The Implications Of Amenity Wards On The Equity Of Health Care At Meru District Hospital

Maryjoy Kaimuri
School of Medicine and Health Sciences,
Department of Nursing, Kenya Methodist University.
mkaimuri81@yahoo.com

Abstract

Amenity wards in public hospitals were established with the aim of retaining specialists in public sector and for generating additional funds to run the health facilities. However, the effects of these establishments on equity of health care have not been assessed. The purpose of this study was to assess the implications of amenity wards in public hospitals on equity of health care. This study aimed at achieving four main objectives to include determining the material resources allocated for patient care in amenity wards and general wards; to determine the number of human resources allocated for patient care in amenity wards and general wards; to determine the waiting time for patients in amenity wards and general wards and to establish the quality of the facilities in amenity wards and general wards. The study was carried out at Meru district hospital in 2010. The study utilized comparative design. The sampling designs utilized are stratified and simple random sampling designs. The total sample size was 189 respondents. A questionnaire and a check list were used as data collection tools. Data was analyzed using descriptive statistics. The nurse to patient ratio for the amenity wards was 1:2 compared to 1:9 in the general wards. As regards to drugs, all the respondents (100% (n=15)) in the amenity wards reported to having received all the drugs prescribed to them compared to 90% (n=99) of the respondents in the general wards. 40% (n=6) of the respondents in the amenity wards who were scheduled for an elective surgical procedure were taken to theatre immediately and 35% (n=5) were taken after one day compared to 1 % and 25 %(n=28) respectively for the general wards. There is inequitable distribution of human resources for health where more health care providers are allocated to the amenity wards to provide care for very few patients compared to the general wards. Similarly, the amenity wards have higher quality facilities and shorter waiting time compared to the general wards.

Key words: *Health Equity, Equity, Amenity ward, General ward, Human Resources for health, Consumables, Waiting time*

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Background Information

The primary role of the public hospitals is to ensure equitable and accessible healthcare, especially to the marginalized groups. According to EQUINET (1998), health equity is the absence of systematic disparities in health between groups with different levels of underlying social advantage or disadvantage. Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. One of the major functions of a health system is service provision therefore, a health system should strive for both horizontal and vertical equity – treating alike all those who face the same health need, and treating preferentially those with the greatest needs – to be consistent with the goal of reducing health inequalities (WHO, 2000).

Development of amenity wards in public hospitals could result to health inequities putting the disadvantaged groups at further disadvantage. Amenity wards establishments in public health facilities, where public medical personnel may see private patients, have given rise to problems (Leng,C.H, 2004). In most developed countries and many middle income countries, governments have become central to health care systems unlike in low income countries. The involvement of governments is justified on the grounds of both equity and efficiency since they provide stewardship for the performance of the health care system. The issue of equity must be addressed as a matter of urgency if Kenya is to achieve health for all its citizens based on the principle that health is a basic need and not a privilege or a luxury. In Kenya, large segments of the poor still have no access to basic and effective care and they depend on the public hospitals for health care services. Therefore, the government must ensure that health care is accessible and equitable especially for the poor who cannot be able to pay for private practice. The creation of amenity wards is compromising the quality of care for the general patients and also short-charging the poor patients who use subsidized services in the public hospitals.

The government of Kenya has a policy on cost sharing and waiver system for those patients who cannot afford the cost of health care. These were measures introduced to cushion the poor and improve the financial access to health care (MoH, 2005). However, these measures have several setbacks, for instance, on equity considerations; the policy has not promoted access to modern health care, as the targeting approach remains ineffective and there has been no corresponding improvement in the quality of health care. Also, there has been low annual budget allocated to the ministry of health. Therefore, the introduction of amenity wards in public hospitals encourages those who can afford to receive health care. This study seeks to bridge this gap by studying Meru District Hospital which is purposively selected using a comparative design.

