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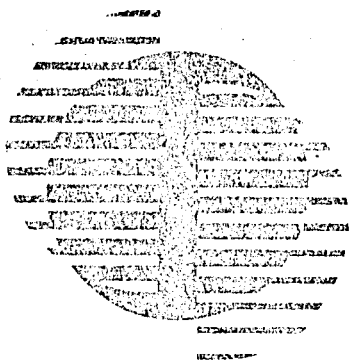
Designing a Family Planning User Fee System

A Handbook for Program Managers



SEATS

Family Planning
Service Expansion
and
Technical Support

By Laurence M. Day
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Introduction

This booklet presents 10 steps for designing or redesigning a Family Planning User Fee System. It has been written for program managers, facility managers, finance managers, administrators, and decision makers, and it can be used at a local, district, regional or national level. If you already have a user fee system (UFS) in place, you may still find it useful to read through this manual to determine if your user fee system includes all of the parts set forth here. If you do not currently have such a system, but anticipate the need for one, you can use this manual to guide you through the design process. And if you don't know whether or not you need or want such a system, this text should help you decide. (*User Fees for Sustainable Family Planning Services*, which was prepared as a companion to this Handbook provides further discussion of issues surrounding family planning user fees.)

As a first step, we encourage each of you to take a moment to reflect on your overall reason for starting (or redesigning) a user fee system at this time. Practically speaking, until you have established your purpose, it will be difficult to concentrate on the individual tasks involved. In other words, it is premature to start thinking about how you're going to set and collect fees if you have not decided why you're collecting them in the first place—that is, what you're going to do with the money.

The most common reason for establishing a user fee system is to ensure the long-term viability of your family planning (FP) delivery system, that is, to stay in business. But not *just* to stay in business; properly designed and implemented, a UFS can allow you to expand your range of services, can lead to improved management and administrative practices, and can generally enhance the overall quality of your facility. For those of you who already have a user fee system in place, working through this manual will enable you to improve your existing system and expand services beyond present limits.

After you have decided on your overall goals, you will then want to consider specific objectives. These will depend on local circumstances, such as the nature of the commitment from donors or certain chronic problems. Some typical objectives include:

- ❑ resupplying or increasing the stock of contraceptives
- ❑ covering salaries or other costs
- ❑ purchasing equipment or otherwise improving the facility
- ❑ expanding or increasing the availability of services
- ❑ undertaking other quality improvement measures

At this point, we invite you to reflect on why you have decided to establish a user fee system and what specifically you hope to accomplish.

Note: A complete set of blank loose-leaf worksheets is included in the pouch on the inside back cover of this Handbook. You may wish to use these blank worksheets or to make photocopies of them to actually fill in your information.

Worksheet 1 — *Objectives and Goals*

Our overall objective is: _____

_____

_____

_____

_____

_____

We intend to use any funds collected to:

1. _____

_____

Timeframe: *(e.g., within 12 months)* _____

2. _____

_____

Timeframe: _____

3. _____

_____

Timeframe: _____

4. _____

_____

Timeframe: _____

Now that you have reflected on why you want to establish a user fee system, and how you intend to use the revenues you collect, it is time to consider the design process, the 10 steps of which are given in Figure 1 below. For most of these 10 steps—which are elaborated one at a time—you will find:

- ❑ a **brief introduction** with an overview of the main considerations involved.
- ❑ one or more **worksheets** to get you started on some of the specific design tasks.
- ❑ **end notes** which comment on certain elements in the worksheets.

Figure 1

Steps in the Design/Redesign of a User Fee System

Step 1	Set cost recovery targets.
Step 2	Establish prices.
Step 3	Develop mechanisms to ensure access to FP services.
Step 4	Estimate utilization and revenues.
Step 5	Evaluate original prices (as set under Step 2).
Step 6	Determine methods for payment of fees.
Step 7	Manage the fees collected.
Step 8	Determine the percent of fees to remain at the facility level.
Step 9	Plan priority activities for which revenues will be used.
Step 10	Monitor and evaluate the performance of the UFS. (Refer to Step 1.)

Step One

Set Cost Recovery Target

As we begin to think of what a UFS will look like, it is useful to set a preliminary and tentative target with a full range of possibilities. Figure 2 shows that cost recovery ranges from 0% (no user fees) to 100% (full self-financing). The figure also shows a number of intermediate levels of cost recovery.

Figure 2

Levels of Cost Recovery

Level I	
No cost recovery	the product or service is offered free of charge. (No costs are recovered.)
Level II	
Nominal cost recovery	a certain (usually minimal) percentage of the cost of the product is recovered. (For example, 5 to 10 percent of total costs are recovered.)
Level III	
Partial cost recovery	all the additional costs directly associated with providing an additional unit of this particular product/service are recovered, but not operating or other ongoing expenses. This is similar to what are known as "marginal costs". (For example, 10 to 20 percent of the total costs are recovered.)
Level IV	
Operating or recurrent cost recovery	the costs of the product/service are recovered, plus all associated "prime costs," such as salaries or supplies. (Recovery may be in the range of 80 percent of total costs, including recurrent and capital costs.)
Level V	
Full or capital cost recovery	all operating costs are recovered as well as infrastructure expenses, capital goods, new building, etc. (100 percent of recurrent and capital costs are recovered.)

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These conceptual "Levels of Cost Recovery" are not intended as definite or exclusive categories; in any given circumstance, cost recovery may not fall neatly into these categories. Indeed, we have intentionally left gaps between these levels; this has been done to stress that often the goal (assuming ability to pay) *is to move the UFS from one level up to the next level*, moving between the transitional stages, at once increasing cost recovery and making sure that more people have greater access to quality services. We can use this as a general framework within which we can define objectives and within which we can assess potential advantages and disadvantages. Thus, it serves to tailor the design of a UFS to maximize benefits of improved availability, access and quality.

Clearly, in order to select from among these levels for setting fees, you will have to undertake either a partial (for level III) or a complete (for levels IV and V) analysis of the expenses of running your FP facility—the costs of providing the various products and services you offer the public. Once you have calculated the relevant costs under each level, you will then know what the appropriate fee would be for that particular level. And this in turn should help you decide which option is appropriate for your situation.

We would point out, however, that the amount of the fee may not be the only—or even the most important—factor in selecting a level. We invite readers to study Figure 3 for a listing of some of the advantages and disadvantages of the various levels of recovery (except for Level V, which does not apply to most settings).

Figure 3

Advantages/Disadvantages of Cost Recovery Schemes

	Advantages	Disadvantages
I. No Cost Recovery	No financial barriers to access. No administrative burden.	May be perceived to be low quality ("what's free can't be worth much"). May indicate the lack of a system to track commodities. Facility is totally dependent on outside support. Future viability of facility is vulnerable due to a lack of any independent source of financial support. Facility lacks own funds to expand/improve services.
II. Nominal Cost Recovery	Perceived value increases. No real financial barriers to access. Lays groundwork for tracking commodities, estimating use, etc. Easier to raise prices in the future with a UFS already in place than to start a UFS from scratch.	Added administrative burden with little additional revenue.
III. Partial Cost Recovery	Permits expanding of services within existing infrastructure. Encourages more sophisticated monitoring of costs and more financial planning. Encourages more efficient operations. Contributes to sustainability.	Requires more sophisticated cost accounting. Requires more sophisticated pricing system. May require instituting a fee waiver system. Higher fees may be barrier for some users.
IV. Operating Cost Recovery	Generates significant resources for improvements in quality and services. Allows independent sustainability.	Fees may exclude more users. Even more sophisticated cost accounting required.
V. Full or Capital Cost Recovery	Generates resources for all operation, maintenance and building and equipment replacement needs. Allows full independent sustainability.	Fees may exclude more users. Even more sophisticated cost accounting required.

The advantages and disadvantages that relate to your program or facility may differ from those suggested in Figure 3. Thinking through these issues will help to confirm whether the target level you have chosen is appropriate. This will, of course, depend on your own circumstances: whether you are interested in cost recovery at a facility level, a program level, or perhaps a district or regional level. It will also depend on the kinds of services you offer.

Using the information provided in Figure 3 as a starting point, you can now set your preliminary target level of cost recovery. Indicate that level by placing a mark in the appropriate box in Worksheet 2. Then, develop a list of advantages and disadvantages that relate specifically to your facility or program.

Worksheet 2

Selecting a Cost Recovery Level

check one

- ❑ I. No Cost Recovery
- ❑ II. Nominal Cost Recovery
- ❑ III. Partial Cost Recovery
- ❑ IV. Operating Cost Recovery
- ❑ V. Operating & Infrastructure Cost Recovery

Advantages:

1. _____
2. _____
3. _____
4. _____
5. _____

Disadvantages:

1. _____
2. _____
3. _____
4. _____
5. _____

Step Two

Establish Prices

To establish your prices, you will have to determine **(1)** how fees will be structured (for example, will there be a single fee for a visit including contraceptives provided during that visit, or a fee for the visit and another fee for contraceptives), and **(2)** what the specific fees will be for those products and services.

1. Determining the Structure

There are a number of simple ways to structure fees. In most instances, the main limitation will be unfamiliarity or a lack of experience with different ways of charging fees. Some of the most common ways that can be used individually or in combination are outlined in Figure 4, which follows. (For a discussion of national policies or strategies, and the effect these could have on your own fee structure, refer to the companion piece "User Fees for Sustainable Family Planning Services" provided along with this Handbook.)

