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PADS GUIDELINES FOR IMPLEMENTATION OF USER FEES

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REACH



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PROVINCIAL AND DISTRICT HEALTH SERVICES STUDY
GUIDELINES FOR IMPLEMENTATION OF USER FEES

Part I. Setting Priorities for Spending Revenues
Generated by User Fees

Part II. Requirements for Fee Administration System

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PART I: SETTING PRIORITIES FOR SPENDING REVENUES GENERATED BY USER FEES

A. Introduction

The major objectives of the Government of Kenya's (GOK) policy to introduce cost sharing into the health service delivery system are to improve the quality of care provided at government health facilities and to increase the efficiency with which these health facilities operate. To meet these objectives, it is currently being proposed that 50 to 75 percent of the revenues collected by each facility would be used by the facility itself to improve both the quality of care it delivers and the efficiency of its operations. In response to a request by the Health Care Financing Steering Committee, the Provincial and District Study (PADS) Team has prepared draft guidelines of criteria that could be used to prioritise decisions as to how these revenues should be spent by a facility. These criteria could be used by a committee at the facility itself, by some other decision making body within the district, or by the Ministry of Health (MOH). The PADS Team presents the following approach towards establishing decision-making criteria for spending the portion of collected revenues that will be retained by the facility.

B. Alternative Views of Priorities

In developing an approach to setting priorities, the perspectives and views of several different groups of people need to be taken into consideration. The perspectives of patients and members of the community as to what expenditures they would consider most necessary to improve the quality of services at a particular facility may differ from those of doctors, nurses, or of other facility staff. The technical perspectives of administrators and policy makers may provide yet a different view of how fee revenue should be spent to improve the quality and operation of services. Examples of these differing view points can be summarized briefly as follows.

PERSPECTIVES

Patient and Community Members

- Availability of drugs/
medical staff
- Adequacy of hospital
hotel services
- Availability and convenience
of services
- Quality of services

Doctors

- Diagnostic equipment
- Drugs and dressings

- Quality of living/working
quarters
- Patient workload
- Cleanliness and hygiene

Nurses and Other Staff

- Linens and supplies
- Quality of living/working
quarters
- Patient and staff food
- Cleanliness and hygiene

Administrators and Managers

- Meeting operating needs
- Maintenance needs
- Financial sustainability
- Improving operating
efficiency

Policy Makers

- Equity considerations
- Political considerations
- Viability of the system
- Consistency with government
policy

It is clear from the above summary that many different priorities for spending revenues may exist, and there is potential for disagreement. Thus, it is desirable to determine criteria which will help decision-makers to prioritize the needs for expenditures from fee revenues in any particular facility. This is complicated by the need to balance the technical requirements for improving services with client expectations of what those improvements should be. The shared objective of all the above groups, nevertheless, is to have a well-run health facility which delivers good quality health care to the community. If general criteria for setting priorities for fee revenue expenditures can be established, these criteria can provide a basis for dialogue and communication among these various groups about how fee revenue should be spent to improve services at a facility.

C. Trade-offs to be Considered in Setting Priorities: Quality, Quantity, Efficiency

Those whose task it will be to make decisions about spending fee revenues will readily understand that trade-offs are involved. The amount of revenue generated by each facility is likely to be small relative to the need for expenditures, especially during the first few years. Resource limitations may be such that making improvements in the quality of patient care (such as repairing diagnostic equipment to improve effective treatment) will limit the resources available for quantity improvements (such as increasing the outpatient preventive services and curative services). Thus, choices for quality and quantity improvements will compete with each other. Specific areas that may compete for the fee revenue resources and touch upon both quality and quantity of services include:

- Providing appropriate drugs and medications
- Providing proper patient management
- Addressing subjective perceptions of quality
- Providing adequate therapy
- Maintaining hygienic conditions
- Maintaining appealing or pleasing physical surroundings
- Reducing waiting time
- Increasing time spent with health care providers
- Handling proper triaging or filtering
- Training and deploying qualified staff
- Maintaining proper functioning of equipment
- Maintaining appropriate and adequate supplies
- Providing good food in adequate amounts
- Improving proper communication among providers
- Improving communication between providers and patients

The need to address issues of cost and efficiency may also compete for fee revenue resources. Specific areas which touch on cost and efficiency include:

- Eliminating of bottlenecks which lead to inefficient resource use
- Increasing allocation of resources to primary health care and preventive services
- Meeting requirements of chronically underfunded areas

D. Perspectives of Policy Makers, Administrators, and Clients in Nakuru District

The PADS Team conducted interviews with clients who were attending government facilities and with administrators and policy makers in Nakuru District to gain an understanding of the perspective of these groups as to how fee revenues should be spent. Summaries of the interviews are as follows:

1. Clients

Interviews were conducted with 1,697 outpatients at clinics, hospitals, health centers, and dispensaries in Nakuru District. All were asked to rate the quality of services at the facility they were attending. Most outpatients (76 percent) rated services provided at health facilities as good and dispensaries generally received the best ratings. For those who rated services as fair or poor, 34 percent said it was because waiting time was too long, 31 percent because there were no drugs, 12 percent thought that staff were discourteous, and five percent considered the staff were not qualified. Two percent gave a lower rating because there was no doctor at the facility.

