueprint-Vision 2030 of attaining highest standards of healthcare delivery

d) Need to sustained progress and achievements and make smooth transition to the desired institutional state

e) Need to build regional capacity of centers of specialization in different medical fields to address access and equity concerns taking into consideration population, disease burden, poverty, past investment amongst others

3.2 The Options Considered



Option 1: Establishment of an autonomous National Health Facility Management Authority to oversee semi autonomous national hospitals

The first option considered was that of the government establishing a National Health Facility Management Authority as an oversight body for all national health referral facilities under an appropriate instrument such as an Act of Parliament or subsidiary legislation (Legal Notice). This authority will define standards and norms for operation of national referral facilities amongst them inclusion and exclusion criteria. In creating this desired governing body, the Ministry will piggyback on the current health legislative review process being undertaken and leverage on the following: a) the provision in the Public Health Act for activation of the Central Board for Health and possible redefinition of its roles and responsibilities and; b) restructuring of the National Hospital Services Committees and the Hospital Services Management Fund.

The twenty one national health referral facilities that are overseen by the Authority will be run as semi autonomous agencies also created under an appropriate instrument. The autonomy enjoyed by the hospitals will range from governance to managerial functions such as finance, procurement, human resource and information. In this option increasingly more decision making control authority will be transferred to the hospital management. The redefined governance arrangements will entail a reconstituted board of directors that will be responsible for the running of the facilities. This will require a paradigm shift in terms of culture and funds flow and is expected to free the ministry of health from service delivery and enable it concentrate on its constitutional function of policy, standards regulation.

If the authority and selected facilities are converted into State Corporation then they will be accorded greater managerial autonomy and control inputs and issues related to their running. Elements of independence will include full financial performance , ownership accountability by being controlled by their governing bodies, having corporate plans/bidding performance agreements with the supervisory agencies, subsidy arrangements, the board of directors exercising absolute responsibility for the performance of the hospital and being fully accountable to the Minister for Health. The relevant law will create a legal infrastructure to protect the rights of the employees who exchange their status of state employees to that of the corporation/authority. In this arrangement also it is envisaged that the facilities will focus on hospitals to focus on developing and expanding those hospitalization as well as make improved use of their recourses as they will be held more accountable for their actions. The transaction costs will vary with the legal route chosen, the cheaper route being subsidiary legislation and conversion to corporation being more expensive.

Option 2: Maintain the Status quo with the facilities as budgetary organizations under the national government with increased level of semi autonomy

In this case, the hospitals will continue to run as part of the national government under a department of the Ministry of Health and the government will continue to controls all strategic issues and determine most day-to-day decisions. Such decisions include those relating to related to delivery of services, staffing, revenue of the hospital and infrastructure. The government will continue determining the budgetary allocation, services rendered, patients served, and charges for these facilities. The autonomy currently enjoyed in the area of financial management will be sustained and enhanced. This option is not aligned to expectations of keeping the central level focused on policy and regulation as opposed to service delivery, and may present difficulties in linkages with county governments and other regulatory agencies.

Option 3: Establishment of one Autonomous agency to run all seventeen hospitals

The creation of an autonomous agency through subsidiary legislation or an Act of Parliament and giving that organization autonomy, as distinct from granting autonomy to each and every hospital is another option considered. This means that effectively the autonomous agency will replace the section of the Ministry of Health that is responsible for administration of national referral health facilities. The merits of this approach include the fact that the government will have to deal with one autonomous organization as opposed to many. Secondly, it will be easier to monitor flow of both financial and human resources. Thirdly, the effectiveness of having the system of one-window for all inputs, processes and outcomes will enable the government to smoothly roll out its policies and standards. The key demerit is the possibility of the government diluting the autonomy by unnecessary control (both administrative and political). Secondly the effects of suboptimal leadership will affect all hospitals.

Option 4: The government can outsource the management of the selected national health referral facilities

This option entails transferring the management of the selected public hospitals to third party agencies which operate either for profit or not for profit. The hospitals will indeed be removed from direct control by the national government and operate fairly independently and be exposed to market forces. This approach will not aid the government in meeting its social responsibilities for health effectively as it will lead to inequities.