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Figure 4

Common Ways of Structuring Fees

	Advantages	Disadvantages
Fees-for-Services		
The most common payment mechanism, these are made at the time a service is provided. The full amount is paid based on the existing schedule when a client arrives at a facility or before the client leaves the facility.	Familiar to everyone, which makes it easy to introduce and continue.	Requires a detailed fee schedule.
Bundled Fees		
A single fee each time a patient arrives at a facility, which covers counseling, clinical services, laboratory services, and contraceptives.	Once payment is made, client has full access to services and com-modities. Accounting is very simple.	Must take into account all costs involved in a visit or service. May unfairly charge those who use fewer services to subsidize those who use more services.
Registration or Fee Cards		
Cards have been widely used in UFSs around the world, most commonly for well child care. A single fee is paid which is valid for a given period, and all regular services and goods are provided free thereafter until that period is over. Depending on preference, a single fee may be charged for any type of method, or a different fee for each type of method. The card can be issued for any length of time. It can be issued instead of fees for services, or it can be an option.	Provides a ready source of information on needed follow-up, timing, etc. The client may be more motivated to continue services to "get what is coming to them." If cards are used for other services (e.g., child immunization), people will be familiar with them and FP services can be built upon the local experience.	Cards have to be kept at the facility or by the client. Involves another item which must be filled out and kept. The up-front investment may discourage use.

How will fees be structured in your program or in your facility?

Worksheet 3 — *Payment Structure*

Note: Some Managers may want to use more than one payment structure.

❑ **Out-of-Pocket**

Description _____

_____

_____

❑ **Bundled Fees**

Description _____

_____

_____

❑ **Registration or Fee cards**

Description _____

_____

_____

2. *Setting Fees*

While you may change these prices as you work through the rest of this design, you need a rough figure to get the process started. Prices or user fees are normally established in one or a combination of three ways:

A. *Based on the market price of comparable products or services.*

B. *Based on the ability of users to pay.*

C. *Based on the costs of the products and services provided by the FP center.*

Each of these three ways is discussed in the following pages. It is recommended that you work through all three before deciding which will be most useful.

A. *Setting User Fees Based on Market Price*

In this approach, information is required to determine what is happening in the market. The program manager should address the questions outlined below in Worksheets 4 and 5. This should be done for each of the services offered (such as a medical consultation, an injection of Depo-Provera or an IUD insertion) and each of the products offered (such as a cycle of Lo-Femenal or a set of vaginal foaming tablets).

Worksheet 4 — *Looking at the Market*

Service/product: _____

1. Is this product/service offered elsewhere? ❑ Yes ❑ No

   If no, *market information is, of course, not appropriate.*

   If yes, *continue to 2.*

2. Is the product/service truly the same (same quality product, same level of service)? ❑ Yes ❑ No

   If yes, *continue to 3.*

3. Where is it offered? (list all sources) _____

   _____

4. What is the cost from each source? _____

   _____

Once you have analyzed the market, you can then calculate your fee based on this information.

NOTES:

In the simplest case a FP product might be available to consumers at a nearby location. If so, you may want to base your price on "the market" and set your price at the same level, or slightly higher, or slightly lower, depending on other competitive factors. You may want to set a different price for a variety of reasons:

- ❑ To draw more clients to the clinic—so you set fees below the market price.
- ❑ To discourage use of a service or product at your clinic—so you raise fees above the market price.
- ❑ To take advantage of your convenient location—so you set fees above the market price.
- ❑ To subsidize the price of one product with revenues earned on another product.

Whatever considerations you, the manager, choose to emphasize, your understanding of the present market can only improve your decision-making about fees.

Worksheet 5

Calculating the Fee Based on Market Price

A. FP product/service to be offered _____

Where is similar product offered?	Location	Price

B. Average current market price of this FP product/service (add up all of the prices and divide by the number of prices obtained) _____

C. Adjustment factor *(percent you wish to change above or below the market price)* _____

D. Price of FP product/service to be offered _____

(Multiply B x C)

B. Setting Fees Based on the User's Ability to Pay

To use this approach, you must be able to estimate the average per capita income of your target group; that is, you must be able to differentiate the average per capita income of your catchment area from broader (e.g., national level) data. Then you must estimate what percentage of per capita income is generally spent on health care and what percentage on family planning. If family planning services have not been available or have been underutilized in the past, you must determine whether spending on FP will replace spending on health or whether it will represent an additional expense. Realistic expenditure estimates are essential; in making these estimates, you may find it helpful to make comparisons with other areas, programs and even countries.

Once you have estimated yearly expenditures on FP services per capita or per household, you must set fees so that average FP expenditures over the course of a year do not exceed the estimated figure. To do this, you must determine a typical FP purchase pattern for a year. For example, if per capita (or per household) income is $1,000 and family planning expenditure is expected to be 2% of that, then the typical purchase package would not exceed $20. This target price would cover a year of family planning services and contraceptives. If the service involved clinical visits, then a visit and a year of contraceptives would total 20. If a visit is more involved (for an IUD insertion, for example), then the price can be increased so that it totals several years' worth of payments.

The following worksheet offers a formula for calculating the fee based on the user's income. It may be difficult to determine the average per capita or per household income for your target population; it may be useful to check census data or data from recent demographic and health surveys. Or, information might be available from a university economics program or from a government agency. As a very rough or last resort estimate, national level data from 1989 are provided in Appendix 1.

Worksheet 6

Calculating the Fee Based on User's Ability to Pay

A. Per capita (or per household) income _____

B. Percent of **(A)** spent on health care _____%

C. Percent of **(A)** spent on family planning (must be less than **(B)** _____%

D. Amount to be expended on FP per year (A x C) _____

E. Anticipated number of visits/services per year _____

F. Anticipated units of product to be used per year _____

1	2	x	3	4
Service or Product	**Estimated units/year**		**Price per unit or service**	**Charges per year**

G. Total services and units of product per year _____

Should correspond to total of item (E) and item (F)

H. Total Charges* _____

Should correspond to item (D)

**If H is substantially greater than D, then modify your prices until F = D.*

C. Setting Fees Based on Recovering Costs to the Facility

Below we offer worksheets for calculating costs and fees under Levels II, III, and IV. We have excluded Level I (no cost recovery) for obvious reasons, and we have also excluded Level V, as it will not apply to most users and involves, in any case, a complicated series of calculations. For Level III, marginal cost recovery, we have offered two different variations: Worksheet 8 uses an example of recovering contraceptive costs, whereas Worksheet 8a offers an example based on recovering part of the salary costs. This alternative (8a) may be more useful if your program or facility receives all of its commodities free of charge, from the government, for example, or from other donors. Of course, these are only examples, and you will need to calculate costs and fees based on your own conditions.

Worksheet 7

Calculating the Fee Based on Nominal Cost Recovery (Level II)

	Your calculations	*Example based on commodity costs*
1. Bulk cost of product to facility	_____	*(500 condoms for 2500 francs)*
2. Cost per unit to facility	_____	*(5 francs)*
3. Percent of (2) to be charged user	_____	*(e.g., 20%)*
4. Price per unit to user	_____	*(1 franc)*

Worksheet 8

Calculating Fees Based on Partial Cost Recovery (Level III)

	Your calculations	Example based on commodity costs
1. Bulk cost of product to facility	_____	*(500 condoms for 2500 francs)*
2. Cost per unit	_____	*(5 francs)*
3. Price per unit to user	_____	*(5 francs)*

In this case, the facility or program completely recovers the cost of buying this product but not any associated operating expenses. This option assumes that all staff and infrastructure are already in place, and paid for by some other sources, when the product is bought. That is, the objective is to cover the additional cost of providing an additional unit of service, rather than to recover the costs of elements already in place.

Worksheet 8a

Calculating Fees Based on Partial Cost Recovery (Level III)

An alternative example

	Your calculations	Example based on salary costs
1. Total cost of salaries to facility	_____	*(100,000 francs)*
2. Percent of salary costs to be recovered as marginal costs	_____	*(20%)*
3. Total amount to be recovered	_____	*(20,000 francs)*
4. Total patient visits per year	_____	*(5,000)*
5. Price per unit to user	_____	*(4 francs)*

In this case, the facility or program recovers some part of the costs of providing services or products, in an attempt to cover the "partial cost" of providing that service or product. The portion of salaries recovered is used as a very rough estimate of what that "partial cost" would be.

Worksheet 9

Calculating Fees Based on Operating Cost Recovery (Level IV)

1. Annual operating costs of facility

contraceptives	_____
rent	_____
salaries	_____
supplies	_____
utilities	_____
repairs	_____
other	_____
Total	_____

2. Annual number of client visits _____

3. Operating cost per visit *[(2) divided by (1)]* _____

4. Average price to user per visit
[same as amount in (3)] _____

5. Price *[amount in (4)]* to be distributed as

Price per visit	_____
Price for contraceptives *(may be calculated as a one-year supply)*	_____
Total Price *[same as amount in (3)]*	_____

In this case, the facility recovers completely the cost of buying this product and associated operating expenses. We have not gone into detail about methods for calculating "unit costs", as this can become a very elaborate process. There already exist several useful manuals for performing cost analysis, including *Cost Analysis in Primary Health Care: A Training Manual for Program Managers* by the World Health Organization and the Aga Khan Foundation (1990).

