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FINANCIAL MANAGEMENT INFORMATION SYSTEMS IN FOUR ZAIRIAN HEALTH ZONES

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In collaboration with the

SANRU Project

Resources for Child Health Project

REACH

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FINANCIAL MANAGEMENT INFORMATION SYSTEMS IN FOUR ZAIRIAN HEALTH ZONES

FINAL REPORT OF A STUDY SPONSORED BY THE BASIC RURAL HEALTH PROJECT (SANRU) AND RESOURCES FOR CHILD HEALTH PROJECT (REACH)

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LIST OF ACRONYMS USED IN TEXT

AG	Administrateur-Gestionnaire (Administrator)
BCZ	Bureau Central de la Zone (Central Office of Zone)
CS	Centre de Sante (Health Center)
FMIS	Financial Management Information System
GOZ	Government of Zaire
HC	Health Center
HGR	Hopital General de Reference (General Reference Hospital)
ITM	Institut Technique Medical (Medical Technical Training School)
MCZ	Medecin Chef de la Zone (Chief Medical Officer of the Zone)
MDH	Medecin Directeur de l'Hopital (Hospital Medical Director)
MIS	Management Information System
MPH	Master's in Public Health
PCZ	Plan Comptable Zairois (Zairian Chart of Accounts)
PHC	Primary Health Care
REACH	Resources for Child Health Project
SANRU	Projet de Soins de Sante Primaires en Milieu Rurale (Basic Rural Health Project)
SPTK	Sante Pour Tous Kinshasa (Health for All Kinshasa)
USAID	United States Agency for International Development

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Taryn Vian

Cambridge, December 16, 1987

I. EXECUTIVE SUMMARY

This report presents the results of a study conducted between July and October, 1987, which examined financial management information systems in four health zones in Zaire. The study was jointly sponsored and financed by the Zaire-based SANRU Project (a bilateral GOZ/USAID basic rural health project) and the Washington-based REACH Project (Resources for Child Health, a centrally-funded USAID Project which provides technical assistance in immunization technologies and health care financing world-wide).

The study was undertaken as part of a joint program of health financing activities developed by the SANRU and REACH projects to improve the sustainability of Zaire's primary health care system. This system relies on a network of 306 health zones, each comprised of a reference hospital (offering inpatient services) and satellite health centers (offering basic curative, preventive, and promotive health care services). Accorded a great deal of administrative autonomy by the Department of Public Health, the zones are expected to self-finance, i.e. cover most of their operating costs with the revenue they generate from fees and other means.

SANRU/REACH collaboration began in 1986 with the Health Zones Financing Study, which collected information about cost recovery schemes operating currently in ten health zones. The study identified a number of weaknesses which make it difficult for zones to recover costs, thus imperiling the sustainability of the health care system. Accounting and financial management systems were highlighted as a critical area of concern in this regard. A second study was thus designed to identify strengths and weaknesses in the health zones' financial management information systems (FMISs) so that plans for systems improvements can build on existing strengths and give priority attention to urgent needs.

Two Zairian team members represented the SANRU Project: Citizen Munkatu, an operations research expert, and Citizen Manunga, a management control specialist with experience in accounting and hospital administration. REACH team members included Taryn Vian, an American health economist, and Dr. Miaka, a Zairian doctor with extensive administrative experience in public health.

The four zones studied illustrated different levels of complexity and sophistication in financial and general management practices. Three were rural zones supported by the SANRU Project, and one zone was urban, receiving assistance through the bilateral, GOZ/Belgian Project Sante Pour Tous Kinshasa (Health for All Kinshasa). Information was collected through discussions, interviews with key informants, observations, and analysis of reports and other documentation. The product of the field investigations was

a set of four case studies which documented how the systems worked and how well they responded to decision-making needs. The individual cases were then analyzed together in order to point out similarities and differences and draw general conclusions.

SUMMARY OF FINDINGS

1. Organizational Structure, Reporting Relationships and Staff Roles

- Bifurcated Systems. The information systems in the health zones are bifurcated: one independent system serves the reference hospital and another system serves the central office and peripheral health centers. This division is natural, given the complicated organizational structure, multifarious services, and special information needs of the reference hospital. Efforts to improve FMISs in the health zones should assume the continued existence of two separate systems.

- Reporting Relationships. Three zones exhibited a centralized management model, with all health centers reporting directly to the central office. One zone used a decentralized model where health centers reported to reference health centers, which summarized data before reporting to the central office. The latter system did not work well, although this may be due to factors other than design.

- Bookkeeping for Health Centers. The amount of bookkeeping performed by the central office for the health centers varied greatly between zones. This bookkeeping was often repetitious: transactions which had already been recorded at the health center level were recorded again in the books of the central office. The zones with greater duplication of bookkeeping had difficulty presenting an accurate picture of central office operations independent of the health centers' situation.

- Staff Roles. The chief medical officer of the zone (MCZ), the medical director of the hospital (MDH), and the hospital and zone administrators (AGs) were staff members with top management responsibilities in the zone system. The head nurses at the health center level also had supervisory responsibilities, generally making operational decisions. Hospital department heads were not given many management responsibilities. The AGs performed most financial accounting tasks, aided by cashiers and secretaries. A nurse was usually responsible for pharmacy management, aided by the AG.

- Staff Performance. Most AGs interviewed had received initial training in accounting and health administration but lacked on-the-job refresher training. There was a tendency in some cases to follow procedures without a clear understanding of the

purpose behind them. The MCZs had received refresher training in management, though the MDHs had not. Both managers showed some ability to use the financial information being produced by their systems; however, most planning decisions did not seem to be based on written financial information or analyses.

2. Performance of FMIS Operations

• Recording. Transactions were being recorded chronologically in journals in all zones and hospitals visited. Only one zone posted transactions by type to a ledger. Systems were primarily cash-based, or cash with accrual adjustments at the end of the period. Single-entry bookkeeping was used exclusively. Most zones had established rules for the kind of documentation necessary to justify transactions (receipts, invoices, etc.), but often these procedures were not rigorously enforced. There was an alarming paucity of written documentation for the systems, such as accounting instructions, written policies, and technical notes.

• Classifying. Generally, the zones did not use a system of well-defined accounts (chart of accounts) for classifying transactions. When the zones recorded transactions they described them in a few words, and it was based on this description that the transactions were later reorganized for the financial statements. Since such descriptions are open to multiple interpretations at the end of the period, this practice is less than ideal. Once the financial statement has been compiled, it becomes difficult to check the work of the accountant, because his classification of transactions depended to a large extent on personal judgement rather than objectively defined criteria.

• Internal Control. All zones visited conducted daily control of the cash journal both in the hospital and at the central office level. However, a major weakness in internal control was the lack of a chart of accounts and methods of bookkeeping which would allow the books of the zone to be balanced on a monthly basis. Managers seemed to rely a great deal on the good faith of employees, which in small, start-up organizations might not lead to problems but is not a desirable policy in more complex environments, like the zones visited.

• Reporting and Analysis. All zones attempted to produce cash flow statements, usually one for each unit, although not all the statements produced were of adequate quality. Two zones produced income statements, and no zones produced balance sheets. Financial statements were not annotated, although staff could usually explain apparent anomalies. If statements are to fulfill accountability requirements and be addressed to governing committees and external audiences, they must be accompanied by explanatory notes so that they answer more questions than they raise.

A general problem found in all zones was the absence of established management reporting requirements. Zones have a need for regular management reports which analyze budget performance, cost containment efforts, efficiency, proposed changes in strategies and objectives, etc. In some cases these topics are being discussed during meetings, but decisions are being made more on intuition than on written information and analysis.

3. Success in Meeting Information Needs

To evaluate how well the zones' FMISs meet information needs of managers, it is important to examine zone objectives. Survival is the most basic objective of Zaire's health zones, and because external resources are scarce, collecting enough revenue within the zone to cover operating expenses is a major concern. Three kinds of information are important for survival: information for operational decision-making, management control and strategic planning, and measuring accountability.

- Operational Decision-Making Needs. In most health facilities visited, information seemed adequate to allow basic operations to procede normally, and minimum controls were in place to prevent gross fraud and abuse. The drug supply accounting systems were not adequate in three out of four zones, however, which means that stock-outs were a real danger and waste was occurring. This is a recognized problem in the zones and all zones have made attempts recently to improve systems.

- Management Control and Strategic Planning Needs. Four types of decisions which are critical to the survival of the zones include pricing, cost containment, cash management, and long-range planning. The FMISs were not generating the information needed to make these decisions, primarily because there were no systems for cost accounting, including internal codes for assigning costs to responsibility centers, procedures for allocating indirect costs, and well defined products or services for each unit or department. Two zones prepared budgets, but no zone engaged in regular budgetary control.

- Accountability Needs. Clear, well-annotated financial statements prepared according to generally accepted accounting principles contain sufficient information to enable the community and others to hold zone managers accountable for the zone's financial condition and performance. Unfortunately, none of the zones visited had produced a full set of adequate financial statements. Zones were unable to prepare balance sheets which measure assets and liabilities, and no zone had produced reliable income statements for all health units, including a consolidated income statement for the zone

as a whole. Two zones appeared capable of producing such statements, but were not convinced of the need for them, while the other two zones needed further technical training to enable staff to prepare statements.

4. Motivation, Incentives and Resistance to Change

- Willingness to Learn. Health zone staff interviewed were hard-working, enthusiastic and receptive to suggestions for improvements in their FMISs. Both managers and operational staff seemed eager to learn ways to improve their own job performance and better manage the affairs of the zone. As could be anticipated, people were more receptive to changes for which they could feel a real need, or fully understood the objectives.

- Motivation Through Decentralized Management. The idea of motivating employees by decentralizing management decision-making, i.e. giving department heads and health center nurses more responsibility for the performance of their units, and evaluating them according to efficient and effective use of resources in achieving set objectives, was not greeted with much enthusiasm by top management. Explanations for this reluctance included lack of adequately trained staff to handle such responsibility, potential for abuse, and difficulties in communications within the zone.

SUMMARY OF RECOMMENDATIONS

Figure VI.3 in Section VI presents a resume of the recommendations which we believe will improve financial management in Zaire's health zones. These recommendations are discussed in more detail below.

1. Adopt FMIS Goals for Health Zones

- Strong Systems. **Because of the limitations of simple financial accounting systems (characterized by single-entry bookkeeping, cash accounting, and no cost information), the long-term goal of health zones should be to develop strong FMISs, featuring financial and cost accounting for both the central office/health centers network and the reference hospital.** Strong systems are characterized by double-entry bookkeeping, accrual accounting, and a set of well-defined accounts, and produce standard financial statements and internal management reports with cost and budget information (see Figures VI.1 and VI.2, in Section VI). Zones should also move toward adopting automated systems using microcomputers, eventually.

• Training. In addition to systems development, significant resources must be devoted to upgrading the training of both accounting staff and health zone managers in how to operate information systems and, more importantly, how to use financial information to improve decision-making. The SANRU Project has already recognized the importance of training managers in financial management skills. Further training should build on this foundation, continually linking new developments in systems to the requisite training for operators and users.

2. Organize Implementation Planning Meeting

We recommend that SANRU and REACH organize a meeting for the purpose of developing strategies for implementing changes in systems design and training that will serve to further the goals suggested above.

Investment in planning is critical to insure that goals and objectives are understood and accepted by all, and that plans for implementation are logical and feasible. Fundamental implementation issues must be resolved, including how to sequence activities targeted to improve zone versus hospital accounting and financial management practices, and how to integrate training activities with financial accounting technical assistance. It would be unwise to make such decisions without first soliciting ideas and input from the many governmental, non-governmental, and international offices, projects, and training institutuions which are active in the areas of accounting, health financing, training of health professionals, and the promotion of sustainable primary health care systems.

Representatives of these groups should be invited to an implementation planning meeting where the findings and recommendations of this report can be discussed, and experiences and opinions exchanged. The objectives of the meeting should be to:

1. Discuss the long-range goals, objectives, and priorities recommended in the report;
2. Identify resource possibilities and constraints;
3. Discuss sequencing and timing of implementation activities;
4. Form work groups.

One result of the planning meeting should be the establishment of two working groups; one for systems design and testing, and the other for training. These working groups will be responsible for designing detailed implementation plans, as well as providing continued strategic and technical supervision of implementation activities.

3. Design and Test Three Stages of FMIS Improvements

Concerning systems design, one of the first objectives should be to assure that all zones have adequate written documentation for the simple single-entry accounting systems which already exist.

Our first recommendation is therefore to develop, field test and disseminate accounting procedures manuals and financial management notes for simple, Stage 1 systems, concentrating on areas where accounting practices are particularly weak (drug supply system, cash receipts and disbursements, advances against salaries, health care benefits and free care, and reimbursement systems). Procedures manuals and financial management notes should be developed for both the zone and the reference hospital and distributed in distinctive loose-leaf binders. The binders will permit pages to be easily replaced as the procedures manuals and notes are periodically updated.

Field testing of procedures manuals and financial management notes should take place in one or two zones and last at least one year. The test will be helpful not only for clarifying and refining the technical materials, but for gaining additional insight into the most appropriate training methods for teaching financial management. The test will also help SANRU and REACH deepen their understanding of the process of systems development in general: how to introduce and facilitate organizational change smoothly and efficiently, while respecting the administrative autonomy of the health zones. This insight and understanding will prove valuable to planners working in many areas of the SANRU project, in additional to health financing.

Our second recommendation regarding systems design is to develop and field test accounting procedures manuals and financial management notes for Stage 2, strong financial accounting systems, featuring double-entry bookkeeping and accrual accounting. This should include the development of a standard chart of accounts for health zones, adapted from the Zairian national chart of accounts (PCZ). Once again, procedures manuals and management notes should be written for both the zones and the reference hospital, following the same format as those developed for Stage 1 systems. The project Santé Pour Tous Kinshasa (SPTK) is engaged currently in testing a double-entry bookkeeping system in several urban health zones. While the system being tested is somewhat unusual because it is adapted to the particular needs of the SPTK project, their experience will be edifying for SANRU and REACH as well and should be monitored closely.

Finally, we recommend development and field testing of accounting procedures manuals and financial management notes for Stage 3 systems (cost accounting) for the zone and reference hospitals. Hospital cost accounting should be a priority concern at this level, given the high volume of diverse services and well-defined service departments or "responsibility centers" found in reference hospitals, and the important pricing decisions faced by hospital managers. Cost accounting is a particularly helpful management tool in such settings.

4. Design Pre- and In-Service Training Strategies, Including the Establishment of Regional Teaching Zones

As FMIS design efforts produce new materials and define new responsibilities and tasks for zone and hospital staff, pre- and in-service training strategies must be revised and new curriculum added. We recommend, therefore, that strategies and curricula be revised and designed, which will permit managers, administrators, and other operating personnel to understand and use the accounting procedures manuals and financial management notes described above. This should include the establishment of regional teaching zones which exhibit model financial information systems in operation.

The principle behind teaching zones is much the same as the principle behind teaching hospitals: in addition to providing health services within their catchment areas, one of the primary goals of these zones will be to accept interns from other zones and train them in the operation of advanced management systems and financial management decision-making. The teaching zones should provide longer internships and training seminars for MCZs, hospital directors, experienced AGs and accounting secretaries. As the health zones begin to decentralize management organization and create a new cadre of middle managers with significant decision-making responsibilities, the teaching zones should provide internships at this level as well.

The teaching functions of these zones should be subsidized by the government or donor agencies at the beginning, with the eventual goal of self-financing through charges to health zones which sponsor interns. The hands-on experiential learning model is likely to be more effective than the current program of classroom refresher training, and the cost per training hour will probably be less because of the location in the regions and the reduction in travel costs. It is difficult to make any projections about cost at this point, however.

CONCLUSION

The administrative autonomy of the health zones and their struggle for financial independence cause them to operate in ways that are strikingly similar to small, non-profit businesses. Lessons learned from the business world are perhaps not irrelevant, therefore. One such lesson can be gained by reading the works of a Japanese business executive, Akio Morita, Chief Executive Officer and Chairman of the Board of SONY Corporation. In his book Made in Japan, Morita writes:

> No theory, plan or government policy will make a business a success: that can only be done by people . . . In the long run--and I emphasize this--no matter how good or successful you are or how clever or crafty, your business and its future are in the hands of the people you hire.

Zaire's health zones, like businesses, are deeply concerned about their bottom line. The reasons for their concern are different, however: the health zones care about their financial performance not for profit, but for survival—and for people: the health and well-being of the communities they wish to serve. While the stated objective of this SANRU/REACH activity is to improve financial management information systems, a second and equally important objective is human development, i.e. training and educating health zone personnel to provide them with the skills they need to manage successfully. Only financially healthy, well-managed zones can fulfill their mission to provide high quality comprehensive primary health care services to the Zairian population.

II. INTRODUCTION

> Proper planning and monitoring of the development of primary health care systems will require new approaches to the collection and use of financial information if benefits anticipated from primary health care are to be fully realized...There is a clear need for further development in this area through a combination of national effort and collaborative interchanges of ideas and experiences.
>
> —WHO, 1984

The government of Zaire has selected primary health care as its strategy of achieving the goal of health for all by the year 2000. The primary health care (PHC) system which Zaire's Department of Public Health has set out to establish relies on a network of 306 health zones, each comprised of a reference hospital and satellite health centers. Health centers offer basic curative, preventive and promotive health services, while reference hospitals handle more complicated cases and provide inpatient care.

A significant amount of administrative autonomy is accorded to the health zones by the Department of Public Health. Although the government continues to play an important role in supervision and training, each health zone is responsible for developing organizational structures and management systems best suited to its needs, including systems for recovering costs and managing financial resources. Constrained by the limited government budget for recurrent health expenditures, the Department of Public Health expects health zones to finance most of their operating costs through the revenue they generate from fees and other means. The government believes that this self-financing policy will help assure the long-term sustainability of the PHC system.

Health zones benefit from their administrative autonomy because it allows them to respond better to the diverse environments which they face. Zones differ, for example, in terms of health infrastructure, presence of non-governmental health providers, geographic accessibility, cultural beliefs and practices, etc. At the same time, autonomy frequently means that zones struggle to reinvent the wheel, i.e. to resolve management problems which others may have solved before them, or for which there exist standard approaches known to produce good results.

To help avoid costly and frustrating duplication of efforts, the government of Zaire has recognized the need to promote an exchange of learning experiences between zones. One example is the 1986 Health Zones Financing Study (Bitran, Munkatu, et al) which analyzed 10 zones' cost-recovery systems in order to recommend ways to improve cost-recovery capabilities.

Co-sponsored by the Zaire-based SANRU Project (a bilateral, GOZ/USAID-funded basic rural health project) and the Washington-based REACH Project (Resources for Child Health, a centrally-funded USAID project), the Health Zones Financing Study found that on average, the zones were able to cover 80% of operating costs with operating revenues. At the same time, the study also identified a number of weaknesses which make it difficult for zones to self-finance, thus imperiling the sustainability of Zaire's PHC system. One of the most striking weaknesses was the lack of reliable and directly usable financial information to support management decisions. Many of the zones' financial difficulties could be traced to problems with accounting and weak financial management skills of key decision-makers.

To remedy this situation, the authors recommended that health zones devote time and resources to improving financial information systems and training staff at both the operational and management levels.

Based on these and other findings, SANRU and REACH developed a joint program of health financing activities whose purpose is to improve the sustainability of Zaire's primary health care system. The first activity undertaken through the program is designed to strengthen financial management information systems (FMISs) in the health zones. The three principle objectives of the activity are described below:

1) First, zone mangers will be better able to make rational decisions about financial matters and using financial information, including operational, management control and strategic planning decisions.