3.3 Preferred Option

In terms of evaluating the preferred organization of the public hospital system, cognizance was taken of the varying levels of independence that can be granted to subunits based on regional experiences. Restructuring may entail transferring authority for planning, management, resource mobilization, and resource allocation from the central level government and agencies to: field units of central government, semi autonomous public hospitals, regional or functional authorities or nongovernmental private organizations.

The more appealing options based on considerations of current structures and capacity were: making of the national referral facilities semi autonomous and transfer of decision making to independent governing bodies; and that of setting up of public hospitals as a quasi governmental organization and making this body autonomous. The latter has the advantage of administrative efficiencies and is easier to monitor and regulate. However, the disadvantage is dilution of autonomy at the individual hospitals and also adversity in leadership may affect all the hospitals involved. Recognizing that the current national teaching and referral hospitals in Kenya operating as individual semi autonomous hospitals have had governance challenges, a **blend** of the two is recommended as elaborated under **Option 1** above. This will ensure that best and promising

practices are shared easily through the national authority and at the same time decision making on day to day operations is entirely left to the individual national health referral facilities.

4. Implementation Roadmap

Leveraging on current initiatives in terms experiences and lessons learnt, the following key activities will be undertaken:

- *Ensuring that a suitable legal and policy framework exists for the establishment of the National Health Referral Facilities Management Authority and twenty one (21) additional national health referral facilities;*
- *Finalization and formalization of selection criteria for the designated national health referral facilities as well as sharing with the facilities the phased roadmap for implementation;*
- *Creation of a Task Force prepare relevant guideline defining the roles and responsibilities of the national authority and the individual facilities during both the preparatory phase and after transition;*
- *Fortify and sustain the systems improvement initiatives to increase the selected facilities readiness as national health referral facilities;*
- *Adopt revised facility management structure; and*
- *Consolidate technical support in strengthening financial information, human resource, and commodity management.*

Past reform initiatives by the Ministries of Health with assistance from development partners have yielded valuable lessons that are helpful in formulating a successful implementation process. Some of the key lessons include: a) health reforms are difficult, complex and long term; b) hospital reforms require extensive systemic changes and that fragmented interventions are insufficient c) commitment by health workers, hospital managers, policy makers is a pre

requisite; and d) hospital reforms cannot occur in isolation and must be accompanied by simultaneous changes in the entire health system.

The establishment and successful functioning of the national health referral facilities will be done leveraging on existing structures in the Ministries of Health and following a comprehensive and integrated approach. The diversity of the selected national health referral facilities makes it difficult to prescribe a rigid and very specific roadmap for the transformation of the facilities to the desired state of national referral facilities. As such the facility specific local conditions, resources, administrative capacity will guide the formulation of the individual institutional roadmaps. The implementation roadmap outlined below is the general one focusing on the priority areas and is divided into two broad sections: a) Preparatory and Facilitation Phase and b) the Transformation Phase/Conversion Phase.

4.1 Preparatory and Facilitation Phase

Preparatory phase comprises activities that should be undertaken at the national level and also at the individual national health referral facility. At the national level, the following is envisaged:
Ensure that an appropriate legal and policy environment exists for the proposed structures.
The Ministries of Health working with other Ministries, Attorney General Chambers and Parliament will provide a legal basis for the phased establishment and transformation of national health referral facilities through revision of existing regulations. Existing regulations limit public hospitals in generating substantial revenues, restrict the number of private beds and fee levels, and restrict hospital's authority in management of human resources, borrowing funds, owning assets and even in terms of social responsibility of hospitals to the public.

The Ministry of Health will also **finalize and formalize selection criteria for the designated hospitals as well as share with the facilities, the phased roadmap.** The systems improvement support to be provided to the selected facilities will be articulated. Additionally, the Ministry of Health working with the Public Service Commission and other stakeholders like the regulatory bodies will develop and adjustable coordinated and detailed plan of options for employees of the public hospitals during the transition phase. The selection criteria for board members of the national health referral facilities management authority and individual hospitals will also be established borrowing from the experiences of the National Hospital Management Services Committee and the Hospital Management Committees. An initial board of directors will first be appointed in an advisory capacity and later with full authority for the transformation.

