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DRAFT REPORT

2 APRIL 1991

RECOMMENDATIONS ON USER FEES IN GOVERNMENT AND MISSION HEALTH SERVICES

Prepared for:

Ministry of Health
Government of Swaziland

US Agency for International Development/
Swaziland

Prepared by:

Charles C. Stover
Management Sciences for Health
Primary Health Care Project

April 2, 1991

Cover Memorandum To: Distribution

From: Charles Q. Stover
Management Sciences for Health
Primary Health Care Project

Re: Recommendations on Fees for Government and Mission Health Facilities

Attached is the first draft of my report, including recommended changes in the fee schedule which has been in effect since April, 1987.

I will complete the final report and return copies via air freight within three weeks. The final report will contain additional financial analysis, complete ANNEXES, and more specifics on procedural recommendations.

I would appreciate any comments on the draft report. Comments can be sent to me via fax through Jane in the Primary Health Care office at 45520. Bernard McLoughlin is working out of Room 234 and can get any notes you leave in that office to Jane.

Many thanks for your assistance. I hope that this report will meet your need and expectations.

Distribution:

Mr. C.M. Mkhonza, Principal Secretary, MOH
Dr. E. McGrath
Mr. C.V. Kunene
Mr. R.P. Thompson
Dr. Vincent Joret
Mr. Jay Anderson, US/AID
Mrs. Anita Sampson, US/AID
Mr B. McLoughlin

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RECOMMENDATIONS ON USER FEES IN GOVERNMENT AND MISSION HEALTH SERVICES

Prepared for the Ministry of Health
Government of the Kingdom of Swaziland

This project addressed specific issues regarding fees charged for health services in government and mission facilities. The terms of reference prepared by the Ministry of Health included the following tasks. The specific sections responding to these tasks are listed below each item.

This project was completed during the period from March 13 through April 2, 1991. The methodology consisted of interviews with central and regional Ministry of Health (MOH) officials and staff, health workers and administrators in hospitals, health centres, clinics, and regional offices. In addition, data from MOH and Treasury report, plus reference material from previous studies, were used.

This work uses the findings in An Assessment of User Fees in Swaziland's Health Services, by D.H. Collins, Management Sciences for Health, 3 May 1990, as well as other studies cited in the bibliography in Annex G.

TERMS OF REFERENCE

1. Recommend the level of fees for non-private patients which will be introduced in April 1991 taking into consideration inflation, the relationship that fees bear to the cost of delivery, individual services and people's ability and willingness to pay.

2. Recommend the level of fees for private patients looking carefully at the possibility of recovering the full cost of services.

3. Clarify the recommended revised fee structure to eliminate any variations between Government and Mission facilities.

4. Recommend and document revised a detailed procedure for:
   a) the collection of fees from patients who attend after hours;
   b) collecting outpatient consultancy and ancillary service fees;
   c) authorising credit to company patients;
   d) improving the invoicing, collection and reporting of unpaid accounts.

5. Recommend and document a detailed procedure for the collection, recording and accounting of community funds.

RECOMMENDATIONS ON USER FEES IN GOVERNMENT AND MISSION HEALTH SERVICES

A. EXECUTIVE SUMMARY

1 Table 1 contains the recommended fee schedule for government and mission facilities for both non-private and private fee patients. The proposed increases take into account ability and willingness of patients to pay, inflation, cost of service delivery, and opportunity to collect from medical aid coverage. General fees are increased in line with inflation, yet remain affordable. Private fees are increased more substantially to bring them closer into line with costs, in order to gain reimbursement from medical insurance plans.

2. The Government of Swaziland (GOS) policy context used for these adjustments is outlined in the following section. The basic tenets are that modest fees for health care services are appropriate, and should be applied uniformly in government and mission facilities. These fees should not impose a barrier to access to health care services.

3. The process of introducing the fee changes is considered at least as important as the fee schedule itself. A small working group reporting to the Principal Secretary could handle the implementation. Specific steps for introduction are cited in a following section.

4. Recommended steps include public announcements by the Ministry of Health, media coverage, and direct communication to communities through chiefs and to the health facilities. The announcements should include the reasons for the fee changes, as well as the effective date. A minimum of 4-8 weeks lead time from the date of the announcement until the effective date of the increases will avoid surprising patients.

5. Review and revision of the fee schedule should be an annual process. Annual reviews will permit smaller incremental adjustments to be made. This review is particularly important regarding private fees, which may need to be adjusted as cost accounting data for the hospitals improves.

A small working group could be charged with this task. It should involve gathering suggestions from financial, clinical, and administrative staff in a cross-section of government and Mission facilities via questionnaires and personal interviews. Data on general inflation, health care inflation, wage increases, and service costs from hospitals should be used as well.

6. The Mission facilities should adjust their fee schedules to

remove the minor variations which exist at present for general patients. A consultation process between government and Mission staff should address these differences.

7. In the area of private in-patient fees, the proposed schedule continues the current practice of setting minimum fees, so that facilities with documentable costs above the new levels would be allowed to maintain higher fees. This is only an issue for R.F.M Mission Hospital, with its higher cost structure

8. Specific procedures and management steps are recommended for collecting after hour fees, collecting consultancy and ancillary service fees, authorizing credit to company patients, and improving the management of unpaid accounts In most cases, these issues relate to the larger government hospitals, and not to the Mission facilities, which have more effective collection practices in place.