Problem Statement

Many public hospitals in Kenya are developing amenity wards to run concurrently with the general wards with an aim of generating additional income and retaining the specialists. The revenue generated in the amenity wards is supposed to be invested in the hospital to improve the quality of services such as 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 wards (MOH, 2008).Kinuthia,J. (2002) points out that the best health care is given within the amenity wards as opposed to the general wards. The scarce resources are diverted to the amenity wards leaving the general wards with very few resources to run the simplest of their operations. According to the Coalition against Health Care Privatization (2007), the amenity wards have become 'private hospitals' within public hospitals. In their report, they argue that the amenity wards are encouraging the specialist to concentrate in treating of private patients at the expense of the ordinary patients who cannot afford amenity service. The independent variables measured in this study were human resources, material resources, waiting time and quality of the facilities and their effect on the dependent variable which is equity of health care

Materials And Methods

A comparative design was utilized to assess the implications of amenity wards on equity of health care. The amenity wards were compared to the general wards on material resources, the numbers of human resources, waiting time and quality of the facilities. The study population included both the patients/ consumers of care (450 from the general ward and 50 from the amity ward) and the health care providers (165 nurses, 25 doctors and 21 clinical officers) at the Meru district hospital. A sample size of 189 respondents was determined. Proportionate allocation was used to determine the exact number of respondents in each stratum to include 51 nurses, 7 doctors, 6 clinical officers, 110 patients from the general ward and 15 patients from the amenity ward. Questionnaires and a checklist were used as tools for data collection. The questionnaires were administered to the respondents by the researcher and five research assistants. The questionnaire consisted of both open-ended questions to collect in-depth information and closed-ended questions to gather specific information. Key informants were interviewed to obtain in-depth information on the operation of the units. A check list was used to assess the quality of the facilities in both the amenity wards and the general wards. The researcher physically observed the cleanliness of the facilities in both of the units. Data was coded and entered into the SPSS statistical software. Data was analyzed using descriptive statistics. Study findings were presented in form of tables, graphs and pie charts.

Results

Allocation of human resources

The respondents were asked to indicate how frequently they were reviewed by the various categories of the health care providers. As showed in table 1, 96.4 %(n=106) of the respondents in the general wards were reviewed every day by both the clinical officers and the medical officer interns. However, the same percentages of the respondents in the general wards were reviewed by the medical officer and the consultant only during the ward round.

On the other hand, 26.7 %(n=4) of the respondents in the amenity ward were reviewed by the consultant every day, 13.3 %(n=2) were reviewed on patient request and 53.3% (n=8) were reviewed immediately

Table 1: *Patient review by various categories of health care providers*

Ward category	Provider category	Immediately on admission	Once/day	During ward round	On patient request
Amenity	Clinical officer	80%(n=12)	0.9% (n=1)	0%(n=0)	0%(n=0)
	Medical officer intern	86.7% (n=13)	0%(n=0)	0%(n=0)	0%(n=0)
	Medical officer	13.3%(n=2)	53.3%(n=8)	6.7%(n=1)	13.3%(n=2)
	Consultant	53.3%(n=8)	26.7%(n=4)	0%(n=0)	13.3%(n=2)
General ward	Clinical officer	1.8%(n=2)	96.4%(n=106)	1.8%(n=2)	0%(n=0)
	Medical officer intern	1.8%(n=2)	96.4%(n=106)	1.8%(n=2)	0%(n=0)
	Medical officer	1.8%(n=2)	0%(n=0)	96.4%(n=106)	0%(n=0)
	Consultant	1.8%(n=2)	0%(n=0)	96.4%(n=106)	0%(n=0)

on admission. Also, 53.3 %(n=8) of the patients in the amenity ward are reviewed by the medical officer every day.

Test for significance indicates that patient review by various categories of health care providers is dependent on the ward the patient is admitted into. Further analysis of the contingency table showed that the ward category and patient review are dependent ($p<0.001$). From the cell percentages, the patients who are admitted in the amenity wards are most likely to be reviewed immediately on admission than those admitted to the general wards.

The actual numbers of nurses working in each unit was established and the ratio of nurse to patient was calculated. The nurse to patient ratio for the amenity wards was 1:2 as compared to 1:9 in the general wards (Table 2). The number of the doctors for each unit was not established because they work in both units.

Table 2: *Actual numbers of human resources for health*

	Amenity wards			General wards		
	Staff number	Patient number	Ratio	Staff number	Patient number	Ratio
Nurses	13	25	1:2	33	303	1:9

Material resources such as drugs and consumables

All the respondents (100% (n=15)) in the amenity wards reported to having received all the drugs prescribed to them compared to 90% (n=99) of the respondents in the general wards. Only 10%(n=11) of respondents in the general wards stated that they did not receive all the drugs prescribed to them with the main reason being that the drugs were not available in the hospital hence they were requested to buy.