Another key activity is for the Ministry to **clarify asset ownership or trust holding.** At this stage it is envisioned that the assets of the national health referral facilities will he be held in trust by the

authority on behalf of the government. The Ministry will **prepare relevant guidelines defining the roles and responsibilities of the national authority and the individual facilities during both the preparatory phase and after transition** into the desired status. These will cover all issues relating to management authority and responsibility, revenue goals, assets ownership, access to funds, employment options, and procurement guidelines.

The Ministry will also be responsible for **publicizing the proposed changes** to the relevant stakeholders and ensuring that they are engaged at all stages of the process. Therefore, an appropriate communications plan aligned to a ministerial communication strategy will be developed and adjusted to the different phases of the transformation. Further, the Ministry will make necessary adjustments including an **internal assessment of roles and responsibilities** arising from the reorganization and ensure that an appropriate team is assigned the task of steering the process.

At each of the selected facility, the following will be undertaken:
An inventory will be undertaken of the facility staff, assets and liabilities in order to appreciate the current state and prepare a capital and operational requirements plan. Liabilities will need to be addressed during the transition phase while the human resource inventory will facilitate the costing of the staffing options by the hospital management and the Ministry. The human resource assessment will be undertaken in a rational manner using workload to determine staffing levels - based on rationally established service norms and standards.

Simultaneously, an **assessment of internal organization and operations** will be undertaken to provide a baseline for **strategic planning** and clarify facilities strengths and weaknesses. The areas of focus will be organization structure, systems, processes and procedures in terms of decision making, roles and responsibilities, performance monitoring, supervision and control, quality of care, communications and staff capabilities. Acknowledging that many assessments have been undertaken and several of the facilities have developed strategic plans, attempts will be made to ensure that there are no duplications and alignment is obtained.

In implementing the strategic plans prepared by the individual facilities, continued support will be provided in **strengthening the priority areas.** At this stage, the envisaged areas of systems strengthening include : financial management systems, responsive commodities and supplies management systems, infrastructure and equipment upgrade, in hospital capabilities for costing services, human resources management function, proactive quality improvement and peer review programs.

Alongside the above activities, the Ministry will ensure that linkages with health regulatory

agencies, county health authorities, other relevant ministries and agencies like the audit organization are optimized.

4.2 Organization and Management

Prior to the establishment of the national health referral facilities management authority and the operationalisation of the individual facilities as semi autonomous agencies, and as an enabler for actualizing the preparatory activities proposed above, the Ministry responsible for medical services will create a taskforce/ secretariat with the responsibility of preparing the ground for the National Health Facility Management Authority through an appropriate legislation within one year. The roles of the taskforce will include but not be limited to;

- Develop Terms of Reference for the authority
- Develop a phased implementation plan for both the authority and the facilities plan bearing in mind the readiness of the individual institution
- Implement the revised management structure as well as undertake capacity strengthening of systems (Financial Management, Commodity Management, Information, and Human Resource) at the selected hospitals
- Undertake an inventory status of the selected hospitals
- Carry out a Human Resource Audit of the selected hospitals

The revised management structure for the selected hospitals is well aligned with the desire to grant the selected hospitals increased autonomy and takes into consideration: the need to allow for efficiency and effectiveness; deficiencies in current hospital structure; and promising experiences. Further the overarching need to match authority and responsibility while ensuring a balance between clinical and nonclinical functions is embedded. The key features of the proposed structure that are deemed to be improvements from the current unwieldy structure are: Hospital committees/boards will be given greater accountability, to the extent of their having holistic fiduciary responsibility for the hospital; the hospital directors will act as executives on a fulltime basis and thus will not provide expert clinical services for most of their time as has been the case currently; there will be three deputy directors in charge of clinical services, nursing services and administrative services thus permitting improved clinical governance and better medical staff organization while at the same time elevating supporting functions; the key positions will be filled competitively, contracts agreed and performance monitored and evaluated; and each position has clear terms of reference (detailed personal specification and job description).

4.3 Funding and Investment Policy

The improvement and restructuring of the national health referral facilities, including the strengthening of the facilities that are currently operating at a lower level, requires considerable

funding. Four different sources of funding are envisioned at this stage:

a) National budget – The national budget will have priorities relating to modernization of these selected facilities to rightfully play their mandate. For this investment, the Ministry will use, for a part, the national budget and for the rest, one or several loans negotiated with financial institutions. The Equalization Fund established under the Constitution of Kenya 2010 will also be utilized to ensure equity in health financing.

b) Public Private Partnerships – the national health referral facilities guided by the national authority will identify opportunities for PPP and assess them for exploitation. PPP will explore as a mechanism for financing facility infrastructure while ensuring that financial, management and legal risks are managed. Recent experiences of support by Private companies to hospitals through their corporate social responsibility programs lend credence to this approach.