Interviews were conducted with a total of 375 inpatients at Nakuru Provincial General Hospital (PGH) and Naivasha Hospital. Each patient was asked to identify problem areas at the hospital and rank it as fair or poor. The results are as follows:

PROBLEM	NAKURU PGH		NAIVASHA	
	POOR	FAIR	POOR	FAIR
1. Reliability of meals	25%	53%	14%	37%
2. Quality of food	25%	51%	18%	33%
3. Cleanliness of ward	15%	46%	7%	42%
4. Availability of bedding	46%	37%	58%	31%
5. Absence of confidentiality/privacy	45%	34%	32%	54%
6. Drug availability	3%	26%	5%	26%
7. Attitude of staff	3%	25%	2%	7%
8. Adequacy of diagnosis	1%	20%	1%	21%

When asked what they would most like to see improved, inpatients at Nakuru reported as their top three priorities: alleviate bed sharing (19 percent), availability of drugs (18 percent), and availability of beds and linens (14 percent). At Naivasha the three top priorities were; bedding and linens (36 percent), blankets (20 percent), and drug availability (14 percent).

2. Administrators and Policy Makers

Interviews with 28 policy makers and administrators in the Nakuru District identified 14 priority areas for which the collected revenue should be used (Table 1). Drugs and other supplies were listed most frequently as the priority for revenue spending (64.3 percent). The next most frequently mentioned priority was fueling and maintenance of vehicles (39.3 percent). Three other areas regarded as priorities by more than 20 percent of administrators and policy makers were; maintenance and repair of buildings and equipment, purchase of bedding, linen and patients' food; and facility expansion of Maternal and Child Health (MCH)/Family Planning (FP) units and maternity wards. Other priorities for expenditure mentioned by less than 20 percent of the interviewed policy makers were: purchase of equipment; employment of adequate staff; improving water supply; purchase of vehicles; construction of staff housing; fencing the facility; improving staff morale; and purchasing general supplies.

TABLE 1

Priority Areas for Spending Fee Revenues

Priority Area	Proportion of Policy Makers Identifying Priority Area (in %)
Drugs and Supplies	64.3
Fuel/Maintenance of Vehicles	39.3
Maintenance/Repair of Buildings	28.6
Bedding, Linen, Patient's Food and Equipment	28.6
Facility Expansion: MCH/FP, Maternity	21.4
Purchase of Equipment	14.3
Improvement of Water Supply	14.3
Employment of Adequate Staff	10.7
Purchase of Vehicles	10.7
Construction of Staff Houses	3.6
Fence the Facility	3.6
Improve Staff Morale	3.6
Purchase General Supplies	3.6
Other Priority to be Determined by Facility Management	3.6

These interviews revealed that priorities varied considerably from one facility to the other depending on the nature of the particular problems faced by a facility at any given moment. Therefore, it would seem important that the criteria for determining how revenues are to be spent should be flexible and general so that they can accommodate local needs.

E. Criteria for Setting Priorities for Spending Fee Revenues at the Facility Where Revenue is Generated

To help ensure that both the facility and the community are to benefit from the money collected, it is helpful to have criteria that define appropriate areas of expenditures. These criteria can provide the guidelines that facility decision-makers need to set the priorities for how to spend fee revenues. Three general criteria can be considered.

1. Eliminate life threatening conditions.

Examples of expenditures would include repairing buildings which are in danger of collapsing, repairing broken sterilisation equipment, purchasing essential drugs and supplies.

2. Consume fewer resources/make more resources available.

Examples of expenditures would fall under several categories:

- a. Repairing equipment and buildings where present conditions lead to unnecessary expenses and resource waste, e.g., repairing broken equipment so that patients do not have to be transported to other facilities.
- b. Improving managerial performance and capacity by purchase of equipment which can improve management operations, improving office space.
- c. Reducing the cost of providing services by the purchase of better equipment, developing facility-based diagnosis and treatment protocols which reduce the average length of stay, number of prescriptions, and outpatient visits, and expanding primary health care (PHC) services.

3. Improve the quality or availability of services.

Examples of expenditures include improving the availability of supplies and drugs, improving the appearance of the facility, expanding services to satisfy the health needs of the community.