In regard to consumables such as gloves, 100% (n=15) of the respondents in the amenity wards reported to having been provided with everything they required as compared to

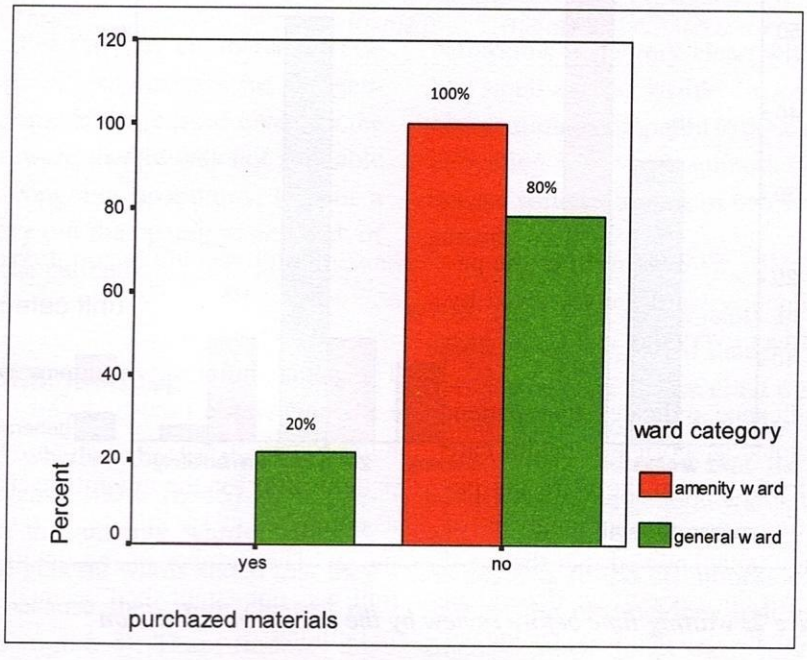

Figure 1: *Purchase of materials by the consumers*

80% (n=88) of the respondents in the general wards as indicated on figure 1. 20% (n=22) of the respondents in the general wards had purchased materials such as gloves, cotton wool and branulars. Some of the reasons cited by those who had purchased materials were they were not provided by the hospital. when the health care providers were asked if the sterile gloves were available in the units where they work, 85%(n=8) of the respondents in the amenity wards affirmed they were available as compared to 78%(n=41) of the respondents in the general wards who said that these materials were not available.

Waiting time

64% (n=10)of the respondents in the amenity wards stated that they waited only for one day before they were reviewed by the doctor on admission compared to 55% (n=61) of respondents in the general wards who had to wait for 2-4 days as indicated on figure 2.

Figure 3 indicates the waiting time for elective procedures. 40% (n=6) of the respondents in the amenity wards who were scheduled for an elective surgical procedure were taken to theatre immediately and 35% (n=5)

