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BASICS
TRIP REPORT

Regional Conference on Managing Cost Sharing in Government Health Programs in Developing Countries

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The Partnership for Child Health Care, Inc.

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Regional Conference On Managing Cost Sharing In Government Health Programs In Developing Countries

8 - 11 May 1995
Nairobi, Kenya

Kenya Health Care Financing Secretariat
Ministry Of Health
Nairobi, Kenya

Kenya Health Care Financing Project
Technical Assistance Provided By:

Management Sciences For Health
Boston, MA, USA

Carr Stanyer Gitau & Co
Nairobi, Kenya

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The Kenya Health Care Financing Secretariat and Kenya Health Care Financing Project's technical assistance team are grateful to all who worked in many different ways to make the conference, "Managing Cost Sharing," a success.

We were honored to have the Minister for Health, Honorable Joshua Angatia, officially open the conference.

We are grateful to the participants from the ten different countries represented at the conference who made extremely valuable contributions, some at very short notice. A list of all participants is included on the next page.

Special thanks to the USAID Regional Office for Eastern and Southern Africa (REDSO), the BASICS, project and USAID/Kenya for providing logistic and financial support for the conference. We are particularly grateful to Ray Kirkland, Richard Sturgis, Gary Newton, Kate Colson, Sophia Ladha, and Esther Kibe for all their support.

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Appendix A contains a full list of participants and their contact addresses.

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BASICS	Basic Support for Institutionalizing Child Survival Project
FP	Family Planning
HIS	Health Information System
HPN	Health, Population, Nutrition
IEC	Information, Education, Communication
KHCFP	Kenya Health Care Financing Project
MOH	Ministry of Health
N/A	Not Applicable
NGO	Non-governmental Organization
PHN	Population, Health, Nutrition
REDSO	Regional Economic Development Services Office
STD	Sexually Transmitted Disease
TB	Tuberculosis
USA	United States of America
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

This conference was part of USAID Regional Economic Development Services Office for East and Southern Africa (REDSO), USAID/Kenya, and the Kenya Health Care Financing Projects (KHCFP) ongoing initiative to foster communication and exchange in health care financing among countries in the region.

Participants were drawn from ten African countries and from the USA. Funding for this activity was provided by the USAID-funded BASICS project and the Kenya Health Care Financing Project.

Subjects covered in the conference included cost sharing policy issues, implementation, fee setting, levels of management, financial management, quality of care, and monitoring and evaluation.

Participants developed action plans based on what they had learned at the conference. These action plans are included in Section V.

The future direction of regional collaboration in health care financing was also discussed. Suggested areas of collaboration included:

- Visits to countries which have experience in a particular area, e.g., decentralization - Uganda, Ghana.
- Regional meetings to address a few critical issues, e.g., financial information systems, health information systems, national health insurance schemes, and development of consulting skills.
- Help to coordinate donor activity in health care financing.
- Create a network to improve sharing of reports of significant studies, sharing technical assistance needs, etc.
- Visits by the Kenya program's Health Care Financing Secretariat and technical assistance team.

Most participants (over 90 percent) rated the overall conference as being from good to excellent. The participants were equally enthusiastic about the cost sharing manual that was used during the conference.

I. INTRODUCTION

This report describes the four day conference entitled, *Managing Cost Sharing*, which was held in Nairobi, Kenya, from 8 to 11 May, 1995.

The conference was attended by participants from ten African countries (Uganda, Tanzania, Malawi, Botswana, South Africa, Ghana, Mozambique, Zimbabwe, Ethiopia, and Kenya), guests from USA (Harvard University, and Data for Decision Making Project), and from USAID/Kenya.

This conference was the culmination of an initiative started in 1994, by REDSO, USAID/Kenya, and the Kenya Health Care Financing Project (KHCFP) to foster communication and exchange in health care financing among countries in the region. Representatives of the governments of Malawi, Ethiopia, Uganda, Tanzania, and of USAID/Senegal have traveled to Kenya to learn about the country's experience in health financing, in particular, its cost sharing program. For their part, members of the KHCFP and the Kenya Ministry of Health have visited Ethiopia and Tanzania. USAID missions in Zimbabwe, Eritrea, and Zambia have expressed interest in collaborating in the regional health financing network.

Financial and logistical support for the conference and for the regional collaboration was provided through two USAID-funded projects, the BASICS project and the Kenya Health Care Financing Project.