2) Secondly, communities, the Department of Public Health, and donors who have contributed resources to the health zones will have access to information necessary to hold zone managers accountable for how resources were used in the pursuit of health objectives. In addition, the SANRU Project will be better able to monitor and evaluate the progress of health zones toward the goal of sustainable PHC systems.

3) Finally, the improvement of financial management systems in zones will contribute to the institutionalization of good management practices and requisite structures. As health zones develop, operations become more complex and zones need to have firmly established administrative systems in place to help them manage through this complexity, independent of transient personalities.

This report presents the results of a study conducted between July and October, 1987, which examined existing FMISs in four health zones. The information contained in the report focusses on the strengths and weaknesses of existing systems, and will be used

to see that plans for improvements build on those strengths and give priority attention to the most urgent needs identified.

Following this introduction (Section II), the methodology of the study is presented (Section III). Section IV contains a review of key concepts and vocabulary in accounting and information systems, and may be skipped by readers who are familiar with these topics. The findings of the study are presented in Section V, and recommendations and conclusions may be found in Section VI.

III. METHODOLOGY

> The only thing basic about basic health services is the name, which is usually misleading.
>
> —O'Connor, 1980

1. TEAM

The study was co-sponsored and co-financed by the SANRU and REACH Projects. Team members included two representatives of the SANRU Project: Citizen Munkatu Mpese (team leader for SANRU), Division Chief for Studies and Operational Research, and Citizen Manunga Mapele, Bureau Chief of Management Control for Health Zones. Two REACH consultants completed the team: Taryn Vian (team leader for REACH), Health Economist with Abt Associates, Inc. and Dr. Miaka-mia-Bilenge, former Regional Health Inspector for the Eastern Kasai, currently pursuing an MPH degree at Boston University. Both Citizen Munkatu and Ms. Vian participated in the previous REACH-sponsored Health Zones Financing Study in 1986.

2. TIME LINE

The 11-week study included 7 weeks in Zaire and 4 weeks in the U.S. During the Zaire work, 2 weeks were spent in Kinshasa developing questionnaires and preparing for field work, 4 weeks were spent visiting 4 health zones to conduct the investigations, and one week was spent in Kinshasa writing individual case studies for each zone visited and preparing a preliminary cross-case analysis. The four weeks in the U.S. were spent expanding the preliminary cross-case analysis into the final report.

3. APPROACH AND SELECTION OF ZONES

As with the 1986 Health Zones Financing Study, the approach adopted for the Financial Management Information Systems (FMIS) study was a series of case studies. The team preferred the case study approach to other approaches, such as a self-administered survey, because it enabled us to examine each information system in its own context. The researchers were able to spend time in each zone, watching the FMIS operate within its unique setting, and talking at length with the people who were responsible for the design and operation of the systems as well as the decision-makers who used the information.

SANRU Project staff made recommendations about which zones to include in the study, based on their knowledge of the zones from supervisory visits or reports

received. The study team sought to include zones which illustrated different levels of complexity and sophistication in financial and general management practices. The team also wished to learn from the experience of other donor agencies grappling with the same issues; we sought, therefore, to include an urban zone aided by the Belgian-assisted Project Sante Pour Tous Kinshasa (Health for All Kinshasa). The four zones eventually selected are described in Table III.1.

The team gathered data through a series of discussions, observations, interviews with key informants, background reading and analysis of reports and other documentation. A questionnaire was used primarily as a discussion guide; most of the questions were open-ended. Separate questionnaires were developed for the central office (BCZ--Bureau Central de la Zone), hospital (HGR--Hopital General de Reference), health centers (CS--Centres de Sante) and health posts (PS--Postes de Sante), and pharmacy depot. (A questionnaire was also developed to collect information from the ITM (Institut Technique Medical); however, it was not used because only one zone visited had such a school and no staff were present to be interviewed at the time.) A list of the questions used for the central office can be found in Annex A. Questionnaires for the other units were very similar, but shorter.

The product of the field investigations was a set of individual case studies which explained how each zone's FMIS supported operational and management decision-making, especially regarding financial issues. At the end of each visit, the team held a session with the staff of the zone to convey our impressions. We identified what we felt were the major strengths and weaknesses of the zone's FMIS and gave specific suggestions for ways in which the system could be improved. The individual case studies were analyzed together later on, in order to point out similarities and differences among the systems and draw general conclusions, where appropriate.

We were aided in our analysis by previous work by Citizen Manunga who visited 15 health zones in the first six months of 1987, assessing the quality of management systems and verifying progress toward self-financing. A note on Citizen Manunga's methodology and general findings is presented in Annex B.

TABLE III-1

CHARACTERISTICS OF FMIS STUDY HEALTH ZONES

ZONE	REGION	EXPECTED LEVEL OF FMIS	INFRASTRUCTURE	REMARKS
NSELO	BAS-ZAIRE	Low	26 HCs 1 RHC 1 HGR (50 beds) 1 Pharmacy Depot 1 Zone Pharmacy 1 Hospital Pharmacy	Relatively young zone, never before visited by SANRU. Nselo had just begun receiving SANRU assistance. Since the zone was unknown, research team's expectations were low. CBZO (Communanté Baptiste de Zaire Occidental) involved in management of 5 HCs. Catholic Church involved in management of RHC. MCZ is Zairian. Zone Admin. is Dutch. Hospital managed by zone personnel.
DUNGU	HAUT-ZAIRE	Intermediate	30 HSs/HPs 3 RHCs 1 HGR (200 beds) 1 Pharmacy Depot 1 ITM 1 Zone Pharmacy 1 Hospital Pharmacy	Visited during 1986 Health Zones Financing Study. Pharmacy depot managed by BDOM (Bureau Diocesian des Oeuvres Medical), the medical service of the Catholic Church. Belgian cooperant doctors and interns periodically assigned in health zone. MCZ and hospital directors, plus both administrators were Zairian.
KANIAMA	SHABA	High	13 HCs 1 HGR (164 beds) 1 Zone Pharmacy 1 Hospital Pharmacy	Visited during 1986 study. Belgian cooperant doctors periodically assigned in health zone. MCZ and zone administrator both Zairian. Hospital director Belgian, hospital administrator Zairian.
KIKIMI	KINSHASA	High	7 HCs 1 Centre Hospitalier (36 beds) 1 Zone Pharmacy 1 Hospital Pharmacy	Visited during 1986 study. Urban zone. Currently testing new double-entry bookkeeping system developed by the Project Santé Pour Tous Kinshasa. Due to change in personnel, the zone had not yet switched over to new books when team arrived for study. Zone staff not available for detailed interviews, so case study of this zone is somewhat limited in scope. Zone personnel all Zairians; hospital center director is a Belgian Catholic Sister. No hospital administrator.

4. SCOPE OF QUESTIONNAIRES

The major areas covered by the questionnaires included:

- organization and reporting structures
- information needs
- systems descriptions
- motivation, incentives and resistance to change

The first section, organization and reporting structures, included such questions as: How is the zone organized; What are the various management and staff roles and responsibilities; Who occupies these positions and what is their training and experience; How do the different health units relate to one another? The responses to these questions helped the team to understand the logic of existing information flows and some of the needs which they were intended to address.

The next section addressed information needs. The questions focussed on how managers make strategic planning decisions, such as adopting an auto-financing policy, changing the payment system, and opening or closing a health facility. Managers were also asked to discuss how they make pricing decisions. Finally, respondants were questioned about information needed to fulfill reporting requirements to external donors and zone governing bodies.

Information needs relating to specific functions (personnel, drug supply, cash management, etc.) were further explored in the third section, systems description, which collected information about the nuts and bolts of the information systems. Three areas of accounting were covered: financial accounting, cost accounting, and budgeting. (Most technical terms used in this report are defined in the glossary found in Annex C. Some key concepts are also explained in Section IV, which follows.)

Questions centered around the basic operations of recording, classifying, and summarizing (collectively referred to as "transaction processing"), as well as reporting and analyzing information. The team sought information about how these operations take place, and for what purposes. Separate parts of the questionnaires dealt with the important sub-systems of personnel, drug supply, and the treatment of subsidies and fixed assets.

The final topic covered in the questionnaire was motivation, incentives and resistance to change. Respondants were also given the chance to provide a "wish list" of their major concerns and own ideas for how their situation could best be improved.

The findings of the study are presented in Section V, following a review of key concepts and vocabulary (Section IV). In presenting the findings, the organizational structure and operations of the systems will be discussed first, followed by an evaluation of how well the systems responded to management information needs.

IV. WHAT IS AN FMIS? KEY CONCEPTS AND VOCABULARY

> The board of trustees had only a general idea of the way in which the Center's activities were funded and no idea at all of the important relationships among the sources of funding. Through hindsight, it appears probable that the administrators of the Center did not either. They were exceptionally dedicated people; and they paid dearly for their lack of financial acumen in the form of almost daily crises, overwork, and low salaries.
>
> The most compelling reason for undertaking the effort of cost accounting is the chance to get paid for what one does.
>
> —Case Study of South Shore Mental Health Center, Massachusetts, 1971

This section provides useful background information for readers who are unfamiliar with the language of finance, accounting and information systems. Many important concepts are explained, including the difference between financial and cost accounting; various meanings of the word "control"; and double-entry bookkeeping. Readers who are already familiar with these subjects may wish to skip this section and turn directly to Section V.

There are several traditional ways of looking at FMISs. Accounting texts, for example, distinguish between two types of accounting: financial and cost accounting. In Zaire budgeting is sometimes considered as a third type of accounting.

A second analytical framework examines systems from the viewpoint of operations or steps which make up an FMIS. Usually there are five: recording, classifying, summarizing, reporting and analyzing information. Finally, information systems analysts will often evaluate systems in terms of information needs the information system is designed to support. These include accountability needs (information required to demonstrate how zone resources were used to achieve programmatic objectives), and decision-making needs, including operational, management control, and strategic planning decisions.

Each of these three frameworks is introduced below, although our team found that the distinction between types of accounting was somewhat artificial, and that it was more important to concentrate on the second two view-points: examining how well the zone performed the various operations of information management and how well-suited the FMIS was to the decision-making needs it was meant to support.

1. TYPES OF ACCOUNTING

1.1 Financial Accounting

The financial accounting system is that system which produces the annual financial statements of an organization. In the U.S. this usually includes the balance sheet, statement of revenues and expenses, and statement of changes in financial position. Most Zairian health zones produce only a statement of revenue and expenses if they produce any financial statement at all other than a cash flow report.

Financial statements are often intended for external audiences, including oversight boards, and show the financial position of the organization as a whole. They are historical in nature, precise, and (if the system works well) accurate. Financial statements prepared according to generally-accepted financial accounting practices are used by governments for tax purposes.

1.2 Cost Accounting

By contrast, the cost accounting system (also called management accounting or cost finding) produces reports which are intended for the use of managers within the organization. The information collected in the basic transaction processing steps of the financial accounting system is reclassified and reported in ways that call attention to the costs and revenues of individual units within an organization, such as service centers or departments. The purpose of the reclassification is to generate the costs of the products or services produced by the units, information which is useful for pricing. Cost accounting can also be used to measure the performance of individuals and departments, helping managers to evaluate how well they have spent limited resources to fulfill organizational goals. In addition, it can be used to predict the financial consequences of alternative choices or policies being considered by the organization.

1.3 Budgeting

A budget is a plan of action, expressed in quantitative terms. Because budgets are future-oriented, the budgeting process is sometimes considered part of the cost accounting system. The budget process has three objectives: to communicate the goals and objectives of the organization, to motivate employees to achieve these objectives and to promote cost-awareness among employees, and to monitor and evaluate actual performance as it relates to planned performance, taking corrective action if necessary.

2. FMIS OPERATIONS OR STEPS

Another way of looking at an FMIS is to examine both financial and cost accounting in terms of the operations or steps required to get information from raw data to a form in which it is usable for decision-making. The five important steps in this process are recording, classifying, summarizing, reporting and analyzing.

2.1 Recording

The first step in an accounting system is to record information. To understand how events (called "transactions") are recorded, it is important to examine:

- What accounting books or forms are used?
- What types of events get recorded?
- Is the bookkeeping single-entry or double-entry?
- What supporting documentation is required and how is it kept?
- What kind of internal control takes place?

2.1.1 Books

Basic manual bookkeeping ordinarily requires that transactions be recorded first in a journal or journals, in chronological order, then in a ledger or ledgers, organized by type of transaction (i.e. one page for each type of expense, revenue, asset or liability).

2.1.2 Events Recorded

Accounting systems may be kept on cash or accrual basis. Cash accounting records only cash transactions, e.g. cash disbursements and receipts. Accrual accounting provides a way of recording non-cash transactions as well, such as purchases made on credit, services provided but not yet paid for, changes in inventory. It is important to know how an accounting system treats all kinds of transactions which may affect the financial position of the organization, including receipt of operating or investment subsidies, purchases of equipment and other fixed assets, advances against salaries, loans, etc. It is possible to keep books on a cash-basis and make accrual adjustments at the end of the reporting period.

2.1.3 Single-entry versus Double-entry Bookkeeping

Probably the single most important characteristic of an FMIS is whether the bookkeeping process is single-entry or double-entry. Single-entry bookkeeping involves recording transactions by making one entry into the books, according to whether the transaction was an expenditure or a receipt. For example, a supply purchase is recorded as an expenditure, and money collected from drug sales is recorded as a receipt. Single-entry bookkeeping does not preclude the use of two sets of books, journals and ledgers. Within both books, though, each transaction is recorded with only one entry.

Single-entry bookkeeping is easy to understand and simple to perform; however, the system doesn't work well if the volume of transactions to be recorded is large, or if the organization needs to be more precise about the classification of operations (for example, distinguishing between operating expenses and purchases of long-term assets). With single-entry bookkeeping it is very difficult to verify whether operations have been recorded properly. The common expression "balancing the books" refers only to double-entry bookkeeping; with a single-entry system there is nothing to balance, therefore errors are far more difficult to detect.

Double-entry bookkeeping means that each transaction which is recorded requires at least two entries in the journal or ledger. The "double-entry" must be composed of a debit entry (by convention an entry on the left side of an account) and a credit entry (an entry on the right side of an account). Both debits and credits can either increase or decrease an account depending on the type of account. For example, if supplies are purchased with cash, the transaction involves an increase in the account "supply expense" (debit) and a decrease in the account "cash" (credit). To record drug receipts, two "double-entries" are required. First, the "cash" account increases (debit), and the "revenue" account increases (credit). The transaction also affects the "cost of goods sold" account, which increases (debit), and "drug inventory" account, which decreases (credit).

Because every transaction involves one or more "double-entries", the books in a double-entry system must balance, i.e. the sum total of credit entries must equal the total of debit entries. If the bookkeeper has made a recording error, the books will not balance, and the error can be traced and corrected. The set of accounts for classifying transactions is different from what exists in a single-entry system. This characteristic of double-entry bookkeeping allows for better monitoring of changes in assets and liabilities (what the organization owns and what it owes), and facilitates the calculation of costs of services or products, which the cost accounting system is designed to provide.

The draw-backs of double-entry bookkeeping are that it is conceptually difficult to master and requires special training of accounting staff.

2.1.4 Supporting Documentation

Each transaction which is recorded must be supported by some sort of documentation or proof; for example, receipts, bills, invoices, etc. In examining an FMIS it is important to note what supporting documentation is required for each type of transaction, as well as the procedures which have been established for verifying and conserving this documentation.

2.1.5 Internal Control

Internal control refers to the set of procedures, cross-checks, and approvals designed to assure the security of the financial assets of an organization. Internal control mechanisms reduce the possibility of recording errors, miscalculation of balances, fraud or embezzlement. Internal control also increases the likelihood of detecting such problems should they occur. Examples of internal control procedures include regular verification of arithmetic calculations, established approval procedures for each category of expense, separation of duties between staff approving requests for funds and staff handling cash disbursements, bound books with numbered pages, entries in ink, etc. Internal control is different from management control. The latter concept is discussed further on in this Section.

2.2 Classifying

The second step of an FMIS is classification. Whether transactions are recorded in a double-entry or single-entry bookkeeping system, they are usually regrouped somehow by type.

A double-entry bookkeeping system requires that the organization establish a well-defined set of accounts into which transactions are classified as they are recorded. These accounts are given individual numbers, as well as descriptive titles (cash, salary expense, equipment, etc.). The list of account numbers, titles, and descriptions of contents is called a chart of accounts (plan comptable in French). In Zaire a national chart of accounts has been established (Plan Comptable Zaircis, or PCZ) and is currently in use in most private enterprises. The government would like to see public services adopt the PCZ as well, adapting it as is necessary for the particular needs of each sector. With certain adaptations, the PCZ could be made suitable to the needs of the health zones, as will be discussed later in the report (Section VI.4.2).

A system of internal codes may also be used in conjunction with the chart of accounts, to indicate the department or unit within the organization which is responsible for the transaction (for example, pharmacy, pediatrics, health center no. 5, etc.) The internal code number is used in addition to the account number indicating the nature of the transaction (i.e. expense or revenue category). This addition type of classification by department or unit is essential for cost-accounting.

2.3 Summarizing

In order for information to flow through the FMIS, the hundreds of individual transactions occurring each day must be summarized in some way. An interesting characteristic of a health zone FMIS is how this process takes place: what guidelines exist for calculating totals on a daily, weekly, monthly or other basis; how much detail is required at each level of the system? In the summarization process, detail is lost, but trends are more readily observable. The level of detail or of summarization necessary at each level in the FMIS is predicated on the decision-making responsabilities of the staff at that level.

2.4 Reporting

The fourth major step of an FMIS is reporting. Financial statements and written reports are the vehicle by which most information reaches users. Financial statements should be prepared according to generally accepted standards of accounting. They should be well-annotated and should show a fair, undistorted picture of the financial condition of the organization. Other written financial reports should have a purpose, and should be designed with a particular audience in mind. Once the purpose and audience are known, the report contents, format and periodicity can be evaluated to see if they are appropriate given the decision-making needs of the users.

2.5 Analyzing

The final operation in the FMIS is analysis of financial information. Information presented in financial statements can be manipulated and scrutinized in many ways, according to the needs of decision-makers. One common form of financial analysis is ratio analysis, an analytical tool used to pinpoint and isolate significant relationships between different amounts on financial statements.

Evidence that health zones conduct analysis of financial statements or other reports or data is a clear indicator of financial management ability and usually means that financial information presented in the formal reports is actually being used to make decisions.

3. INFORMATION NEEDS

The third framework often used for evaluating information systems is by examining the information needs that the system was designed to support. First of all, financial information is needed by the zones in order to demonstrate to the government of Zaire, external donors, and above all, the members of the community, how their contributed resources (i.e. subsidies and user fees) were used by the zone to achieve health objectives. Zone managers are stewards who have accepted responsibility for the management of these resources. As such, they are accountable for assuring that the zone uses the resources as efficiently and effectively as possible.

In addition to accountability needs, the health zones need financial information to help guide decision-making. Different decisions require different types of information, and the FMIS must be flexible and complex enough to fulfill these needs.

Management decisions fall into three basic categories: operations, management control, and strategic planning.

- Operational decisions: monitor and measure current data on the daily activities of the zone, e.g. patient flow, changes in drug and supply inventories. They include decisions about how to schedule the daily activities and staffing needs of facilities, as well as determining consumption requirements, miscellaneous supply needs, etc.

- Management control decisions are concerned with the allocation of resources and the pursuit of strategies. They involve choices about how to spend resources efficiently and how to measure effectiveness in achieving objectives. The word "control" in this sense differs from internal control, which is concerned with making sure proper accounting practices are followed to secure the safety of the financial assets of the organization.