9. Additional accounting work is necessary at each hospital to better manage accounts receivable. Specific steps include accounting for revenue earned (based on units of service delivered) as a benchmark for collections, monthly accounts receivable reports, and specific followup techniques, particularly with medical aid plans and companies.

10. In large part, the resolution of these collection problems lies in the Ministry establishing norms of performance for the hospitals, and the hospital management team taking responsibility for meeting those expectations. When approached in a direct manner, these issues can be resolved on a timely basis (two-three months). The government hospitals will require additional patient accounts staff to handle collections after hours, weekends, and holidays.

11 The most effective technical assistance for establishing better collection procedures will come from the mission hospitals, and through exchange with the patients accounts staff in the government hospitals. It is worth considering arranging for part-time assistance from someone like the patients' accounts manager at R.F.M. Hospital to work with the administrative team at each government hospital to make specific improvements in procedures.

12 There is general agreement that the exemption from paying fees based upon a letter from the patients' chief is an awkward and difficult procedure Each government hospital should designate a senior official (such as the accountant) to authorize free care on behalf of the institution within guidelines established by the hospital's management team. This procedure works effectively in the mission hospitals, where only a small number of patients avail of the exception process. Again, technical assistance from the Mission hospitals in this area

would assure this approach is workable.

13 A procedure for handling of community funds is included. This procedures is intended to avoid potential misunderstandings between clinic staff and community leaders over accounting for the funds. It is considered a preventive approach, since there do no appear to be problems as yet.

14 Along with paying moderate fees for health care services, patients will expect to improved services, in terms of access, quality, and convenience. This is an important feature for health care staff to remember in implementing fee collections. It is important to attempt to reduce waiting times, and streamline procedures wherever possible on the patient's behalf.

15. There is a strong justification to pursue the pilot project in fee retention for government facilities. The ability to retain a portion of the fees collected should serve the purposes of both the Ministry of Health for improved services through more flexible management and funding, and those of the Ministry of Finance for additional revenue.

FEES WITHIN NATIONAL HEALTH POLICY OBJECTIVES

In the National Health Policy dated July, 1983, the Government of Swaziland has taken responsibility through the Ministry of Health

> "to improve the health status of the Swazi people by providing preventive, promotive, rehabilitative, and curative health services which are relevant and accessible to all." 1 (National Health Policy, Swaziland Government, July, 1983. p. 7.)

The related policy regarding financial access is stated in the same policy document.

> "A fundamental MOH policy is that no person should be denied health services because of an inability to pay for them. At present inequity exists in that financial access to health services may vary among families of even similar socio-economic status, depending upon where they live and which sector provides the services in their area. A uniform fee structure will be established to participate in the financing of their own health services." (National Health Policy, pp. 10-11.)

Moderate fees for government and Mission facilities have been in effect since the 1960's. Consistent with these government policies the fee levels were standardized between Missions and government facilities in 1984. Subsequent revisions in fees were accomplished in 1986, and 1987.

Fees provide a modest yet still significant element in financing and delivering health care services in Swaziland. They are accepted as part of the overall health policy provided that they do not restrict access to needed care.
There are at least three reasons for charging moderate fees for health care services.

1. To raise revenues to finance part of the cost of health services:
   - For mission facilities, fee income provides direct financial support for a portion of their operating costs,
   - For government facilities, fee income provides indirect support to the government to supplement other revenues in financing health services.

2. To reinforce clinical and administrative policies in health programs, such as discouraging excessive use or correcting imbalance in the utilization of services.

3. To encourage the commitment of individual patients to a level of personal responsibility in their own health care.

RESEARCH METHODOLOGY FOR

PROPOSED FEE SCHEDULE

Table 1 includes the recommended fees to be implemented as soon as possible, while allowing 4-8 weeks of lead time for communicating the changes The recommendations were based upon interviews and meetings with 65 officials and staff of the central and regional Ministry of Health, and clinical and administrative staff in 18 government and Missions health facilities and offices. The individuals interviewed and the facilities visited are listed in ANNEXES F and G

The current fee schedule was discussed with the interviewees. In addition, the more general topics listed below were also addressed. While this setting of fees is surely more an art than a science, the cross-referencing of different opinions and data provide a relatively sound basis for the changes recommended in Table 1.

1. **Ability and Willingness to Pay-** During the interviews with nursing staff and administrative staff, the first questions asked were their recommendations concerning what levels of fees are affordable and what are patients' willingness to pay.

2. **Access to Services by Patients-** The question of whether existing fees raised any barrier to patients' accessing care was also addressed. In general, in the vast majority of cases there was no known problem. With one interviewee, involving the payment for an ancillary service, concern was expressed that individuals may have decided not to pursue care. The issue appeared to lie not in the fee structure per se, but in the lack of authority for the government hospital to allow free care without an explicit letter from the chief.

3. **Inflation-** The inflation rate are measured by the Consumer Price Indices compiled by the Department of Economic Planning and Statistics shows the following rate of increase since the last fee change in April, 1987:

	Annual Change (%)			
Indices	1987	1988	1989	1990
Middle & High-Income	12.0%	12.2%	9.5%	11.4%
Low-Income	16.2%	6.3%	10.8%	12.4%
All Groups	13.1%	10.7%	9.4%	11.4%

The compound rate of inflation for all groups for the four

year period is an increase of 52.6%. While medical inflation, specifically in certain areas such as drugs, may have increased at a greater rate, the level of 50% increase is used as benchmark for keeping rates in line with general inflation.