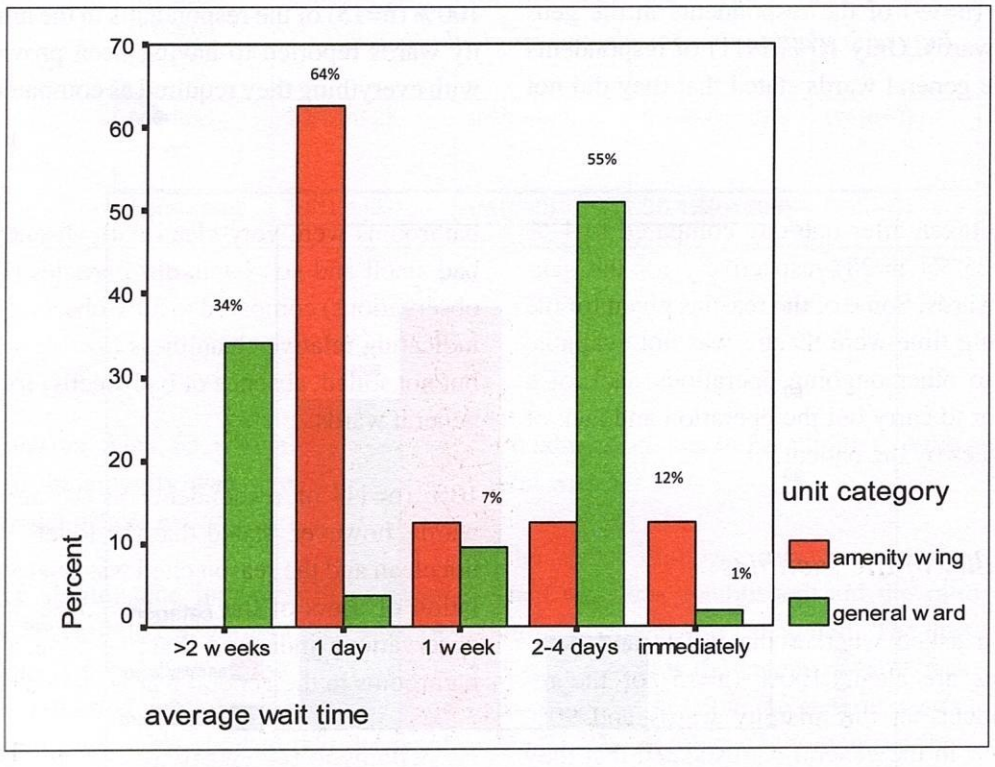

Figure 2: *waiting time before review by the doctor on admission*

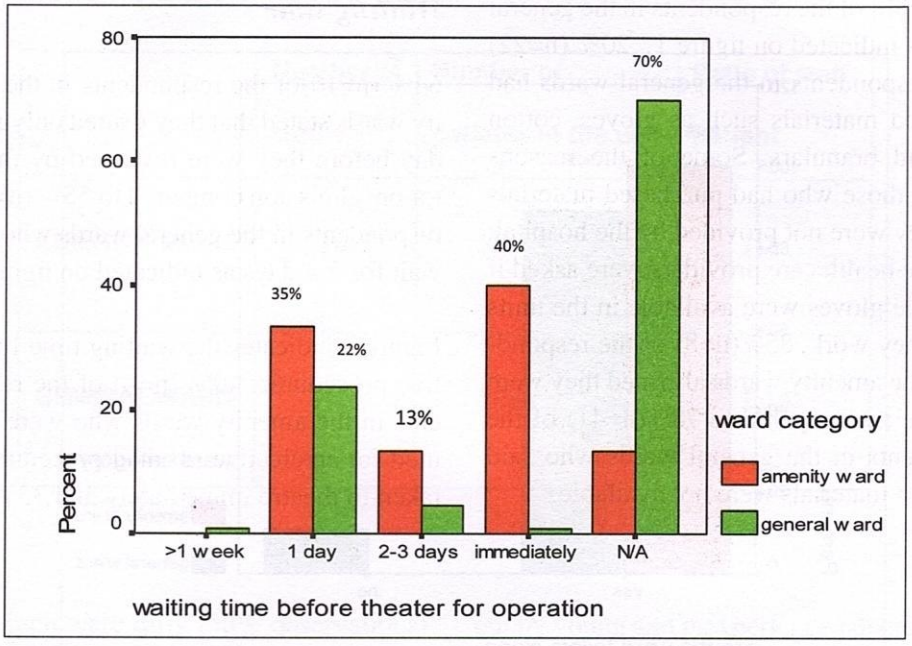

Figure 3: *waiting time for elective surgical procedures*

were taken after one day compared to 1 % and 25 %(n=28) respectively for the general wards. Some of the reasons given for the waiting time were theatre was not available due to other ongoing operations, lack of a doctor to carry out the operation and lack of finances by the patient.

Quality of the facilities

When asked whether the toilets and bathrooms are clean, 100% (n=15) of the respondents in the amenity wards and 90% (n=99) in the general wards stated that they were clean because they were cleaned on a daily basis (figure 4). These findings are further supported by the observations which indicated that the amenity wards toilets and bathrooms were very clean with absence of bad smell and no visible dirt particles (75% observations) compared to 50% observations indicating relative cleanliness (visible stains but not soiled, absence of bad smells) for the general wards.

10% (n=11) of respondents in the general wards, however, stated that the toilets were not clean and the reason cited was overpopulation of users of the facilities. 50% of the observations indicated that the toilets and bathrooms in the general wards were dirty.