- Strategic planning decisions are concerned with choosing and defining goals, objectives, policies, and future directions for the zone. In the case of FMIS improvements, strategic planning decisions include the adoption of systems development goals and objectives, and the selection of a set of activities which will facilitate the progression from simple accounting systems to more sophisticated financial management and accounting systems.

There are no clear-cut boundaries between types of decisions; in reality, decisions lie on a continuum. At one end, operational decisions are repetitive and programmed to a large extent: the decision is dictated by a set of instructions or an established policy. Usually the treatment of patients is prescribed by a nursing manual, for example, and drug requisitions are filled out according to an established minimum threshold or reorder point. On the other hand, management control and strategic planning decisions involve longer time frames, are less structured, and require more aggregated data and summarized information than operational decisions. These decisions are often made under uncertainty and depend on prediction and creativity. They may also require information from outside of the zone (i.e., price schedules of competing providers, regulations issued by central authorities, etc.).

As stated earlier, the distinction between types of decisions is important because information needs will vary depending on the type of decision. Operational decisions involve historical, internal data, often in much detail. Strategic planning decisions use predictive and external data, aggregated to provide information about trends and alternatives. Management control decisions depend on a mix of historical and predictive, internal and external data to provide regular reports as well as special analyses.

4. CHOOSING A FRAMEWORK

Initially our team attempted to analyze the three types of accounting separately, but determined that this was not a natural framework for the study. We therefore set two chief tasks for ourselves:

- documenting and criticizing the five steps of each FMIS studied; and
- evaluating how well the FMIS met accountability and decision-making needs of zone managers.

Section V presents the findings of the individual case analyses.

V. FINDINGS

> Professionals were asking controversial questions about the relative values of different activities. Should they give priority to services for adults or for children; to after-care and group services or to conventional doctor-patient treatment; to social services or clinical services? There was no information available to aid the administration in evaluating any of these problems; the director was forced to make decisions solely on intuition and judgement.
>
> -- Case Study of South Shore Mental Health Center

The study findings are organized around four headings: 1) organizational structure and reporting relationships, including the roles, responsibilities and training of key personnel; 2) performance of the basic FMIS operations of transaction processing, reporting and analysis; 3) successfulness of the zones in meeting information needs both for accountability and decision-making purposes; and 4) comments about motivation, incentives and resistance to change.

1. ORGANIZATIONAL STRUCTURE AND REPORTING RELATIONSHIPS

1.1 Basic Structure

The infrastructure found in the zones was described previously, in Table III.1. Most important to the study of financial systems is the bifurcation between the reference hospital on the one hand, and the central office plus health centers, health posts and reference health centers (hereafter referred to collectively as health centers) on the other. Indeed, the BCZ and health centers were referred to collectively as "the zone" by most personnel interviewed, presumably because the BCZ and comprehensive health centers did not exist before the health zone strategy was introduced, while reference hospitals usually boast long institutional histories.

In each zone visited, the team found two separate information systems: one for the hospital and the other for the zone. This division is natural given the complicated organizational structure, multifarious services, special information needs, and institutional history of the reference hospital as an independent and autonomous unit. Efforts to improve financial management and FMISs in the health zones should assume the continued existence of two separate systems in each zone. Large, complex reference health centers may want to use a hospital FMIS adapted to their internal bookkeeping needs, but should report as a health center within the zone FMIS system as well.

1.2 Other Organizational Units

Hospital and zone pharmacies were considered as part of the hospital or zone FMIS. The ITM (medical training school for nurses) seemed to operate independently and was not considered an integral part of the zone FMIS. While services and resources shared between the zone and the ITM may have some impact on the zone's financial position, cost accounting and analysis techniques can be used on an ad hoc basis to measure the impact of such cost-sharing, rather than building the ITM into the information system as a regular reporting unit.

Pharmacy depots were also considered to be outside the zone and hospital FMISs, because they were usually run by outside parties (missionaries, etc.) and were not supervised or controlled by zone managers. They interacted with the zones as any other supplier might, and were treated in the same way.

1.3 Relationship Between BCZ and HCs

1.3.1 Planning role

In all zones but Dungu the planning role assumed by the BCZ was the same and followed a centralized management model. In this model, the BCZ needs to have a clear and detailed picture of the financial operations of each health center (HC) for planning purposes, i.e. decisions to open or close facilities, change prices, increase salaries, distribute resources, organize training seminars, etc. This level of relationship does not require any integration of bookkeeping, but the BCZ must receive regular reports on HC operations.

The three zones which had adopted a centralized management model recognized the importance of centralized information on health center financial operations, although not all were equally successful in executing this task.

In Dungu the relationship between the BCZ and the health centers was not very clear, and seemed to vary depending on the location of the health center, with the BCZ assuming more responsibility for HCs which were close by. Dungu is currently struggling to define a role for reference health centers in the supervision of HCs and has experimented with various ways of centralizing HC financial information first at the RHC and later at the BCZ level. These experiments have not yet shown much success in that the RHCs have failed to provide the BCZ with an adequate picture of HC operations. Nonetheless, the decentralized management structure envisioned by Dungu is theoretically sound and is already in place in other zones.

1.3.2 Bookkeeping for Health Centers

Some of the more striking differences in the systems studied can be attributed to differences in the financial management functions performed by the BCZ for the HCs. Entering each zone it was impossible to predict whether the BCZ, HCs, or both would be responsible for:

- recording financial transactions
- paying health center salaries
- assuming cost of initial, start-up drug inventory
- assuming responsibility for deficits or surpluses.

In Nselo, for example, HC and BCZ bookkeeping are completely integrated. Receipts and expenditures of each HC are initially recorded by the HC and subsequently entered in the books of the BCZ, salaries are paid by the BCZ (with HC receipts), HCs are expected to repay the cost of their initial start-up drug inventory and any past operating deficits, and any remaining surplus of revenue is kept for the HC under its own account within the BCZ.

At the other extreme, Kikimi's HCs are managed completely independently: no HC expenditures or receipts are recorded in the books of the BCZ, each HC has its own bank account in a cooperative, salaries (although calculated by the BCZ) are paid by the HCs, and each HC is allowed to keep its excess revenue over expenditures.

Both Dungu and Kaniama have partially integrated systems, with salaries being paid by both the BCZ and the HCs, and some HC transactions recorded in the books of the BCZ. In Kaniama no HC is responsible for its deficits, but neither is a HC allowed to keep an operating suplus. In Dungu a minimum salary is guaranteed to HC employees, and beyond this HCs are allowed to supplement salaries with their excess of revenues over expenses.

All zones seemed to be moving toward individual pharmacy accounts for each HC (i.e. separation of bookkeeping). This is meant to insure better control over drug consumption and to encourage health centers to keep drug purchases in line with consumption.

The level of integration of bookkeeping and the number of management responsibilities assumed by the BCZ for the HCs will influence the design of the FMIS. Should HCs be obliged to deposit all receipts at the BCZ? Should the BCZ pay HC salaries? Should HCs be allowed to keep excess revenue over expenses? Should accounts be set up so HCs will know how much they have "banked" at the BCZ, or the extent to which their own operating deficits have been financed by other health units? There may not be any best answers to these questions: the appropriate responses will depend heavily on the physical infrastructure and economic conditions found in the zones. The pros and cons of various forms of organizational design of health zones would be an interesting topic of discussion at refresher training for zone managers. As a general rule, though, the less integration of BCZ and HC bookkeeping the better, as integration tends to obfuscate the financial picture of individual health units. Any integration of financial information should take place at the level of reporting and analysis.

1.4 Management Roles and Responsibilities

1.4.1 Staff

The chief medical officer of the zone (MCZ), the medical director of the hospital (MDH), and the hospital and zone administrators (AGs) were staff members with top mangement responsibilities in the zone system. The head nurses at the HC level also had supervisory responsibilities, generally making operational decisons. Hospital department heads were not given many management responsibilities, had no role in the development and control of budgets, and were not evaluated on the basis of their department's performance.

Accounting staff included the AGs, aided by the cashier or cashiers, and the people put in charge of the pharmacies (usually nurses). Sometimes a secretary would have minor bookkeeping responsibility. (One exception to this was in Nselo, where the "accounting-secretary" for the zone had major responsibilities which in other zones were assumed by the AG. This assignment of responsibilities is partially due to Baptist influence in the zone--the accounting-secretary position is one found in many CBZO zones. It may also be explained by the fact that the AG in Nselo was very busy, being responsible for both the zone and the hospital, and serving as a HC nurse-supervisor as well.)

1.4.2 Responsibilities of Administrators (AGs)

Generally, the AG maintained the books, prepared financial statements and reports, analyzed data, prepared for and gave financial presentations at administrative council and management committee meetings, and collaborated with the MCZ or hospital director in strategic planning and management control (pricing) decisions. The AG also controlled the operations of accounting staff below him, supervised the financial management of HCs, and helped train HC nurses or management committee members in financial management skills. He often played a major role in drug supply and distribution for the zone, and in zones where budgets were used, he would have responsibility for budget development.

Most of the AGs interviewed had received initial training in accounting and health administration, but lacked on-the-job refresher training specifically related to their experience. There was a tendency in some cases to blindly follow procedures without clearly understanding what they were trying to do.

1.4.3 Responsibilities of the MCZ and MDH

The MCZ's financial responsibilities included controlling the books kept by the AG, and reviewing, modifying and approving drug orders. The MCZ was also involved in the budget process. The MDH performed these functions as well, for the hospital.

Most importantly, the MCZ and MDH assumed a large amount of responsibility for making decisions about financial matters, and recommending actions to the administrative council or management committees. Such decisions included opening or closing facilities, attempting extra-medical "projects" to increase zone revenue (selling charcoal or raising cattle, for example), changing prices or payment system, reorganizing reporting or supervision responsibilities, seeking out funding from external sources and many other planning and management decisions (see Annex D for a list of decisions made by zone managers, collected from the 10 zones participating in last year's Health Zones Financing Study. This year's study found similar results). Often these decisions were made based on intuition and judgement, as financial information on which to base decisions was lacking.

The MCZs in Dungu and Kaniama had received refresher training by SANRU in management, including financial management. Kaniama's system showed direct evidence of this training, which the AG had attended as well. Dungu's systems (both zone and hospital) had changed considerably since last year's Health Zones Financing Study, due in

large part to suggestions made by that team of consultants. The systems in place in Nselo were largely borrowed from the financial information system used in the zone of Vanga, where the MCZ of Nselo had spent a 3-month medical internship. All this indicates that training seminars, supervisory visits and intra-zone exchanges have all had a positive effect on the development of management systems in the health zones.

2. PERFORMANCE OF FMIS OPERATIONS

Table V.1 summarizes the findings regarding how well the zones performed the basic operations of an FMIS. More detail is provided below:

2.1 Recording

2.1.1 Books

Transactions were being recorded chronologically in journals in all zones and hospitals visited, although in one hospital the team judged the recording process to be incomplete and inadequate. Transactions were also being posted (i.e. recorded again) by type to the ledger in Nselo. An attempt was being made to post to the ledger in Dungu, but there was much confusion because of the inadequately structured system of accounts. Kikimi did not use the ledger, and Kaniama did not appreciate the need to post to ledgers.

2.1.2 Events Recorded

Systems used either cash accounting exclusively (Nselo), or cash accounting with accrual adjustments at the end of the exercise (Kaniama, Kikimi, Dungu). Separate records were kept of non-cash transactions, but they were not always integrated into the financial statements at the end of the period. In other words, the cash picture was not always adjusted completely to show the effects of non-cash transactions on financial position. Major problem areas in this respect were: health care received free by personnel and their families, advances against salaries and loans to personnel, movements of stock, billed services to third party payers, cash subsidies and donations in-kind or in-service.

TABLE V-1

SUMMARY OF FINDINGS
FMIS OPERATIONS

CHARACTERISTIC / ZONE	RECORDING					CLASSIFYING	SUMMARIZING & REPORTING	ANALYSIS
	Basic Books Used	Cash vs. Accrual Accounting	Single or Double Entry Bookkeeping	Supporting Documents	Internal Control	Chart of Accounts	Statements and Financial Reports	Management Reports and Analysis
NSELO	Journal Ledger	Cash	Single	Procedures exist; not rigorously applied	Sufficient, given single entry	HGR, yes BCZ, internal codes only	Cash Flow only. Too summarized; irregular	Rare
DUNGU	Journal attempt at ledger	Cash, attempt at accrual adjustments	Single	Procedures exist; not rigorously applied	Sufficient, given single entry	No	Cash Flow mixed inappropriately with accrual	Rare
KANIAMA	Journal	Cash with Accrual Adjustments	Single	BCZ, good; HGR, inadequate procedures	Sufficient, given single entry	No	Cash Flow and income Statement; inventory reports good; regular reporting	Semi-annual budget variance report ratio analysis & annotated final statements
KIKIMI	Journal	Cash with Accrual Adjustments at HC level only	Single	NA*	NA*	No	BCZ, Cash only; Cash Flow and income Statement for HCs; good regular reports	Done by Sante pour Tous Kinshasa

*Difficult to judge in short time spent in zone.

2.1.3 Bookkeeping

The zones used single-entry bookkeeping systems, i.e. each transaction was recorded with one entry in the books, rather than two counter-balancing entries as demanded by a double-entry system. As a result it was impossible to assess the accuracy of entries or measure the reliability of the data collected by the zones.

2.1.4 Supporting Documentation

Most zones had established accounting procedures which required receipts, invoices, bills and other forms of documentation to justify cash disbursements and receipts. Often, however, these procedures were not followed rigorously and operating staff did not seem to fully understand the need for supporting documentation. Supporting documents could have been filed in a more orderly fashion in most zones (The BCZ of Kaniama is an exception; here, files are well-maintained and carefully labeled for easy access.). In Kaniama and Kikimi, some written accounting instructions governing these procedures were available, although not all procedures were written down. No zone seemed to have an established procedure for verifying the authenticity of supporting documentation.

2.1.5 Internal Control

All zones visited stated that they conducted daily control of the cash journal, both in the hospital and at the BCZ level. Monthly control procedures were rarer. All entries in the journal are recalculated during the control process, and supporting documents examined. One weakness identified was that the person controlling the books rarely initialed them afterwards, to verify that a control had taken place. Most zones had established approval procedures for different levels of expenses, although these were not written down, and sometimes not vigorously enforced.

Most zones respected a division of responsibilities between the staff allowed to approve requests for funds and the staff handling cash disbursements.

Some zones used commercially-produced bound books with numerated pages, although other zones, concerned with keeping costs down, replaced bound books with school-type notebooks ruled by hand. All zones recorded transactions in ink, although sometimes entries were corrected later by erasing or writing over. Accounting staff need to be taught how to correct mistakes through additional entries, rather than adulteration of original entries.

A major weakness in internal control is the lack of a system of accounts which would permit double-entry bookkeeping and allow the books of the zone to be balanced on a monthly basis. People seemed to rely a great deal on the good faith of employees, which in small, start-up organizations might not lead to problems but is not a desirable policy in more complex environments, such as the zones visited.

2.2 Classifying

None of the four zones visited operated with a system of well-defined accounts (chart of accounts, or "plan comptable" in French) for classifying transactions, although most zones regrouped transactions into major categories of expenses and revenues for the establishment of financial statements at the end of the period. Only one hospital (Nselo) used a chart of accounts.

When the zones recorded transactions they generally described them in a few words, and it was based on this description that the transactions were later reorganized for the financial statements. The practice of classifying transactions at the end of the period rather than during the initial recording step is less than ideal; if transactions are not classed definitively in established accounts as they occur, the "descriptions" are open to multiple interpretations at the end of the period. For example, a transaction described as "purchase of fuel" might be classified as supervision, transport, or supplies when compiling the financial statement. Once the financial statement has been compiled, it becomes difficult to check the work of the accountant, because his classification of transactions depended to a large extent on personal judgement rather than objectively defined criteria.

The BCZ of Nselo uses what they call a chart of accounts but which is largely only a limited portion of a chart--a set of accounts (also called internal, or "destination" codes) that refer to the department or unit within the zone which is responsible for the transaction. Thus there are accounts for each health center, and for several functions of the BCZ (supervision, training, general administration). Internal codes or account numbers designating "responsibility centers" are an important step in building a zone's capacity to perform cost accounting and program budgeting (planning of revenues and expenses by services, programs or departments), but should be combined with revenue, expense, asset and liability accounts to provide a complete set of accounts for classification purposes.

As a final note, the HGR of Dungu did not use a chart of accounts, but did keep track of which departments or services were responsible for generating particular reve-

nues and expenses that could easily be assigned by service. No efforts were made to allocate overhead costs, due to lack of training in cost accounting methods.

2.3 Summarizing and Reporting

These two operations are discussed together since transactions are usually summarized to facilitate the reporting step. The findings are organized according to the following headings:

- financial statements
- other financial reports

2.3.1 Financial Statements

No zone produced a balance sheet (i.e. a statement reporting the financial position—assets and liabilities—of a health unit or a consolidated picture of all the units, at a particular point in time).

Two zones, Kikimi and Kaniama, produced annual income statements (i.e. statements reporting the financial performance—revenues and expenses—of the health unit or zone as a whole, for a specific period of time, such as a year). In Kikimi, monthly income statements were produced for the health centers only, while in Kaniama, quarterly and annual income statements were produced for the BCZ, HCs and HGR. (Unfortunately, because the basic books of the hospital were not in order, the hospital's income statement was unreliable and of little value for decision-making.)

Dungu BCZ attempted to produce an income statement but was not entirely successful due to lack of technical expertise.

Many units prepared cash flow statements, including all HCs in Kikimi, Kaniama, and Nselo; hospitals in Dungu, Kaniama and Nselo, and the BCZ in Dungu, Kaniama, and Kikimi. The BCZ of Nselo produced a statement noting only account balances, which is not an adequate financial statement.

Overall, Kikimi and Kaniama showed the greatest mastery of financial reporting skills. In Kikimi the HC nurses actually prepare their own cash flow and income statements each month, while in Kaniama the nurses prepare only the cash flow statement and the BCZ administrator makes the accrual adjustments necessary to prepare the income statements.

Financial statements in all zones are rarely annotated, although the staff could usually explain apparent anomalies. If statements are to fulfill accountability requirements and be addressed to external audiences, they must be accompanied by explanatory notes so that they answer more questions than they raise.

2.3.2 Other Reports

Aside from the standard financial statements, a general problem found in all zones was the absence of established management reporting requirements. Crucial financial information was found buried in the minutes of an administrative council meeting, a supervisor's field report (which included medical supervision results as well), and MCZ trip reports. Sometimes such documents contained a layman's summary of financial reports presented by the zone or hospital administrator during a meeting, but rarely was the complete version of the administrator's report distributed or even filed officially. In addition to the standard financial statements, the zone's have a need for regular management reports which interpret the statements and report on matters such as budget performance, cash position, gains in cost containment or efficiency, proposed changes in strategies or objectives, etc. It is apparent that such topics are being discussed currently, and that actions are being taken based on these discussions, but frequently the information on which the decisions are based is not documented in writing.

While part of the problem is that in some zones information exists but is not written down, in other zones important management information does not exist at all. All four zones were weak in the areas of cost accounting, budgeting, and monitoring and evaluation of financial decisions. Only Kaniama reported unit cost data (an all zone average cost-per-episode and cost-per-patient day) and seemed to be aware of the need for regular monitoring of the effects of financial decisions. Management reports probably do not exist because managers are unaware of the value of such reports as an aid in decision-making.