A task force established to facilitate setting up and operationalisation of the National Health Referral Facilities Management Authority and preparing designated facilities for conversion

c) Development Partners – Financial resources and technical support availed by development partners will be coherently accessed and utilized within existing arrangements.

The National Health Referral Facilities Management Authority and the 21 national health referral facilities will prepare strategic plans articulating the objectives, foreseen activity, both human and financial resources needs. The strategic plans will be supported by operational plans and budgets per year specifying the evolution of activity, human resources and support services.

5. Financial Implications

5.1 Investment Costs

Capital costs for the targeted hospitals are based on historical financial experience of the facilities. In deriving these preliminary estimates considerations were made regarding the following:

- Facility Information – facility size and capacity;
- Desired status of service to be offered; and
- Existing facility long term plans (strategic plans and investment plans).

The improvement and restructuring of the national health referral facilities, including the strengthening of the facilities that are currently operating at a lower level, will require considerable funding. Four different sources of funding were envisioned at this stage:

a) National budget – for modernization to play their mandate;

b) Loans, grants and donations from partners;

c) Own generated resources from user fees for operational purposes;

d) Public private partnerships; and

e) The Equalization Fund, where applicable.

Recent experiences of the facilities support lend credence to this approach.

Based on this approach, the following table gives the projected initial capital costs to make the facilities reach the level of national referral level.

Table 1: Investment Cost Estimates for the Proposed National Referral Facilities

	No	Facility Name	Capital Investment Estimate
Provincial General Hospitals	1	Nakuru Provincial General Hospital	855,000,000
	2	Embu Provincial General Hospital	780,000,000
	3	Kakamega Provincial General Hospital	1,000,000,000
	4	Jaramogi Oginga Odinga Hospital	905,000,000
	5	Garissa Provincial General Hospital	1,180,000,000
	6	Nyeri Provincial General Hospital	670,000,000
	7	Coast Province General Hospital	920,000,000
High Volume Hospitals	8	Kisii Level 5 Hospital	835,000,000
	9	Machakos Level 5 Hospital	1,170,000,000
	10	Bungoma Hospital	835,000,000
	11	Thika Hospital	835,000,000
	12	Kitale Hospital	835,000,000
	13	Malindi Hospital	835,000,000
	14	Meru Hospital	835,000,000
Northern Arid Regions Hospitals	15	Moyale District Hospital	905,000,000
	16	Lodwar District Hospital	1,010,000,000
	17	Wajir District Hospital	955,000,000
	18	Marsabit District Hospital	1,180,000,000
High Volume Specialised	19	Spinal Injury Hospital	671,000,000
	20	Pumwani Maternity Hospital	500,000,000
	21	Mathari Mental Hospital	955,000,000
		Total	**18,775,000,000**

5.2 Recurrent Costs Estimates

In estimating the initial recurrent budget estimates for the proposed national referral facilities, consideration was given to the current recurrent costs; spending proportions for key budget category items and the level of performance. More detailed estimation would require a specification of the norms and standards, a process that is still in progress.

Table 2: Recurrent Cost Estimates for Proposed Referral Facilities

	No	Facility Name	Total Recurrent Costs
Provincial General Hospitals	1	Nakuru Provincial General Hospital	451,111,111
	2	Embu Provincial General Hospital	444,293,984
	3	Kakamega Provincial General Hospital	425,333,333
	4	Jaramogi Oginga Odinga Hospital	489,777,778
	5	Garissa Provincial General Hospital	315,777,778
	6	Nyeri Provincial General Hospital	418,888,889
	7	Coast Province General Hospital	1,095,555,556
Higher Volume Hospitals	8	Kisii level 5 Hospital	386,666,667
	9	Machakos Level 5 Hospital	386,666,667
	10	Bungoma Hospital	335,111,111
	11	Thika Hospital	380,222,222
	12	Kitale Hospital	328,666,667
	13	Meru Hospital	315,777,778
	14	Moi Hospital	348,000,000
[illegible]	15	Isiolo District Hospital	329,000,000
[illegible]	16	Lodwar District Hospital	259,000,000
[illegible]	17	Wajir District Hospital	338,515,152
[illegible]	18	Mandera District Hospital	306,303,030
[illegible]	19	Siaya County Hospital	336,666,667
[illegible]	20	Pumwani Maternity Hospital	474,000,000
[illegible]	21	Mathare Mental Hospital	490,000,000
		Total	**8,705,364,692**