As pertains to the cleanliness of the floors, 75% of the observations indicated that the amenity wards floors were very clean with no litter on the floor, no bad smells and no visible dirt particles compared to the general

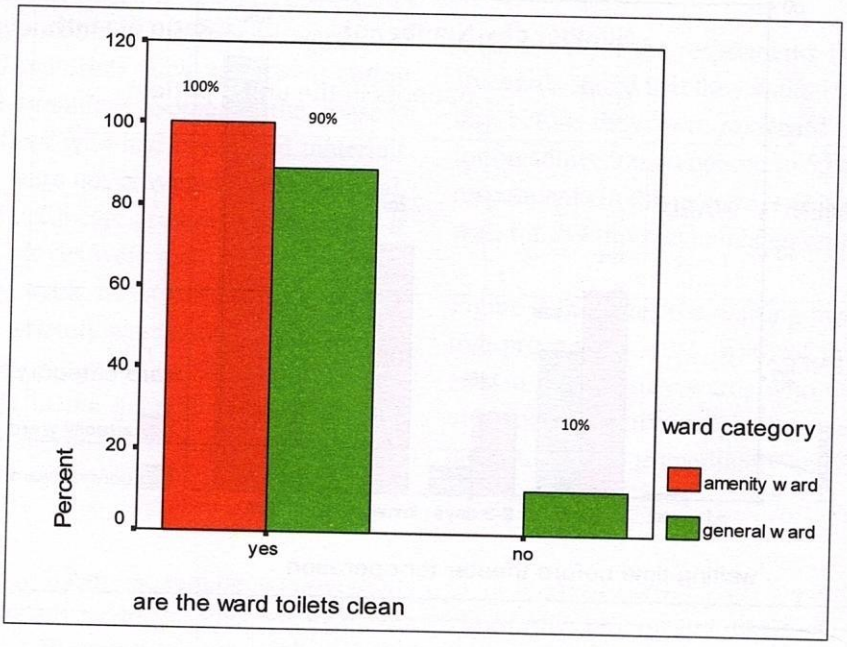

Figure 4: *Cleanliness of the toilets and bathrooms*

Table 3: *Cleanliness of the floors*

		Frequency	%
AMENITY WARD	Very clean	3	75
	Relatively clean	1	25
	Dirty	0	0
GENERAL WARD	Very clean	0	0
	Relatively clean	2	50
	Dirty	2	50

Table 4: Number of cleaning staff

	Number of staff	Number of patients in the unit	Ratio of staff: patient
AMENITY WARD	10	25	1:2
GENERAL WARD	21	303	1:14

wards which were dirty (50% observations) in that they were wet and littered with food particles, gloves, cotton wool, gauzes whiles others had blood on them(Table 3).

In regard to the number of cleaning staff, a mean ratio of 3 patients to 1 cleaner exists in the amenity wards compared to 14:1 in the general wards as shown in the table 4

Discussion

Human resources for health

Literature reviewed showed that there is preferential allocation of human resources to amenity wards patients compared to those in the general wards. According to a report published by Coalition against Health Care Privatization (2007), the amenity wards were encouraging the consultants to concentrate in treating of private patients at the expense of the ordinary patients who cannot afford amenity service. As a result, the treatment of ordinary patients was being carried out by young and inexperienced doctors who are under the supervision of the specialists. This concurs with the findings of this study which indicates that the consultants review the patients in the amenity wards immediately on admission, once every day and on patient request compared to patients in the general wards who are reviewed only during the ward rounds. In contrast, the patients in the general wards are reviewed by the clinical officers and the medical officer interns on a daily basis. It is worth noting that the clinical officers and the medical officer interns are under the supervision of the consultants. A similar study by Sheahan (2007) indicated that the public patients in public hospitals were disadvantaged because the consultants were spending too much time working with their more lucrative private patients. In Israel's capital city Jerusalem, the main argument against amenity wards was that they create an inequitable system of care because they reduce the access of public patients to senior surgeons (Gur et al, 2006).

Similarly, there exists a difference in the al-

location of health care providers between the two units with the amenity wards being favoured. The study findings indicate that the amenity wards have more allocation of nurses compared to the general wards. This is despite the fact that the general wards have a higher number of patients which translates to a higher workload. This may compromise the quality of care delivered to the patients in the general ward. This is supported by a similar study carried out in Zambia by McPake et al (2004) which indicated that the amenity wards are distinctly better staffed on a per-patient basis with a nurse to patient ratio of 1:4 in general wards and 1:1 in amenity wards.