Although cost sharing in public health care systems was the main agenda for the conference, alternative health financing options were also discussed in order to put cost sharing elements in to perspective. A generic manual on the management of cost sharing programs was developed by the Kenya Health Care Financing Program Secretariat and technical assistance team. This was presented at the conference as the principal reading material around which the entire conference was structured. The comments on the content and presentation of the manual that were received from the participants are being incorporated in the final version of the manual which will be published soon.

A display of health care financing publications was available for the participants to browse through. Details of the publications (title, source) were also made available to each participant.

II. OPENING ADDRESSES

Dr. Ray Kirkland, REDSO PHN: Welcoming Address

In his welcoming address, Dr. Kirkland provided background for the regional collaboration which led to this conference. The need for regional collaboration in the area of health financing became apparent to REDSO staff who were working in the region. They noticed that

experiences or lessons learned in dealing with common issues and problems in one country were not known by, available to, or utilized by other countries in the region. This led to the development of a regional initiative in population and health entitled, "Regional Health Networks." The Regional Health Networks aim to strengthen the collection, dissemination, and utilization of experiences and lessons learned across countries in the region.

The health network's activity has sought to identify cross-cutting issues or problem areas of high priority in the region and to focus attention on these problems/issues. One such high priority area is that of health financing. Health financing was also chosen as a focus area because there was a ready body of experiences and lessons learned here in Kenya, which if shared, could be of benefit to other countries in the development of their health financing programs and policies. A collaborative arrangement was worked out with USAID/Kenya and the Kenya government's Health Care Financing Program to begin the process of sharing the lessons learned in Kenya. He observed that Kenya has one of the most successful cost sharing programs in Africa, and countries which are designing or implementing similar programs could learn from Kenya's experiences. In addition, Kenya will also learn from other countries and this, in turn, will improve the implementation of the Kenya program.

While this conference is an important outcome of the collaboration that has been fostered through the regional initiative, there will be an even more important outcome from the conference itself: the more formalized regional network. REDSO sees this conference not as the culmination of their support to this area, but in many ways as the beginning. We hope that it will continue to expand over the coming years.

Dr. Kirkland then invited the Honorable J. Angatia, Minister for Health, to make the opening speech.

Honorable J. Angatia, Minister for Health: Opening Address

The Minister for Health welcomed participants to Kenya and pointed out that this conference would serve as a forum for sharing experiences on the problems experienced in the implementation of cost sharing in health. Kenya would also benefit from the experiences of other countries.

He gave a brief overview of the health care system in Kenya since its independence. He noted that promises made at the time of independence had proved very difficult to keep. For example, at independence, the people of Kenya were promised free education and free medical care. Due to rapid population growth and the availability of limited resources, the government has been unable to meet the demand for free education and health care. Cost sharing was therefore introduced for both education and health care.

The introduction of cost sharing in health in 1989 was not well received by the public. This led to the program being partly suspended after nine months. A better approach was adopted in 1992

when the new fees were introduced. The fees were phased and introduced at nominal levels only. Also, good management systems were put in place before the new fees were introduced. The lowest facility level, the dispensary, is still free of charge. There was more public acceptance this time around and the program is now quite well established.

It is, however, necessary to be realistic about how far cost sharing can go towards financing health services. In Kenya, the cost sharing revenue is expected to reach a level of about 14 percent of the non-wage recurrent budget of the Ministry of Health, or about 14 million dollars per year. Although this amount is significant, it is no where near what is needed to finance basic health services. But without these funds from cost sharing, the health services would be in worse shape than they are currently.

In the last five years, the Ministry of Health has also been planning and implementing health financing alternatives other than cost sharing. Alternatives that have been explored include efficiency improvements, revenue generation, shifting resources to higher priority programs, and the development of insurance options. There is in Kenya a thriving non-governmental health sector that provides a substantial amount of curative and primary health care services on a fee-for-service basis. There are also private-for-profit providers in Kenya who provide care for those who can afford to pay for their services. One of the government's key strategies is to encourage and support the obtaining of care through the mission and private sector. The Ministry has also been exploring ways of encouraging the expansion of health insurance, including improving the efficiency of the National Hospital Insurance Fund.

Although the Kenyan cost sharing program is acknowledged as one of the best in Africa, it is important to keep in mind that this program is not perfect and that there is a need to learn from other countries' experiences.