NOTES:

You, the manager, should know that it is quite likely—and very desirable—for the facility or program to move from one level to the next over the medium- to long-term (always assuming the user's ability to pay). You thereby make more FP services available to more people, and increase the sustainability of the facility or program.

It is important to keep in mind that there is a relationship between cost, perceived value and quality—and to understand the effects of these on demand. As discussed in *User Fees for Sustainable Family Planning Services*, maximum utilization of products services typically does not occur at Level I, but somewhere above it; highest utilization is *not* found where services are free. Your goal in this regard should be to find that equilibrium point where both utilization and cost recovery are at their highest.

In some cases the fees charged for one service can be used to subsidize other services. For example, the fees for high-demand services, like condoms or oral contraceptives, may be such that they generate more than their share of costs and could therefore be used to subsidize other services (which may even have a higher priority). If this is one of your goals, then you will need to take this factor into account when setting the fees for certain high-demand services.

Finally, there is the question of whether to have a sliding scale of fees. A sliding (or multi-tiered or differential) fee structure subsidizes services for those who cannot pay. In some countries, households that are certified as poor by community leaders are given vouchers for FP services. In other countries, a client's own word or documentation from a village chief determines an individual's income and hence his her eligibility for a reduction of or waiving of user fees. Eligibility criteria for sliding-scale fees are similar to those for waivers, which are discussed under Step 3 below. Of course, while reduced or zero fees may be realistic with regard to certain methods of contraception, they may not be appropriate for all methods because of social implications.

Now, based on the calculations performed, you can fill in the following information:

Worksheet 10 *Summary of Pricing and Fee Structures*

1. Pricing method used _____

2. Cost recovery level expected _____

   Including what % of contraceptive costs _____

   Including what % of recurrent costs _____

3. The tentative fee schedule will be

Services

Consultation _____

IUD insertion _____

Surgical procedures

Norplant _____

Minilap _____

Vasectomy _____

Contraception

Condoms (per ___) _____

Cycle of oral contraceptives _____

IUD _____

Injection _____

Other _____ _____

Other _____ _____

Step Three

Develop a Waiver System to Help Ensure Access to Family Planning Services

We have mentioned in several places the effect that prices have on the utilization of family planning services. Regardless of whether many, or even most, people may be willing to pay moderately increased prices, there are always those who cannot afford to pay at any price. And as these are often the people most in need of family planning assistance, we need to make special provisions to ensure that no one is excluded from these services.

The proportion of clients who are truly unable to pay in any given area of any given country can be difficult to ascertain. Typically, there are at least three groups of people who may have difficulty paying fees:

1. There are those who can pay even though payment may be difficult. This group will pay if the services and goods are seen as valuable and important, and if fees are within reach.
2. There are those who can pay a certain amount, but not the full fee set by the facility. Or they may be able to pay at certain times, such as during or immediately after the harvest, but not at other times.
3. There are those who are truly unable to pay any amount at all.

This section describes simple approaches to establishing and implementing a waiver system to ensure that everyone who is interested in family planning, regardless of their ability to pay, has adequate access. The proportion of people in your UFS who will be unable to use services if fees are introduced will depend on many factors, such as the fee structure and the local economy. The percent of exempt users is certain to have a considerable impact on the performance and success of any UFS. If the criteria for exemption are too loose, or are loosely applied, people who are in fact able to pay may be exempted and revenues thereby lost. On the other hand, if the waiver system is too stringent, needy people may be denied services. This latter consequence is especially counterproductive and undesirable, as unwanted pregnancy among the poorest people will have particularly disastrous results for the families involved. For this reason, you would normally want to err on the side of giving too many free services—rather than too few—and to figure this bias into your planning, pricing, and revenue projections. At the same time, it should be your goal to structure the waiver system in such a way that it exempts only those people who would otherwise have no access to services.

Thereafter, you should rely on regular monitoring and evaluation to make sure your system is working the way you intended.

To design an effective waiver system, you will need to answer the following questions:

1. How will eligibility for waivers be decided?
2. How many waivers, as a percentage of all services, will you allow?
3. What method of waiving will you use?
4. How long will waivers be valid?
5. Who will have authority for issuing waivers?
6. How will waived or free services be accounted for?

1. *How will eligibility for waivers be decided?*

Determining eligibility (also called "means testing") involves two steps: specifying criteria and specifying how each criterion will be weighed in deciding eligibility. It is important to be as specific as possible about these two steps so that your eligibility criteria are carefully formalized and clear to everyone. That is, if someone meets the criteria, he or she is eligible for waivers; if someone does not meet the criteria, he she is ineligible. Clients may not agree with the decision, but they should not be able to fault the process. And while the facility or program can help clients to obtain waivers, it should be seen as the client's obligation to demonstrate that he or she qualifies for the waiver. The process of determining eligibility (i.e., administering the questionnaire) must be carried out by a designated individual such as a social worker.

Below we offer a sample questionnaire you can use for collecting information on which to base your decision to waive or not to waive user fees. For each question, we offer suggestions on how to use the information to make your decision. Some questions may not be appropriate for your particular clientele, or there may be other information which you find to be more useful. In either case, these may serve as a useful beginning. (For those who wish to use this questionnaire, we offer a version without the commentary in the pocket in the back of this Handbook.) It is up to you, the manager, or you in conjunction with your "user fee committee" or "waiver committee", who must determine how you define the actual instrument for determining eligibility, and the scores you will use. As you read through this sample questionnaire, you will get some ideas about scoring. For example, you may determine that if a user is in poor health and unemployed, with an unemployed spouse, with several children, they are automatically eligible for a waiver. Again, you must decide upon the criteria and their scoring.

Figure 5

CONFIDENTIAL ***Sample User Questionnaire*** **CONFIDENTIAL**

Clinic Name: _____ ***Date:*** _____

1. Client Name: _____ Number: _____

Address: _____

(Certain locations may be known to be poorer than others.) _____

_____

2. Apparent health of client: ❑ good ❑ fair ❑ poor

(Someone who is disabled or in poor health may not be able to work or may already have high health care costs.)

3. Marital status: ❑ married ❑ unmarried

(A single woman with children may be less able to pay. Married couples may have two incomes and therefore be more able to pay.)

4. Occupation: _____

(Certain categories of occupations would normally be required to pay: civil servants, teachers and other professionals, health care workers, etc. Someone who is unemployed would obviously be less able to pay.)

5. Occupation of spouse: _____

(This should shed additional light on the family's financial situation. Even if the spouse has a low-paying job, the very fact that there are two people employed is significant. Even if both husband and wife are unemployed, this doesn't automatically mean they should be eligible for a waiver.)

6. Education level:

❑ no formal education
❑ primary school only
❑ some secondary school
❑ post secondary
❑ college graduate

(People above a certain level of education can be assumed to have some income-earning potential. For example, most families in which either the husband or wife has at least a high school education should be able to pay. A low level of education may indicate the inability to pay, but not in and of itself [not all uneducated people are poor].)

7. Education level of spouse:
- ❑ no formal education
- ❑ primary school only
- ❑ some secondary school
- ❑ post secondary
- ❑ college graduate

(Even if the user in front of you has little education, the spouse might be better educated and therefore have earning potential.)

8. Employer of client and client's spouse:

Client _____

Spouse _____

Does client give permission to contact these employers? ❑ Yes ❑ No

(This information can be used to verify employment and salary. Knowing that his/her employer may be contacted may prevent the user from giving false employment information.)

9. Income:

Client _____

Spouse _____

Other Family _____

Total Household _____

10. Name/address of closest relative:

_____

_____

_____

_____

(This gives you another potential source for verifying eligibility information. Moreover, even if the user is unable to pay, perhaps a close relative is able to pay. Approaching relatives requires considerable discretion because of the sensitivity of the issue involved and the need to protect confidentiality.)

Figure 5

11. Name address of community leader:

_____

_____

Does the client give permission to contact this community leader? ❑ Yes ❑ No

(This gives you someone else to contact to verify inability to pay.)

12. Number of children: _____

(People with large families may be less able to afford fees, especially someone who is unmarried. But you should try to find out if any of the children are employed.)

13. Ages of children: _____

(Children under 12 are likely to be in school or at least not generating any income.)

14. Number of children in school: _____

(If the user has children in school, this may indicate an ability to pay, as at least he/she can pay school fees. If the user has school age children who are not in school, this may indicate he/she can't afford school fees and may not be able to pay. Answers here should be checked with other sources.)

15. How did the client get to the facility?

❑ in own car ❑ in relative's car
❑ by taxi ❑ collective taxi
❑ by bus ❑ motorcycle
❑ bicycle ❑ animal
❑ on foot

(If the user came by car or taxi, this may suggest ability to pay or at least of a relative to pay. If the user walked, check the address: if his/her home is far, this may suggest inability to pay.)

16. Does the client smoke? ❑ Yes ❑ No

(If the user can afford cigarettes, he/she should be able to pay.)

17. Is the client wearing shoes? ❑ Yes ❑ No

(If no, the user may be poor. Also note the condition of the shoes.)

18. What is the physical appearance of the person/any accompanying children?

_____

_____

(If the person is malnourished or accompanying children are, this may indicate inability to pay.)

19. Number of outpatient visits in the last 6 months: _____

(If the person has been ill, he/she may not have been able to work or may have incurred high health costs.)

20. Number of days in hospital in last 6 months: _____

(As in 18, the answer could indicate lost income or high health costs, hence inability to pay.)

