



Sustainable eye care at Kitale Eye Unit



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Eye care services are an integral part of health services. It is therefore important that eye care programmes are designed with financial sustainability in mind so they can become self-sufficient within a reasonable period of time. This article describes how costs were kept low, income was generated, and quality eye care was maintained at Kitale Eye Unit, a department within the Kitale District Hospital, the county referral hospital for Transzoia (population 1 million) in Kenya.

The unit has one ophthalmologist, three ophthalmic clinical officers and six nurses. They are all employed by the ministry of health. Four support staff (clerks, cleaners and cashiers) are employed by the hospital.

Capital development costs, such as building and equipping the eye unit, start-up costs of training personnel and support for outreach programmes were provided by Operation Eyesight Universal (OEU).

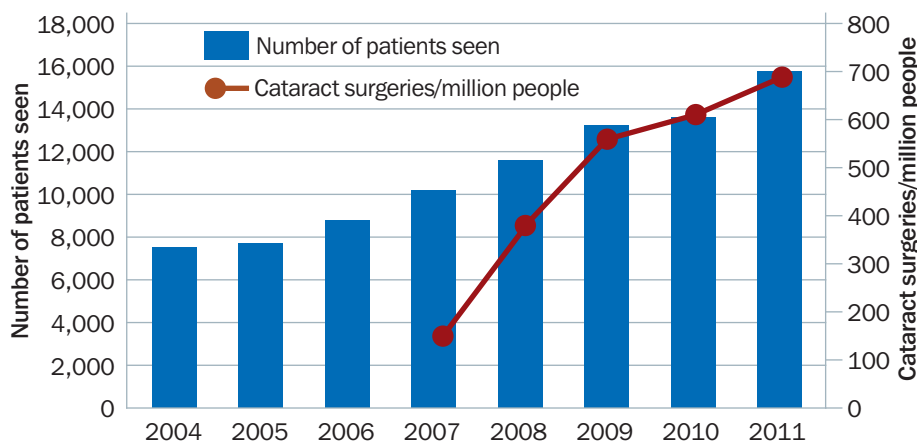
About 60% of the recurrent expenditure is funded by government, 18% comes from internally generated revenues, and the rest (22%) is supported by partner non-governmental organisations (NGOs).

Keeping costs low

Human resources management

The people are the most important asset in any organisation. Eye care workers are scarce and expensive to recruit. Various methods have been used to utilise available staff optimally, for example training, motivation, target setting, and task shifting. These will be discussed in more detail in a future issue of the *Community Eye Health Journal*.

Figure 1. Patients seen and cataract surgical rate at Kitale eye unit



Kitale eye unit was built and equipped with support from Operation Eyesight Universal.

Time management

There are three surgical days in a week. At first, operations are booked on just the first day. Once this day is full, bookings will be made on the next surgical day and so on. This maximises use of theatre space as well as the surgeon's time.

Supplies: surgical consumables

One of our goals is to make eye care affordable by reducing the cost of surgical consumables. This has been achieved as follows.

- 1 Consumables for cataract surgery are purchased in bulk directly from manufacturers, reducing the costs by up to 50%.
- 2 A trachoma surgery kit with essential consumables has been developed in collaboration with Deepak Enterprises in India. This has made it cheaper to conduct trachoma surgery.
- 3 All surgeons perform small-incision sutureless cataract surgery as day surgery. Admissions are at the patient's

request or when there are complications that necessitate it. The costs associated with overnight admission and sutures are therefore avoided.

Increasing income

We have several ways of increasing income in Kitale.

Fee for service (user fees)

All patients pay for the services provided. This fee can be paid by their insurance or out of pocket for those without medical insurance. The consultation fee and user fee for procedures are levied as per hospital guidelines. The funds generated go to a common hospital pool and quarterly budgets are developed to spend the revenue.

Ophthalmic pharmacy

An ophthalmic products pharmacy was established with seed support from OEU. Medicine was procured in bulk, directly from the manufacturers.

A profit margin of 30% was added to the cost of eye drops. This profit is divided as follows:

- one third to support the outreach programme
- one third to the hospital to pay utility bills
- one third to increase stocks.

In 2011 and 2012, the proceeds from the pharmacy supported two surgical camps and the surplus was enough to sponsor 70 cataract operations.