Material resources

Comparison of drug availability in both units showed a slight difference (10%) with the results indicating that majority of the patients received all the drugs that were prescribed irrespective of the unit that they were admitted in. This concurs with the work of McPake et al (2004) that showed that drugs prescribed to patients in the amenity wards were readily provided by the hospital compared to the patients in the general wards who purchased most of the drugs that were prescribed to them.

Another disparity noted was that the sterile gloves were readily available in the amenity wards while patients in the general wards had to purchase their own sterile gloves for examination. Although patients in the general wards reported having purchased the sterile gloves, results indicated that patients in the maternity section were requested to purchase sterile gloves and cotton wool prior to admission in the ward.

Waiting time

In the United Kingdom, a regular public opinion survey has indicated for several years that waiting for specialist assessment and waiting for elective surgery are perceived, respectively, as the first and second most important failures of the health care system (Hurst & Siciliani, 2003). This survey is further supported by the findings of a research conducted in Zambia which indicated that the amenity ward patients waiting time was less compared to patients in the general wards (McPake et al, 2004). Similarly, results of this study show that the patients in the general wards waited longer for elective surgery compared to patients in the amenity wards. This trend can be explained by the fact that the amenity patients have a greater access to consultants who in turn slot them into the theatre waiting list overlooking those who are already booked from the general wards. Also, the consultants feel obligated to attend to the amenity wards patients immediately since these patients are admitted through the consultant clinics that are outside the hospital and they have paid upfront for the procedure. As a result, the patients in the general wards end up waiting longer for the same procedure.

Quality of facilities

Amenity wards are not unique to Kenya as other countries such as Indonesia, Singapore, and Zambia have systems in which amenity wards are established within public hospitals to attract fee-paying, high-income patients. Literature reviewed has shown that amenity wards offer better hotel amenities to those able to pay for these additional amenities, but the clinical quality of care remains the

same in all the wards in the hospital. However, in this study a disparity in the quality of facilities in the two units was noted where the general wards toilets, bathrooms and the floors were dirty most of the time compared to the amenity wards which was very clean. McPake et al (2004) observed a similar trend in a study he carried out in Zambia which showed that the toilets in the general wards were dirty, (60% of observations) while those in the amenity wards were almost always clean (95% of observations). The contributing factor to this trend is that the cleaning staff allocation is skewed in favour of the amenity wards irrespective of its patient load. Hence, more cleaning staff are allocated to the amenity wards to serve a very small population of patients. This agrees with the work of McPake et al (2004) which showed a mean ratio of 5 patients to 1 cleaner in the amenity wards, and of 13:1 in the general wards.

Conclusion

The second national strategic plan (NASSP,2005-2010), is about reversing the downward spiral of Kenya's health status by reducing the health inequalities. However, this goal cannot be achieved if the amenity wards are having negative implications on equitable provision of health care as shown by the findings of this study. Comparison of allocation of resources of clinical significance found a disproportionate use of resources between the two units. There is inequitable distribution of human resources for health where more health care providers are allocated to the amenity wards to provide care for very few patients compared to the general wards. Similarly, the amenity wards have higher quality facilities and shorter waiting time compared to the general wards. In view of the foregoing, it is right to conclude that the amenity wards have a negative effect on the equity of health care provided at the Meru district hospital.

References

Adano, U. (2008). The health worker recruitment and deployment process in Kenya: an emergency hiring program. *Human resources for health*. (Online).Available from: http://www.human-resources-health.com/content/6/1/19 (Accessed March 4, 2009). doi:10.1186/1478-4491-6-19

Allin, S. (2006). Equity in the use of health services in Canada and its provinces.(Online). Available from: *http://www.lse.ac.uk/collections/LSEHealth/pdf/LSEHealthworkingpaperseries/LSEHWP3.pdf* (Accessed January 14th, 2009). Working Paper No: 3/2006

Association of Private Hospitals, M. (2004). Amenity wards in public sector hospitals. Malaysia: APHM.