III. CONFERENCE OVERVIEW

The conference covered all major aspects of cost sharing as a means of health care financing. This was achieved through lectures, readings, and discussions. Most of the materials were based on the generic manual on cost sharing, "Cost Sharing - Guidelines For Introducing And Managing Cost Sharing In Government Health Programs In Developing Countries," which is being developed by the Kenya Health Care Financing Project. Participants also made presentations based on experiences from their own countries. The topics covered during the conference are summarized below:

1) **Health Financing Alternatives**: The objective was to put cost sharing in the context of other health financing options including insurance, efficiency, resource allocation, and the strength and constraints of government financing.

2) **Policy:** The topic identified the policies that cover the fundamental aspects of cost sharing, including the cost sharing objectives, retention and control of revenue, additivity related to government funding, and protection for vulnerable groups.

The Ethiopian participants shared their country's experiences on policy formulation as it pe to cost sharing.

3) **Implementation:** Participants were exposed to the different aspects of implementing cost sharing policies, weighing the merits and demerits of various alternatives.

Participants from Tanzania presented their experience with implementing a national cost sh program which is now in its second year.

4) **Fee Setting:** The issues covered here included the identification of what services will be charged, what proportion of costs will be recovered, and how the vulnerable groups are protected.

Presentations by the participants from Uganda and Zimbabwe dealt with fee setting and protecting vulnerable groups, respectively.

5) **Management:** This session dealt with the different levels of management for a cost sharing program. The session explored the roles and responsibilities of the four levels at which cost sharing is managed: national, regional, district, and facility.

6) **Financial Management:** The purpose of this session was to help develop skills to ensure tl cost sharing revenue is maximized and wisely spent.

The Ghanaian participant made a presentation on cost sharing management in Ghana

7) **Expenditure:** The focus of this topic was to understand the planning process for spending (sharing revenue and choosing areas on which to spend these funds.

The participants from Uganda and Mozambique presented their views on this subject.

8) **Quality of Care and Local Public Information:** Participants were helped to recognize the different perceptions of quality of health care and how cost sharing revenue can be used to a quality of care.

The participant from Botswana presented her country's experiences on quality of care.

9) **Monitoring and Evaluation:** In this topic, an understanding of the need for, and the differe methods of monitoring and evaluating a cost sharing program were addressed.

The participant from Ghana shared Ghana's experience in the evaluation of its cost sharing program.

Field Trips: In addition to the above topics, the participants also made a day long field trip. Two groups went out: one to the Embu Provincial General Hospital and the other to the Nakuru Provincial General Hospital. Each group also visited a health center on their way back from the provincial hospital. The objective of these field trips was to allow participants to witness the implementation of cost sharing in Kenya.

Action Plans: Participants developed proposals focusing on the areas where they felt that their countries' health care financing programs could be improved. A summary of these action plans is included in Section IV. Participants also shared their thoughts on developing the regional health financing network.

IV. ASSESSMENT OF COUNTRY USER FEE PROGRAMS

A. Introduction

Each country represented at the conference completed a questionnaire that gave a summary of their health financing program. What follows is the summarized version of the key issues and options in each country. A copy of the questionnaire used for this exercise is included in Appendix B.

B. Botswana

Financial and Equity Policies:	
• Cost recovery objectives:	Nominal cost recovery: 5-10%
• Retention of revenue:	100% at the central accounts/Treasury
• Additivity to other revenue:	Yes, not considered at the time of budget
• Protection policy ('safety net')?	Yes
Organizational Policies:	
• Management structure:	Part of day-to-day management of health facilities
• Legal or administrative status:	Act of parliament
• Form of user fee program:	Consultation fee
• Bottom-up vs. top-down implementation:	The system has always been in place

Fees and Exemptions:	
• Fee type:	Attendance fee
• Fee services:	Consultation, lab tests, X-ray, medical exam, inpatient days, deliveries, private outpatients at government hospitals
• Fee levels:	Affordability to low income groups
• Graduation of fees:	Fees are not graduated
• Insurance:	No insurance, but a medical aid scheme
• Exemption criteria:	Encourage complete treatment of illness, Protect vulnerable groups
• Administration of exemptions:	MOH committee on fees
• Fee adjustment:	MOH discussion, probably after 10 years
Financial Management:	
• Fee collection system: Standard procedures?	No
• Banking systems:	Money is sent to the treasury
• Recording: What records are kept?	Copies of receipts
• Reporting: Routine reports?	No
• Audit and oversight functions:	None
• Relationship to the government accounts: Communication with counterparts?	No
• Interactive systems development:	None
Revenue and Expenditure:	
• Expected use of revenue:	N/A
• Expenditure process:	N/A
Staffing, Training, Supervision:	
• Staff for user fee program:	N/A
• Implementation of training:	N/A
• Targeted supervision:	N/A