In applying these general criteria to the problems of improving the quality of services and the efficiency of operation at a facility, the PADS Team proposes five priority areas for expenditure of fee revenues. These priorities can provide general guidelines to decision-makers regarding how fee revenues are to be spent. They are not presented in any proposed order of importance. Rather, the priority areas are intended to suggest guidelines for decision making. The particular order of importance will need to differ according to local conditions and community needs. Flexible use of these guidelines and local discretion are essential elements if fee revenues are to be used successfully to improve the operation of facilities and the quality of care they deliver.

F. Priorities for Expenditures of Fee Revenues

Priority Area #1: Address life threatening physical and medical conditions.

- a. Undertake urgently required repairs and maintenance to buildings, installations, and equipment where present conditions are a danger to human life.
- b. Undertake urgently required purchases of drugs which are essential to meet life threatening conditions.

Priority Area #2: Address unacceptable hygienic and sanitation conditions.

- a. Undertake required repairs and maintenance to buildings, installations, and equipment where present conditions contribute to infection and disease.
- b. Undertake required purchases of supplies and equipment to meet sanitation and hygienic standards.
- c. Undertake required purchases of dressings and syringes to meet sterile condition requirements.

Priority Area #3: Address conditions where resources are being wasted.

- a. Undertake repairs and maintenance of equipment where non-functional (broken or improperly stored) equipment causes additional expenditures in other areas.

b. Purchase supplies and drugs where insufficient quantities cause underutilization/inappropriate use of manpower and equipment.

c. Undertake required repairs and maintenance where present conditions are likely to destroy equipment.

Priority Area #4: Address conditions which will improve efficiency.

a. Undertake improvements in management operations.

b. Undertake productivity increasing improvements.

c. Improve reliability of services, installations.

Priority Area #5: Address conditions which will improve the quality of care.

a. Undertake improvements in diagnostic capacity/capability.

b. Undertake urgent improvements to satisfy staff and client perceptions of what is needed to provide better health services.

Within each of these priority areas, decision-makers are likely to identify the need for several types of expenditures. Each of these expenditure requirements must be further evaluated. The first three priority areas listed above address the need to restore and rehabilitate facilities and services. Decision-makers may decide it is necessary to undertake these types of improvements first in order to sustain the operational performance of the facility and its services. Improvements in quality and performance could rank second under these circumstances.

Decision-makers will also want to determine whether expenditures are likely to be small or large, and whether they are one time expenditures or will require on-going funds. Some expenditures, such as development and personnel expenditures, are more appropriately made at the Ministry of Health. Others, such as on-going operating expenses or emergency needs, are more expeditiously undertaken at the facility or district level. In some facilities, items that contribute to staff and client perceptions of quality of services may have much higher ratings for expenditures than those that do not. Similarly, expenditures which satisfy more than one priority area may be considered more important than those that address only one priority area.

The critical issue here is that the criteria for determining priorities for expenditures need to be flexible. The criteria should

provide general guidelines within which facilities will have the ability to decide what expenditures are most important to meet their unique, or local conditions.

G. Implementation Issues for Expenditure of Fee Revenue

As facilities begin to collect fees and anticipate how these revenues can be used, several implementation issues arise. Some of these issues are identified as follows.

1. Decision making procedures for expenditures need to be established: who decides; at what level; where will expenditures occur; how will expenditures be made; what will be the frequency and timing of expenditures.
2. Categories for acceptable expenditures at each decision making level need to be elaborated (i.e., labor/personnel, materials, supplies, training, spare parts, pharmaceuticals, etc.).
3. Information needs and requirements for making expenditure decisions need to be identified (i.e., on-going reports on status of buildings, installations, equipment; client and staff surveys; cost estimates; utilisation assessments; etc.).
4. Training requirements for staff who will take on new or expanded roles and responsibilities connected with planning for use of fee revenues need to be identified. Appropriate training programs also need to be developed and implemented.

If fee revenues are to contribute to improvements in the quality of care delivered by government facilities, the mechanisms and procedures for spending these revenues need to be simple and flexible. Complicated mechanisms with many reporting and approval procedures frustrate facilities and clients. Adequate and appropriate guidelines and procedures already exist for hospitals and health centres to procure locally the goods and services they require so long as they have funds available. To the extent that facility staff are unaware of these guidelines and procedures, training programs which will orient staff to their use need to be undertaken quickly. This system has allowed facilities to meet urgent expenditure needs in the past. These procedures are sound and could most appropriately accommodate a facility's decisions to spend fee revenue. If these procedures are deemed satisfactory and appropriate for spending fee revenue, then many of the issues regarding implementation of revenue expenditure, as identified above, will be resolved in taking the decision to use existing mechanisms and procedures.