Outreach

Eye drops and spectacles for reading are sold during outreach services to those who can afford to pay. The proceeds are

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used to provide transport and meals for eye workers.

Local philanthropists

We have partnered with local service clubs, companies and philanthropists to support patients who are poor. The clubs include Lions clubs, which support surgical camps and trachoma activities.

Maintaining quality

Maintenance of the quality of eye services is continuous and dynamic. The three key processes are:

- 1 Identification of areas that need improvement.
- 2 Analysing areas of difficulty and proposing solutions.
- 3 Monitoring progress and providing feedback to staff.

At Kitale, identification of areas that need improvement is achieved through auditing surgical outcomes (such as cataract outcome) and getting feedback from patients about their experiences at the eye unit. A staff meeting is held every 2–3 months to discuss surgical outcomes and patient feedback. Probable solutions are also identified. Some of the solutions proposed so far have included purchase of essential equipment, continuous medical education for staff to keep them updated about current management of eye conditions, customer relations training, and refresher training for cataract surgeons.

Monitoring of progress and feedback to staff is done through quarterly reports, which are prepared by the eye department. Supportive supervision by Kenya's national eye coordinator motivates staff to achieve better quality. Output has increased as a result (Figure 1).

Conclusion

In every unit, the eye care team is responsible for diversifying and improving quality of services in order to attract all clients, both those without funds and those who can pay for service. At the same time, managers have to be innovative in staff motivation, revenue generation, community support, political support, and hospital administration support. These days, government policies in Kenya allow innovation and freedom to think outside the box.

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Further reading

- 1 Shamanna BR, Dandona R, Dandona L, Rao GN. Financial Sustainability. *Journal of Community Eye Health* 2001;14:7–8.
- 2 Thulasiraj RD, Sivakumar AK. Cost Containment in Eye Care. *Journal of Community Eye Health* 2001;14:4–6.



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Clinica Oftalmologica Divino Nino Jesus (DNJ) in Peru exemplifies how one small eye clinic can become sustainable, grow, and influence national eye care strategies.

DNJ was established in 1996 and initially provided general health care. From 2006 onwards, CBM Latin America helped DNJ to focus on eye care and later sponsored a DNJ leadership team to attend an International Eye Foundation (IEF) sustainability workshop in Paraguay. DNJ then started a two-year change process toward sustainability with technical assistance from IEF and Guatemala's Visualiza.

Leadership commitment

IEF worked with the hospital management to develop a business plan which included:

- a focus on patient needs and expectations
- the creation of product and service choices
- good management practices
- standardisation of protocols.

The budget focused on:

- procurement
- cost reduction
- pricing structures
- patient willingness to pay.

Overall, the business plan relied on a detailed analysis of current capacity and an understanding of future demand for services, including what people might be willing to pay.

Initially, there was some resistance from the leadership and staff to charging fees for services, as most patients had been treated free of charge (except for a small number of private patients).

Overcoming resistance to change

In our experience, gaining the trust of people in key leadership positions is possible but can be slow; it involves carefully discussing any sensitive issues. Relationships have to be carefully nurtured.

The key to overcoming resistance is to change the way these leaders think. Help them to see the benefits of the proposed change by linking the result of the changes to the vision, mission, goals and financial returns of the organisation.

The leaders must develop confidence in the change process. Help them to

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International Eye Foundation

Planning sustainable services at Clinica Oftalmologica Divino Nino Jesus.

At DNJ, the following product and service choices have been introduced:

- A standard intraocular lens (IOL) vs. a more expensive foldable IOL.
- 'First come, first served' or 'fast track' when attending outpatient examinations (see opposite page for more detail).

Who is subsidised?

To determine what percentage of patients should be subsidised – and what percentage can be treated free – DNJ used a formula based on estimated population income.

Rich or very rich patients (5% of the population) can choose to pay for foldable IOLs and fast track, which have a higher fee. This means that the hospital makes a bigger profit from these patients and the profit can then be used to subsidise the poor and very poor patients.

Middle-income patients (55% of the population) cover the full cost of their care: the basic cost of consumables plus the costs of overheads such as staff time, electricity, and other related costs.

Poor patients (30% of the population), pay a reduced fee which covers only the cost of consumables; DNJ subsidises them by paying the overhead costs.

Very poor patients (10% of the population) receive services free – they are fully subsidised. DNJ pays all the