2. How many waivers, as a percentage of all services, will you allow?

Deciding what percentage of fees to waive is something of a balancing act. On the one hand, you want to serve the maximum number of potential users, but on the other hand, you want to collect enough revenue to be able to maintain and expand services. If you have too strict a policy, potential users may be denied access. If you have too lenient a policy, you will lose revenue, you will spend an inordinate amount of time issuing waivers, and you will be doing a fundamental disservice to those who are paying fees.

There is no recommended percentage; some programs increase use without issuing any waivers while others waive 5-10% of fees. What is most important is to monitor your system carefully and correct for mistakes. (See Step 9 for more information.)

3. What method of waiving will be used?

It is not always necessary to waive the entire cost of a product or service. You might want to consider using discount or "partial" waivers. While these are somewhat complicated and involve more paperwork, they are a legitimate option. There are at least three types of partial waivers:

- ❑ the client pays a percentage of the costs of his/her visit
- ❑ the client pays for the product (contraceptives, etc.) but not for the consultation
- ❑ the client pays for the consultation but not for the product

4. How long will waivers be valid?

Waivers can be issued on a one-time/per-visit basis, for a longer period of time or several visits, or even for a full year. If you plan to review and perhaps change your waiver system periodically, then you may not want to issue waivers for long periods.

5. Who will have authority for issuing waivers?

You should designate someone at the service delivery site to be responsible for authorizing and issuing waivers. If there is a social worker attached to your facility, he/she would be an obvious choice. This person would apply the agreed-upon criteria and decide whether a user was eligible or not. Normally, you would not select the clerk or cashier for this role as the waiver should be issued before the client comes to the payment point.

6. *How will waived or free services be accounted for?*

Waived services should be recorded in the same manner as any other service. That is, a fee or charge is recorded and the amount collected is noted. In the case of a waiver, the amount collected will not be the same as the charge or will be "0," with a notation in the ledger referencing the relevant waiver (ideally by number). See Step 6, parts 1, 2, and 3 for more details.

It will be important to monitor the waiver system closely to be sure it is having the intended effect. You may have to adjust your expectations of what percentage of fees can be waived and/or adjust your waiver criteria. See Step 9.

You should now have decided what the elements of your waiver system will be:

1. Instrument by which eligibility for waiver will be decided: _____
2. The total waivers allowed, as a percent of all services, will be: _____%
3. The method used for waiving will be: _____
4. Waiver will be valid for: _____
5. Waiver will be authorized by: _____
6. Waived services will be accounted for by: _____

Step Four

Estimate Utilization and Revenues

Once you have set your fees, the next step is to estimate utilization and, based on utilization, projected revenues. Once revenues have been estimated, you can later compare actual revenues with the projected figures to help determine (1) whether you have set your fees too high or too low, and (2) whether your waiver/exemption system (see Step 4) is working as intended.

In and of itself, the process of developing utilization and revenue projections provides management with a number of useful tools and skills to improve health service delivery and efficiently manage resources. Specifically, you can use the process to:

- ❑ enhance your understanding of the dynamics of how your facility and how the broader FP service delivery system in your area function;
- ❑ enhance revenue, such as in response to recurrent cost crises;
- ❑ estimate the amount of "off budget" revenues which may become available for buying additional inputs (commodities, equipment, staff);
- ❑ plan pricing to encourage demand for a broader method mix;
- ❑ improve access to services and improve efficiency by, for example, identifying seasonal fluctuations in demand and scheduling increased outreach efforts by staff during off-peak periods;
- ❑ plan for improving the quality of services, e.g., by setting targets or milestones for monitoring and evaluating the use of specific methods or the use of a particular delivery site whose use has fallen off; and
- ❑ plan for improving the quality of services by buying additional drugs or other supplies with revenues generated through user fees.

Designing an Approach

While there are many methods for estimating use and revenues, the most common is to develop a forecast based on existing data from previous periods of operation. In this instance, such data would include any records of all products and services dispensed by the facility and any fees that were collected. The following worksheet presents some questions for you to think about before designing an approach suitable to your site.

Worksheet 11

Considerations in Designing Use/Revenue Estimates

1. Purpose or intended use:

How precise do your projections need to be?

❑ Very precise ❑ Somewhat precise ❑ Very rough

What are you going to use your projections for?

❑ For budgeting ❑ For strategic planning ❑ To estimate additional resources

2. Availability of data:

Is the data you need to collect available or easily obtained?

❑ Yes ❑ No

Is the data

❑ utilization-based (= of client visits per method) or

❑ population-based (= of people or households in area and estimated prevalence of contraceptive use)?

3. Special equipment:

Can the estimates be made with existing equipment (paper and pencil, calculator), or ❑ Yes ❑ No

is a computer necessary? ❑ Yes ❑ No

If a computer is necessary, is one available? ❑ Yes ❑ No

4. Staff skill levels:

Does your staff have the skills to gather and sort the data and perform the necessary calculations? ❑ Yes ❑ No

If a computer is needed, is there someone available to run it? ❑ Yes ❑ No

5. Match between level of effort and intended use:

Are the time and effort involved reasonable given the intended use of the information? ❑ Yes ❑ No

Note: *An effort which requires several weeks of data collection and analysis may not be justified.*

6. Scope of analysis:

Will you be making estimates for

❑ a single facility or

❑ several facilities comprising one service network

❑ an entire district

❑ region

❑ country

Estimating Utilization and Revenues

The revenue from a particular service is a function of the amount of use of that service multiplied by the fee per use, minus any waived or exempted fees. This can be expressed in a simple mathematical equation:

$$R = u(f) - w,$$

which means

Revenues = estimated use * (fee per use) - total of waived or unpaid fees

In other words, the key to being able to estimate revenues is to accurately estimate use. If you calculated your estimated revenues from each of your services, you would have the total estimated revenues for that particular period. (To take this a step further, if you were then able to estimate your costs for that same period, you would know whether to expect a revenue surplus or a shortfall. And this in turn would be an important consideration in deciding whether to raise or lower your user fees.)

In any estimating scheme, your starting point would have to be the previous period; that is, the *actual* use as documented by your records. From the actual use, you then project either an increase, a decrease or no change.

Below we offer a sample worksheet for estimating utilization and revenues for condoms:

Worksheet 12

Estimating Family Planning Utilization and Revenues

A. Calculating total estimated use:	*Your calculations*	*Example*
1. # of client visits in previous year:	_____	*(10,000)*
2. projected increase for coming year or:	_____	*(1,000)*
3. minus the projected decrease for coming year:	-_____	
4. equals total projected use for coming year:	_____	*(11,000)*
B. Calculating total estimated revenues:		
1. fee per visit:	_____	*(1 franc)*
2. total # for coming year:	_____	*(11,000)*
3. pre-waiver (projected gross) revenue total (#1 x #2):	_____	*(11,000 francs)*
4. % of #2 to be waived:	_____	*(20%*)*
5. revenue to be waived (% in #2 x #3):	_____	*(2,200 francs)*
6. projected total revenue (#3-#5):	_____	*(8,800 francs)*

** Based on previous year's percent plus/minus any estimated increase or decrease.*

Using this worksheet as a model, managers should be able to calculate use and revenue estimates for most services offered.

Step Five

Verify Consistency in Steps One Through Four

You have now defined objectives and goals, set cost recovery objectives, established prices, developed mechanisms to ensure access to family planning services for all men and women, estimated utilization levels, and projected revenues. At this point, it is important to confirm that all of these steps are consistent and to evaluate the prices set. The prices should be such that, given the estimated level of waivers which will be allowed, and given projected utilization, the estimated level of revenues will be sufficient to meet your cost recovery targets. If these numbers are not all consistent, you need to repeat the process this far and change either (1) targets, (2) prices or (3) percentage of fees which will be waived. This is the same kind of exercise that you will have to carry out periodically as part of the evaluation and monitoring process; by doing it at this point, you will be refining your user fee system before getting to the pilot testing stage.

Summary Worksheet

Verification of decisions made in Steps One through Four

We intend to use any funds collected to

1. _____

2. _____

3. _____

4. _____

Our target cost recovery level is

- ❑ I. **No Cost Recovery**
- ❑ II. **Nominal Cost Recovery**
- ❑ III. **Partial Cost Recovery**
- ❑ IV. **Operating Cost Recovery**
- ❑ V. **Operating & Infrastructure Cost Recovery**

The percent of recurrent or operating costs we intend to recover is _____%

The pricing method we are using is _____

(continued on following page)

Summary Worksheet - continued

The fee schedule will be

Services

Consultation _____

IUD insertion _____

Surgical procedure _____

Contraception

Condoms (per ___) _____

Cycle of oral contraceptives _____

IUD _____

Injection _____

Other _____ _____

Other _____ _____

Total projected use for coming year _____

Pre-waiver (projected gross) revenue total _____

Percentage of fees to be waived _____

Projected total revenue _____

Total costs _____

Percentage of costs recovered _____%

These total projected revenues are consistent with cost recovery targets

❑ yes ❑ no

If not, repeat with modification to

❑ prices ❑ waiver level or ❑ targets

Step Six

Determine Methods for Payment of Fees

While certain users will never be able to afford the fees—whatever the cost and whatever the payment method you choose—there are other users who may be able to pay at certain times but not at others. It is important not to automatically relegate these people to the waiver system, to offer them free services, but rather to devise ways to allow them to pay when they are able to. This not only captures otherwise lost revenues, but it is more fair to those users who are paying. And it may make it possible for you to lower your fees overall.