3. **Costs of Services-** Due to lack of available data, hospital unit service costs could not be used as a test for fee level reasonableness. However, in the course of the interviews, considerable anecdotal information in the cost of specific services was given. It is anticipated that if the proposed unit costing system is introduced, specific unit cost factors, particularly for the larger hospitals, will be available.

4. **Clinical and Administrative Impact-** The ease of administration, including making as few changes in current procedures which have worked well, was taken into account. In some cases, the fee was rounded to a multiple of E.050 to minimize the difficulties in making small change, particularly in a clinic setting.

In specific cases, the staff interviewed suggested ways in which fees helped support certain clinical and administrative goals. For example, the fee differential between clinics and hospitals was increased slightly to continue to reinforce the use of clinics for primary care. Another example was in the area of lodgers' fees. The number of lodgers on the wards causes congestion in many hospital wards. It was suggested that an increase in fees for lodgers might partially alleviate this problem.

5. **Patient Service and Convenience**

6. **Future Fee Increases-** Since it is anticipated that the fee schedule will be reviewed and adjusted (at least in part) on an annual basis, Fee increases recommended in Table 1 are kept to reasonable levels, with the anticipation that areas where further increases were considered appropriate could be adjusted in the future. The primary objective was to provide for reasonable increases without setting up financial barriers to access to care.

7. **Revenue Generated-** The increased amount of revenue was estimated after the fee schedule was developed. This approach is consistent with trying to assure that fees are affordable and are not driven by revenue targets.

SPECIFIC FEE ADJUSTMENTS

1. Outpatient (General)

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TABLE 1

MINISTRY OF HEALTH 2 APRIL 1991

UNIFORM FEE STRUCTURE FOR ALL GOVERNMENT AND MISSION HEALTH FACILITIES

SERVICE DESCRIPTION	1987 FEE	1991 RECOM LEVEL	AMT CHG
1. OUTPATIENTS (GENERAL)			
Consultation and Medication Clinic	$1.00	$1.50	$0.50
Consultation			
Health Centre	$1.25	$1.75	$0.50
Hospital	$1.50	$2.00	$0.50
Medication (per prescription)		$1.00	
X-Ray (per X-Ray)	$1.75	$2.50	
(but I.B. Patients free)			$0.00
Laboratory (each test)	$1.00	$1.50	$0.50
All reattendances	free	free	$0.00
Public Health visits	free	free	$0.00
Late call Fee: Weekdays after 5:00 p.m., Saturdays after 1 p.m., all Public and Bank Holidays (Instead of regular fee)			
Consultation and Medication Clinics	$1.00	$2.00	$1.00
Consultation			
Health Centre	$1.25	$3.00	$1.75
Hospitals	$3.50	$4.00	$0.50
Medication (per prescription)	$1.00	$1.50	$0.50
2. OUTPATIENTS (PRIVATE)			
(to be seen by appointment in afternoon only)			
Consultation minimum charge	$10.00	$20.00	$10.00
Reattendance minimum charge	$8.00	$15.00	$7.00
Medication minimum charge (per prescription)	$5.00	$10.00	$5.00
X-Ray minimum charge (per X-Ray)	$2.50	$7.50	$5.00
Laboratory minimum charge (per test)	$2.50	$5.00	$2.50
3. IN-PATIENTS (GENERAL)			
First 10 days (per day)	$2.00	$3.00	$1.00
After first 10 days (per day)	$1.00	$1.50	$0.50
Waiting Maternity Cases (per day) with Doctor's order	$0.30	$0.50	$0.20
Lodgers (per day)	$0.30	$1.00	$0.70
Laboratory Test (per test)	$1.00	$1.50	$0.50

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X-Ray (per X-Ray)	$1.75	$2.50	$0.75
Special meals requested by patient (per day)		$7.50	$7.50
Minimum Deposit for each admission		$15.00	$15.00
HOSPITAL ACCOMMODATION (PRIVATE) INCLUDING MATERNITY			
Private (1 or 2 beds):			
First 10 days (per day)	$20.00	$35.00	$15.00
After first 10 days (per day)	$10.00	$15.00	$5.00
Semi-private (more than 2 beds):			
First 10 days (per day)	$10.00	$10.00	$10.00
After first 10 days (per day)	$ [illegible]	$13.00	$6.50
X-Ray (per X-Ray)	$2.50	$5.00	$2.50
Laboratory Test (per test)	$2.50	$5.00	$2.50
Special meals requested by patient (per day)		$15.00	$15.00
Minimum Deposit per admission		$90.00	$90.00
Waiting Maternity and Lodgers are half above rates			
DENTAL CHARGES			
Check-up	free	free	$0.00
Set-up Appointment		$0.50	$0.50
Scaling/Polishing	free	$0.50	$0.50
Temporary Filling		$1.00	$1.00
Extraction- Adult (per tooth)	$1.00	$1.50	$0.50
- Child (per tooth)		$1.00	$1.00
Filling- single surface (per tooth)	$1.50	$2.00	$0.50
double surface (per tooth)	$2.00	$2.50	$0.50
triple surface (per tooth)	$2.50	$3.00	$0.50
Root Canal		$2.00	$2.00
Disembaction		$5.00	$5.00
Fixation-Mandible Fracture		$7.00	$7.00
Dental X-Ray	$1.50	$2.00	$0.50
Dentures- charge for base	at	$5.00	$5.00
additional charge per tooth	cost	$5.00	$5.00
Full Denture (upper or lower)		$40.00	$40.00
Full Denture (upper and lower)		$80.00	$80.00
Denture Repairs and Readjustments	at cost	$5.00	$5.00
OPERATIONS (GENERAL)			
Minor (needing local anaesthetic)	$7.00	$11.00	$4.00
Major (needing general anaesthetic)	$14.00	$22.00	$8.00
If more than two operations per admission, charge for subsequent operations at minor rate			
OPERATIONS (PRIVATE)			
Minor (needing local anaesthetic)	$7.00	$22.00	$15.00