Kaniama had a model reporting system for drug supply and distribution. This included reports from both the health centers and the zone pharmacy which enabled zone managers to track the value of drug consumption and drug inventory on a monthly basis.

2.4 Analysis

Kaniama performed ratio analysis of financial statements (as recommended in the SANRU-sponsored refresher training module on financial management).[1] Ratios calculated included:

1) gross margin on drugs: sales minus cost of goods sold, expressed as a percentage of sales;

2) auto financing ratio: operating revenue minus operating expenses excluding depreciation, expressed as a percentage of operating revenue;

3) external dependency ratio: external subsidies expressed as a percentage of all expenses; and

4) net income: total revenue minus total expenses, expressed as a percentage of total revenue.

The staff of the zone understood what the ratios were meant to convey, and were able to interpret them. Ratios were calculated within one period rather than between periods.

No other zones performed ratio analysis. Both Kikimi and Kaniama analyzed and compared performance across health centers. Kimbau's analysis was performed on a spreadsheet, but was not actually prepared by zone staff; Santé Pour Tous Kinshasa staff prepared the quarterly report and gave a copy to the BCZ. It was not clear how the analysis was used by the zone managers. Again, as with the financial statements, analyses were inadequately annotated.

3. SUCCESS IN MEETING INFORMATION NEEDS

Before we can evaluate how well the zones' FMISs meet information needs of managers, it is important to examine what these needs are in relation to zone objectives.

The purpose of the health zones is to provide quality primary curative, preventive and promotive health care services to the Zairian population. According to both geo-

[1] In reviewing a draft of this report, Ricardo Bitran noted that these ratios are not easily interpreted as formulated here. He suggests that Ratio 1 would be easier to understand if expressed as a percentage of cost of goods sold, and Ratios 2 and 4 would be better expressed as percentages of expenses. Ratios 2 and 3 should always equal 100%, which provides a way to cross check arithmetic calculations.

graphic and economic access to services, and the high quality of those services, are thus critical organizational goals which in turn dictate decision-making and information needs of managers.

Yet, before zone managers can dedicate themselves fully to pursuing these organizational objectives, they must feel confident that the system itself will survive. Financial survival of health zones is crucial to assure long-term sustainability of the primary health care system, and therefore, long-term provision of good quality comprehensive health care services. People don't like to think of financial sustainability as a primary goal--the real goal is "health for all" or "quality primary health care services." But as O'Connor points out in his book Managing Health Services in Developing Areas, about lessons learned from 10 years of experience in Afghanistan, "every organization devotes a significant proportion of its resources to that most basic of all objectives: survival." Survival is the most basic objective of Zaire's health zones, and because external resources are scarce, collecting enough revenue within the zone to cover operating expenses becomes a major concern. The zones must feel confident that they will survive before they can concentrate resources on promoting other organizational objectives.

Given this basic objective, four questions

1) What operational, management control, and strategic planning decisions must be made to assure survival;

2) What information is needed to make these decisions;

3) How well have the zones done in producing and using information to make decisions; and

4) Are zones being held accountable for using resources in ways that are efficient and effective in the pursuit of health sector objectives?

These questions are addressed in more detail below.

3.1 Operational Decision-making Needs

At the most basic level, financial information is needed to make operational decisions, i.e. those decisions required to maintain daily zone activities such as curative services, well-baby clinics and promotional activities. Financial information doesn't need to be highly processed or analyzed in order to serve operational decision-making needs. The data collected and recorded in daily bookkeeping is generally sufficient.

In most health facilities visited, information seems adequate to allow basic operations to procede normally, and minimum controls are in place to prevent gross fraud and abuse. (Dungu is one exception, where about two-thirds of the health centers operate independently, with only medical supervision and no financial control.)

The drug supply accounting sub-systems seem weakest: inadequate data collection means that orders might not be placed on a timely basis and stock-outs are a real danger. All zones have made attempts recently to improve systems, so this is a recognized problem. Payroll systems are adequate in most zones.

3.2 Management Control and Strategic Planning Needs

Decision-making needs related to management control and strategic planning are discussed together because the same managers and committees make both types of decisions. In principle, management control decisions are made by middle management (department heads) while strategic planning decisions are the prerogative of top management and advisory committees. The health zones exhibit only one level of management, however, where all types of decisions (beyond operational decisions) are made. As zones progress, a natural organizational development will be to create a level of middle management and decentralize decision-making responsibilities, putting middle managers in charge of controlling efficiency of certain parts of the organization and evaluating performance according to objectives. Top management will then be free to focus on more strategic, long-range planning, developing new strategies, policies and goals for the zone to pursue.

Many questions in the study solicited information about what decisions people make, how they make them, and how they perceive their information needs. The team found that managers have difficulty expressing information needs, and are unclear about how to use information to make decisions. The problem for designing systems improvements thus includes not only assuring that good information is produced and delivered into the right hands, but that people understand how to use the information to improve decision-making. Training in financial management skills must be a major component of systems improvements.

Because expressed needs were minimal, the team decided to evaluate existing systems according to norms of what decisions managers <u>should</u> be making, and what information <u>should</u> be used to help support those decisions. The following four classes of decisions were considered critical to the survival of the zones, and are explored in the next pages:

1) Pricing and alternative choice decisions;
2) Cost containment decisions;
3) Cash management decisions;
4) Long-range planning decisions.

3.2.1 Pricing and Alternative Choice Decisions

All pricing decisions are predicated on the established self-financing goals and policies of the health zone. These goals and policies (which are long-range planning decisions, see Section 3.2.4) will determine the parameters for pricing decisions; for example:

- Does the zone want to become financially self-sufficient (i.e. operating revenue equals operating expenses) in the short-run, medium-run, or long-run?
- Should the zone expect that donors and the GOZ will withdraw their aid sometime in the future? Is this desirable?
- Does the zone want to be financially self-sufficient with regard to capital as well as operating expenses?

In the case where a zone wishes to become financially self-sufficient with regard to operating expenses in the short-run, fees charged for drugs and services must cover operating costs incurred during the year. This doesn't mean that the price charged for each good or service must be equal to or greater than its cost--some goods and services may be priced lower than cost to encourage utilization if this is socially desirable (as in the case of public services), and others may be priced higher than cost in order to subsidize under-priced goods and services. But overall, revenue must be enough to cover expenses, and a good pricing strategy based on sound cost information will help assure that this happens, without allowing segments of the population to be denied health care because of inability to pay.

In addition to deciding what prices to charge for services, managers are frequently faced with choices involving two or more alternative programs or investment opportunities. For example, managers may need to decide whether to transfer beds from one hospital department to another, or whether to invest in bicycles for health centers versus a motorcycle for the BCZ. Like pricing decisions, alternative choice decisions require cost information: managers need to be aware of the start-up and recurrent costs required by each alternative, so that they can measure whether the zone's resources are sufficient and whether the program or investment seems worthwhile.

In this study, as in the 1986 Health Zones Financing Study, the research team found that pricing and alternative choice decisions seem to be based more on judgement and intuition than on cost analysis or projections. Although Kaniama did calculate an average cost per curative episode figure for 1986, no zone attempted to calculate marginal cost (an important piece of information as a point of departure for pricing decisions), nor did any zone attempt to calculate costs of preventive and promotive services, or analyze possible effects of price discrimination policies or future price increases. The lack of financial information and analysis on which to base decisions is an especially acute problem at the hospital level where cost-recovery performance is lowest and a wide variety of inexpensive to very costly services are provided to many payer groups.

At the zone level, Dungu managers claimed to have considered cost in setting the price of a curative consultation at the health center level. They said the price had been estimated by calculating a break-even price based on the average cost of running a health center, normal utilization, and average population with access. The calculation had not been performed properly, however, and had never been revised to take into account true utilization, population and cost data because this information was largely unavailable.

The importance of studying potential effects of changes in pricing strategy is illustrated by Dungu hospital, which in 1986 implemented a price increase without consulting its major third party payers--the Diocese Services (Garage, Pharmacy Depot, etc.). The price increase caused a retaliation on the part of the Diocese Services: as the cost of health benefits for their employees went up, the Diocese managers were forced to increase the prices of their products and servies too. As a result, the hospital found the cost of its inputs (fuel, repairs, etc.) going up again, the very reason they increased their prices in the first place. After this pricing strategy failure, hospital managers agreed to meet with the different Diocese managers in the future before putting into effect any other price changes.

Managers need to learn how to sort out and identify various kinds of costs--direct and indirect, fixed and variable--as well as learning methods for allocating indirect costs to activities and departments. Internal codes for various support service departments and direct service departments need to be promulgated and used to classify transactions, in addition to the chart of accounts. Managers need to learn how to use cost information in making pricing decisions, and to understand the relationships that exist between prices, utilization, revenues and payer category. They must also be taught how to estimate cost implications of alternative choices such as expanding a program or opening a new facility.

Cost accounting information and pricing decisions should be priority concerns for the reference hospitals especially, where more varied and costly services are offered than in the health centers.

3.2.2 Cost-containment Decisions

Zones should be concerned not only with generating adequate revenue, but also with rationalizing or controlling expenses, to be sure financial resources are spent efficiently and waste and abuse are minimized. None of the zones visited mentioned explicitly a concern with efficiency except in the area of drug supply, where all zones were preoccupied with safeguarding the initial stock of drugs in the zone pharmacy and controlling drug consumption in the health centers.

Once again, in order to make decisions about how to keep costs down, managers need actual cost data. In addition they need to have an idea of what things should cost, i.e. standards of efficient performance against which they can measure actual performance. The budget is an extremely useful tool for measuring efficiency, as are standard unit costs. Although three zones and two hospitals prepared budgets, the budgets were often "squeezed", i.e. showed unrealistically low expenses in an effort to make the budget balance. Budgetary control was not rigorously enforced. No zone had calculated standard unit costs or set performance objectives for department heads or head nurses in health centers.

3.2.3 Cash Management Decisions

A third important area of financial management is decisions regarding management of cash. How to avoid cash shortages, or deal with them when they occur, and how to invest cash surpluses are critical decisions. Kaniama was concerned with several cash management issues, including how to avoid stockouts of drugs, seen as a potential danger because of the limited number of times the BCZ could procure drugs each year and the large cash needs at procurement time, and how to stagger drug distribution and salary payments to health centers in order to avoid cash shortages. Nselo hospital was concerned with cash flow problems caused by the large number of advances accorded to personnel each month. Dungu and Kikimi were also concerned with cash flowing through the revolving drug fund.

Cash management decisions require information about the timing, size and predictability of cash outflows and inflows as well as options for dealing with surpluses and deficits. Kaniama seems to have done well in managing its cash problems. Other

zones could improve cash management decisions by making regular projections of cash balances, using historical information about cash inflows and outflows.

3.2.4 Long-Range Planning Decisions

Long-range planning issues which can have a powerful impact on financial sustainability include such decisions as

- What should be the auto-financing policy for the zone as a whole?
- What kind of expansion of services should we plan for over the next ten years?
- What should be our relative priorities among curative, preventive, and promotive services in the next five years?

These decisions require historical and predictive information about internal and external social and economic environments, competitors, government policies, community priorities and a wealth of other quantitative and non-quantitative information. The FMIS can provide some of the necessary historical and predictive information to help assess the financial implications of different options.

Long-range planning decisions in the health zones are usually made during meetings of the administrative council or management committee of the zone. The zones do not prepare background documents on the specific options to be discussed at these meetings. More general financial information is sometimes made available however. For example, in Kaniama the financial statements are distributed, and council and committee members receive a copy of the full annual report of the zone every January.

Some of the long-range decisions which zone managers discussed with the team included a change in payment system which Kaniama adopted in 1987; various revenue-generating activities initiated or planned by Dungu (selling charcoal, raising fish, etc.); and the opening and closing of health facilities, which occurred in all zones. No written analyses were available on these topics, and when questioned, managers were not very specific about how the decisions were made, or what information was considered.

Strategic planning decisions need to be supported by a thorough analysis of all aspects of the issue at hand--not just financial aspects, but social, cultural and economic aspects as well. Individual studies should be conducted and written reports distributed to all decision-makers, to help them think through the issues and to be sure that everyone has access to the same facts. Such reports will serve as reference documents in the future, when similar decisions must be made by the same or different decision-makers.

3.3 Accountability Needs

As stated earlier, zone managers need financial information to demonstrate to the community, government and donors how they used resources to achieve objectives. Zone staff are accountable for having managed resources as efficiently and effectively as possible.

Clear, well-annotated financial statements, prepared according to generally accepted accounting principles, contain sufficient information to enable the community and others to hold zone managers accountable for the zone's financial condition and yearly performance. (To hold managers accountable does not mean to blame them; rather, to hold accountable is to demand a reasonable explanation of how and why resources were used as they were.)

Unfortunately, none of the zones visited was able to produce a full set of adequate financial statements. As pointed out in Section V 2.3.1, zones were unable to prepare balance sheets which measure assets and liabilities; neither could they produce reliable income statements for all health units, including a consolidated statement for the zone as a whole. In the case of Kaniama and Kikimi, the staff seem capable of producing adequate income statements (including the consolidated statement), but do not see the need. In Dungu and Nselo further technical training is needed to enable staff to prepare adequate statements.

To enhance the reliability of financial data, and to enable managers to account for assets and liabilities as well as revenues and expenses, double-entry bookkeeping is needed, including adoption of a standard chart of accounts such as the Plan Comptable Zairois, adapted for health zones.

As a final note, the zone of Nselo provides each health center management committee with an account statement on a monthly basis. This is an excellent way of providing members of the community with information needed to hold the chief nurse accountable for the management of the health center. Training of committee members is conducted to develop their financial management skills and to assure that they understand how to use the financial information provided in the statements.

Training such as this should be extended to all oversight committees with community, government and donor representation functioning in the health zones. This will insure that when provided with accurate financial statements and reports they are able to interpret and use that information both to hold zone managers accountable and to suggest changes to improve the zone's performance.

4. MOTIVATION, INCENTIVES AND RESISTANCE TO CHANGE

Health zone staff interviewed by the team were hard-working, enthusiastic, and receptive to suggestions for improvements in their FMISs, with the one exception of Kikimi where the team did not spend enough time with staff to make any judgements. Both managers and operational staff seemed eager to learn ways to improve their own job performance and better manage the affairs of the zone. This was especially true in Nselo and Dungu where existing systems were weaker than in Kaniama and Kikimi. Dungu had made substantial progress in financial management since last year, and hac implemented a great number of suggestions made by the 1986 Health Zones Financing Study team. Zone staff were eager to participate in this year's study as a chance to make more progress.

Regarding motivation, managers volunteered some interesting ideas, especially regarding motivation of health center nurses and committee members. Some current practices include:

- free health care or health care at reduced price
- responsibility-related bonuses
- bonuses related to excess of revenue over expenses
- travel money to atterd meetings; refreshments after meetings
- bicycles for health center staff
- penalties for tardiness

The idea of motivating employees by decentralizing management decision-making, i.e. giving department heads and health center nurses more responsibility for the performance of their units, and evaluating them according to efficient and effective use of resources in achieving set objectives, was not greeted with much enthusiasm by top management. Explanations for this reluctance included lack of adequately trained staff to handle such responsibility, potential for abuse, and difficulti ; in communications within the zone. Still, management training refresher courses should continue to introduce and promote discussion about such organizational design issues, emphasizing the information needs and motivational concerns created by various forms of organization. Clearly, as health zones mature the current organizational structure, with its heavy reliance on top management, will no longer be tenable, and zones will depend more and more on middle managers. Motivating these managers to use resources efficiently will be a challenging new task.

VI. RECOMMENDATIONS AND CONCLUSIONS

> Machines and computers cannot be creative in themselves, because creativity requires something more than the processing of existing information. It requires human thought, spontaneous intuition, and a lot of courage.
>
> —Akio Morita, Made in Japan

1. SUMMARY OF FINDINGS

The findings presented in the previous section may be summarized as follows:

The zones studied all exhibit simple financial accounting systems, i.e. Stage 1 of the FMIS development path illustrated by Figure VI.1 (showing design features of the four stages) and Figure VI.2 (showing performance characteristics). Briefly, the major differences between the stages are that Stage 1 uses single-entry bookkeeping and cash-based accounting; Stage 2 relies on double-entry bookkeeping and full accrual accounting; Stage 3 features cost accounting; and Stage 4 is an automated system. Although all the FMISs studied fell into Stage 1, the systems found in Kaniama and Kikimi were more developed than those of Nselo and Dungu.

The greatest strength of the systems studied was in the processing and reporting of cash transactions. In addition, Kaniama and Kikimi showed competence in making accrual adjustments, and Kaniama's drug supply accounting system was extremely good.

The principle weakness of the zone's financial information systems was that simple, Stage 1 systems are not powerful enough to deal with the financial complexity of health zone operations: even the best simple financial accounting systems—and Kaniama and Kikimi are probably two of the best in the country—are limited by their own structure and cannot produce the level of accurate, reliable and useful information needed to make the myriad operational, management control, and strategic planning decisions managers face everyday. A concomitant problem was weak financial management skills on the part of key decision-makers; even given access to good financial information it was not clear that managers would know how to use that information effectively to monitor, evaluate, and take actions to improve the financial situation of the zones.

Our recommendations are presented in Sections 2-5, and are summarized in Figure VI.3.