A simple approach to spending fee revenue at the facility level would be to incorporate anticipated fee revenue into the forward budget of a facility. Facilities should plan their forward budgets according to the improvements they wish to make, the volume of

patients to whom they expect to provide services, and the revenue that they anticipate from these patients. Planning and approval for expenditures for fee revenue would then be accommodated automatically in the forward budget process.

PART II. FEE ADMINISTRATION MECHANISMS

A number of changes will be necessary in order to strengthen the fee administration systems in government health facilities. Many facilities have been collecting modest fees on a very small scale for some time. However, the administrative and control mechanisms currently in use are inadequate to handle the volume of revenue that will be collected when all clients at a facility are required to pay fees. Interviews conducted by the PADS Team with 28 administrators and policy makers in the Nakuru District identified strengthening of auditing and accounting as a necessary requirement for expanding fee collection of fees.

This part of the report has three sections. First, the findings regarding the current operation of facility fee administration systems are presented. The findings are followed by a presentation of suggested criteria for strengthening fee administration systems. The last section presents implementation issues that need to be considered.

Section I: Findings Regarding Operation of Current Fee Administration System in Nakuru District

A. Hospital Fee Administration

Government hospitals have a revenue office which is responsible for fee collection. Hospitals charge an inpatient fee of Kshs 15/= per admission, a maternity fee of Kshs 40/= per delivery, and other fees such as charges for medical examinations, circumcisions, and x-ray and physio-therapy services rendered to patients referred by private practitioners. Other miscellaneous charges include deposits for crutches and telephone charges for non-official calls.

The money is collected by accounts clerks, usually of job groups D and E. At Nakuru Provincial General Hospital, money is collected by three clerks (job group D). One clerk (job group D) collects money at Naivasha Hospital.

At both hospitals, inpatients clear their bill at the revenue office upon discharge. The patient is issued a receipt whose number is entered in the hospital's inpatient register against the patient's name. In the case of medical examination, fees are paid and a receipt is issued before the person is seen at the clinic. The receipt for both inpatients and outpatients is from a sequentially serialized book issued by the district accountant or MOH office. The receipt is issued in quadruplicate. The clerk records the receipt in the cash book and enters receipt number, patient number (for inpatient), patient name, and date.

The clerk turns the money collected over to the hospital cashier at the end of the day who puts it in the hospital's safe. The accounts assistant is responsible for reviewing the receipt book and the entries in the cash book, and for accounting for the money collected. The hospital cashier surrenders the money along with the supporting cash book ledger sheet and receipts to the district revenue officer, on a regular schedule (usually once a week).

The district internal auditors are responsible for reviewing the cash book ledger sheet and receipts, and for auditing the facility receipt and cash books. The PADS Team found, however, that auditing is not regularly done by internal auditors.

B. Health Center Fee Administration

Health centers currently collect fees for maternity, medical examinations, and circumcision. At some health centres, no staff are employed to handle fee administration. In one health centre, the sister-in-charge was responsible for collecting fees from inpatients while the public health technician collected the outpatient fees. In another health centre, the clinical officer in-charge collected the fees. At a third health centre, one clerk (job group E) was responsible for fee collection.

Health centres obtain receipt books from the district MOH office. They surrender the money collected and the duplicate of the receipts or the finished receipt books, to the revenue clerk at the MOH office or the district treasury at least once a month. Health centres maintain records of money collected in their cash book registers and record the amount collected and receipt numbers.

There were no special measures taken by the facilities to ensure that the money collected was safe. Money collected was kept in drawers or cabinets for a week to a month before it was taken to the district treasury. The facilities usually had one night watchman for the security of the whole facility. The reasons given by the facility administrators for not taking special security measures was that the amount of money collected was too small to warrant such measures.

Comprehensive accounting is not done by the health centres. Accounting and auditing is the responsibility of the district treasury. The auditors usually use documents supplied by the MOH office for audit purposes.

C. Dispensary Fee Administration

Fees were not collected for services at dispensaries. Two of the four dispensaries visited in Nakuru were collecting Harambee funds from the users of the facilities for specific projects. In one dispensary, there was a contribution of Kshs 20/= per month per family towards the construction of a maternity ward. Each family was expected to contribute a total of Ksh 400/=. The fund had raised Ksh 17,055 in 1987/88 and Ksh 15,544 in 1988/89. In another dispensary, each family was expected to contribute Kshs 50/= per year towards a Harambee Development Fund. Families were allowed to contribute gradually, paying a little each time they went for treatment.

In one dispensary, procedures for accounting for funds collected and spent were informal. Receipting for money paid was rather irregular. When a receipt book is available, the patient is issued a receipt upon payment. When a receipt book is not available, payment is recorded in an exercise book, and a sheet of paper is given to the patient as receipt. Money collected is given to the treasurer of the Harambee project at the end of the month. The treasurer uses the money to pay suppliers of various building materials or labour, without banking the money first. At the end of each month, a subordinate staff prepares a statement of the money collected and surrenders this to the treasurer. No auditing of the funds has been conducted to date.