C. Ethiopia

Financial and Equity Policies:	
• Cost recovery objectives:	Partial cost recovery
• Retention of revenues:	Central accounts/Treasury
• Additivity to other revenue sources:	User fees to revenue
• Protection policy ('safety net'):	Yes
Organizational Policies:	
• Management structure:	It's part of existing unit
• Legal or administrative status:	Official government policy
• Form of user fee program:	Comprehensive fee-for-service
• Bottom-up vs. top-down implementation:	In place at all levels
Fees and Exemptions:	
• Fee type:	Variable service fees, card fee
• Fee services (all inclusive fees):	Consultation, laboratory investigation, X-ray, medical exam and certificates, inpatient days, deliveries
• Fee levels: How are fees set?	Option of program officials
• Graduated fee:	No
• Insurance: Revenue from insurance?	Yes
• Exemption criteria:	MOH staff, complete treatment of illness, young children, economic considerations
• Fee adjustment:	Pending, not addressed since introduced 40 years ago
Financial Management:	
• Fee collection system: Standard procedures?	Yes
• Banking systems:	Money is sent directly to bank
• Recording: What records are kept?	General journal at facility level

• Reporting: Routine reports?	Yes, quarterly on revenue collected, expenditures, and exemptions
• Audit and oversight functions:	There are audits at every level: facility, region and national
• Relationship to government accounts: Communication with counterparts?	Yes, user fee or revenue earned from services part of normal government revenue
• Interactive systems development:	System has been in place for 40 years with no modifications
Revenue Expenditure:	
• Expected use of revenue:	No experience
Staffing, Training, Supervision:	
• Staff for user fee program:	Cashiers and accountant
Public and Provider Awareness:	
• Key messages:	No
• Provider orientation and information:	None
Community Involvement:	
• Community involvement:	None
Monitoring:	
• Monitoring impact:	None done
• Quality of care:	Assessed regularly, standard checklist
Theft, Abuse, Fraud:	
• Source of loss:	Theft, abuse, fraud
• Point of collection problems:	Yes, disciplinary action = demotion, suspensio transfer
• Banking and accounting problems:	No
Revolving Drug Fund Issues:	
• Selection:	Combination of public and provider preference
• Capitalization:	Yes, profit margin calculated to ensure stabilit

• Demand-based supply:	Yes, managed
• Quality assurance:	Yes, in place
• Accounting for drugs:	Adequate
Managing for Success:	
• Key staff in place:	Yes
• Performance targets:	None
• Monitor performance:	No
• 80/20 rule for setting priorities:	Yes

D. Ghana

Financial and Equity Policies:	
• Cost recovery objectives:	Partial cost recovery
• Retention of revenue:	100% is retained at the facility
• Additivity to other revenue sources:	User fee added to current revenue
• Protection policy ('safety net'):	Yes
Organizational Policies:	
• Management structure:	It s part of existing unit
• Legal or administrative status:	Law, act of Parliament
• Form of user fee program:	Comprehensive fee-for-service, revolving drug fund
• Bottom-up vs. top-down implementation:	In place at all levels simultaneously
Fees and Exemptions:	
• Fee type:	Variable service fees
• Fee services (all inclusive):	Consultation, laboratory investigation, X-ray, medical exam and certificates, inpatient days, deliveries, mortuary, physiotherapy
• Fee levels: How are fees set?	At cost of providing services

• Graduated fee:	Yes, by consultation and investigation
• Insurance: Any revenue from insurance?	No
• Exemption criteria:	MOH staff, encourage complete treatment of illness, e.g., TB, STD, protecting vulnerable groups
• Administration of exemptions:	Medical officer, social worker from community
• Fee adjustment:	Pending, not adjusted since 1985
Financial Management:	
• Fee collection system: Standard procedures?	Yes
• Banking systems:	Money is sent directly to bank
• Recording: What records are kept?	Facility and district records by type of revenue
• Reporting: Routine reports?	Yes
• Audit and oversight functions:	Not regularly conducted
• Relationship to the government accounts: Communication with counterparts?	Yes
• Interactive systems development:	Yes, guidelines set and recently revised
Revenue and Expenditure:	
• Expected use of revenue:	Encourage patient care items. Discourages capit and salary related payments
• Expenditure process:	Proposed: Head of accounts department, medica officer Approved: District health management team
Staffing, Training, Supervision:	
• Staff for user fee program:	Accounting Department staff
• Implementation of training:	Accounts staff, medical professionals, matron
• Targeted supervision:	Regional and district health management teams
Public and Provider Awareness:	
• Key messages:	Yes