FIGURE VI.1

DEVELOPMENT STAGES IN FINANCIAL MANAGEMENT INFORMATION SYSTEMS DESIGN FEATURES

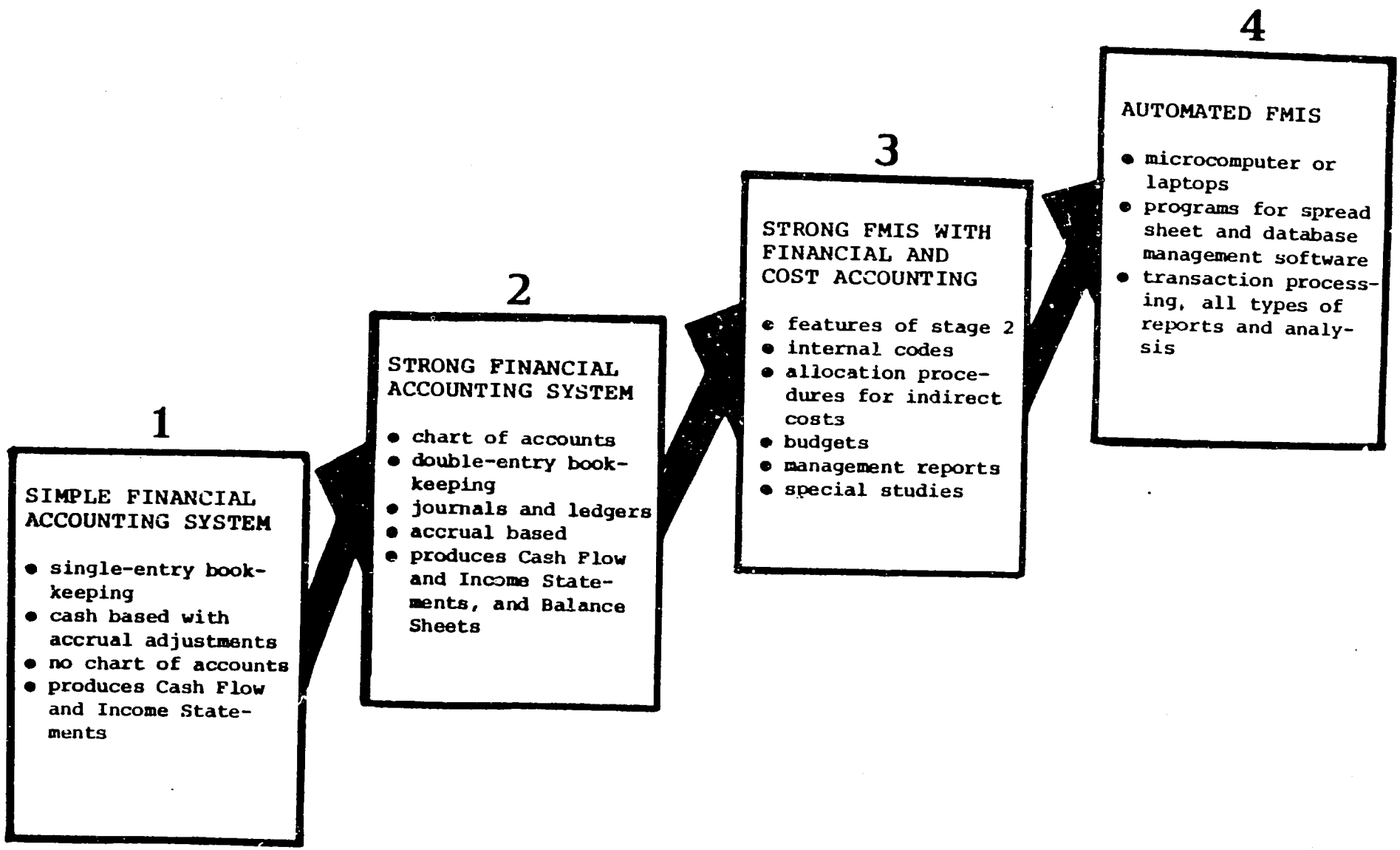


FIGURE VI.2

DEVELOPMENT STAGES IN FINANCIAL MANAGEMENT INFORMATION SYSTEMS
PERFORMANCE CHARACTERISTICS

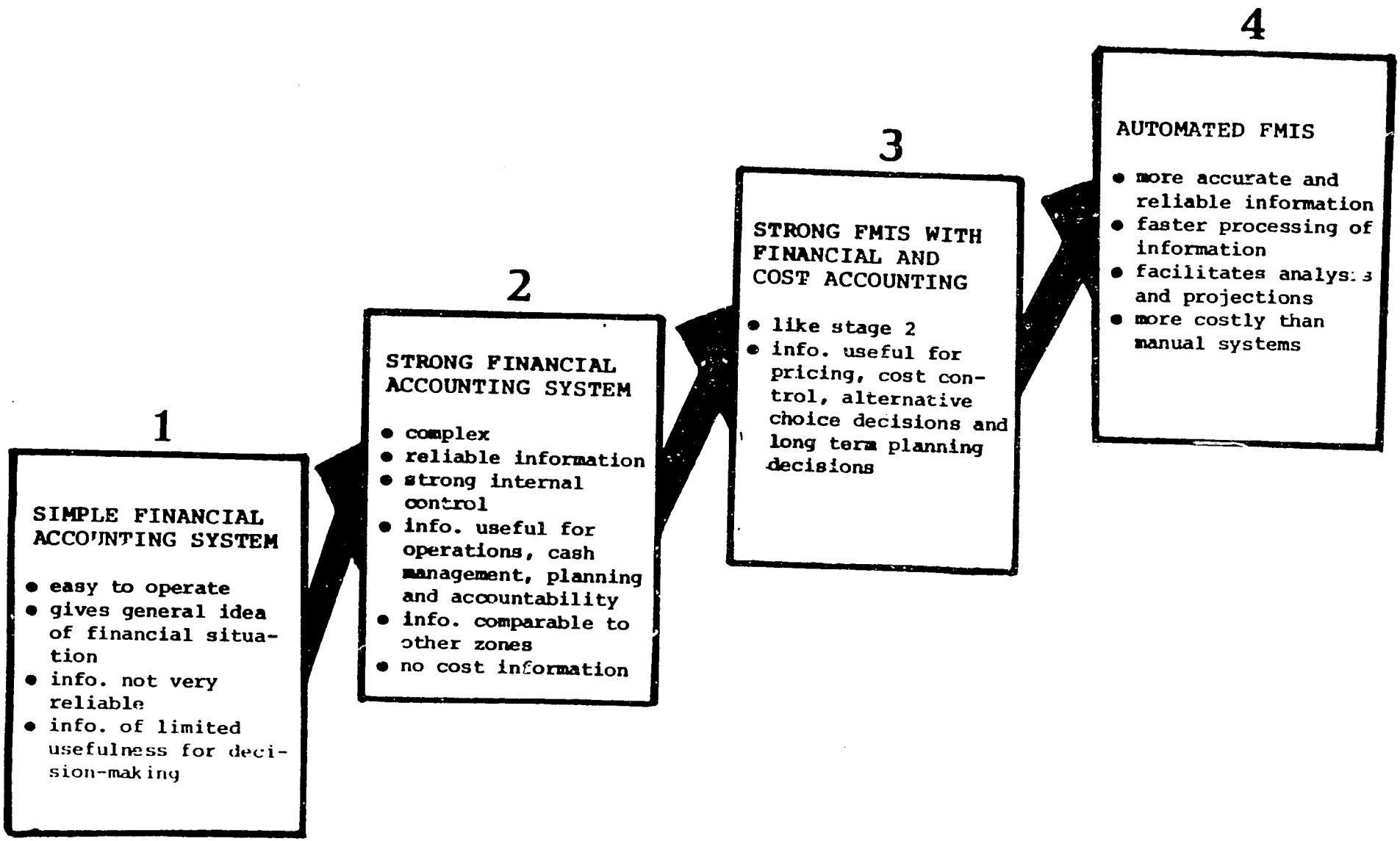
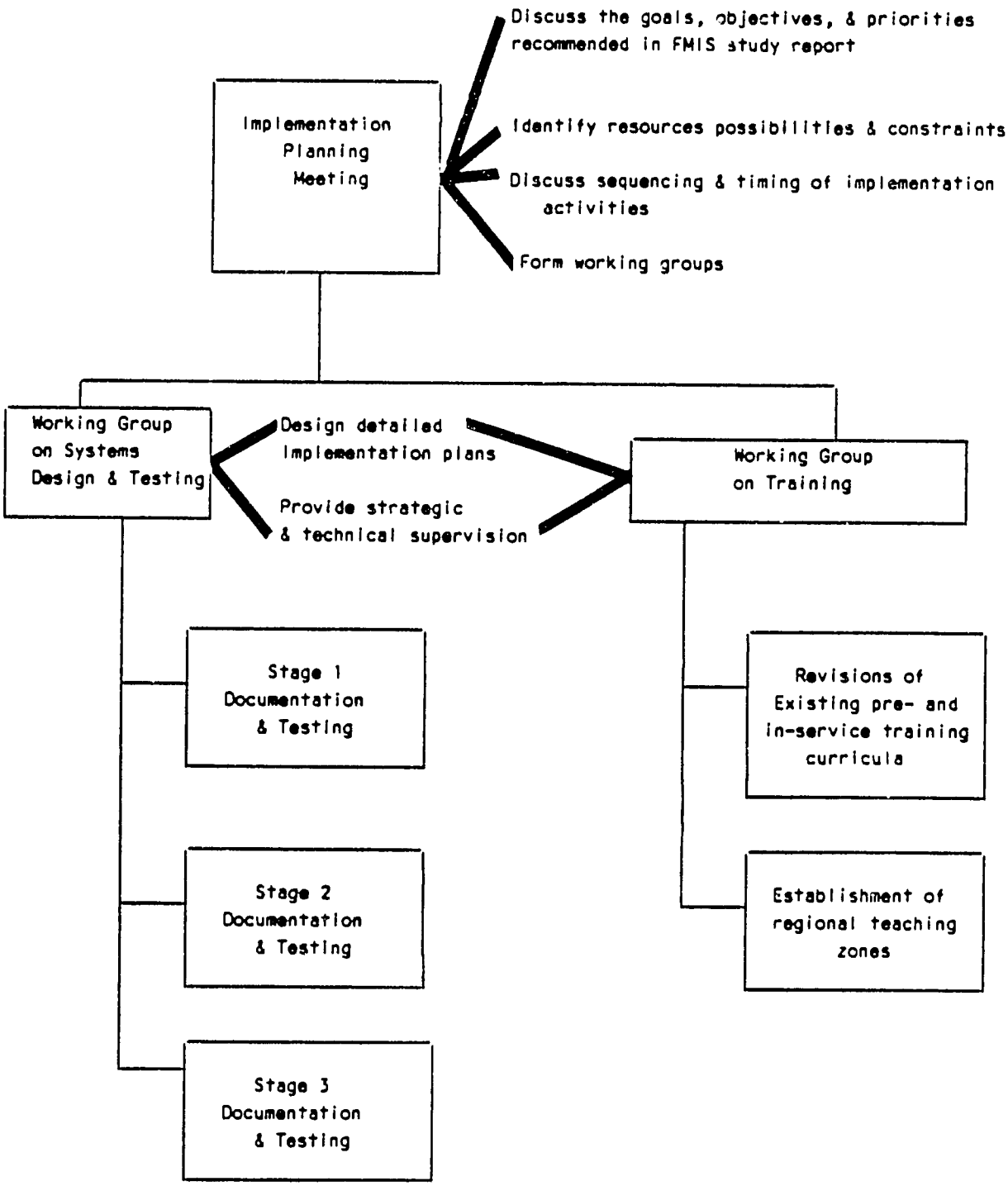


FIGURE VI.3: RECOMMENDATIONS FOR IMPROVEMENT OF FMISs IN ZAIRE'S HEALTH ZONES



2. RECOMMENDED FMIS GOALS FOR HEALTH ZONES

Because of the limitations of simple financial management systems, the long-term goal of health zones should be to develop strong financial management information systems featuring both financial and cost accounting (Stage 3), ideally moving also toward automated systems using microcomputers (Stage 4).

Many people would say that such a goal is too ambitious and would be impossible to achieve. A more pragmatic goal would be to strengthen simple accounting systems in all zones, so that they can function at the level of Kaniama or Kikimi. While there is no doubt that reinforcement of simple systems would be beneficial to the zones and is a worthwhile activity in the short-run, setting goals is not about the short-run. Setting goals is about deciding where we want to be far in the future, deciding what we think the world should look like, and committing ourselves to what we think is right, fair, and good. The establishment of sustainable primary health care systems covering the entire population of Zaire is not a simple, short-term objective, and what would make sustainable PHC systems a reality is not simple, Stage 1 accounting systems. The complexity of the health zones demands strong Stage 3 or 4 systems: this must be the goal. Health professionals should not be discouraged by the long distance which must be traveled to attain this goal, but neither should we be complaisant and satisfied having achieved anything less.

In addition to systems development, significant resources must be devoted to upgrading the training of both accounting staff, health zone managers, and oversight committees in how to operate information systems and, more importantly, how to use financial information to improve decision-making. O'Connor states that inadequate training is a major problem with the use of information systems.

> People assume that decision-makers will take appropriate action if they have accurate information. The fact is that the recipients of analyzed data may know neither <u>how</u> to interpret them, or <u>what</u> management decisions they should make from them.

The SANRU project has already recognized the importance of training managers in financial management skills, and includes a three-day financial module in their management refresher training seminar held annually. Further training should build on this foundation, continually linking new developments in systems to the requisite training for operators and users.

3. IMPLEMENTATION PLANNING MEETING

Having proposed goals and presented findings which describe the current state of affairs, the question which remains is how do we get from here to there? **We recommend first of all that SANRU and REACH organize an implementation planning meeting for the purpose of developing strategies for implementing changes in systems design and training that will serve to further the goals suggested above.**

Investment in planning is critical to insure that goals and objectives are understood and accepted by all, and that plans for implementation are logical and feasible. Many of the changes which we believe are necessary (and which are described in Sections 4 and 5) will require careful planning; for example, decisions concerning the timing of zone versus hospital assistance, maintaining the correct balance between training and financial accounting technical assistance, etc. It would be unwise to make such decisions without first soliciting ideas and input from the many governmental, non-governmental, and international offices, projects, and training institutions which are active in the areas of accounting, health financing, training of health professionals, and the promotion of sustainable PHC systems.

Representatives of these groups should be invited to an implementation planning meeting where the findings and recommendations of this report can be discussed, and experiences and opinions exchanged. The objectives of the meetings should be to:

1. Discuss the long-range goals, objectives, and priorities recommended in the report;
2. Identify resource possibilities and constraints;
3. Discuss sequencing and timing of implementation activities;
4. Form work groups.

Two fundamental implementation questions should be addressed during the meeting. First, how should training activities (revisions of existing curricula for pre- and in-service training, development of new curricula, implementation of new training strategies) be integrated with the more technical, systems development activities (designing accounting procedures manuals and financial management notes, field-testing materials)? And secondly, what is the best way to sequence activities targeted to improve zone versus hospital accounting and financial management practices? Should zones be helped first? Should activities designed for zones and hospitals be undertaken concurrently? Should the implementation plan shift back and forth between the two, planning activities to help zones first, then hospitals, then back to zones? There is no one correct answer, and such issues will probably provoke healthy debate among participants.

One result of the planning meeting should be the establishment of two working groups, one for systems design and testing, and the other for training. These working groups will be responsible for designing detailed implementation plans, as well as providing continued strategic and technical supervision as implementation activities proceed.

Section 4 contains recommendations concerning systems design and testing, while Section 5 presents training recommendations.

RECOMMENDATIONS FOR SYSTEMS DESIGN AND TESTING

4.1 Develop, field test and disseminate accounting procedures manuals and financial management notes for simple, Stage 1 systems, concentrating on areas where accounting and financial management practices are particularly weak (drug supply system, cash receipts and disbursements, advances against salaries, health care benefits and free care, and reimbursement systems). Procedures manuals and financial management notes should be developed for both the zone and the reference hospital.

Concerning systems design, one of the first objectives should be to assure that all zones have adequate written documentation for the simple single-entry accounting systems which already exist. We recommend that accounting procedures manuals be prepared and distributed to all zones in special, distinctive loose-leaf binders. The binders will permit pages to be easily replaced as the procedures manuals are periodically updated.

The procedures manuals should provide a general introduction to financial accounting systems in zones and hospitals, including a review of basic accounting concepts and principles. In addition, the manuals should contain detailed instructions, flow charts, and sample forms, records, and reports for five areas where existing accounting practices seem particularly weak: drug supply system, cash receipts and disbursements, advances against salaries, health care benefits and free care, and reimbursement systems. Early, visible success in improving management control in these areas will build support and enthusiasm for further FMIS development activities.

In addition to developing procedures manuals for accounting staff, financial management notes should be written for key decision-makers. The notes should first explain the goals and objectives of the different subsystems or areas described above. Secondly, the notes should describe how to monitor and evaluate performance in these areas and suggest decisions which can be made with the resulting information. Techniques for financial analysis should be provided, as well.

The field test of procedures manuals and financial management notes should take place in one or two zones, and last at least one year. The test will be helpful not only for clarifying and refining the technical materials, but for gaining additional insight into the most appropriate training methods for teaching financial management. The test will also help SANRU and REACH deepen their understanding of the process of systems development in general: how to introduce and facilitate organizational change, while respecting the administrative autonomy of the health zones. This insight and understanding will prove valuable to planners working in many areas of the SANRU project, in addition to health financing.

Current in-service training should be modified to include instruction in how to use the procedures manuals and management notes (see also Section 5).

4.2 Develop and field test accounting procedures manuals and financial management notes for Stage 2, strong financial accounting systems, featuring double-entry bookkeeping and accrual accounting. This should include the development of a standard chart of accounts for health zones, adapted from the Zairian national chart of accounts (PCZ). Once again, procedures manuals and management notes should be written for both the zone and the reference hospital.

The procedures manuals and financial management notes should follow the same format as those developed for Stage 1 systems. The Project Santé Pour Tous Kinshasa (SPTK) is engaged currently in testing a double-entry bookkeeping system in several urban health zones. While the system being tested is somewhat unusual because it is adapted to the particular needs of the SPTK project, their experience will be edifying for SANRU and REACH as well, and should be monitored closely. Recommendations regarding dissemination of Stage 2 materials are discussed in Section 5.

4.3 Develop and field test accounting procedures manuals and financial management notes for Stage 3 systems (cost accounting) for the zone and reference hospitals.

Following the development and testing of documentation for Stage 1 and 2 systems, cost accounting manuals and management notes should be written. Hospital cost accounting should be a priority concern at this level, given the high volume of diverse services and well-defined service departments or "responsibility centers" found in reference hospitals, and the important pricing decisions faced by hospital managers. Cost accounting is a particularly helpful management tool in such settings. Recommendations regarding training and dissemination of Stage 2 and 3 materials are discussed in the following section.

5. RECOMMENDATIONS FOR TRAINING

5.1 Design pre-service and in-service training strategies for managers (MCZs, MDHs), administrators (AGs), and other operating personnel which will enable them to understand and use the accounting procedures manuals and financial management notes described in Section 4.

As FMIS design efforts produce new materials and define new responsibilities and tasks for zone and hospital staff, pre- and in-service training strategies must be revised and new curricula added. The Training Task Force should discuss possible strategies and develop proposals for necessary interventions in this area. It is likely that Stage 1 systems improvements can be implemented without radical changes in existing training strategies, although some changes in curricula will be necessary. Stage 2 and 3 improvements will require more far-reaching adjustments, however, such as the introduction of financial management internships in regional "teaching zones" operating model financial systems. The teaching zone strategy is described below.

5.2 Establish model Stage 2 and Stage 3 financial systems in at least one "teaching zone" per region, to provide opportunities for hands-on training of management and operational staff.

The principle behind teaching zones is much the same as the principle behind teaching hospitals: in addition to providing health services within their catchment areas, one of the primary goals of these zones will be to accept interns from other zones and train them in the operation of advanced management systems and financial management decision-making. The teaching zones should provide longer interships to AGs just coming out of school as well as short refresher internships and training seminars for MCZs, hospital directors, experienced AGs and accounting secretaries. As the health zones begin to decentralize management organization and create a new cadre of middle managers with significant deicison-making responsibilities, the teaching zones should provide internships at this level as well.

The teaching functions of these zones should be subsidized by the government or donor agencies at the beginning, with the eventual goal of self-financing through charges to health zones which sponsor interns. The hands-on experiential learning model is likely

to be more effective than the current program of classroom refresher training, and the cost per training hour will probably be less because of the location in the regions and the reduction in travel costs. It is difficult to make any projections about cost at this point, however.

6. CONCLUSION

The administrative autonomy of the health zones and their struggle for financial independence cause them to operate in ways that are strikingly similar to small, non-profit businesses. Lessons learned from the business world are perhaps not irrelevant, therefore. One such lesson can be gained by reading the words of a Japanese business executive, Akio Morita, Chief Executive Officer and Chairman of the Board of SONY Corporation. In his book Made in Japan, Morita writes:

> No theory, plan or government policy will make a business a success; that can only be done by people...In the long run—and I emphasize this—no matter how good or successful you are or how clever or crafty, your business and its future are in the hands of the people you hire.

Zaire's health zones, like businesses, are deeply concerned about their bottom line. The reasons for their concern are different, however: the health zones care about their financial performance not for profit, but for survival—and for people: the health and well-being of the communities they wish to serve. While the stated objective of this SANRU/REACH activity is to improve financial management information systems, a second and equally important objective is human development, i.e. training and educating health zone personnel to provide them with the skills they need to manage successfully. Only financially healthy, well-managed zones can fulfill their mission to provide high quality comprehensive primary health care services to the Zairian population.