In the second dispensary, all the money collected was receipted. The receipt book was issued by the District Officer's office and a receipt issued for the money deposited. The nurse-in-charge was responsible for preparing a statement of how much was collected. The dispensary was staffed by one enrolled nurse.

D. Problems in Fee Collection and Administration

There are several weaknesses associated with these fee collection and administration practices which will create problems if the present mechanisms are not changed or modified when the new fee charges are implemented. Two problem areas stand out as particularly troublesome. The first is the inadequacy of accountability and security measures. The second is the inability of the receipting system to process the large volume of patients who will be required to pay.

Policy makers and administrators in Nakuru District agreed that accountability and security presented a major problem. Table 2 summarizes the major shortcomings of current fee administration practices that they identified.

TABLE 2

Perceived Constraints To Fee Administration

CONSTRAINTS	% POLICYMAKERS
Inadequate safety of collected money	60.7
Shortage of qualified accounts personnel	32.1
Weak accounting system	14.3
Misappropriation of collected money	14.3
Lack of adequate stationery(receipt books)	3.6
Difficult to collect money from ill patients	3.6
No established system of waiving fees	3.6
Possible disappointment of people's expectation of how money collected is used	3.6
Inability of people to pay	3.6

Note: Figures do not add up to 100% because some of the policy makers identified several constraints.

In order for fee collection and management of fee revenues to function properly, changes in policies and procedures will be required to strengthen the safety, security, and accountability measures. Alternative mechanisms for receipting patients, particularly outpatients, need to be developed to assure that the volume of patients can be handled effectively by the facility.

E. Criteria for Design of Fee Administration System

A fee management system must provide for three functions that are essential to accountability and control of cash collected:

- Efficiency
- Security
- Cost-effectiveness.

The efficiency of the system to collect and account for money depends on the personnel responsible for managing the money at the facility and the procedures that they use. The security of the system to control funds and ensure that misappropriation and pilferage of cash does not occur depends on the audits and verification done by district office accountants. The cost-effectiveness of the system depends on the simplicity of the mechanisms and procedures which make up the system.

The collection and management of fee revenue requires several tasks which can be looked upon as components of the system. Collecting user fees will require the development of a patient invoice (bill), recording of cash receipt, verification of cash deposit, and reconciliation of cash transactions. The following table provides an overview of the tasks associated with the process.

Key Design Issues

The collection and management of fee revenues requires several administrative tasks. These tasks can be summarized as follows:

- Inform patients
- Render bill
- Collect payment
- Secure cash
- Deposit revenue
- Record revenue
- Control audit

Underlying each of these tasks are key issues related to personnel, policies, and procedures, documentation and timing. These key issues require that decisions be taken to design an adequate fee management system. Table 3 summarizes these issues, and then these components are discussed in more detail below.

TABLE 3

Collection and Management of Fee Revenue Tasks

<u>Administrative Tasks</u>	<u>Documents</u>	<u>Timing</u>	<u>Responsible Personnel</u>
Inform Patients	Fee Schedule	Quarterly	Clinic
Render Bill	Service Bill	Immediate	Clinic or Accounting
Collect Fee	Receipt	Immediate	Clerk or Accounting
Secure Cash	Register	Immediate	Clerk or Accounting
Deposit Revenue	Deposit Slips	Daily	Clerk or Accounting
Record Revenues	Accounting	Daily	Accounting
Control Audits	Receipts Register Slips Service Bills Cash Records	On Demand	Auditors

1. Inform Patients

To eliminate the possibility of confusion and misunderstanding that patients may experience, adequate communication mechanisms must be developed. These mechanisms must be implemented so as to inform patients of the fees that will be required for services at health centres, and hospitals. The issues of informing the patient are:

- 1) what information to communicate;
- 2) when to communicate it, and how often; and
- 3) what types of communication will be most effective.

Communication methods will be influenced by the fee policies that the government adopts. Flat fees for outpatient services will require different types of communication than fees that are variable by type of service (for example, charges to inpatients for each day in the hospital or for diagnostic tests). Charges can be displayed in the facility, but given language and literacy constraints, verbal communication will also be necessary.

Communication to patients about fees will need to be an ongoing process. Inflation will require that fees be changed so that the purchasing power of these revenues is not eroded. The frequency with which the GOK decides to review and change fee levels to accommodate inflation will determine how often new information about fees will have to be communicated to patients. Each fee change will require new information transmittal to the patients.