5.3 Estimates for the National Referral Facilities Management Authority

In estimating the budget for the National Referral Facilities Management Authority (NRFMA), the proposed roles as articulated in the Position Paper as well as experience of the institutions with closely related roles in other sectors were taken into account.

It is assumed that the NRFMA will adopt a functional structure headed by a Chief Executive Officer and overseen by a Board of Directors. The estimates also assume the authority will have the following key functions: quality and safety, finance, strategy and planning, shared services, human resources and internal audit. Further, it is assumed that the structure will be thin with a maximum of 30 staff and overseen by a board comprising nine professionals. The estimated annual cost for the authority is KES 222 Million and that for the five year period is KES 944 Million.

Table 3: Cost Estimates for the Proposed Referral Facility Management Authority

Item Description	Qty	Target	Unit Cost	Frequency	YEAR 1 ESTIMAT	5 YEAR ESTIMATE
Recurrent Costs						
Personnel costs						
Chief Executive	1	1	6,000,000	1	6,000,000	30,000,000
5 Divisional Heads	5	1	4,800,000	1	24,000,000	120,000,000
10 staff	10	1	2,400,000	1	24,000,000	120,000,000
10 staff	10	1	1,250,000	1	12,500,000	62,500,000
5 staff	5	1	1,200,000	1	6,000,000	30,000,000
Board of Directors (Assumed 9 board members allowances)	9	1	360,000	1	3,240,000	16,200,000
Other Personnel costs (including medical and professional development estimated at 30% of the costs above)					24,994,200	124,971,000
Office overheads						
Utilities			50,000	12	600,000	3,000,000
Office rent			250,000	12	3,000,000	15,000,000
Motor vehicle running and maintenance					4,000,000	20,000,000
Equipment maintenance					2,500,000	12,500,000
NPHFMA activities						
Quality and Safety			15,000,000	1	15,000,000	75,000,000
Strategy and Planning			5,000,000	1	5,000,000	25,000,000
Financial Monitoring			8,000,000	1	8,000,000	40,000,000
Monitoring and Evaluation			17,000,000	1	17,000,000	85,000,000
Internal audit			12,750,000	1	12,750,000	63,750,000
Operational Research			3,000,000	4	12,000,000	60,000,000
Capital Costs						
Office equipment and information systems						
Office equipment and information systems			15,000,000	1	15,000,000	15,000,000
Office furniture			10,000,000	1	10,000,000	10,000,000
Motor vehicles	4	1	4,000,000	1	16,000,000	16,000,000
GRAND TOTAL						

APPENDIX: National Public Health Facilities Management Authority

Functions of the National Public Health Facilities Management Authority

- To control, regulate and administer all matters related to the management and development of national referral public hospitals in Kenya;
- To ensure the application of efficient and appropriate techniques, systems and standards for the delivery of healthcare in the national referral facilities;
- To appoint such staff as it considers necessary on such terms and conditions (including salaries, allowances, other remunerations and disciplinary control) as the Authority may determine;
- To fix qualifications and terms and conditions of service relating to staff;
- To consult with the Minister / Cabinet Secretary on matters of national health policy and capital development programmes for national referral facilities;
- To operate, construct, equip, furnish, maintain, manage, secure and repair all property for use by the general public;
- To facilitate the use of national referral facilities for service, teaching and research;
- To establish and develop relationships with national, county and international bodies engaged in similar or ancillary pursuits;
- To collaborate with educational institutions, such as the Universities, the Kenya Medical Training College, Technical and Vocational Institutes and any other recognized training institutions in research and in the education and training of persons in medicine, nursing, dentistry, pharmacy, bio-medical and health science fields, as well as any related ancillary and supportive fields.