ANNEX A

LIST OF QUESTIONS FROM STUDY QUESTIONNAIRE

ETUDE SUR LE SYSTEME D'INFORMATION DE GESTION FINANCIERE

BUREAU CENTRAL DE LA ZONE

REPONDANT(S)_____

ZONE DE _____

I. GENERALITES

1. Données Géographiques, Démographiques, et Economiques

1.1 Location (rég., S/R), superficie, date de la création et direction

1.2 Limites

1.3 Population et ses caractéristiques (densité, TOT, groupe âge...)

1.4 Végétation et saison

1.5 Activités économiques

1.6 Voies d'accès

2. Infrastructure médicale

2.1 C.S.

a) Nombre et appartenance
b) Fonctionnel ou non
c) Nbre de nouveaux cas par mois, en moyen
d) Population désservie

II. ORGANISATION

A. Introduction

Le but de ces questions est de comprendre:

1. La structure de la zone;
2. Les attributions et les rélations entre les unités;
3. Les attributions et les rélations entre le personnel aux niveaux differents;

Si nous comprenons les éléments ci-haut cités, cela nous aidera à mieux anticiper et établir les besoins d'information qui se trouvent à chaque niveau.

B. Expliquez l'organisation et le fonctionnement de la zone (organigramme).

1) Attributions des differentes unités (BCZ, HGR, ITM, CSR, CS, PS, ASV, différents comités).
2) Les relations qui existent entre les unités en ce qui concerne:

--médicaments et le matériel

--supervision

--cas référés

C. Expliquez l'organisation et le fonctionnement du bureau central.

1) Attributions des postes.
2) Personnel plus leur formation.
3) Grille de personnel

D. LA PLANIFICATION

1. Quelle est votre politique sur l'autofinancement des formations sanitaires de la zone ? Utilisez-vous les recettes d'une formation pour subventionner une autre, par exemple, les recettes d'un centre de santé créditeur pour subventionner un centre de santé déficitaire ? Comment êtes-vous arrivé à cette politique ?

2. Comment établissez-vous les critères pour ouvrir ou fermer un centre de santé ?
[ENQUETEUR : Chercher à savoir les informations qu'ils utilisent].

3. Quel est votre mode de paiement est comment l'avez-vous choisi? Quels sont les indicateurs que vous utilisez pour évaluer ce système ?

4. Comment déterminez-vous la tarification des soins ?

III. COMPOSANTS DU SYSTEME DE LA COMPTABILITE GENERAL

Le but de cette section est de comprendre comment le système d'information fonctionne actuellement et d'évaluer l'efficacité et l'efficience du système. Nous allons d'abord concentrer nos efforts sur le système de la comptabilité générale; puis dans la section suivante, nous allons regarder la comptabilité budgetaire et la comptabilité analytique.

Les sujets qui seront touchés sont les suivants:

1. Enregistrement et livres de base
2. Plan comptable
3. Contrôle
4. Rapports
5. Subsides
6. Investissements
7. Médicaments et Inventaire
8. Personnel

1. ENREGISTREMENT ET LIVRES DE BASE

1.1 Expliquez-nous le déroulement du travail comptable à partir de l'encaissement jusqu'au rapport.

[ENQUETEUR : Les restes des questions sont pour éclaircir les points obscures]

1.1 Quels sont les livres utilisés pour la comptabilité pour votre unité ?

[ENQUETEUR : voir les documents et les livres et en savoir l'utilité].

a) pièces justificatives (reçus, factures, quittances).
b) livre de caisse
c) conservation des pièces justificatives
d) journal pour les opérations non-monétaires
e) grand-livre, reprennant tous les comptes ouverts dans l'unité.
f) cahier des conventionnés
g) expliquez-nous les instructions comptables sur les :
   - pièces justificatives (comment il fait pour faire sortir l'argent de la caisse)
   - avances
   - rapports
h) autres à préciser

[ENQUETEUR : Noter si leur système comptable est en parti simple ou en parti double]

2. PLAN COMPTABLE

2.1 Decrivez-nous comment votre plan comptable est organisé et comment vous l'utilisez ?

[ENQUETEUR : voir le plan et noter les codes des comptes Noter si les transactions ci-après sont reprises dans les numéros de code :

a) recettes de chaque catégorie
b) dépenses de chaque catégorie
c) les avoirs
d) les dettes
e) les créances (accounts receivable)]

2.2 Quel est le contenu des comptes suivants :

a) médicaments ?
b) salaires
c) fournitures de bureau
d) supervision.
e) transport

[ENQUETEUR : Noter si le contenu est écrit].

3. CONTROLE

3.1. Est-ce qu'il y a un contrôle de la caisse ?

3.1.1. Qui le fait ?

3.1.2. Quelle en est la périodicité ?

3.1.3. Quels sont les domaines du contrôle ?
[ENQUETEUR : exemples :
a) séparation entre l'ordonnateur et le caissier
b) l'authenticité des pièces justificatives
c) exactitude arithmétique
d) livrets non-détachables et paginés].

3.1.4. Quel est votre système de contrôle des avances ?

3.2. Est-ce que vous avez un compte en banque ?

3.2.1. Est-ce que vous faites le contrôle de ce compte ?
[ENQUETEUR : Chercher à savoir quelle sorte de contrôle par exemple la vérification de modalité d'établissement des chèques].

3.3. Est-ce que vous faites le contrôle de la paie ?
[ENQUETEUR : Par exemple, vérification de la feuille de paie, présence journalière].

ENQUETEUR : Noter l'organisation du secrétariat et la conservation des documents.

4. RAPPORTS

4.1 Après tous les travaux comptables que vous faites, quels rapports financiers vous élaborez ?
[ENQUETEUR : Noter les contenus, la périodicité, les destinataires, s'il y a un modèle à suivre et garder des exemplaires].

4.2 Qu'est-ce qu'on fait de ces rapports ?
[ENQUETEUR : Chercher à savoir s'ils utilisent les rapports à prendre les décisions et s'ils se réfèrent aux rapports de temps en temps].

4.3 Est-ce qu'il y a un rapport sur le personnel ?
[ENQUETEUR : Noter le contenu, la périodicité, les destinataires, s'il y a un modèle à suivre, et garder un exemplaire si possible].

4.4 Qu'est-ce qu'on fait de ce rapport ?
[ENQUETEUR : Chercher à savoir s'ils utilisent le rapport à prendre les décisions et s'ils se réfèrent au rapport à temps].

4.5 Est-ce qu'il y a un rapport pour les matériels et les médicaments ?
[ENQUETEUR : Noter comme question 3.3.].

4.6 Qu'est-ce qu'on fait de ce rapport ?
[ENQUETEUR : Noter comme question 3.4.].

4.7 Est-ce qu'il y a d'autres rapports ? (Par exemple, les comptes rendus, les procès-verbaux).
[ENQUETEUR : Contenu, périodicité, destinataire, modèle à suivre, exemplaires].

4.8 Qu'est-ce qu'on fait de ces rapports ?
[ENQUETEUR : Comment ces rapports sont utilisés].

4.9 Comment utilisez-vous des informations des sources informelles ?
[ENQUETEUR : Par exemple, l'information verbale sur les vols des médicaments, rapports non-officiels comme une lettre anonyme. Nous voulons évaluer l'importance des sources informelles dans l'organisation].

5. SUBSIDES

5.1 Est-ce que vous recevez les subsides ? Decrivez-nous les sources.
[ENQUETEUR : Noter si le subside était pour le fonctionnement ou pour l'investissement].

5.2 Comment comptabilisez-vous les subsides ?
[ENQUETEUR : Vérifier si tous les subsides sont comptabilisés et si non, pourquoi pas].

5.3 Y-a-t-il une intégration des subsides dans la comptabilité globale ?
[ENQUETEUR : Vérifier dans les rapports financiers si les subsides sont effectivement repris].

5.4 Comment valorisez-vous les services des volontaires ou coopérants expatriés ?

5.5 Qu'est-ce que les donnateurs attendent de vous en retour de l'assistance reçu ?
[ENQUETEUR : Noter les rapports ou d'autres documents exigés].

6. INVESTISSEMENTS

6.1 Enregistrez-vous les investissements ? Si oui, comment les enregistrez-vous ?

6.3 Faites-vous les amortissements ?

6.3 Si oui, quel est votre mode de calcul des amortissements ?
[ENQUETEUR : Chercher à savoir la méthode utilisée et qu'est-ce qui a déterminé le choix de ce mode de calcul ?].

6.4 Si vous ne faites pas les amortissements, pourquoi pas ?

6.5 Faites-vous des inventaires du matériel ?
[ENQUETEUR : Noter la périodicité].

6.6 Comment se fait la planification des investissements et de la maintenance ? L'objet est de savoir la source des informations utilisées pour cette planification.

6.7 Comment contrôlez-vous l'utilisation et la maintenance des véhicules et des équipements ?

a) Véhicules b) Equipements

6.8 Avez-vous des bâtiments présentement en construction ? Si oui, est-il possible de connaître la valeur de chaque bâtiment au stade actuel ?

7. MEDICAMENTS

7.1 Décrivez les procédures suivies pour commander les médicaments. L'objectif consiste à savoir tous ce qui entourent cet acte de commande.

7.2 Comment déterminez-vous le stock de sécurité et la périodicité de commande des médicaments ? L'objet de la question vise à connaître les informations à partir desquelles vous déterminez ces éléments.

7.3 Comment contrôlez-vous la consommation des médicaments?

7.4 Comment contrôlez-vous la validité des médicaments ?

7.5 Quel est votre mode de tarification ?
[ENQUETEUR : Chercher à savoir les informations considérées].

7.6 Faites-vous les inventaires ? Si oui, à quel rythme?

7.7 Etes-vous satisfait de votre système actuel de gestion des médicaments ? Expliquez pourquoi ?

8. PERSONNEL

8.1 Comment le personnel est-il géré ?

a) selon le statut du personnel de carrière de la fonction publique ?

b) selon le code de travail ?

c) d'après d'autres procédure écrites.

8.2 Quels sont les documents et les dossiers que vous gardez sur le personnel ?
[ENQUETEUR : Regardez quelques dossiers et décrire le contenu].

8.3 Comment fixez-vous le salaire d'un employé ? Selon quels critères ?

8.4 Comment calculez-vous les salaires du personnel ? [ENQUETEUR : Noter gain (base, prime, ancienneté), retenu (impôt, INSS, taxes), net].

8.5 Décrivez-nous votre système de paiement des salaires.

IV. BUDGET ET COMPTABILITE ANALYTIQUE

1. BUDGET

1.1 Faites-vous les prévisions budgétaires ? Si oui, les faites-vous pour les secteurs suivants :

a) investissements
b) trésorerie
c) médicaments
d) autres charges de fonctionnement
e) recettes de fonctionnement

[ENQUETEUR : Voir les budgets].

1.2 Sur quelle base le budget est-il établi ? (étapes et information réquise).

1.3 Qui participe à l'élaboration du budget ?

1.4 Quand le budget est-il élaboré ?

1.5 Faites-vous le contrôle budgétaire; c'est-à-dire la comparaison entre les prévisions et les réalisations et l'analyse des écarts ?

2. COMPTABILITE ANALYTIQUE

2.1 Est-ce que vous dressez un compte d'exploitation pour chaque service ou entité aussi bien que pour la zone en général ? Si oui, pourquoi les faites-vous ?

2.2 Enregistrez-vous les dépenses et les recettes par service ou de façon globale ?

V. MOTIVATION

1. Qu'est-ce qui est prévu pour permettre ou stimuler les différents comités et personnel de faire leur travail ?

2. Tenez-vous des réunions pour la compréhension des objectifs par tout le personnel ?

3. Est-ce que vous avez un système d'échellonnement des grades ? Décrivez-le.

VI. PERMEABILITE DU CHANGEMENT

1. Est-ce que vous considérez que votre organisation actuelle est définitive ? Pourquoi ?

2. Qu'est-ce que vous souhaiteriez changer dans votre système actuel et quelles sont vos préoccupations majeures ?

ANNEX B

NOTE ON CURRENT SYSTEM FOR MANAGEMENT CONTROL OF HEALTH ZONES BY SANRU

In the six months since Manunga has been with SANRU, he has visited 15 zones in his capacity as Chief of Management Control, Division of Planning and Supervision. He hopes to visit 50 SANRU-assisted zones by next spring. His primary objective in visiting these zones is to assess the quality of management (personnel, financial, material and drugs supply, and general administration) as well as verifying progress towards autofinancing and self-management. A secondary objective of his visits is to control the use of SANRU funds for supervision, training, and rehabilitation of infrastructure.

So far, Manunga has been able to spend only two days per zone, time he considers largely insufficient. He spends this time at the BCZ, evaluating the central office operations, and has not evaluated the management of hospitals nor has he dealt directly with health centers.

Using a management checklist with 100 points, Manunga scores each zone according to a somewhat subjective five-category scale (very bad, bad, sufficient, good, very good). The checklist is divided into seven areas: Organization (general administration); Financial Management; Management of Drug Supply; Management of Material and Equipment; Supplies Management; Personnel Management, and Autofinancing/Self-Management Capacity.

So far Manunga has only had time to report on 7 of the 15 zones. He produced a combined report on these zones, but in the future hopes to produce individual reports on each zone visited. This will enable him to go into more depth on the strengths and weaknesses of each zone.

A zone is scored "very bad" or "bad" if current management systems in place are unable to permit minimum levels of planning, operation and control. This is usually detected by the lack of essential documents and by the ignorance of personnel as to the need for and use of these documents.

A zone is "sufficient" if enough documents exist so that an acceptable level of plannning, operation and control is evident. Concerning financial management, this means that the important documents are in place which allow the zone to follow cash movements and adequate control measures exist to protect the financial resources of the zone. For drugs/mat. it means that stock movements are followed and that material is tracked.

Concerning autofinancing, Manunga examines the level of cost accounting of the zone to determine if the accounting system permits the zone to identify sources of funds and destination of expenses in such a way as to tell which health facilities are autofinancing and which aren't.

"Good" and "very good" are used to signal not only correct maintenance of documents, but full reports and analysis.

In his report of 7 zones, Manunga added a sixth category of evaluation, "insufficient" which indicates that the essential documents exist, but they are poorly maintained and used.

Manunga judged that 5 out of the first 7 zones had sufficient systems in place for general administration, personnel management, drug supply, material and supplies management. Only one zone had a sufficient financial management system, however, and all zones were classed as insufficient concerning autofinancing capacity and the role of the health committee in controlling the health centers.

Some findings which were consistant across the zones included:

- Lack of written procedures and instructions, both for general administrative tasks and for bookkeeping and accounting functions in particular. Most zones rely on oral transmission of operating procedures, responsibilities, and tasks.

- Mixing of hospital and zone drugs in the managment of the two pharmacies. Although most pharmacies kept stock cards for each drug, evidence of a summary record and overall monitoring and control of stock movements was lacking.

- Health center receipts covered 40 to 70% of operating expenditures in the zones visited.

- Health committees did not control the management of their health centers, due to insufficient training in bookkeeping.

- All zone personnel with administrative and management responsibilities suffer seriously from lack of training in such tasks. In general the MCZ shouldered the major management responsibilities, and usually had not received training in administration and finance. Where permanent administrative personnel existed (accountant, secretary, administrator), they also had often not received sufficient practical training.

- In six of the seven zones visited a secretary was in charge of administration and accounting. Only one of these secretaries was training in accounting and management.

The management evaluation checklist used by Manunga is attached to this note. Since many of the 100 points included in the checklist are not self-explanatory, I have included an annotation of the checklist to clarify the more obscure points.

(Seven zones visited: Kikongo, Moanza, Idiofa, Ipamu, Mokala, Sona-Bata, and Kisantu. Sub-regions of Kwilu and Lukaya.)

PROJET SANRU (USAID-DSP-ECZ)
SSP EN MILIEU RURAL
B.P. 3555
KIN I

ZSR N°: - - - - - - - - -

Le - - / - - /19. - -

FICHE D'APPRECIATION DE LA GESTION
DES RESSOURCES DES ZONES DE SANTE
EN MILIEU RURAL

DOMAINE DE GESTION	APPRECIATION TM	M	S	B	TB
I.Organisation:					
1.-Organigramme de la zsr:					
2.-Conformation avec politique ssp (BCZ,HGR,CSR,COM.S,CS)					
-Supports de l'efficacite					
3-Plans d'action					
4-Repartition de responsabilites					
5-Emission ecrite des instruction					
6-Systeme de delegation					
7-Collecte,trait.,diffusion et conservation des informations (cfr travaux bur+classeur)					
8-Rythme des reunions et vulgarisation objectifs zsr)					
9-Calendrier annuel des activite					
10-Direction (auto,democ,laisser-faire)					
-Controle					
11-Indicateurs :					
12-Domaines du controle (techn.adm.et financier)					
II.GESTION RESS FINANCIERES					
1.-Reglement financier et de comptabilite					

2.-Controle interne (ordonnateur/caissier)					
3.-Ordre dans la comptabilite					
4.-Plan comptable de la zsr					
5.-Comptabilite a partie double					
6.-Enregistrement analytique des recettes et depenses					
7.-Livres comptables essentiels (JGJ,caisse,GL,balance)					
8-Composition du rapport financ					
9-Periodicite du rapport financ					
10-Reglement d'authentification des pieces justificatives					
11-Antecedents du personnel de comptabilite					
12-Utilisation de la caution pou caissier					
13-Compte bancaire de la zsr					
14-Controle du courrier (central-decentral)					
15-Pieces just.a modele unique					
16-Separation ressources ZS de ressources des tiers					
17-Existence d'un budget de fct					
18-Prevision de tresorerie					
19-Delai de validite des B. Provisoires					
20-Reglement des avances s/salaire					
21-Bilan de fin d'exercice					
22-Calendrier du controle de la caisse et par qui					
23-Prevision d'audit ext.& par qu					
24-Organisat. de la perception					
25- Pourqoui ?					

26- Conservat. des Pces justific.					
III GESTION DES MEDICAMENTS					
-Organisation de l'approvision:					
1-Budget previsionnel?					
2-Ce bugdet est etabli par qui?					
3-Sur base de quoi?					
4-Programmme d'approv.?					
5-Pays d'approv.-pq?					
6-Liste standard de medic. a commander					
- La commande:					
7-Faite par qui?					
8-Comment (ecrite,orale)					
9-utilisation des bons (Requisition)					
-Reception et stockage:					
10-Existence pharmacie de zone					
11-Lieu de stockage de med					
12-Competence du charge de phar					
13-Systeme d'enregistrement entrees-sorties					
14-Fiches stocks,registres stocks					
15-Politique pour medicament a expiration imminente					
16-Systeme de rangement					
17-Seuils de securite ou d'ala-					
18-Rythme des inventaires					
-Repartition					
19-Fiche de requisition par cs					
20-Liste type					

21-CS=autofinances en medic?					
22-Controle d'utilisation des medicaments dans cs					
23-Prix de vente prefixés de medicament					
24-Analyse des ecarts /utilisati on/cs et explication					
IV GESTION MATERIEL ET EQUIPEMENT					
-La commande					
1-D'apres besoin recenses d'avance?					
2-Apres conformation avec ressour ces disponibles?					
3-Sur base ecrite?					
-Stockage					
4-Depot principal					
5-Systeme d'inventaire et d'enre- gistrement					
6-Classement des bons de livrai- son					
-Sortie de stock					
7-Sortie des registres de stock					
8-Etablissement d'un bordereau de sortie					
9-Inscription sur la fiche du service beneficiaire					
-Controle et entretien					
10-Instructions ecrites/materiel					
11-Calendrier d'inspection					
12-Detection et interpretation des ecarts					
12-Inventaire annuel					
-Materiel roulant					
14-Instructions ecrites/leur usage					

15-Cahier de bord vehicule					
16-Rythme des entretiens et ou ?					
V.-GESTION FOURNITURES					
1-Budget d'approvisionnement					
2-Magasin					
3-Fiches de stock					
4-Requisition					
5-Responsable					
6-Prevision de distribution et de quantite					
VI-GESTION DU PERSONNEL					
-Embauchage					
1-Systeme d'identification, recrutement et selection					
-Utilisation du personnel					
2-R.O.I.					
3-Description de postes					
4-Relatios professionnelles bien definies					
-Promotion					
5-Organisation generale du service					
6-Dossiers individuels(+contenu)					
7-Criteres prealables d'avancement					
8-Programme de formation					
-Evaluation du personnel					
9-Fiche d'appreciation					
10-Supervision					

VII. AUTOFINANCEMENT ET AUTOGESTION					
1-Contribution de chaque CS					
2-Contribution de l'etat					
3-Contribution des organismes (ONG)					
4-Participation de la population					
5-Constitution des amortissements					
Cotes partielles					
Cotes maximum					
Pourcentages partiels					
	Moye			%	

APPRECIATION GLOBALE

ECHELLE CARACTERISTIQUE:.....Pourcentag

1. Pas besoin de formation (1)
2. Besoin d'une formation generale en gestion (1)
3. Besoin d'une formation indispensable en: (1).....
   a).....c).....
   b).....e).....
   c).....f).....
4. Besoin d'une formation facultative en: (1)
   a).....d).....
   b).....e).....
   c).....f).....
5. Autre suggestion:.....