2. Render Bill

Accountability and control of revenue will require that every patient be given a bill for services rendered. However, a simple, uncomplicated system is required. For flat charges, such as for an outpatient visit, this procedure is not necessary. For services for which there are variable charges, such as inpatient or specialised services, a service bill or invoice is essential. The issues in the design of patient bills are:

- (a) the content of the bill (it will vary depending on the nature of the fee schedule);
- (b) who receives the bill (direct or third party billings such as employers or NHIF);
- (c) where the bill is given and by whom (accounting office/clerk, ward/nurse); and
- (d) when the bill is rendered (before service rendered or at discharge--how to allow for third party billing or absence of financially responsible party).

3. Collect Payment

A system will have to be developed to collect the user fees. If payment is not collected at time of service, the probability of collecting the revenue diminishes with time. However, it is essential to keep the payment collection system simple and uncomplicated. A system which involves a lot of paperwork, such as writing receipts, will be time consuming and expensive. A receipt-writing system for outpatient services will be particularly cumbersome, expensive, and will cause long delays for patients. The collection issues include:

- (a) design of the payment receipt

(for services with variable charges, this could be a copy of the bill or the cash receipt book--for flat rate services, particularly outpatient visits, a stamp could be used to indicate payment--Annex 1 of this report describes a proposed system based on revenue stamps);

(b) who collects the payment

(clerks hired and trained to collect fees, personnel already in the facility who are designated this additional responsibility--who and how many will differ according to size and type of facility);

(c) when the payment is collected

(depends on who collects, if the nurse or clinical person collects then the payment will be collected at time of service, if it is a clerk then it should be prior to providing service or discharge);

(d) where the payment is collected

(number and location of collection stations--see Annex 2 for further elaboration); and

(e) the form of payment (cash, cheque, or in-kind).

4. Secure Cash

The cash or cheque collected must be secured at the facility to eliminate the potential for misappropriation, pilferage, loss or misplacement. Safeguarding the cash within the facility includes:

(a) how and where to secure the cash

(lock box, cash register, safe);

(b) who has responsibility for safeguarding the cash

(in-charge, security officer); and

(c) what supporting record of the cash receipts should be retained

(copies of the service bill are essential but a cash register of total receipts is needed--format depends on level of clerical sophistication at the clinic/hospital).

5. Deposit Revenue

The collected fees should be recorded and deposited in a separate and secure account for each facility. This account could be in an approved account with the district commissioner's office or a local bank account. Given that the magnitude of funds which could be

collected by many facilities is likely to be large, the use of bonds should be encouraged. Mobile banking services may provide the most effective mechanism for more remote facilities to deposit their funds. The design issues to consider are:

- (a) where to deposit the cash, i.e., with the chief, with the district officer, in a local bank account

(the availability of deposit facilities, security, and how decentralized the system should be must be considered);
- (b) how frequently deposits should be made

(greater frequency increases control and security but increases the administrative tasks and costs);
- (c) who deposits the money

(local person, central office comes to collect it, different or same person who collected the money);
- (d) whether any cash from the revenues should be retained by the clinic for minor expenditures

(to replenish petty cash); and
- (e) what forms should be used to summarise the cash holding

(bank deposit slips).

6. Record Revenue

The revenues should be recorded in a separate and secure account for each facility. It could be an account that is part of the district's accounting system or an individual bank account. The issues are what type of bookkeeping system should the facility maintain, and where should accountability and control reside.

A simple accounting system that provides cash receipts and expenditure vouchers is probably the only feasible system at the health centres and dispensaries. The hospitals should provide detailed cash analysis by type of revenue and be accountable for expenditures. Double entry standard accounting systems are ultimately essential for all hospitals. The district office currently maintains an accounting system that can record all revenues and expenditure by facility. The district offices detailed accounting of revenue and expenditures can form the basis for cost recovery analyses and fee setting revisions for various service user charges.

The disbursement to hospitals and health centres of the 50 to 75 percent of revenues collected by the facility may be handled in many ways, two of which are discussed here:

- (a) allocated with the authorised incurred expenses from the central budget fund, which would require an estimate for the first allocation and a reconciliation at the end of the year; and
- (b) money collected will be maintained in a separate revenue fund for each facility through a bank account or the district commissioner's account.

The standard procedures for expenditure of funds are adequate and sufficient and should be applied to the expenditure of revenue. The greater the flexibility that a facility has for spending the revenue that it generates from fees, the greater will be the incentive for the facility to collect the fees.

7. Control Audit

Control procedures are critical functions of the fee management system in order to ensure that misappropriation of funds and cash pilferage do not occur. The issues related to the control and auditing aspects include:

- (a) what records to keep;
- (b) how often to audit;
- (c) who conducts the audit;
- (d) what actions to take when irregularities are encountered (irregularities due to incompetency vs. dishonesty).