Users who can't pay at certain times—whose incomes are seasonal, who are presently paying off some kind of debt, etc.—could be accommodated through a variety of alternatives such as (1) prepayment, (2) deferred payment, (3) installment payment, and (4) third-party payment.

Prepayment

Some users may know that while they can afford certain services at the moment, they may not be able to afford them later. An example might be a pregnant woman who is presently working but will have to quit work when her child is born or a farmer who just got his semi-annual payment for his harvest. In these cases, you would estimate these users' FP needs for the next few months or even for the next year, and collect the fees in advance. These payments would be recorded, and there would be no additional payment at the actual time the product or service was delivered. This would allow you to "bundle" services into a prepaid fee and would also serve as an incentive to users to follow through and use the services they have already paid for. As such, you should also review the payment structure you selected in Worksheet 3, as prepayment and registration cards can naturally go together.

Deferred payment

A client often needs a service at a time when he or she cannot pay. There is no need to waive this user's fees or postpone the service (which might discourage the user) if an arrangement can be made to collect the money at a later time. This approach works best where small amounts are involved. However, the bookkeeping burden involved for small amounts means that this is probably not a cost-effective practice. Deferred payment should therefore not be encouraged except when it is really necessary.

Installment payments

This is a variation on deferred payments, with the added advantage of making it possible for users to have access to certain more costly services (e.g., VSC) they might not otherwise consider. As with deferred payment, however, the bookkeep-

ing burden involved for small amounts means that this is probably not a cost-effective practice. This should only be used when it is really necessary.

Third-party payments

In many countries, someone other than the client may be able to pay for the service, such as insurance companies, employers, social security or cooperatives.

Each of these methods has its advantages and disadvantages, which are given in Figure 6 below. In all cases, it is important to remember that the success or failure of these approaches will depend on (1) the effectiveness of your bookkeeping system and (2) the extent to which your user population is familiar with these concepts (i.e., educated by facility or program staff).

Figure 6

Alternate Payment Methods

	Advantages	Disadvantages
Prepayment	Guarantees user's access for an extended period. Especially useful in areas where income peaks at harvest time. Allows for a set of services to be bundled under a single prepayment.	Requires additional planning commitment from user. Requires minimal additional paperwork by provider.
Deferred payment	Makes access easier for user. User may have more method choices.	Requires an extra bookkeeping entry and follow-up. Can be abused, as some users who can pay now will choose to pay later. May discourage those who owe from coming back to clinic.
Installment payments	User may be more able to pay over a longer period of time, thus increasing revenues. User may be able to afford more costly services.	Requires multiple bookkeeping entries and follow-up. Has potential to overburden client and facility with excessive debt.
Third-party payments	Increases revenue without adding direct costs to user.	Requires extra work to locate arrange third-party contribution. May require special billing procedures.

Step Seven

Manage the Fees Collected

Once you have set your fees and established a payment system, you are faced with the issue of how to handle the money that comes in. How to manage—that is, how to record, safeguard, and report on—revenue once it is in your hands is critical to the long-term success of your venture. This part of your work has six basic tasks, given below.

1. Determining the amount to be collected.
2. Collecting the appropriate amount.
3. Recording total charges, any adjustments, and net amounts collected.
4. Reconciling the amounts collected.
5. Depositing fees collected.
6. Summarizing total amounts collected and preparing management reports.

You will perform steps 2 through 6 on an ongoing basis as you collect fees. Step 1, based on a combination of fee schedules and waiver policies, will only have to be performed occasionally, as part of the ongoing monitoring and evaluation of your UFS. Figures 7-12 below outline the specific procedures to follow when executing each step, while the notes following each figure discuss important considerations for each step. Sample forms for entering, reconciling and reporting revenues are provided in the pocket in the back of this Handbook. These cannot easily be photocopied and used, but they do provide samples of forms you can create for your own logs.

Figure 7

Task 1: Determining the Amount to be Collected

A. Obtain a completed registration or encounter form from the user which describes the service or services provided. This is usually filled out by the provider.

B. Obtain the current fee schedule.

C. Find and record the fee for each service listed on the form.

D. Total all fees and record on the form.

E. Determine payment classification of user and calculate amount due:

1. Full-pay users will owe the amount listed under D above.
2. Partial-pay users will owe a percentage of D.
3. Exempt users will owe nothing.

NOTES

The encounter form may not be necessary in those instances where the facility offers only one service or charges only one fee regardless of the service provided. Note that under C the person who collects the fees (usually the cashier) will record the same fee for the same service whether or not the user will actually be charged that amount. This will enable you to keep track of the percentage of your fees that are being subsidized (waived) or otherwise absorbed by the facility.

Figure 8

Task 2: Collecting the Appropriate Amount

A. Request payment in full for the amount due from the user.

B. Collect cash from the user.

C. Record amount received in a daily cash log and, if separate, in the receipt book.

D. Give a receipt to the user as proof of payment.

E. Place cash received in locked cash box or cash drawer.

NOTES

The timing of collection may vary; you can either collect fees before the service is provided or after. Fees can be collected in advance if the provider has one charge for all services. This has the advantage of better control, i.e. users are not provided services until they have demonstrated the ability and willingness to pay for them. However, collecting fees prior to the visit can sometimes create a bottleneck and make patients late for their appointments.

Fees will normally be collected after the visit if different fees are charged for the various services and it is not known ahead of time exactly what services the user will require. For example, the user may be scheduled for a consultation but during the consultation it is determined that a pregnancy test is needed. In that case, the user should be charged for the consultation as well as for the lab test. If fees are collected after services are provided, controls are needed to ensure that users do not leave without paying.

Fees should always be collected in a professional manner. Cashiers should be considerate but firm in requesting payment. Most importantly, the collection policy should be applied consistently to all users.

It is also important that users be informed of the total amount of fees and the amount due even if the user is exempt from payment. Experience has shown that if users are aware of the "value" of services received, they tend to use the services appropriately.

Finally, collection policies and procedures should contain a contingency plan for those users who are unable or unwilling to pay for services. As discussed in a prior section, it is important that the policies do not deny access to services but that those who are able to pay do so. There are several options for those cases where users are either unable or unwilling to pay:

- ❑ Users can be requested to return for services when they have the necessary payment. Obviously, this policy is enforceable only if the ability willingness to pay is determined prior to services being rendered. Furthermore, managers should be careful that such a policy does not deny access to care and result in undesirable outcomes.
- ❑ Users can be billed for services subsequent to the visit. While this policy may be a good one, it may not be cost-effective. Billing users for services subsequent to the visit requires an established accounts receivable system. That is, charges must be documented, an invoice must be produced and delivered to the user, and follow-up on payment must be performed until the amount is paid in full. Moreover, there is some probability that the amount may never be paid.
- ❑ Users may be exempted from payment on a case-by-case basis. The decision to exempt a user from payment should be made by a manager and, moreover, should never be the responsibility of the cashier. Individual exemptions from payment should be the exception rather than the rule; otherwise, collection policies will not be effective over the long term. Exemptions were discussed above under Step 2.

Figure 9

Task 3: Recording Total Charges

A. Record fees collected in a daily log (same as 2C in Figure 6). Use separate columns for cash, checks, and vouchers.

B. Record gross charges and any waived (adjusted) charges in same or separate log.

NOTES

As noted earlier, it is important to keep a record of gross charges and of adjustments in order to determine whether your user fee system is really working. If you are waiving large percentages of your fees, then your waiver system may be too lenient. On the other hand, if you are waiving almost no fees, then perhaps your waiver system is too strict. Or, a high percentage of waivers may indicate that your

fees are too high, and a low percentage may indicate fees are too low. It is important for you to review the patterns, determine how well it is functioning, and make changes to strengthen both the fee structures and the waiver system.

Figure 10

Task 4: Reconciling the Amounts Collected

A. At the beginning of each day:

1. Count the amount in the cash box and confirm that the total is the same as the amount shown as "beginning cash" from the previous day.

B. At the end of each day:

1. Remove all cash from the cash box and separate bills and coins by denomination.
2. Count cash, record on the cash reconciliation form, and total the amounts.
3. Count out the amount kept as "beginning cash on hand" and record this amount as a deduction on the cash reconciliation form. Deduct the cash on hand from the total cash to determine the total amount of cash collected.
4. Total the amount of cash collected according to the daily log and record on the reconciliation form.
5. Compare the total from the log to the total cash collected.
6. If there is a difference:

   a. Re-count cash, including cash on hand.

   b. Re-add cash total and cash collected total.

   c. Match encounter forms to daily cash log.

   d. Match receipt book, if separate, to daily cash log.

   e. If there is still a difference, record this on the cash reconciliation form.
7. Place cash, excluding cash on hand, in a deposit bag, and place the cash on hand back into the cash drawer.

C. Also at the end of each day:

1. Total all checks and make sure these are the same as the column totals for checks on the daily log.
2. Total all vouchers and make sure these are the same as the column totals for vouchers on the daily log.

Figure 11

Task 5: Depositing Fees Collected

A. Count the cash and agree to the cash reconciliation sheet.

B. Complete the deposit slip (with duplicate) in the total amount collected.

C. Deposit the amount with the appropriate financial institution.

D. Attach a copy of the deposit slip to the cash reconciliation form and file.

NOTES

All fees collected should be deposited in total; that is, before any expenditures are taken out. Deposits should be made by someone other than the cashier.