Le superviseur

(1)-Soulignez la proposition appropriee.

TABLEAU DE CLASSIFICATION

Echelle carasteristique	Etendue de la formation (organisation, finances, stock
Tres mauvais	-Sauf domaine ou l'echelle s egale, ou superieur a suffi
Mauvais	-Idem

Suffisant	-Formation scindee en 2 \ 1.Domaines exigeant une f obligatoire(mauvais et tr 2.Domaines a formation fa et non iminente suffisant
Bon	Idem
Tres Bon	Idem

(*)-Pour l'echelle "suffisant nous considerons qu'une proportion depassant 30%,necessite la programmation d'une formation dans quelques domaines classes dans cette categorie

Explanation of Selected Items in the SANRU Management Evaluation Checklist

Organization

1. Does the zone have an organigramme? Is it standard?

2. Does the zone have all the elements required to implement a PHC strategy?

3. Does the HZ elaborate action plans?

4. Are the responsibilities of staff members clearly defined and logically assigned?

5. Are there written procedures for admin/management activities?

6. When the MCZ has to leave the zone, does he officially leave someone else in charge?

7. Are documents classed in an orderly way?

8. Do staff get together regularly? Do they all understand the goals and objectives of the zone?

9. Does the accountant have a calendar of when activities are to take place (when the books should close, for example).

10. What is the management style of the MCZ? How are decisions made? Why did the MCZ adopt this management style?

11. How does the zone know when objectives have been reached? How do they measure performance of personnel?

12. In what areas do controls exist (technical aspects, financial/admin.?)

Financial Management

1. Is there a document which defines the tasks of the financial staff and how they are to carry them out?

2. Is there separation between the person who approves an expense and the person managing the cash box? Are there other aspects of internal control? (ledgers and journals with bound and numbered pages, etc.)

3. Are books in general order?

4. Does the zone have a chart of accounts?

5. Is there double-entry bookkeeping?

6. Are transactions classified by both object and service (resp. center)?

7. Does the zone keep all the essential books (General Journal, Cash Journal, General Ledger, Trial Balance)?

8. What is the composition of the "financial report"? Does it include 1) cash flow statement; 2) income statement; and 3) comparison of budgeted with actual revenue and expenses?

9. How often is the financial report produced (sufficient = monthly)

10. Are there rules which determine the supporting documents necessary for each type of transaction? (bills, invoices, signatures, etc.)

11. Has the zone ever had any problems with financial personnel, misappropriation of funds, etc.? What were the circumstances? What changes were made as a result?

12. Is there a security deposit required from the cashier, to be applied against possible future shortages in the cash box due to miscalculation or misappropriation of funds.

13. Does the zone have a bank account or other account to keep money safe?

14. Is there a good system for recording incoming and outgoing mail?

15. Are standard printed forms used for invoices, receipts, etc.? Are forms made up which are unique to the zone? (better for control if forms can't easily be falsified or purchased in the market)

16. Is there separate accounting for subsidies?

17. Does the zone use an expense budget?

18. Does the zone make cash flow projections?

19. When money is advanced from the cashbox for purchases, how soon is it accounted for with a receipt or bill?

20. Is there a fixed date when advances are accorded (from salaries)? Are there rules governing advances against salaries?

21. Does the zone produce an income statement or balance sheet?

22. How often is the cashier controlled, and by whom?

23. Does the zone schedule periodic external audits, and by whom? (0/15)

24. How is reception of money organized? Who takes the money, and how long is the "circuit"—i.e. how many people handle the money between the initial receiver and the final cash box? Are the proper receipts issued along the way?

25. Why is the system organized as it is?

26. How are supporting documents kept? Chronological order, separate dossiers?

Drug Supply

1. Is there a budget for drug expenses and revenue?

2. Who establishes the budget? Is there input from many sources (different services, MCZ, pharmacist)?

3. How is budget established? Did zone look at historical figures, cost, past ruptures of stock?

4. What is the rythmn of procurement? What problems exist with communication and how have they been resolved?

5. Where are drugs procured, and why?

6. Is a standard list of drugs used to guide order?

7. Who orders drugs for the pharmacy?

8. How is an order made? Written or oral? How does money leave the cash box?

9. What documentation is used for releases of drugs from pharmacy?

10. Is there a zone pharmacy?

11. Where are drugs stored?

12. What are the responsibilities and qualifications of the person in charge? Who does he report to? How is his work controlled?

13. How are entries and releases of stock recorded? What documents are used?

14. Do stock cards exist? Is the zone controlling the stock of each type of drug? Can the zone tell the total value of stock in the pharmacy at any time?

15. What does the zone do with drugs which are close to expiring? Do they try to sell them to other nearby health zones or private facilities, or to exchange drugs with other facilities?

16. How are drugs stored on shelf? Alphabetically or by type? Better not to organize by type, because this makes ar ibiotics easier for a thief to find.

17. Are minimum levels of stock set (emergency stock)? How are levels determined?

18. How frequent are inventories?

19. Is there a standard requisition form for health centers to order drugs from the BCZ?

20. Is there a list of drugs recommended for health centers, or can they order whatever they want?

21. What proportion of health centers succeed in autofinancing with respect to drug supply?

22. How is drug utilization controlled in health centers? Are drug sales compared to number of consultations and diagnoses, to make sure they correspond?

23. Does the BCZ fix prices, or are health centers allowed to fix their own prices?

24. Are actual utilization statistics compared to budgeted to detect variance? Are variances analyzed?

Material and Equipment

1. Are equipment and material purchased according to established needs?

2. Do purchases consider available financial resources?

3. Are orders made orally or in writing?

4. Where are equipment and material stored?

5. Are stock cards used? What information is available on cards?

6. How are receipts and records of distribution of equipment classified?

7. How are movements of stock recorded?

8. Is there a system of documentation for release of an item from stock?

9. Is record kept of what service/individual has received what equipment/ material?

10. Do people receive written instructions of how to use and maintain equip/ material?

11. Is there a regular schedule for inspection?

12. Is there variance reporting?

13. Does an annual inventory take place?

14. Are there written instructions or manuals for the use and repair of vehicles?

15. Is a log book kept to record use of vehicles?

16. How often is maintenance done on vehicles? Where?

Personnel Management

1. Are there written criteria for selection/recruitment of personnel?

2. What rules exist to guide personnel and define procedures, benefits, rights, etc. "Reglements d'ordre interieur"

3. Are there written job descriptions?

4. Are reporting relationships well defined?

5. How is the personnel system organized? (separate office?)

6. How are personnel files kept? What are the contents? Do files contain only records of negative actions (sanctions, etc.)?

7. Is there established criteria for advancement in the zone? (0/15)

8. Is there a program for refresher training, and does the zone use people who have been trained? In what capacities?

9. Is there a personnel evaluation form?

Autofinancing

1. Does the zone keep accounts that indicate clearly the contribution of each health center?

2. Does the zone keep accounts that indicate clearly the contribution of the government of Zaire?

3. Does the zone keep accounts that indicate clearly the contribution of non-governmental organizations?

ANNEX C

GLOSSAIRE TECHNIQUE...TECHNICAL GLOSSARY

ACTIF.....ASSETS

Le coté gauche du bilan. L'actif comprend les immobilisations (terrain, équipement), les stocks (valeurs d'exploitation), et les disponibles les créances sur les clients, (l'argent en caisse, et en banque).

L'actif renseigne sur l'utilisation des ressources. On l'appelle aussi "destination" ou emplois". Les valeurs de l'actif sont classées dans un ordre de liquidité croissante. On va des valeurs les moins liquides (immobilisations) vers les plus liquides (caisse et banque).

AMORTISSEMENTS.....DEPRECIATION

Constatation comptable de la dépréciation d'une immobilisation (matériels, équipements, bâtiments, véhicules, etc.) La dotation aux amortissements est enregistrée au compte d'exploitation et constitue une charge non décaissée pour l'entité.

AVOIR.....CREDIT SIDE OF AN ACCOUNT

Un autre nom pour le coté droit d'un compte. Voir aussi CREDIT.

BALANCE.....TRIAL BALANCE

Tableau dressé a intervalles réguliers qui présente les movements et les soldes de tous les comptes ouverts dans l'organisation. Ce tableau permet l'établissement du bilan et du compte d'exploitation. Avec la balance on peut vérifier si les principes de la comptabilité en partie double ont été bien suivis. Cependant, la balance ne garantit pas que les comptes appropriés ont été effectivement utilisés. C'est nécessaire de faire un contrôle interne envue de s'assurer de l'exactitude des imputations.

BILAN.....BALANCE SHEET

Tableau résumant à un moment précis le patrimoine de l'organisation. Le bilan montre à gauche les actifs de l'organisation (les emplois ou la destination de l'argent) et à droit les passifs (les ressources ou l'origine de l'argent). Donc, à gauche nous voyons ce que l'organisation possède, et à droite ce qu'elie doit a des tiers, plus ses fonds propres et les résultats.

Le bilan est une représentation statique de la situation d'une organisation.

BON DE CAISSE (OU BON DE DÉPENSE).....CASH VOUCHER, SUPPORTING DOCUMENT FOR A CASH DISBURSEMENT

Pièce portant l'autorisation d'effectuer un décaissement.

BON DE SORTIE.....WITHDRAWL VOUCHER

Normalement, pièce justificative autorisant la sortie d'un actif (matériel on marchandise) mais, parfois ce mot est utilisé pour désigner abusivement un bon de dépense.

BORDEREAU D'ENVOIE.....STATEMENT, NOTE, PACKING SLIP

Pièce justificative accompagnant la livraison des stocks ou matériels. Cette pièce est établie par le fournisseur et doit être contresignée par le bénéficiaire. Généralement elle est établie en plusieurs exemplaires.

BUDGET.....BUDGET

Généralemant conçu comme un état prévisionnel des recettes, et des dépenses d'une entité pour une période donnée, le budget est ainsi une répresentation chiffrée des objectifs de l'organisation. Ces objectifs peuvent être à court terme ou a long terme. C'est pour cette raison que l'on distingue les deux budgets suivants: budget de fonctionnement (généralement établi pour une année) et budget d'investissement (à long terme).

CAHIER DES AVANCES.....NOTEBOOK OF ADVANCES AGAINST SALARIES

C'est le document dans lequel les entités enregistrent les avances reçues par le personnel. Il s'agît des acomptes octroyés aux agents sur leur salarires. Ces avances sont récupérables.

CAHIER DES CONVENTIONNES.....NOTEBOOK FOR INSURED PATIENTS

Généralement les entreprises paient la facture des soins reçus par leur personnel á la fin de la période (souvent le mois). Pendant le mois les centres de santé enregistrent les données relatives à ces services dans un document appellé "cahier des conventionnés." Le total de la valeur des services ainsi repertoriés représente la facture à payer par l'entreprise employeuse à la fin de la période.

CAHIER DE SOINS PERSONNEL.....NOTEBOOK OF HEALTH CARE BENEFITS TO PERSONNEL

C'est le document dans lequel on enregistre la quantité et la valeur des soins dispensés gratuitement au personnel oeuvrant dans l'organisation.

CARNET DE BAR.....TYPE OF RECEIPT BOOK

C'est un carnet comportant plusieurs timbres numérotés et détachables. Ces timbres constituent des quittances ou des reçus remis au malade au moment de la perception des fonds par les services financiers de zone des santé ou des hôpitaux.

CHARGES.....EXPENSES

Ce sont des emplois définitifs correspondant à des consommations de biens et services nécessaires au fonctionnment de l'entité. Inscription à gauche du compte d'exploitation. Exemples: stock consommé, transport, salaires, frais généraux, amortissement.

CODIFICATION INTERNE.....ACCOUNT NUMBERS FOR RESPONSIBILITY CENTERS

Liste reprenant le numéro de code attribué, aux différents sections ou centres de responsabilité (exemple: les services) habilités à engager les dépenses (voir aussi Plan Comptable).

COMPTABILITE ANALYTIQUE.....COST ACCOUNTING, MANAGEMENT ACCOUNTING, COST FINDING

C'est la comptabilité des côuts et des prix de revient. Elle permet de saisir les données à la fois selon leur nature et selon les centres de responsabilités. C'est un outil d'éclairage des décisions de gestion. La comptabilité analytique est un mode de traitement des données comptables dont les objectifs sont: 1) Outil d'évaluation (connaître les différents coûts de l'organisation et de ses services); 2) Instrument d'analyse (expliquer les résultats en fournissant une grille d'analyse); et 3) Support de décisions (établir des prévisions de charges et de produits, constater les réalisations et fournir une base chiffrée pour l'explication des écarts).

La fonction de signalisation exige que l'entité aie une comptabilité analytique aussi bien que la comptabilité générale.

COMPTABILITE GENERALE.....FINANCIAL ACCOUNTING

La comptabilité générale est la façon d'enregistrer, classifier, et resumer les opérations afin de produire les rapports financiers tels que le compte d'exploitation et le bilan à la fin de l'exercise. Une fois établis, ces rapports montrent la situation comptable de l'organisation. Ces documents sont utiles pour évaluer le passé et servent également de base à l'élaboration des projections pour l'avenir.

La comptabilité générale et la comptabilité analytique sont toutes autonomes, et néamoins complémentaires dans leur utilisation.

COMPTABILITE MONETAIRE, NON-MONETAIRE, ET COMPLETE.....CASH-BASED ACCOUNTING, ACCOUNTING FOR NON-CASH TRANSACTIONS, ACCRUAL ACCOUNTING

La comptabilité monétaire enregistre exclusivement les transactions qui concerne les entrées et les sorties des espèces au niveau de la caisse. Elle se préoccupe des opérations, réalisées comptant. Une telle comptabilité est partielle. Pour être complète elle doit aussi rendre compte des opérations non-monétaires, telles que les mouvements de stock, les dons en nature, les créances douteuses, les amortissements, etc.

Seule une comptabilité complète, donne une vision juste de la situation financière de l'entité.

COMPTABILITE EN PARTIE SIMPLE OU PARTIE DOUBLE.....SINGLE-ENTRY or DOUBLE-ENTRY BOOKKEEPING

La tenue des livres comptables peut être faite selon deux principes: la "partie simple" ou la "partie double." La parti simple consiste à enregistrer dans un cahier ou un classeur, de façon chronologique, l'ensemble des opérations effectuées par l'organisation selon les critères de dépenses ou de recettes. La tenu d'un tel document est réalisable quand le nombre d'opérations à enregistrer est faible. Mais si les opérations sont nombreuses, cette comptabilité ne permet pas le contrôle d'exactitude à l'aide de balances et ne permet pas le suivi de la modification générale du Patrimoine.

La comptabilité dite en partie double nécessite une double inscription appellée une écriture. Cette écriture se décompose en un débit et un crédit. Par convention, le crédit est à droite d'un compte, et le débit à gauche. La partie double permet plus de contrôle, parce qu'à la fin de la période, si la comptabilité a été bien tenu, une balance doit ressortir de l'ensemble des comptes, ce qui n'est pas le cas pour la comptabilité dite en partie simple. (Voir Balance).

COMPTE.....ACCOUNT

Dans le sens technique de la comptabilité, les comptes sont utilisés pour classifier des transactions, soit par nature, soit par destination. Le comptable classe dans un même compte les opérations intéressant un même objet ou transaction. Un "compte banque" enregistre ainsi toutes les informations intéressant la banque (dépôts, retraits, virements etc.). Chaque compte a la proprieté de montrer: A) les augmentations; B) les diminuations; et C) la balance après les transactions.

COMPTE D'EXPLOITATION.....INCOME STATEMENT OR STATEMENT OF REVENUES AND EXPENSES

C'est un tableau qui permet de dégager le résultat de l'exploitation, c'est-à-dire de l'activité. Ce tableau comprend au débit (à gauche) les charges d'exploitation et au crédit (à droite) les produits d'exploitation. Le solde de ce tableau indique le résultat qui est soit un bénéfit, soit une perte.

CONTROLE D'ENREGISTREMENT.....VERIFICATION OF INITIAL RECORDING AND POSTING OF TRANSACTION

C'est l'ensemble des procédures suivie pour verifier l'exactitude arithmétique des reports, et si les imputations ont été faites dans des comptes appropriés. Le contrôle d'enregistrement fait partie du système du contrôle interne.

CONTROLE DE GESTION.....MANAGEMENT CONTROL

Voir Fonction de Signalisation.

CONTROLE INTERNE.....INTERNAL CONTROL

L'ensemble des processus et procédures établis pour assurer de façon permanente la securité des actifs d'une organisation. Le système du contrôle interne doit diminuer la possibilité de détournements, des erreurs et doit permettre la détection à temps des indices de faiblesse, d'inefficience ou de vieillissement des structures.

CREANCE.....ACCOUNT RECEIVABLE

C'est un droit que possède l'organisation sur des tiers, ce droit résulte souvent des dettes contractées par ces derniers (les tiers) vis à vis de l'organisation.

CREDIT.....CREDIT (d'un compte)

Par convention, il s'agit de la partie droite d'un compte. "Créditer un compte" c'est donc inscrire une somme au crédit d'un compte. Ceci peut signaler une augmentation ou une diminuation d'un compte; le tout dépend de la nature du compte. (ex. Lorsque le compte caisse est crédité, ceci signale une diminuation de l'avoir en caisse.)

On parle d'un compte créditeur quand le total au crédit est superieur au total du débit.

DEBIT.....DEBIT (d'un compte)

Par convention, it s'agit de la partie gauche d'un compte. "Débiter un compte" c'est donc inscrire une somme au débit d'un compte. Ceci peut signaler une augmentation ou une diminuation d'un compte, le tout dépend de la nature du compte. (ex. Quand le compte de caisse est débité, ceci signale une augmentation de l'avoir en caisse).

On parle d'un compte débiteur quand le total du crédit est inferieur au total du débit.

DEMANDE DE PROVISION, BON PROVISOIRE OU ETAT DE BESOIN EN LIQUIDITE.....CASH ADVANCE REQUEST

C'est un document permettant un décaissement au titre de provision destinée à réaliser une dépense dont l'importance est difficile à estimer. Seul le montant exact de la dépense appuyée d'une pièce justificative (facture, reçu etc.) sera noté dans le livre de caisse. Les délais maximum de justification de tels bons doivent être clairement établis.