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Major (needing general anaesthetic)	$14.00	$48.00	$26.00

8. PHYSIOTHERAPY

Out-patient (per week)		$1.50	
In-Patient		free	

9. ORTHOPAEDIC WORKSHOP (GENERAL)

Orthosis (See separate schedule)			
Prosthesis (See separate schedule)			

10. AMBULANCE SERVICES

Referred cases, including to Johannesburg minimum charge	free	free	$0.00
Journeys throughout the country (per journey)	$5.00	$8.00	$3.00

11. DELIVERY

ALL	$1.00	$3.00	$2.00

12. MORTUARY

Hospital bodies:			
Adult (per day)	$1.00	$2.00	$1.00
Adult Shrouding	$2.00	$4.00	$2.00
Child (per day)	free		$0.00
Child Shrouding	free		$0.00
Infant (per day)	free		$0.00
Infant Shrouding	free		$0.00
Outside bodies:			
All bodies	$2.00	$5.00	$3.00
Shrouding	$3.50	$8.00	$4.50

Charges will commence two days after a post mortem or three days after death

13. ROUTINE MEDICAL EXAMINATION

Without X-Ray, Laboratory	$2.50	$5.00	$2.50
With X-Ray	$5.00	$8.00	$3.00
With Laboratory	$5.00	$7.00	$2.00
With X-Ray Laboratory	$7.50	$12.00	$4.50

14. INTERNATIONAL VACCINATIONS

Including Cholera, Yellow Fever and Typhoid. Single and Combinations	$2.50	$4.00	$1.50

N.B.
(1) All patients are expected to pay the service charges.

No one will be denied service due to inability to pay. Anyone unable to pay will have the fees waived upon presentation of a letter from their Chief certifying inability to pay.

(2) Non-resident general outpatients and inpatients will be charged three times the general rates. Non-resident private outpatients and inpatients will pay the private rates.

(3) Prison patients and police requests are free.

(4) Reattendances. A reattendance is defined as a followup visit within seven days, or within a longer time period only if authorized in writing by the clinician.

(5) All attendances for T.B., Leprosy and Mental Services shall be free.

(6) For general inpatients, for cases in which there is more than one admission per year for 10 days or more, all subsequent admissions are free. Deliveries count as one admission.

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TABLE 1H

GOVERNMENT OF SWAZILAND

MINISTRY OF HEALTH

ORTHOPAEDIC WORKSHOP GENERAL PRICE LIST

ORTHOSIS	ADULT	CHILD	PROPOSED INCREASE ADULT	1.4 CHILD
. Above knee caliper/thigh corset	$60.00	$30.00	$84.00	$42.00
. Above knee caliper/pelvis band	$50.00	$25.00	$70.00	$35.00
. Above knee caliper	$48.00	$24.00	$67.20	$33.60
. Weight relieving caliper	$40.00	$20.00	$56.00	$28.00
. Knee cage	$35.00	$17.50	$49.00	$24.50
. Below knee caliper/two bars	$35.00	$17.50	$49.00	$24.50
. Below knee caliper/one bar	$17.50	$8.75	$24.50	$12.25
. Surgical boot	$45.00	$22.50	$63.00	$31.50
. Shoe converted to boot	$18.00	$9.00	$25.20	$12.60
0. Arch support	$20.00	$10.00	$28.00	$14.00
1. Shoe raising 1 layer thick sole	$3.50	$1.75	$4.90	$2.45
2. Shoe raising 1 layer hard sole	$4.50	$2.50	$6.30	$3.50
3. Repair shoe raising/layer	$1.00	$0.50	$1.40	$0.70
4. Stirrup	$4.00	$2.00	$5.60	$2.80
5. Lateral shoe raising/layer	$2.00	$1.00	$2.80	$1.40
6. Medial shoe raising/layer	$2.00	$1.00	$2.80	$1.40
7. Metatarsal bar	$4.00	$2.00	$5.60	$2.80
8. Knee cap	$3.00	$1.50	$4.20	$2.10
9. Spinal brace	$40.00	$20.00	$56.00	$28.00
0. Taylor brace	$50.00	$25.00	$70.00	$35.00
1. Milwaukee brace	$250.00	$125.00	$350.00	$175.00
2. Robert Jones brace	$50.00	$25.00	$70.00	$35.00
3. Butterfly brace	$70.00	$35.00	$98.00	$49.00
4. Plastizote collar	$20.00	$10.00	$28.00	$14.00
5. Wood crutches	$10.00	$8.00	$14.00	$11.20