Figure 12

Task 6: Summarizing and Reporting

A. At the end of each day:

1. Sum the total fees on all encounter forms and record in the daily log.
2. Transfer total charges and collections from the daily log to the monthly summary.

B. At the end of each month:

1. Sum daily charges and collections for all days during the month and record the total on the monthly summary.
2. Transfer the monthly totals to the yearly summary.

C. At the end of each year:

1. Sum monthly totals for all months during the year and record the total on the annual summary.

NOTES

The information thus summarized should make it clear to management if the user fee collection system is working. Two ratios are commonly used to measure the efficiency of the collection system: Gross Collection Percentage and Net Collection Percentage.

Gross Collection Percentage is equal to:

$$\frac{\text{Cash Collected for the Month/Year}}{\text{Gross Fees for the Month/Year}}$$

This ratio measures the amount collected as compared to the gross fees charged for services. It is thus a function of (1) the facility's collection policy, (2) the facility's mix of patients by payment classification, and (3) collection efforts by the cashier.

Net Collection Percentage
is equal to:

$$\frac{\text{Cash Collected for the Month/Year}}{\text{Gross Fees Less Exempted Fees}}$$

A third ratio will provide management with an indication of whether the UFS is achieving its purpose in terms of the percentage of cash being charged (prior to waiver adjustments), to determine if this is consistent with the targets which underlay the whole user fee system.

$$\frac{\text{Gross Fees Charged } \textit{(before adjustments)}}{\text{Total Costs}}$$

Step Eight

Determine What Percent of Fees Will Remain at the Site

In deciding whether to charge user fees and what fees to set, it is important to know whether the fees collected—in whole or in part—can, in fact, be used at the site. In many countries the law requires that fees collected in public facilities be passed on to the Ministry of Health or Finance or to the Central Treasury. In this regard, you will need to answer at least three basic questions as you start to design your system:

1. Are there laws or regulations controlling the use of fees collected at a facility or in a program such as mine?
2. Do these laws require that all or just a percentage of fees be passed on?
3. Is there any mechanism whereby I can get back some of these fees for use at the service site, once I have passed them on?

If you are obliged to pass on your fees, you are unlikely to be able to expand or improve the quality of services at your facility, and thereby have very little incentive for demonstrating the advantages of a UFS to the public. And this, in turn, could discourage utilization. Moreover, though they may be of some benefit at the central level, you will in effect become fiscal agents for some other level of bureaucracy, taking on an additional administrative burden, complete with additional costs, with no benefits to your site.

There is ample evidence from around the world that collection rates are higher—and services more easily improved—when a high percentage of fees remain at the site where they were collected. Users tend to be more willing to pay when they know their fees will be used on them, that is, to improve the facility they frequent. Moreover, when spending its clients' own money, a clinic is much more likely to make decisions responsive to local needs.

If there are legal reasons why the facility cannot retain fees, there may still be acceptable alternatives. In some countries, fees are handed over to a community council, which can then allocate those revenues as it chooses. In this instance, site managers can argue strongly that revenues collected from family planning services should be used to support the continuance and improvement of such services. As a general rule, you can assume that the further away the final resting place of your revenues, the less likely you and your program will ever see the revenues again.

Based on your review, the disposition of revenues will be

_____% at the local level (clinic, facility or community)

_____% passed on

100 % Total

And based on your earlier revenue projections (in Step 4) and the percentage of revenues which will be available to you for local use, this amount will be approximately _____.

Step Nine

Plan Priority Activities For Which Revenues Will Be Used

At the beginning of this Handbook, you were asked to list the things that you expected to do with any funds generated by the UFS. Now that you have established prices, estimated utilization levels, and projected revenues, you can make some plans for what those funds will be used for. It is very important to make these plans because, as you will have already seen, there will not be any great surplus. Only by planning carefully will you be able to accomplish as much as possible with those limited funds.

First, some criteria are needed to compare possible uses of funds. For example, possible ways to use projected revenues may include purchasing contraceptives, paying a salary, operating a vehicle, buying new clinical equipment, or other needs. These can be compared by setting some simple criteria, such as the following:

- ❑ Will it directly improve the quality of services provided?
- ❑ Will it directly help guarantee a supply resupply of contraceptives or other supplies?
- ❑ Will it enable an expansion of services?
- ❑ Will it be sustainable by not adding additional recurrent costs?

To these, other criteria can be identified and added. This is up to you and your co-workers or clients. The next step is to determine how important each of these criterion is. Perhaps one or more can be eliminated.

Now, each individual priority previously identified should be assessed against these criteria to see whether it "meets the test." A simple way of doing this is to prepare an evaluation matrix. List each criterion against which a priority will be judged along the top of the matrix, and list the possible priorities along the left side. For each potential priority, determine whether it meets each criterion or not. If yes, place a "+" under that criterion; if not, place a "-" there. By adding up the number of "+" or "-" signs for each priority, you will more easily identify the relative importance of each in furthering your overall objectives.

Worksheet 14a — *Evaluation Matrix*

	Criteria				
Priority	***1***	***2***	***3***	***4***	***Total "+"***
1	+	+	-	++	4
2	+	-	+	-	2
3	-	+	-	-	1
4	+	-	-	-	1

As an alternative, you can choose a scoring system other than "+" and "-" signs; for example, a ten-point scale, under which a score is entered next to each potential priority for each criterion (see Worksheet 14b). As yet another variation, those criteria which are more important (e.g., resupplying contraceptives) can be given extra weight, such that the first criterion carries a weight of 3, the second criterion a weight of 2, and the others a weight of 1 (see Worksheet 14c). Then when the scores are added up, they are multiplied by the weight of each criterion.

Worksheet 14b — *Evaluation Matrix*

Example: ***Alternative based on points***

	Criteria				
Priority	***1***	***2***	***3***	***4***	***Total***
1	9	6	1	10	26
2	7	4	8	3	22
3	2	8	4	3	17
4	10	3	2	2	17

Worksheet 14c

Evaluation Matrix

Example:

Alternative based on weighted points

	Criteria								
	1 Weight=3		*2* Weight=2		*3* Weight=1		*4* Weight=1		
Priority	points	weighted score	points	weighted score	points	weighted score	points	weighted score	***Total weighted scores***
1	9	27	6	12	1	1	10	10	50
2	7	21	4	8	8	8	3	3	40
3	2	6	8	16	4	4	3	3	29
4	10	30	3	6	2	2	2	2	40

This should result in a fairly clear picture of the rank order of priorities for which revenues will be used. If the order is still not clear, you can examine pairs of potential priorities. For example, the top priority may be clear, but there is a tied score for the second and third; simply look at these two, and decide which is more important to you, and place that one above the other on the priority ranking.

Next, you need to consider how far the expected level of revenues (projected in Step 3) will go toward completing these priorities. First, estimate how much it will cost to carry out the first priority. If you estimate that there will be resources left after this priority has been completed, move on to the second one. Once you have confirmed your priorities, estimate how much it will cost to carry out each one individually. Use the same time period you used for projecting revenues; if you projected revenues for one year, then estimate what each priority would cost for one year (e.g., purchase of one year's worth of contraceptives, one year's worth of a staff salary, one year's worth of vehicle operation).

Worksheet 15 — *Estimating Costs per Priority*

Total Revenue Available _____

Priority _____ Estimated Cost _____ (-) Revenues Available _____

Priority _____ Estimated Cost _____ (-) Revenues Available _____

Priority _____ Estimated Cost _____ (-) Revenues Available _____

Priority _____ Estimated Cost _____ (-) Revenues Available _____

Considering the costs and the criteria which you are using to determine priorities, are the priorities that you set before still correct? When you have balanced the costs of your priority activities with the amount of revenues projected, this exercise will be finished. You can summarize the results below.

The priorities are:

1. _____

2. _____

3. _____

4. _____

5. _____

Step Ten

Monitor and Evaluate the Performance of the UFS

A user fee system must be continually monitored to ensure that the new fees are not discouraging people from using the services. This is done by periodic studies of utilization levels and patterns to look for declines in use or other significant changes in demand.

Most FP programs already have a system in place for recording and reporting levels of use, with some detail about method mix. Any such form which provides basic FP service statistics can be used.

The simplest way to determine the impact of introducing user fees is to compare levels of use over a given time frame before and after the fee system is instituted. It is important to choose a long enough period in order to minimize the effect of seasonal fluctuations or some other kind of regular variation in use. If, for example, you compare the month just before fees are introduced to the month just after, it's quite likely that this two-month comparison would show a drop in utilization. But this doesn't necessarily mean that your fees are too high. One explanation may be that this is part of the normal monthly change or part of a seasonal change. Or it may be that people tended to concentrate their use of services in the previous month because they knew that new fees were to be introduced. Or, the introduction of fees could have led some people to use services elsewhere, if those services were an option. In these latter two instances, the drop in use is not necessarily permanent; you would need to observe use levels for several months to see if users started to come back, either because they ran out of goods purchased just before the change or because they stopped buying services at an alternative facility. In any event, it would be premature at this point to assume that there was a problem with your UFS.