A simple control will require checking cash receipts against service bills/number of stamps issued. If both the cash receipts and service bills are serialised, the reconciliation of receipts to service bill will provide control against issuing a service bill without collecting money. In the case of stamps, a check of the number in the possession of the person authorized to dispense them against the revenue collected will provide the control.

A procedure that requires the medical personnel to sign the service record (inpatient only) and outpatient registration books (laboratory, radiology, pharmacy, etc.) to show verification of paid fees will allow for reconciliation of patient records with service bills and stamps issued to ensure that there is appropriate documentation for every patient.

E. Implementation Issues

Changes in the existing administrative mechanisms for collecting and managing fee revenues are essential. Accounting and auditing systems must be strengthened, and new procedures and policies will be required. Policy makers and administrators stated the need to involve government officers at the district level in making decisions regarding administrative procedures. One format which was generally favoured was for each facility to have its own account at the district treasury where the revenues would be deposited. Signatories for withdrawals from these accounts could include the District Commissioner or district accountants and members of the facility management committee. Another format was to have the fees included in the Authorisation to Incurr Expenditure (AIE) over and above the MOH allocation.

Once decisions are made regarding the format of the administrative system, recruiting and training of qualified personnel will be necessary. Training for existing personnel, especially those working in health facilities or at the district accounting office, is also essential. It is not possible to understate the need for training. If the management of fee revenue is to be efficient, secure, and cost effective, and if revenues are to contribute to overall improvements in quality and operation, adequate staff preparation and on-going training will provide the critical ingredient to success.

ANNEX 1

Proposal for a Fee Administration System Based on Revenue Stamps for Outpatients

Prepared by Randy Ellis/REACH Project

This section describes a possible administrative system for collecting revenue for outpatient visits based upon the use of revenue stamps. Revenue stamps are an attractive mechanism for collecting a fixed amount of revenue from a large number of clients. A different mechanism may be required for collecting revenue for services with variable revenue per client, such as for inpatient services.

To simplify record keeping, a small "pouch" would be given to a "revenue clerk" at each health facility at the beginning of the day. A typical pouch would contain:

- 1) a small booklet of 100 health revenue stamps; and
- 2) a rubber stamp with the month of year (for instance the stamp used for January would have the word "January" and other official insignia).

At the end of the day, any remaining stamps, the rubber stamp, and any money collected during the day would be returned to the pouch, and the pouch would be turned over to a second official. This second official could be an official such as the facility cashier, hospital secretary, the chief medical officer or some other responsible official. The second official would count it in the presence of the revenue clerk. The amount of money in the pouch would be reconciled against the number of stamps remaining, and any discrepancy would be the responsibility of the revenue clerk. For example, if the fee were Kshs. 10/= and all stamps were used, then Kshs. 1,000/= would be in the pouch at the end of the day. If half the stamps were used then Kshs. 500/= would be in the pouch. The contents of the pouch would be placed in a safe or other secure place at the end of the day, and periodically deposited in a bank or other financial institution. The amount of money collected would be recorded in an official register which both the clerk and other official would sign.

The procedures for giving out stamps would be as follows. Each patient would be expected to provide a small booklet or piece of paper giving their name, sex, date of birth, ID number (for those over age 18), district and residence. Ideally, this booklet would be the patient's medical record book, but in principle it could be any piece of paper to which the patient wanted the revenue stamp attached. It would be essential that the identifying information be on the paper or booklet in order to minimise the potential for the paper with stamps being given to someone else.

The revenue clerk would quickly verify the patient's name, date of birth, and residence, and then receive the patient's fee. The appropriate revenue stamp would be affixed to the patient's medical record book, and a rubber stamp would be stamped on top of the revenue stamp. This stamp would be the patient's receipt for having paid, and would entitle the patient to receive free treatment for the same month.

Health care providers would be required to check to see that a patient had a valid stamp before providing any medical services to a patient. The revenue clerk would have to be issued a small amount of petty cash (say Kshs. 100/=) to start the day with, and a stamp pad. A patient showing a medical record book with a revenue stamp canceled with the current month would be entitled to free outpatient treatment. A revenue stamp without any official rubber stamp imprint would be invalid, and suspicious of having been stolen.

For facilities with large volumes of patients, either more than one pouch per day or more stamps per pouch could be allocated. Alternatively, balances could be reconciled more than once per day, which may be desirable for security reasons.

Fees for lab tests and other services could also be collected through the same mechanism, if the fees always correspond to a multiple of user fees. For instance, a lab test costing Kshs. 20/- could be paid for and two revenue stamps could be attached to the patient's same medical record book. Possibly it would be desirable to have a separate rubber stamp for lab test fees to validate their function. However, for administrative simplicity it would be desirable to use the same revenue stamps.