PROSTHESIS				
. Hip Disarticulation	$1,200.00	$600.00	$1,680.00	$840.00
. Above-knee	$900.00	$250.00	$1,260.00	$350.00
. Through knee	$400.00	$175.00	$560.00	$245.00
. Below knee with thigh corset	$350.00	$150.00	$490.00	$210.00
. Below knee	$300.00	$125.00	$420.00	$175.00
. Syme	$450.00	$225.00	$630.00	$315.00
. Above elbow	$1,000.00	$500.00	$1,400.00	$700.00
. Below elbow	$750.00	$350.00	$1,050.00	$490.00
. One each foot	$100.00	$100.00	$140.00	$140.00

The consultation and medication fee is increased by a modest amount of E0.50 for clinics, health centres, and hospitals.

While there is considered opinion that an increase of E1.00 at the clinics is affordable, a more modest increase of E0.50 is recommended. The progressive scale was used to reinforce the role of the clinic for primary care.

There is considerable debate whether charging for each medicine separately was advisable. Most clinicians believe that charging more for the medicines would increase their value to the patient, reduce waste or loss, and increase compliance with the schedule for taking the medications. However, charging for each medicine would increase the administrative complexity and increase the cost to patients, and would have to be "capped" to avoid an excessive impact on any individual.

The recommended step is to charge a flat fee of E1.0 per prescription (the amount of medicines prescribed for a visit) at health centres and hospitals, but not at the clinics. The fee is not charged at the clinics, since the combined consultation and medication fee is considered more appropriate for nursing visits. The consultant's understanding is that charging for prescriptions this approach had been decided upon in 1987, but was rescinded due to an error in the layout of the fee schedule.

X-Ray and Laboratory fees are increased in line with inflation in those areas, and are still considered modest compared to the costs of the services.

Public health visits and reattendances are kept free in order not to set any barrier to service. However, it is recommended that the definition of reattendance be set at within 7 days unless specified in writing by the clinician for a longer period. Beyond that point, the visit is considered a normal visit. This time frame is generally used at present.

Late call fees are increased by the same amount as the normal consultation and medication fee, using the same progressive scale. In order to avoid confusion as to whether the late call fees are charged in addition to the regular fees, the schedule is set specifically so that the late call fees are charged instead of the regular hour fees.

2. Out-patients (Private)

Private rates are increased substantially, in some cases doubled. There were several reasons for these increases above the general inflation rate. First, the purpose is to make these fees approach the full cost of the service in order to be able to capture revenue from medical aid coverage. In the absence of unit cost data, a high level of precision is not possible. Rates

for private patients at RFM Hospital and limited interviews with private physicians were considered in making the recommendations.

3. In-patients (General)

The rate per day for general inpatient care was increased from E2.00 to E3.00, for the first 10 days, and from E1.00 to E1.50 per day beyond that, in line with inflation. The new rates are considered affordable and reasonable, and modest compared to the cost of inpatient care.

Daily fees for lodgers were increased from E0.30 to E1.00, to reflect the costs of food, and the fact that except for mothers of small children, these patients do not need to be in the hospital. The daily fee for waiting mothers is only increased slightly to E0.50, since they are in the hospital as a potentially high risk pregnancy.

X-Ray and laboratory tests were increased to the same level as out-patient procedures.

A deposit upon admission of E20 is established, in line with the increase in daily rates. The current policy is for a deposit of E16 per day, although the policy is very unevenly applied.

4. **Inpatients (Private) Including Maternity-** In-patient daily rates and X-Ray and laboratory procedures are increased at rates above inflation, for the same reasons as described above under private out-patient services.

These rates remain as minimum rates, so that as institutions establish unit costing data, they will be able to reopen discussions on the fee level. It is presumed that RFM will continue its higher fee level based on its cost structure.

R F.M. Hospital has ordered a copy of the South African Medical Aid rates that was published in the R.S.A. government gazette. The MOH should also get a copy of that listing, as a consideration in establishing private charges.

The deposit upon admission was set at E90, increased in proportion to the increases in daily rates. The current level it E60.

5. Dental Charges- Dental charges are increased at or below the inflation rate, with an increase of E0.50 for extractions, and smaller percentage increases for fillings.

A charge of E0.50 was added for appointments. The purpose of this minimal charge is to reduce the number of missed appointments. The charge would be made after the checkup when an

appointment is set for a specific procedure

A charge of E1.0 is recommended for scaling/polishing, given the amount of time required for the procedure

Additional procedures not included in the 1987 fee schedule, including temporary fillings, disempactions of wisdom teeth, and fixation of a mandible fracture are recommended on the advice of the dentists at Mbabane Hospital
The latter two procedures require minor surgery and are thus more costly

A fee schedule for manufacture of dentures is included as well, although these are not currently manufactured at Mbabane Hospital due to lack of equipment.

6. **Operations-** Fees for the operating theatre were increased by somewhat more than inflation, reflecting the high cost of operations. However, the fee is still considered by be modest given the service. A fee schedule for private patient in the operating theatre was established at levels closer to the operating costs.