The easiest way to determine if fees are really having a negative impact on utilization is to extend the period of observation, typically by looking at utilization data for six months prior to introduction of new fees and for several months after. If utilization levels for each of the several months after new fees are introduced fall below all of the earlier months (that is, the lowest month before introduction still had more users than the highest month after introduction), this would be a stronger indication that the fees were having a negative impact on demand and that modifications might be called for. Based on the tolerance levels you choose (see below), repeated utilization rates below the tolerance level (e.g., for two consecutive months) would trigger a revision in the system, unless there is another clear and obvious explanation. In any case, it is important to rule out the possibility that

these changes in utilization are normal or seasonal and would therefore be expected even without any user fees.

Determining Tolerance Levels

We have repeatedly emphasized that our objective in designing, implementing or updating a Family Planning User Fee System is to strengthen the ability to expand services. The purpose, therefore, of monitoring user fees is to make sure that those fees are not having the opposite effect. There may be some drop in levels of use, but such a drop, if fairly small, may be "tolerated," that is, acceptable, given the overall goal of expanding services. An acceptable drop in use is called a "tolerance level."

It has been suggested elsewhere that a drop in use of 20% would be a maximum tolerance level. This may be considered acceptable in some cases; if, for example, the need for revenues is so great that a program cannot continue without maintaining fee levels, or if it is known that this 20% of former users still have access to and use services somewhere else. But in most cases in which SEATS provides support, 20% would be considered too great a drop.

An easy way to specify the tolerance level is to look at the average (mean) number of users for each method in the preceding six months and to set the tolerance level at, for example, 90% of this mean. A drop below the tolerance level would then trigger a review, which would lead to changes in pricing or in a waiver policy. On the other hand, if utilization does not drop to the tolerance level, the next time you review and update user fees or your waiver policy, you may not have to be so cautious. You will, of course, set your tolerance levels consistent with your goals and local circumstances. Worksheet 16 shows mean utilization levels and tolerance levels for a typical FP clinic or program.

Worksheet 16

Mean Utilization and Tolerance Levels

A. Average monthly visits for previous six months _____

B. Tolerance level _____%

C. Tolerable/acceptable average utilization levels _____ *(A * B)*

Next Steps

Now that you have developed a design for your UFS, you will be ready to begin your plans for implementation. A number of steps will be involved in this process. Specific steps which will be useful as you plan for implementation are as follows:

Pilot Tests

You may wish to test the UFS on a small scale before you introduce it systemwide. Such a test will be particularly important if you are going to introduce it on a regional or national level. A pilot test should be made for a specific period of time (e.g., three or six months), within specific service delivery sites (e.g., all of the sites in one town). At the end of the pilot test period, review each step described above and make modifications to prices, projections, waivers, fee collection, and priorities, as appropriate.

Systemwide Expansion

Once the system has been tested and revised, as needed, you can plan for systemwide introduction. This will involve:

- Training of personnel: All staff will have to be informed about the new UFS. Those staff directly involved in issuing waivers or in collecting and managing fees will have to be trained in their responsibilities and procedures.
- Notifying the public: Announcements should be made well in advance of introduction. These notifications should include the introduction date, the new fees, and positive information about what the fees will be used for. It must be clear that fees will be linked to improved quality or availability of services.
- Setting an introduction date: Set a date which will allow enough time to get everybody ready, and which allows enough time for planning, training, and informing the public.

After Implementation

One point that needs to be emphasized here is that you must review your UFS on a regular basis and look at each of the steps described above to revise and improve your system. If utilization drops below the tolerance levels, you must repeat the steps and reevaluate the pricing structure and the waiver system. If revenues are lower than expected, fees, waivers and utilization must all be examined. Moderate changes in prices and in the number of waivers allowed will be expected, and the system should be updated on a regular basis. At all times, you should be thinking of improving your UFS, moving the level of cost recovery up to the next level.

Appendix 1 - Per Capita GDP and Health Care as a Percent of Income

A	B	C	A	B	C	A	B	C
Algeria	2230		Guatemala	910	13	Papua New Guinea	890	
Angola	610		Guinea	430		Paraguay	1030	2
Argentina	2160	4	Haiti	360		Peru	1010	4
Bangladesh	180	2	Honduras	900	8	Philippines	710	2
Benin	380	5	Hungary	2590	5	Poland	1790	6
Bolivia	620	5	India	340	3	Rwanda	320	3
Botswana	1600	4	Indonesia	500	2	Senegal	650	2
Brazil	2540	6	Iran	3200	5	Sierra Leone	220	6
Bulgaria	2320		Jamaica	1260	3	Slovak Republic	3450	
Burundi	220		Jordan	1640	5	Somalia	170	
Burkina Faso	320		Kenya	360	3	South Africa	2470	4
Cameroon	1000	11	Lao PDR	180		Sri Lanka	430	2
Central African Rep.	390		Lesotho	470		Syria	980	
Chad	190		Madagascar	230	6	Tanzania	130	3
Chile	1770	5	Malawi	180	2	Thailand	1220	5
China	350	1	Malaysia	2160	5	Togo	390	
Colombia	1200	7	Mali	270	2	Trinidad & Tobago	3230	
Congo	940	3	Mauritania	500		Tunisia	1260	6
Costa Rica	1780	7	Mauritius	1990	5	Turkey	1370	4
Cote D'Ivoire	790	9	Mexico	2010	5	Uganda	250	
Czech Republic	3450		Morocco	880	4	Uruguay	2620	6
Dominican Republic	790	8	Mozambique	80		Venezuela	2450	8
Ecuador	1020	5	Namibia	1030		Yemen	650	
Egypt	640	3	Nepal	180	6	Zaire	260	3
El Salvador	1070	8	Niger	290		Zambia	390	7
Ethiopia	120	3	Nigeria	250	2	Zimbabwe	650	4
Gabon	2960		Pakistan	370	3			
Ghana	390	3	Panama	1760	8			

A=Country
B=Per Capita GDP
C=% of household income spent on health care

Source: World Development Report, 1991 (World Bank)

Glossary

Cost Recovery - process of recovering some or all of the costs of providing products and services; synonymous with user fees.

Contraceptive Prevalence - percentage of women of reproductive age practicing contraception.

Cross Subsidization - using funds generated from one service (e.g., laboratory services) to cover part of the cost of another service (e.g., vasectomies). Cross subsidization can also occur based on geography (urban subsidizing rural) or based on income. Subsidies may be intentional and explicit, or they may be unintentional and implicit.

Deferred Payment - a payment which is made at some time after the service is provided. Deferred payments can be used when a client needs a service at a time when he or she is unable to pay.

FEE STRUCTURES:

* **Out-of-pocket Payments** - the most common payment mechanism. Payments are made at the time a service is provided. The full amount is paid based on the existing schedule when a client arrives at a facility or before the client leaves the facility.
* **Bundled Fees** - A single fee each time a patient arrives at a facility, which covers counseling, clinical services, laboratory services, and contraceptives.
* **Registration or Fee Cards** - A single fee is paid which is valid for a given period, and all regular services and goods are provided free thereafter until that period is over.

Installment Payments - a variation on deferred payments, installment payments are paid after a service is rendered, over a period of time. Installment payments make it possible for users to have access to certain more costly services (e.g., VSC) they might otherwise not consider.

Marginal Cost Recovery - all the additional non-fixed costs directly associated with providing an additional unit of this particular product/service are recovered, but not operating or other ongoing expenses.

Market Price - price at which a product or service is offered at other nearby locations

Nominal Cost Recovery - a minimal part of the cost of a product or service is recovered.

Operating Cost Recovery - the costs of the product/service are recovered, plus all associated "prime costs," such as salaries or supplies.

Operating and Infrastructure Cost Recovery - all operating costs are recovered as well as costs of infrastructure, capital goods, new building, etc.

Prepayment - a payment which is made in advance of receiving a family planning service or product which entitles a user, patient, or client to receive services or products for a period of time (e.g. one year).

Revenues - funds which are available from user fees, government allocation, or other sources, that enable activities to take place.

Sliding-scale Fees - fees which are adjusted according to user's ability to pay

Tolerance Levels - an acceptable drop in utilization. A tolerance level may be set, for example, at 90% of the mean number of users for each method in the preceding six months. A drop in utilization below the tolerance level would indicate a need for a review of the user fee system.

User Fees - payments made by the patient, client, or user for products and services received.

User Fee Systems - the set of managerial, administrative or financial structures which govern the setting of prices, collection and management of fees, and spending of revenues.

Waiver System - a system to identify people who cannot afford to pay full price for a product or service. This normallly involves some kind of means testing.

Worksheet 1

Objectives and Goals

Our overall objective is: _____

_____

_____

_____

_____

_____

We intend to use any funds collected to:

1. _____

_____

Timeframe: _____

2. _____

_____

Timeframe: _____

3. _____

_____

Timeframe: _____

4. _____

_____

Timeframe: _____

Worksheet 2

Selecting a Cost Recovery Level

Check one

- ❑ I. No Cost Recovery
- ❑ II. Nominal Cost Recovery
- ❑ III. Partial Cost Recovery
- ❑ IV. Operating Cost Recovery
- ❑ V. Operating & Infrastructure Cost Recovery

Advantages:

1. _____
2. _____
3. _____
4. _____
5. _____

Disadvantages:

1. _____
2. _____
3. _____
4. _____
5. _____

Worksheet 3 — *Payment Structure*

Note: Some Managers may want to use more thatn one payment structure.