Each patient would be expected to provide a medical record book or piece of paper on which the above information could be listed. Medical record books could be purchased in the private sector or possibly from the health facility through a separate transaction. The patient's medical record book would not only provide a record of past fees paid, but also a recording mechanism for referrals and past medical history. The records would become valuable documents, and the patient would find it difficult and undesirable to lend the book to someone else.

For district and provincial hospitals, two revenue stamps, instead of one, could be used to indicate the higher level of fees paid. Otherwise the same accounting mechanism could be used.

For small health centers, since the number of visits per day is small, the revenue clerk would not have to be a full-time employee, and could instead perform other clerical and record keeping functions concurrently. For hospitals and large facilities, the current

accounts clerks could probably do the job. In order to minimise the budgetary impact, the salaries for revenue clerks should be paid out of existing personnel budgets, or by reassigning existing staff if at all feasible.

Each facility will require the following supplies and a adequate budgets for them:

- 1) several small pouches to hold stamps and receipts;
- 2) 12 rubber stamps, one for each month of the year, with appropriate official insignia (to conserve space on the patient's medical record, the stamp should be small, no more than one inch across);
- 3) a stockpile of several ink pads and accompanying ink;
- 4) a register with appropriate accounting forms to be used by the senior official for end of the day accounting and reconciliation purposes, and
- 5) an initial stockpile of revenue stamps (perhaps enough for several weeks).

Revenue and rubber stamps will have some value if stolen, since fee receipts can then be forged, hence both types of unused stamps will need to be stored in a secure place.

Rubber stamps in which the date can be changed by the revenue clerk could also be used, and would require only one stamp per facility instead of 12. However, such stamps would create incentives for the revenue clerk to predate stamps (for the next month, for instance) in exchange for bribes. Also, a rubber stamp good for an entire year (or more) would be more valuable when stolen than a stamp good for only one month of the year. Twelve stamps are relatively inexpensive to provide to facilities.

The security of facilities to store several days of revenues and stamps will have to be reviewed on a facility by facility basis. If necessary, additional funds will need to be allocated for hiring guards or purchasing safes. If revenues are removed and deposited routinely, then relatively few resources for this may be needed.

Revenue stamps appear to be superior to written receipts for a number of reasons.

- 1) They provide the patient with a receipt with a minimum of time spent.
- 2) They build in an efficient accounting mechanism.

- 3) They minimise the amount of paper needed for each patient, which has implications both for the cost of production, and the cost of transport and security. Nakuru PGH handles approximately 1,000 curative outpatients per day (over 300,000 per year). Simply transporting and securely storing that many "receipts", no matter how small they are, will be expensive. In contrast, 1,000 revenue stamps can fit on five pages in a small notebook and are easier to store and transport.
- 4) Revenue stamps that are multiple colours and perforated are more difficult to forge as compared to receipts of one colour, which could be duplicated using photocopiers.
- 5) Revenue stamps attached to a medical record book encourage the patient to bring documents showing prior medical treatment, while small pieces of paper that have no value once they have expired may be discarded.
- 6) Medical record books that are carried by the patient can provide important referral and prior medical treatment, and should be encouraged.

Some consideration should be given for whether the revenue stamp collecting process could be modified to take care of inpatient care. Since the size of the fee collected per patient is larger, fee collections will vary across patients, and the length of time available to collect information can be longer. The necessity of keeping recording times short are not as stringent, and paper receipts are perhaps called for.

ANNEX 2

Location of Fee Collection Stations

Hospital facilities will require a single collection station or a network of collection stations. The size of the hospital and utilisation of outpatient, laboratory, radiology, and other services will determine the number and location of collection stations. The main collection station should be accessible to inpatients and function as the central collection station for all services and satellite collection stations.

For security, control, and safekeeping of the revenues collected, it is recommended that fewer collection stations be authorised. The collected funds and supporting receipts must be turned in to the cashiers office at the end of each day. The cashier will be responsible for recording and reconciling all receipts and depositing the money.

Health centres should require only a single collection station. The personnel assigned responsibility for revenue collection should issue receipts and reconcile receipts to deposits. Revenues collected should be deposited on a daily basis (with the district officer, or chief) on a daily basis. Revenues should be deposited with the district commissioner on a weekly basis. If the facility is in a sub-district, the district officer's office can provide banking services and eliminate the deposit of funds with the district commissioner.

The potential size of daily or weekly collections can represent rather large security risks.

Among the policy makers and administrators interviewed in Nakuru District, there was strong support that each facility should control the money collected: 38.5 percent said that each facility should retain between 60 to 90 percent of the money collected while a similar number preferred that facilities retain 100 percent of revenues. Less than four percent said that facilities should not retain the money collected but that it should be controlled by the District Development Committee (DDC). While the majority of those interviewed did not differentiate between types of health facilities, there were some who argued that hospitals should retain the biggest proportion, followed by health centres and dispensaries.