7. **Physiotherapy-** This service is continued to be charged as an out-patient case with a fee per week, and will carry the modest increase in out-patient consultation. For example, the outpatient fee of E2.00 per week will cover all visits for one week as reattendances.

The fee schedule in use at Mbabane Hospital for orthotics and prosthetics is attached as a separate schedule and listed at Table 1A. These fees are proposed to increase at less than the inflation rate.

8. Ambulance Services

The ambulance rates were subject to considerable debate. Many people argued for going back to a charge per kilometre. However, the complexity of such a system, and the extra burden it would put on rural patients during emergencies, are arguments to the contrary. The basis structure of the current fees was maintained, with an increase to E8.0 for the journey within the country.

9. **Delivery-** An increase in delivery rates from E1.00 to E3.00 is recommended, based on several factors First, the cost of a normal delivery is substantial, given nursing time, sterile environment, and delivery kit. Second, the increase is considered affordable, since it is one of the few medical expenses which is predictable, and known well in advance, and therefore saving for the fee is very possible.

A rate of E5.0 per delivery was suggested by most of the interviewees as an appropriate charge. However, given the large increase from the current level, such an increase should be handled over a 2-3 year period.

10. Mortuary

The increase in the mortuary fee from E1.00 to E2.00 per day is recommended both based on inflation (labor and electric rates), and to encourage relatives to make as prompt arrangements as possible for the funeral and burial of the diseased. At Hlatikulu Hospital, there is some overcrowding at the hospital mortuary which could be alleviated by an increased fee.

The fee is recommended to become effective after three days of death, which is the standard used at R.F.M. Hospital, and which is the period in which most relatives pick up the deceased.

The rate for child and infant bodies remains free.

12. **Routine Medical Examination**- Fees in this area are increased at roughly the inflation rate. These fees are modest, and affordable, and are generally paid by the employer as an initial ongoing condition for employment, and are generally paid by employer as an initial ongoing condition.

13. **International Vaccinations**- A modest increase from E2.50 to E3.50 should not pose any financial barrier to vaccinations.

STEPS FOR IMPLEMENTATION

(Listing of specific steps regarding implementation of revised fee schedule).

DETERMINATION OF FREE CARE STATUS

(Discussion of recommendation about criteria for determining inability to pay).

(Consideration of upper limit on amount to be paid by an individual patient for one hospital admission).

IMPROVED COLLECTIONS

The specific tasks in the scope of work addressed in this section are:

4. Recommend and document revised a detailed procedure for:
   a) the collection of fees from patients who attend after hours;
   b) collecting outpatient consultancy and ancillary

service fees;
c) authorising credit to company patients;
d) improving the invoicing, collection and reporting of unpaid accounts.

Findings

The issue of collections is primarily one for the government hospitals. Among the government hospitals, Mbabane Hospital has the largest amount of uncollected revenue given its volume of service.

Missions facilities seem to have developed sound procedures, due in part to the fact that they depend on fee income to sustain the programs. Government clinics seem to manage well with the nursing staff handling all the transactions. The only issue is collection of after hours fees in a few clinics. This issue can be addressed through the regular clinic supervision process.

The specific areas where collections at present are inconsistent or non-existent at government hospitals are:

- o After hour out-patient fees (after-hours is considered after 5 p.m. on weekdays, after 1 p.m. on Saturdays, and on all holidays),
- o Fees from inpatients discharged after hours,
- o Out-patient consultancy service fees (collection of out-patient ancillary fees seems to be in good order),
- o In-patient private fees, in cases an important person refuses to pay- similarly, certain out-patient private fees,
- o In-patient X-Ray, Laboratory, and Operating Theatre fees- these procedures are often not recorded on the patient record and bill,
- o Fees for lodgers- the presence of lodgers is not noted and the patient usually does not declare them upon discharge
- o Mortuary fees- Because customs and convenience lead people to pick up their deceased relative after dark, the same lack of collecting after-hour fees occurs here.

Recommendations

These specific areas can be addressed through three specific actions and one on-going process. The strategies are straightforward, and should be implemented on an institution-specific basis. Addressing the collections issues at Mbabane Hospital first, then applying the lessons learned to the other government hospitals, seems to be the most sensible approach.

The responsibility of the MOH central management is to establish the expectation that improved collections in these areas must be achieved, facilitate getting the necessary resources, and to review the plans proposed by each hospital and monitor progress and monitor progress against the plan.

The three actions include:

1 Hire additional patient accounts staff at Mbabane Hospital to cover the time periods of 5-11 p.m. on weekdays, Saturdays after 1 p.m., Sundays, and all public and bank holidays. The consultant understands that the Hospital has made such a staffing request to the Ministry.

The cost of this staffing will be more than covered by the increased revenue from late call OPD patients, and inpatient discharges, especially maternity cases The same procedures for outpatient collections, inpatient collections at discharge, and mortuary collections that are used during the daytime would apply to these times. A secure place to lodge this staff person is necessary given lighter security and less staff on duty during these times.

2. Introduce a form for in-patients which is attached to the patient's record. The model for this form is that used at R.F.M. Hospital. The form is printed on the back of the patient information form filled out at admission, with the patient's personal information on it.

This form has places for the nurses of ancillary department staff to mark for X-Rays, Laboratory tests, and Operating Theatre to be marked, as well as lodgers visiting the patient. This form would remain with the patient's record, and would be presented along with the record at discharge as the basis for calculating the patient's bill. A sample for is included as ANNEX ____.