- ❑ **Out-of-Pocket**

  Description _____

  _____

  _____

- ❑ **Bundled Fees**

  Description _____

  _____

  _____

- ❑ **Registration or Fee cards**

  Description _____

  _____

  _____

NOTES

Worksheet 4

Looking at the Market

Service/product: _____

1. Is this product service offered elsewhere? ❑ Yes ❑ No

If no, *market information is, of course, not appropriate.*

If yes, *continue to 2.*

2. Is the product service truly the same (same quality product, same level of service)? ❑ Yes ❑ No

If yes, *continue to 3.*

3. Where is it offered? (list all sources) _____

_____

4. What is the cost from each source? _____

_____

NOTES

Worksheet 5

Calculating the Fee Based on Market Price

A. FP product service to be offered _____

Where is similar product offered?	Location	Price

B. Average current market price of this FP product service (add up all of the prices and divide by the number of prices obtained) _____

C. Adjustment factor *(percent you wish to charge above or below the market price)* _____

D. Price of FP product service to be offered _____

(Multiply B x C)

NOTES

Worksheet 6

Calculating the Fee Based on User's Ability to Pay

A. Per capita (or per household) income _____

B. Percent of **(A)** spent on health care _____%

C. Percent of **(A)** spent on family planning (must be less than **(B)** _____%

D. Amount to be expended on FP per year (A x C) _____

E. Anticipated number of visits services per year _____

F. Anticipated units of product to be used per year _____

1	2	x	3	4
Service or Product	**Estimated units/year**		**Price per unit or service**	**Charges per year**

G. Total services and units of product per year _____

Should correspond to total of item (E) and item (F)

H. Total Charges* _____

Should correspond to item (D)

**If H is substantially greater than D, then modify your prices until F = D.*

Worksheet 7

Calculating the Fee Based on Nominal Cost Recovery (Level II)

1. Bulk cost of product to facility _____
2. Cost per unit to facility _____
3. Percent of (2) to be charged user _____
4. **Price per unit to user** _____

Worksheet 8

Calculating Fees Based on Partial Cost Recovery (Level III)

1. Bulk cost of product to facility _____
2. Cost per unit to facility _____
3. **Price per unit to user** _____

Worksheet 8a

Calculating Fees Based on Partial Cost Recovery (Level III)

An alternative example

1. Total cost of salaries to facility _____
2. Percent of salary costs to be recovered as marginal costs _____
3. Total amount to be recovered _____
4. Total patient visits per year _____
5. **Price per unit to user** _____

Worksheet 9

Calculating Fees Based on Operating Cost Recovery (Level IV)

1. Annual operating costs of facility

contraceptives	_____
rent	_____
salaries	_____
supplies	_____
utilities	_____
repairs	_____
other	_____
Total	_____

2. Annual number of client visits _____

3. Operating cost per visit *[(2) divided by (1)]* _____

4. Average price to user per visit
[same as amount in (3)] _____

5. Price *[amount in (4)]* to be distributed as

Price per visit	_____
Price for contraceptives *(may be calculated as a one-year supply)*	_____
Total Price *[same as amount in (3)]*	_____

Worksheet 10 *Summary of Pricing and Fee Structures*

1. Pricing method used _____

2. Cost recovery level expected _____

   Including what % of contraceptive costs _____

   Including what % of recurrent costs _____

3. The tentative fee schedule will be

Services

Consultation _____

IUD insertion _____

Surgical procedures

Norplant _____

Minilap _____

Vasectomy _____

Contraception

Condoms (per ___) _____

Cycle of oral contraceptives _____

IUD _____

Injection _____

Other _____ _____

Other _____ _____

Worksheet 11

Considerations in Designing Use/Revenue Estimates

1. Purpose or intended use:

How precise do your projections need to be?

❑ Very precise ❑ Somewhat precise ❑ Very rough

What are you going to use your projections for?

❑ For budgeting ❑ For strategic planning ❑ To estimate additional resources

2. Availability of data:

Is the data you need to collect available or easily obtained?

❑ Yes ❑ No

Is the data

❑ utilization-based (= of client visits per method) or

❑ population-based (= of people or households in area and estimated prevalence of contraceptive use)?

3. Special equipment:

Can the estimates be made with existing equipment (paper and pencil, calculator), or ❑ Yes ❑ No

is a computer necessary? ❑ Yes ❑ No

If a computer is necessary, is one available? ❑ Yes ❑ No

4. Staff skill levels:

Does your staff have the skills to gather and sort the data and perform the necessary calculations? ❑ Yes ❑ No

If a computer is needed, is there someone available to run it? ❑ Yes ❑ No

5. Match between level of effort and intended use:

Are the time and effort involved reasonable given the intended use of the information? ❑ Yes ❑ No

6. Scope of analysis:

Will you be making estimates for

- ❑ a single facility or
- ❑ several facilities comprising one service network
- ❑ an entire district
- ❑ region
- ❑ country

Worksheet 12

Estimating Family Planning Utilization and Revenues

A. Calculating total estimated use: _____

1. # of client visits in previous year: _____
2. projected increase for coming year or: _____
3. minus the projected decrease for coming year: - _____
4. equals total projected use for coming year: _____

B. Calculating total estimated revenues:

1. fee per visit: _____
2. total # for coming year: _____
3. pre-waiver (projected gross) revenue total (#1 x #2): _____
4. % of #2 to be waived: _____
5. revenue to be waived (% in #2 x #3): _____
6. projected total revenue (#3-#5): _____

Worksheet 13

Disposition of Revenues

Based on your review, the disposition of revenues will be

_____% at the local level (clinic, facility or community)

_____% passed on

100 % Total

Worksheet 14a — *Evaluation Matrix*

	Criteria				
Priority	*1*	*2*	*3*	*4*	*Total "+"*
1					
2					
3					
4					

Worksheet 14b — *Evaluation Matrix*

Alternative based on points

	Criteria				
Priority	*1*	*2*	*3*	*4*	*Total*
1					
2					
3					
4					

NOTES

Worksheet 14c

Evaluation Matrix

Alternative based on weighted points

	Criteria								
	1	Weight=	2	Weight=	3	Weight=	4	Weight=	
Priority	points	weighted score	points	weighted score	points	weighted score	points	weighted score	Total weighted scores
1									
2									
3									
4									

Worksheet 15

Estimating Costs per Priority

Total Revenue Available _____

Priority _____ Estimated Cost _____ (-) Revenues Available _____

Priority _____ Estimated Cost _____ (-) Revenues Available _____

Priority _____ Estimated Cost _____ (-) Revenues Available _____

Priority _____ Estimated Cost _____ (-) Revenues Available _____

Worksheet 16

Mean Utilization and Tolerance Levels

A. Average monthly visits for previous six months _____

B. Tolerance level _____%

C. Tolerable acceptable average utilization levels _____ *(A * B)*

Summary Worksheet

Verification of decisions made in Steps One through Four

We intend to use any funds collected to

1. _____

2. _____

3. _____

4. _____

Our target cost recovery level is

- ❑ I. No Cost Recovery
- ❑ II. Nominal Cost Recovery
- ❑ III. Partial Cost Recovery
- ❑ IV. Operating Cost Recovery
- ❑ V. Operating & Infrastructure Cost Recovery

The percent of recurrent or operating costs we intend to recover is _____%

The pricing method we are using is _____

(continued on following page)

NOTES

Summary Worksheet - continued

The fee schedule will be

Services

Consultation _____

IUD insertion _____

Surgical procedure _____

Contraception

Condoms (per ___) _____

Cycle of oral contraceptives _____

IUD _____

Injection _____

Other _____ _____

Other _____ _____

Total projected use for coming year _____

Pre-waiver (projected gross) revenue total _____

Percentage of fees to be waived _____

Projected total revenue _____

Total costs _____

Percentage of costs recovered _____%

These total projected revenues are consistent with cost recovery targets

❑ yes ❑ no

If not, repeat with modification to

❑ prices ❑ waiver level or ❑ targets

CONFIDENTIAL **User Questionnaire** **CONFIDENTIAL**

Clinic Name: _____ ***Date:*** _____

1. Client Name: _____ Number: _____

Address: _____

_____

_____

2. Apparent health of client: ❑ good ❑ fair ❑ poor

3. Marital status: ❑ married ❑ unmarried

4. Occupation: _____

5. Occupation of spouse: _____

6. Education level:
❑ no formal education
❑ primary school only
❑ some secondary school
❑ post secondary
❑ college graduate

7. Education level of spouse:
❑ no formal education
❑ primary school only
❑ some secondary school
❑ post secondary
❑ college graduate

8. Employer of client and client's spouse:

_____

_____

Does client give permission to contact these employers? ❑ Yes ❑ No

9. Income:

Client _____

Spouse _____

Other Family _____

Total Household _____

(continued on next page)

10. Name/address of closest relative:

_____

_____

_____

_____

11. Name/address of community leader:

_____

_____

Does the client give permission to contact this community leader? ❑ Yes ❑ No

12. Number of children: _____

13. Ages of children: _____

14. Number of children in school: _____

15. How did the client get to the facility?

- ❑ in own car
- ❑ by taxi
- ❑ by bus
- ❑ bicycle
- ❑ on foot
- ❑ in relative's car
- ❑ collective taxi
- ❑ motorcycle
- ❑ animal

16. Does the client smoke? ❑ Yes ❑ No

17. Is the client wearing shoes? ❑ Yes ❑ No

18. What is the physical appearance of the person/any accompanying children?

_____

_____

19. Number of outpatient visits in the last 6 months: _____

20. Number of days in hospital in last 6 months: _____