DOIT.....DEBIT SIDE OF AN ACCOUNT

Un autre nom pour le coté gauche d'un compte. Voir aussi Débit.

ETAT JOURNALIER DES RECETTES ET DEPENSES.....DAILY STATEMENT OF RECEIPTS AND EXPENSES

Même chose que le registre des recettes et dépenses.

ETAT DE PAIE, FEUILLE DE PAIE.....PAYROLL, PAY SLIP

Un document qui contient toutes les informations concernant le calcul des salaires des employés. Ce document est etabli souvent une fois par mois.

FICHE OU CAHIER DE REQUISITION.....ORDER NOTEBOOK OR FORM

Document utilisé pour enregistrer les commandes de médicaments emanant des entités (exemple: Centres de Santé).

FICHE DE COMPTE.....PAGE OF A LEDGER BOOK

Document sur lequel on note les modifications relatives à un compte. Chaque fiche de compte montre les augmentations, les diminutions, et la balance d'un compte. L'ensemble des fiches de comptes constitue le "grand livre" (ledger book). Si un vrai livre est utilisé pour le grand livre, chaque page sert comme une fiche de compte.

FICHE JOURNAL.....JOURNAL (IN THE FORM OF UNBOUND PAGES)

Document enregistrant chronologiquement toutes les opérations de l'entité. L l'aide d'un papier carbon, les opérations sont inscrites en même temps sur la fiche journal et sur la fiche de compte (grand livre). La fiche journal sert á vérifier l'exactitude des reports.

FONCTION D'AUXILIAIRE D'INVESTIGATION.....STRATEGIC PLANNING

Le système d'information de gestion financière doit fournir les informations nécessaires pour la planification a long-terme, la fixation d'objectifs, de strategies et de politiques. Pour servir cette fonction les données bruts doivent etre traitées et analysées. Les informations qui ressortent de ces analyses permettant souvent les estimations et les projections.

FONCTION DE COMPILATION.....BOOKKEEPING, TRANSACTION PROCESSING

Ensemble des opérations qui resultent dans l'accumulation des données comptables brutes ou semi-traitées se rapportant à la vie et aux activités financières d'une entité. Ces activités comprennent l'enregistrement, classification, et parfois résumé des données. Ces données sont alors disponibles pour des traitements ultérieur répondant aux besoins de décisions.

FONCTION DE SIGNALISATION (CONTROLE DE GESTION).....MANAGEMENT CONTROL

La fonction de signalisation consiste dans le traitement des données financières de manière à produire des rapports ou des analyses qui attirent l'attention des décideurs sur les situations spéciales (par exemple, les écarts entre les prévisions et les réalisations). La fonction de signalisation est aussi concernée par l'évaluation de l'utilisation des ressources de l'entité, et la mésure de l'efficience avec laquelle l'entité a fonctionné.

FOURNISSEURS.....SUPPLIERS, OFTEN USED TO REFER TO ACCOUNTS PAYABLE

Tiers approvisionnant l'organisation.

GRAND LIVRE.....LEDGER BOOK

Document régroupant l'ensemble des comptes ouverts dans l'entité. C'est le livre de "dernier enregistrement." Parfois le grand livre est composé des "fiches de comptes."

LIVRES DE BASES.....BASIC BOOKS OF AN ORGANIZATION

Les livres essentiels, pour la comptabilité, sont les "livres de premier enregistrement," et les "livres de dernier enregistrement." Les livres de premier enregistrement sont les documents dans lesquels les opérations sont notées en premier lieu (le livre de caisse, état de paie, cahier des subsides, etc.). Souvent les entrées dans ces documents sont chronologiques. Les livres de dernier enregistrement sont les documents dans lesquels les opérations sont reportées plus tard (ex., le grand livre, ou les opérations sont organisés par compte). Un autre livre de dernier enregistrement est le registre de recettes, où les recettes sont resumées pour la journée, par rubrique.

LIVRE (CAHIER) DE CAISSE.....CASH JOURNAL OR NOTEBOOK

Livre ou cahier où les opérations monétaire sont enregistrées en premier lieu. Les transactions sont enregistrées en ordre chronologique. Le plus souvent il y a cinq ou six colonnes: numéro de transaction, date, libelle ou déscription de transaction, recettes, dépenses, et balance. Un "cahier" de caisse est moins standardisé, et se trouve souvent au niveau du centre de santé. Le but est le même: le premier enregistrement des transactions financières.

PASSIF.....LIABILITIES AND OWNER'S EQUITY

Le coté droit du bilan, le passif montre d'où viennent les ressources de l'organisation. Ces ressources proviennent soit des tiers (dettes à long- et court-terme) et celles qui appartiennent à l'entité (le capital propre) et les résultats réalises. Les valeurs du passif sont en ordre d'exigibilité croissante. On va des valeurs les moins réalises. Les exigible (fonds propres) aux plus (dettes à court terme).

PIECES COMPTABLES OU PIECES JUSTIFICATIVES.....SUPPORTING DOCUMENTS

Selon les procédures bien établies et les instructions comptables, chaque opération financière qui est enregistrée dans les livres de l'organisation doit être appuyée par une facture ou outre pièce comptable justificative. La livraison d'une réquisition est justifié par un bordereau d'envoie ou par un bon de sortie.

PLAN COMPTABLE.....CHART OF ACCOUNTS

C'est la liste méthodiquement dressée des comptes que l'on se propose d'utiliser pour enregistrer, par le procédé des parties doubles, les opérations effectuées par l'entité.

Le Plan Comptable Zaïrois a été conçu pour l'enemble des entreprises du Zaïre, mais le gouvernement souhaiterait que le plan soit aussi adapté par les services publiques. Bien entendu, les responsables des services, à partir du Plan Comptable, doivent amenager un Plan convenant à leurs besoins. Le Plan Comptable permet la comptabilité à donner tous les résultats utiles à l'entité sous une forme claire, simple et exacte. Si les organisations de même activité (comme les zones de santé) suivent le Plan Comptable Zaïrois, la comparaison entre différentes organisations sera plus facile.

Une codification interne, ajoutée au Plan, peut servir à indiquer la destination ou centre de responsabilité (service, département) qui est bénéficiaire de la transaction.

PRODUITS.....REVENUE

Ensemble des ressourses d'exploitation. Inscription à droit du compte d'exploitation. Les produits les plus courrants comprennent ventes, prestations de service et produits d'activité annexe.

PRUDENCE COMPTABLE.....CONSERVATISM PRINCIPLE

Ce principe de comptabilité exige que le système prévoie des mécanismes permettant la prise en compte immédiate des risques prévisibles et des pertes probables en excluant les avantages non échus.

QUITTANCE.....RECEIPT

Réçu. Une pièce justificative des recettes.

REGISTRE DES MEDICAMENTS; FICHES DE STOCKS.....DRUG REGISTER, STOCK CARDS

Deux methodes pour l'enregistrement des entrées et des sorties des stocks des médicaments. Chaque mouvement de stock est enregistré, et la balance en stock est calculé, par médicament et pour l'ensemble de la pharmacie.

REGISTRE DES RECETTES ET DEPENSES.....RECEIPT AND EXPENSE JOURNALS

Souvent le registre de recettes et dépenses est utilisé pour résumer les recettes et dépenses par jour. Il y a plusieurs colonnes, un pour chaque categorie de recettes et dépenses. Souvent ces registres se trouvent au niveau du centre de santé et de l'hôpital. Parfois les entités gardent un registre des recettes et un registre des dépenses à part.

RELEVÉ DU COMPTE.....ACCOUNT STATEMENT

Document de synthèse qui résume les variations d'un compte durant une period et la balance à la fin de la période. Dans la zone d'Nselo ce document a résumé les entrées et les sortis pour le compte de chaque centre de santé chaque mois. C'etait envoyé au comité de gestion du CS.

SOLDE.....BALANCE

Difference entre le débit et le crédit.

TRESORERIE.....CASH

Valeurs immediatement disponibles dans l'entité (banque et caisse). Le rapport de trésorerié donne la situation des valeurs immédiatement disponsibles, pour une période donnée.

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ANNEX D

Description of Decisions Made in 10 Health Zones

This appendix describes some of the decisions made in the 10 health zones visited during the REACH study (July-August 1986). Most of the decisions were actually made during the time period studied (1985 and first semester of 1986), although some "strategies" are included which may not have been chosen during the past 18 months but were presumably reviewed and found suitable to the zone's needs. For example, the list includes the two-fund accounting system at the health zone level used by all zones except Kindu and Bwamanda, and Bokoro's strategy of combining the financial reports of health centers and the central office.

Most decisions are followed by the initials of one or more zones, in parentheses; these initials indicate at least one zone who made this particular decision. Please note that there are probably other zones who have made the same or a similar decision. Their initials do not appear only because there was not written evidence of these decisions. A key to the abbreviations may be found at the end of the appendix.

The decisions are organized by level, subject, and type of decision.

- Level: Decisions made at the central office and hospital levels are presented together because there is not enough information available to ascertain which decisions affecting the hospital are made by hospital staff and which are made by the central office. The health center level is presented separately, although naturally some decisions affecting the health center are made by the central office.

- Subject: Eight subjects on which decisions are made include:

  Organizational Issues
  Pricing
  Payment Systems
  Financial Management
  Investments
  Personnel
  General Management and Other
  Medical

At the health center level the first subject area (organizational issues) is omitted due lack of information.

- Type: A distinction is made between strategic planning and management control decisions on the one hand and operational decisions on the other. This distinction is important because information needs will vary depending on the type of decision.

It is important to understand, however, that the type of decision often depends on the level of maturity of a health zone. For example, more mature zones may have established many policies already, so their initials may not appear beside a particular policy or "strategy" decision. At the same time, they still need information to review these decisions periodically.

Secondly, actions seen as "decisions" in some zones (e.g., hiring or promoting personnel, ordering drugs) may be referred to as "tasks" in other zones where policies, procedures and guidelines for such activities have been clearly formulated and specified.

The decisions made by the zones follow:

I. CENTRAL OFFICE AND HOSPITAL LEVELS

A. Organizational Decisions (all are planning/control decisions)

1. Wrote definitions for types of facilities (SB)
2. Determined boundaries for areas of coverage for each facility (SB)
3. Decided to increase zone responsibility for management of Baptist (CBZO) facilities, which were functioning poorly (SB)
4. Categorized each facility in zone by type (health post, health center, etc.) (SB)
5. Adopted policy of promoting decentralization and autonomy of health centers, abolishing previous policy of cross-subsidization among health centers (BW)
6. Created management committees (zone, hospital and health center levels), putting more emphasis on committee-style management (KR)
7. Created new organizational chart (KR)
8. Separated operation of central office from hospital, including creating a separate storage room and pharmacy (KR)
9. Adopted "sector" or "subzone" approach to organization of zone, e.g., reference health centers with health centers and health posts reporting to them (BO, BW, BI)

10. Adopted policy of relying more on health posts or health promotion teams (village health workers and traditional birth attendants) to extend coverage (KA, BI)

11. Explored possibility of closing some facilities due to low utilization and duplication of services (SB, BO)

12. Adopted policy of defining facilities not recognized by zone as illegal, and cracking down on illegal providers (SB, BO)

13. Turned dispensary of hospital into independently functioning reference health center (BW)

B. Pricing Decisions (all planning/control decisions)

1. Set and modified prices for services and mark-ups on drugs (KK, KR, BO, SB, DU, KA, KD)

2. Adopted policy of providing free delivery to women who follow a program of pre-natal consultations (BW)

3. Adopted policy of charging identical prices for under 5's clinic, whether or not the child is resident in the health center coverage area (BW)

4. Abolished policy of allowing chronic illness patients to receive free care for other illnesses as well (BW)

5. Abolished policy of allowing health center nurses to determine own mark-up on drugs (KR)

6. Allowed hospital to charge mark-up on drugs identical to health centers (KR)

7. Adopted policy regarding supervision fees for Catholic facilities (SB)

8. Adopted policies regarding free care for various populations (SB, DU)

9. Adopted policy of charging higher prices to non-residents (DU)

10. Adopted policies regarding "free" referrals from health centers, deciding what services should be included in free referral and what must be paid apart (KD, DU, others)

11. Adopted dual price system: prices for services at protestant facilities vs. all other facilities (BO)

12. Adopted policy regarding supervision fees charged to health centers (DU, others)

13. Abolished policy of offering CPN and CPS free at hospital level (DU)

14. Adopted policy of reduced price to members of health center management committees, plus other incentives such as T-shirts and badges, to encourage participation (KA)

C. Payment System Decisions (all planning/control decisions)

1. Changed payment system for health centers from two payer-categories to one, so all patients pay one price (DU)

2. Started (or explored possibility of starting) pre-paid plan for inpatient care (BW, SB, BO)

3. Adopted policy of demanding payment of one-half hospitalization fee in advance, to circumvent problem of people leaving without paying (DU)

4. Adopted policy of daily payment of drugs for hospital patients, to ameliorate same problem as #3 above (DU)

5. Adopted policy of requiring a deposit from patient upon arrival at hospital (BO)

D. Financial Management Decisions (all planning/control decisions)

1. Instituted change in accounting system, separating hospital from central office accounting (BW)

2. Continued strategy of combining financial accounting for health centers and central office (BO)

3. Moved towards an accrual accounting system, assisting health center personnel to calculate depreciation expense for equipment and requiring them to use excess of revenue over expenses for investments in equipment equal to depreciation expense (BW)

4. Identified the need to improve information systems and began reorganization of existing systems (SB, KR)

5. Instituted change in reporting system, separating financial reports for central office, hospital and health centers (DU)

6. Decentralized reporting system, allowing reference health centers to combine health center information, submitting only summary reports to central office (SB, DU)

7. Began accounting for the equivalent value of expatriate salaries subsidy (i.e., what the zone would have to pay a Zairian providing the same services) in order to calculate full cost of providing services (BO)

8. Began accounting for the value gifts-in-kind in financial statements (BO, KR, BW)

9. Operated system of two funds for health center accounting: services and drugs, with the drug fund to function as a revolving fund (all zones except KD and BW)

10. Set standards for health centers to be self-financing: minimum population, density, utilization and staffing (KA)

11. Compiled and approved zone budget (KD, KA)

12. Changed financial accounting system to separate pharmacy (serving the whole zone) from the hospital (BO)

13. Adopted policy of preparing budget for supervisory trips and monitoring execution of budget in order to improve control of supervision costs (BO)

14. Identified need for clearer financial statements (SB)

15. Adopted policy of setting aside revenue from obstetrical services at health center level to be used for investments at discretion of management committee (SB)

16. Controlled drug purchases by health centers, identifying and rectifying anomalies in prescribing habits among nurses (KD)

17. Invested idle cash (drug supply credit from Belgium) (KD)

E. Investment Decisions (operational decisions: 1-3; planning/control decisions: 4-7)

1. Determined need and selected sites for new health centers, maternities (KA, KD, KK)

2. Determined need for infrastructure investments (KA, KD, DU)

3. Purchased major equipment (KA)

4. Adopted plan to target investments and training to improve five health centers per year (KR)

5. Explored possibility of switching to solar refrigerators, because of expense of maintaining Kerosene refrigerators (BW)

6. Continue exploring possible use of micro computers for zone management (KD)

7. Solicited subsidies from external donors for infrastructure improvements (BO)

F. Personnel Decisions (operational decisions: 1-4; planning/control decisions: 5-9)

1. Hired personnel (KK)

2. Determined that a poorly performing nurse should be transferred (SB)

3. Selected replacements for health center nurses on vacation (KD)

4. Recommended promotions (KA, BI, others)

5. Wrote or clarified job descriptions and personnel statutes (KR, KA, SB, KD)

6. Determined training needs and established training plan for health zone personnel (KR)

7. Changed personnel hiring policy to allow more health care management committee input and more "attitude evaluation" as criteria for employment (BO)

8. Determined need to train health center management committee members in management techniques, and to improve their access to information (BO)

9. Rejected a suggestion to centralize personnel management in the zone, reaffirming policy of decentralized self-management of individual facilities (BO)

G. General Management and Other Decisions (operational: 1-5; planning control: 6-10)

1. Scheduled supervisory visits to health centers (SB)

2. Purchased office supplies, fuel (most all zones)

3. Purchased drugs (all)

4. Repaired and maintained vehicles (all)

5. Billed third-party payers (KD, BW)

6. Identified management control as an issue and initiated plan of management by objectives (KR)

7. Evaluated performance of zone according to objectives (KA, KR, BW, SB)

8. Set goals for supervision, including number of visits for each facility per year, amount of time per visit, use of doctors vs. nurses for supervision (BO)

9. Identified need to change process of recording cause of death, to decrease number of deaths listed as "other" (SB)

10. Identified most pressing health problems in zone, in order of priority (SB)

H. Medical Decisions (list includes those decisions made at hospital only, all are operational decisions)

1. Diagnosed patients (all)

2. Treated patients, including deciding amount and type of drugs, number of lab exams, surgery or other procedures, doctor visits, nurse visits (all)

3. Referred patients (all)

II. HEALTH CENTER LEVEL

A. Pricing Decisions (planning/control)

1. Determined mark-up on drugs (KR, in past)

2. Recommended changes in price schedule applied across entire zone (KD, others)

3. Modified price schedule as necessary, without approval of central office (KA)

B. Payment System Decisions (planning/control)

1. One health center decided to pay hospitalization costs above 500 Zaires for its population (hospitalization insurance with 500Z deductible paid out of excess revenues) (BO)

2. Population of zone rejected idea of pre-paid plan for inpatient care (BO)

C. Financial Decisions (operational: 1; plan/control: 2-6)

1. Maintained accounting system, recording debits and credits (all)

2. Chose what to do with excess of revenue over expenses (KA)

3. Controlled cash ledger on a monthly basis (KA)

4. Chose what to do about deficit, including engaging in revenue-generating activities outside of regular operations (BW, KA)

5. Management committee reviewed receipts and expenses on a trimestrial basis (KA)

6. Provided recommendations for next year's budget (KD)

D. Investment Decisions

1. Determined need for equipment and other infrastructure improvements (cementing walls, replacing straw roofing with metal) (KD, BW, most others)

2. Determined need for a maternity, and identified sources of community and other financing (KD)

E. Personnel Decisions (mostly operational decisions, with some control functions)

1. Determined salaries of personnel (based on revenue, with floor and ceiling) (KR)

2. Made recommendations for hiring; evaluated performance of personnel (KK, BI, BO)

3. Determined training needs of health center personnel and extension workers (KA)

4. Determined vacations, family allocations for personnel (KA)

F. General Management and Other Decisions (operational: 1-3; planning/control: 4, 5)

1. Scheduled village activities including mobile team visits for preventive and curative care and health promotion/education activities (KD, BW)

2. Purchased office supplies, nutrition demonstration materials, kerosene or other operating supplies (all)

3. Ordered drugs (all)

4. Controlled drug inventory, daily and monthly, identifying problems or differences between records and physical stock (KA)

5. Set policies in health programs (BI)

G. Medical Decisions (all operational)

1. Diagnosed patients (all)

2. Treated patients including deciding amount and type of drugs, number of lab exams, minor surgery, follow-up visits (all)

3. Referred patients (all)

Zone Abbreviations

Bibanga	BI
Bokoro	BO
Bwamanda	BW
Dungu	DU
Kalonda	KL
Kaniama	KA
Kikimi	KK
Kindu	KD
Kirotshe	KR
Sona Bata	SB