The advantage of this form is that it records in one place the services rendered to the inpatient. At present, the patient accounts staff must page through the physician and nursing notes to decipher what services were delivered. Charges are often missed due to inability to determine just what services were rendered.

3. At Mbabane Hospital, the system for specialist consultations needs to be better organized. A specialist fee for general referrals from the OPD physician has been established. The patient should pay that fee before seeing the specialist physician, and should bring the receipt to the specialists' office for collection there.

Further, in many cases private patients with a specialist referral from their private physician will visit the out-patient clinic first, and receive a referral for specialist consultation which entitles them to pay the general fee rather than the private fee. The OPD physicians should require that the patient with the private referral should pay the private specialist fee first, before coming for

consultation with the OPD physician

Mission/Government Consultation

The ongoing process recommended is to establish a forum for periodic consultation between the government and Mission staff regarding fee collection and appropriate fee levels. Since the Mission staff have solved many of the problems still unsolved at the government hospitals, a periodic dialogue would be fruitful.

The Ministry should consider setting up a one-day workshop with senior accounting staff from the government and mission hospitals to discuss issues in management of patient accounts. The use of a facilitator to help draw out the discussion and focus recommendations would be helpful

The Ministry should consider the retention of someone like the patient accounts manager from R.F.M. on a part-time basis to serve as an in-house consultant to the management of Mbabane Hospital in improving their patient accounts management. If this model proves successful, it could be extended to the other government hospitals.

Credit Authorization

The authorization of credit to company employees should be determined based upon receipt of an appropriate letter of authorization from the company for the patient regarding the specific inpatient admissions. The letter should identify the patient by name, designate whether private or general services will be covered, the contact person and billing address of the company, and a commitment to pay the bill once presented by the hospital within 30 days. A sample letter is included as ANNEX D.

If the patient does not have such a letter, he/she should be charged the deposit for private or general admission, depending upon which service the patient requests. If a letter from the company is presented during the inpatient stay, the deposit should be refunded and the company billed.

The invoicing, collection, and reporting of unpaid accounts is contains several aspects. First, the invoicing should be done as promptly as possible, within one week of discharge. Whenever possible, prior to billing, a phone call to the company should be made to verify the billing address, and other information pertinent to the payment of the bill This verification process will help reduce errors from misinformation at the outset. A copy of the company's letter of authorization should be sent along with the bill

The reporting of unpaid accounts is the next step. On a

monthly basis, a summary of accounts receivable should be prepared in order to identify all outstanding balances. An example of that report for is included as ANNEX E That format is taken from the report on user fees by David H. Collins dated 3 May 1990.

From this monthly listing, specific followup contacts and rebilling should be made to all outstanding accounts. Where phone contact is possible, a phone to call to ascertain the status of the bill is useful. In companies or medical aid organizations with a number of bills on a regular basis, a contact person should be established to facilitate communications.

Medical Aid Billing

Regarding the various medical aid programs, particularly those operating in South Africa, a special effort should be made to master the fee schedules, coding and billing procedures that these plans require. Often, the bills are screened by computer, and bills are rejected if there is some error in coding, etc., but there is no clear information given on how to correct the problem.

Medical aid reimbursement can be a significant part of hospitals' revenue. R.F.M. Hospital estimates that 5-6% of their revenue comes from medical aid. The Ministry should organize a coordinated effort by the government hospitals and the mission hospitals to pool their knowledge of the medical aid billing requirements and perhaps develop a joint system for handling the billing and followup. R.F.M. Hospital seems to have the greatest level of experience at the moment in this important area

Writeoffs

A final component of the management of accounts receivable is to review the outstanding bills monthly to determine which ones can no longer be pursued with a reasonable chance of success. In those cases, the hospital accountant the administrator would agree to "write off" the bill as uncollectible and to cease collection efforts. This step should come only after all reasonable efforts have been made. It is anticipated that this process would be followed for individual accounts, and not for company accounts, unless the company has ceased to operate, or is clearly unable to meet its obligations

Community Fees

The issue of community fees was addressed in David H. Collins report on pp 37-38 He recommended that 'Care should be taken with management of community funds and clear procedures laid down to prevent possible misunderstandings between clinic

staff and communities in the use of the funds."

At present, fees are collected at all government clinics, most mission clinics, and 2 government and mission health centres collect community fees ranging from E.10 to E1.00 per consultation in addition to the regular charges. These funds are turned over to the community committee for use on health related matters. These expenditure often include payment of a night watchman, or minor repairs to the clinic. In some cases the funds are accumulated toward future expansion of the clinic

Although there do not appear to be any major problems at present, with any money transactions there is the possibility of misunderstanding over the collection or expenditure of the funds. Any such misunderstanding could serve to undermine the mutual trust and cooperation between the clinic staff and the community which is an important asset to both parties.

Without adding further administrative burdens on the clinic staff, there are minor changes in the current procedure which should be considered. The first is to reconcile the community fees paid with the tickets used during the process of reconciling the government fees with the regional accountant. For example, if the same process for reconciliation were used for community fees, the accountant could verify the amount received by filling in a specific form, and that amount with a copy of the form cold be given to the community committee. This process would assure the community that all the community fees which were collected were given to the community.