Cairney, R. (1996). Plans to run private facility in public hospital draw some strong opposition in Alberta. *Canadian Medical Association Journal,* 1543-4.pp 1543

Coalition against Health care Privatization. (2007). Cancel the FPP scheme in public hospitals. Aliran newsletter.(Online). Availablefrom:*http://www.aliran.com/index.php?option=com_content&view=article&id=365%3Acancel-the-fpp-scheme-in-public-hospitals&Itemid=24* (Accessed January 6th, 2009).

EQUINET. (1998). *Equity in health*. Retrieved May 26, 2009, from EQUINET Africa: http://www.equinetafrica.org/

Gur, O., Rosen, B., Greenstein, M., Benbassat, J., Halevy, J., & Shapira, S. (2006). Public and Private Patients in Jerusalem Hospitals. Imaj. Available from:*http://www.ima.org.il/imaj/ar06apr-12.pdf* (Accessed March 3, 2009).pp 270-276

Gupta, N., Zurn, P., Diallo, K., & Dal, M. (2003). Uses of population census data for monitoring geographical imbalance in the health workforce: snapshots from three developing countries. *International Journal for equity in health care* , 2 (11). doi: 10.1186/1475-9276- 2-11

Hurst, J., & Siciliani, L. (2003). Tackling excessive waiting times for elective surgery: A comparison of policies in twelve OECD countries. *OECD journal:* available from: http://74.125.47.132/search?q=cache:keHfXhiMDRQJ:www.oecd.org/dataoecd/24/32/5162353.pdf+waiting+time+health+systems&cd=6&hl=en&ct=clnk&gl=ke (Accessed March 24, 2009). pp 39-47

GoK, (2007). Kenya vision 2030. Accessed January 14th, 2009, from Investment kenya website: *http://www.investmentkenya.com/Documents/Publications/Vision_2030_BROCHURE%20_July_2007.pdf* .pp 12-13

Kinuthia, J. (2002). Trading in health care services in Kenya: Are we prepared? Accessed October 28, 2008, from *http://www.wemos.nl/documents/TRADING%20IN%20HEALTHCARE%20SERVICES.pdf*. pp 3-14
Leng, C. H. (2004). Current health care financing issues in Malaysia. Accessed October 28, 2008, from Asia Research Institute:*http://www.ari.nus.edu.sg/docs/wps/wps04_018.pdf*, working paper 18. pp 5-7

Liu, E., & Yue, S. (1999). *Health care expenditure and financing in Singapore*. Accessed March 16, 2009, from Legco: *http://www.legco.gov.hk/yr98-99/english/sec/library/989rp12.pdf*. pp 30

McPake, B., Nakamba, P., Hanson, K., & McLoughlin, B. (2004). Amenity wards in public hospitals: two-tier charging and the allocation of resources in tertiary hospitals in Zambia. Accessed January 5th, 2009, from HEFP website: *http://www.hefp.lshtm.ac.uk/publications/downloads/working_papers/05_04.pdf*, working paper 05/04

MoH. (2005). The Second National Health Sector Strategic Plan of Kenya (2005-2010). Accessed January 6th, 2009, from Ministry of Health: *http://www.drh.go.ke/documents/NHSSP%20II%202005-2010.pdf*

MoH. (2008). Guidelines for the establishment and management of amenity wards in public hospitals in Kenya. Accessed January 7th, 2009, from USAID Website: *http://www.healthpolicyinitiative.com/Publications/Documents/626_1_Kenya_Amenity_Ward_Guidelines.pdf*, pp.2-9

Munene, M., & Kadida, J. (2008). Doctors in the dock over medical mistakes. Accessed January 6th, 2009, from Daily nation: *http://www.nation.co.ke/News/-/1056/470254/-/item/1/-/i68q79/-/index.html*

Owino, W., Odundo, P., & Okech, T. (2001). *Governance of the District Health Systems:A Focus on the Health Management Board sand Human Resource Development Issues*. Accessed March 10, 2009, from IPAR website: http://www.ipar.or.ke/DP27-full.pdf

Sheahan, F. (2007). *Public ward patients are the hospital losers*. Accessed March 3, 2009, from Independent.ie: http://www.independent.ie/national-news/public-ward-patients-are-the-hospital-losers-44582.html

World Health Organization (2000), Health Systems: Improving Performance Geneva. 2000 *http://www.who.int.proxy.lib.uwo.ca:2048/whr/2000/en/whr00_ch4_en.pdf*. pp 47-68