The second stage of monitoring the use of the community funds is more difficult and somewhat beyond the Ministry s jurisdiction. However, since the community fees are designated for a public purpose to assist the clinic or health centre, there is a rationale for government oversight with the consent of the community. One suggestion is for the government auditors to review the community's accounts on a periodic basis, such as every six months, if the community committee has given its agreement.

PROJECTION OF REVENUE INCREASES

(A methodology for projecting revenue increases based on the fee increases, plus a range of estimates for the increased amounts to be realized).

PILOT STUDY- REVENUE RETENTION

(A discussion of the importance of a pilot project to study the feasibility of the MOH facilities retaining a portion of the fee income collected).

ANNEX F

LIST OF PERSONS INTERVIEWED

Ministry of Health

Mr. C. M. Mkhonza	Principal Secretary
Prince Phulhaphi	Undersecretary
Dr. J.J. Mbambo	Director of Health Services
Dr E. McGrath	Deputy Director of Health Services
Mrs. N.T. Shongwe	Chief Nursing Officer
Mr. R. P. Thompson	Senior Financial Advisor
Mr. C.V. Kunene	Financial Controller
Mrs. D. Siyaya	Senior Clerical Officer
Mr. S.S. Hlophe	Principal Personnel Officer
Mr. W. Mbhele	Health Data Analyst
Mr. E. Mnisi	Health Data Analyst

Mbabane Hospital

Dr. N. Khayyam	Chief Medical Officer
Joyce Mlipha	Accountant
Dr. E. McGrath	Senior Staff Physician
Dr. B. Joret	Staff Physician
Mrs. E. P. Hlophe	Senior Radiographer
Dr. L. Ahmadi	Dentist
Dr. Dhlamini	Dentist
Victoria Dhlamini	Patient Accounts Rep
Abigail Shongwe	Staff Nurse

Hlatikulu Hospital

Matron Doreen Dlamini	Matron

Mankayane Hospital

Nurse ?

Pigg's Peak Hospital

Mrs. Busisiwe Zwanw	Administrator
Joyce Tsela	Accountant

Lumbombo R.H.A.

Mr. Mbuli	Regional Health Accountant

Shiselweni R.H.A

Ms. Thoko Maseko	Regional Health Administrator

Government Clinics

Rejoice G. Shongwe	Staff Nurse, Horo Clinic
Sophie S Dlamini	Staff Nurse, Horo Clinic
Bertha Dlamini	Staff Nurse, Luyengo Clinic
Precious Nkomo	Staff Nurse, Luyengo Clinic
Glorious Makuze	Staff Nurse, Musi Clinic

Reginab Mkabinale	Staff Nurse, Musi Clinic
Sister Roste Shabwi	Staff Nurse, Nhlangano Cl
Kate Zwane	Staff Nurse, Nkaba Clinic
Nellie Vilakati	Staff Nurse, PHU, Piggs Pk

R.F.M Mission Hospital

Mr. Mduli	Administrator
Mrs. Young	Patient Accounts Manager

Good Shepherd Mission Hospital

Ms. Dumsile Silelane	Administrator

Emkhuzweni Mission Health Centre

Dr. Jack Nickel	Chief Medical Officer
Matron Astrid Hoyland	Matron
Mr. Dennis Khumwalo	Accountant

Catholic Mission Clinics and Hospitals

Father Somers	Head of Diocesan Clinics and Schools
Sister Camilla	
Sister Concetta	
Sister Rosemary Heenan	Maphiveni Clinic
Sister Helen	
Sister Jabulile	St. Phillips Clinic
Sister Jane	
Sister Joan	St. Mary's Clinic
Sister Judith	
Sister Lydia	
Sister Raphael	St. Phillips Clinic
Sister Regina	
Sizakele Sibiya	St. Mary's Clinic
Sister Lily Toualla	

Other Missions Clinics

Savaphina Johnston	Cana Clinic
Lydia Masuku	Cana Clinic
Sister Johnson	Nazarene Clinic, Pigg's Pk

Other Facilities

Sister Sigley	Salvation Army Cl, Mbabane
Dr. J. W. Stephens.	Private Physician, Mbabane

Primary Health Care Project

Dr. Vincent Joret	Chief of Party, MCH Phys

Ministry of Finance

Lucy Goodhart	Financial Advisor

US Agency for International Development-
Swaziland

Mr. Roger Carlson	Mission Director
Mr. Jay Anderson	Chief, Health and Population
Mrs Anita Sampson	Deputy, Health and Population

ANNEX G

LIST OF FACILITIES VISITED

Central Offices- Ministry of Health

US Agency for International Development

Hospitals

Good Shepherd Hospital	Mission
Hlatikulu Hospital	Government
Mankayane Hospital	Government
Mbabane Hospital	Government
Pigg's Peak Hospital	Government
Raleigh Fitkin Memorial Hospital	Mission

Health Centres

Emkhuzweni Health Centre	Mission

Clinics

Bholi (Lubombo)	
Cana (Manzini Region)	Mission
Horo (HhoHho Region)	Government
Musi (Manzini Region)	Government
Nkaba (HhoHho Region)	Government
Luyengo (Manzini)	Government
Pigg's Peak Nazarene (HhoHho Region)	Mission
St. Mary's (HhoHho Region)	Mission

ANNEX H

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