• Provider orientation and information:	District-level conferences
Community Involvement:	
• Informal involvement:	Advising on collection and use of fee revenue
• Formal involvement:	Decide who receives waivers
Monitoring Impact:	
• Revenue generation:	Yes
• Revenue expenditure:	No
• Quality of care:	No
• Utilization impact:	Yes, by routine reports
Theft, Abuse, Fraud:	
• Source of loss:	Yes, theft and abuse
• Point of collection problems:	Yes, efforts to improve bookkeeping
• Banking and accounting problems:	Yes, training medical officers to check accounts staff
Revolving Drug Fund Issues:	
• Selection:	Patient preference
• Capitalization:	Yes, sufficient
• Demand-based supply:	Drugs available at central points; distribution not well managed
• Quality assurance:	None
• Accountability for drugs versus revenue:	Yes

E. Malawi

Insufficient information to complete questionnaire adequately.

F. Mozambique

Financial and Equity Policies:	
• Cost recovery objectives:	Nominal cost recovery (5-10%)
• Retention of revenue:	100% at the district and facility levels
• Additivity to other revenue sources:	Added to the recurrent budget
• Protection policy ('safety net'):	Yes
Organizational Policies:	
• Management structure:	It's part of existing unit
• Legal or administrative status:	Official, by the government
• Form of user fee program:	Comprehensive fee-for-service
• Bottom-up vs. top-down implementation:	All levels
Fees and Exemptions:	
• Fee type:	Flat service fee, variable service fees
• Fee services:	Consultation, laboratory investigation, X-ray, medical exam and certificates, inpatient days, deliveries, private outpatients at government hospitals
• Fee levels: How are fees set?	Cost plus a percentage (%) mark-up (=/- discount)
• Graduated Fee:	No
• Insurance:	No insurance yet
• Exemption criteria:	Illness-based, e.g., TB, AIDS, leprosy
• Administration of exemptions:	Identified by the health centers and hospitals
• Fee adjustment:	Same since 1987, 1994 adjustment not approve
Financial Management:	
• Fee collection system: Standard procedures?	Yes
• Banking systems:	At the Banco Commercial de Mocambique

• What records are kept:	Service registers and cash analysis
• Reporting: Routine reports?	Yes, reported bi-annually
• Audit and oversight functions:	Yes, at the national level
• Relationship to the government accounts: Communication with counterparts?	Yes
• Interactive systems development:	None
Revenue and Expenditure:	
• Expected use of revenue:	40% painting and maintenance
• Expenditure process: Who must approve?	Proposed: Local senior administrative office Approved: Local director
Staffing, Training, Supervision:	
• Staff for user fee program:	Administrative officer
• Implementation of training:	N/A
• Targeted supervision:	N/A

G. South Africa

Financial and Equity Policies:	
• Cost recovery objectives:	Nominal cost recovery (5-10%)
• Retention of revenue:	100% at the central accounts/Treasury
• Additivity to other revenue sources:	No
• Protection policy ('safety net'):	Unemployed, people earning less than R10,000 p.a., prisoners, children 0-6 years, pregnant women
Organizational Policies:	
• Management structure:	It's part of existing unit
• Legal or administrative status:	No special status
• Form of user fee program:	Comprehensive fee-for-service

Fees and Exemptions:	
• Fee type:	Flat service fees
• Fee services:	All inclusive fees
• Fee levels: How are fees set?	Actual cost of providing service
• Graduation of fee:	Primary clinics, community hospitals, tertiary
• Insurance: Revenue from insurance?	Yes, from private/voluntary insurance schemes
• Exemption criteria:	Children 0-6 yrs; pregnant women; prisoners, disabled; TB; STD/AIDS; FP; immunizations
• Administration of exemptions:	Medical staff and administrators at facility
• Fee adjustment:	Not often
Financial Management:	
• Fee collection system: Standard procedures?	Yes
• Banking systems:	Money is sent directly to Department of Finance
• Recording: What records are kept?	Cash analysis books, kept at the health facility
• Reporting: Routine reports?	Yes, auditing control reports
• Audit and oversight functions:	Regularly at the facility level, performed by provincial health department
• Relationship to the government accounts: Communication with counterparts?	No
• Interactive systems development:	None
Revenue and Expenditure:	
• Expected use of revenue:	All revenue is returned to the central treasury
• Expenditure process:	N/A
Staffing, Training, Supervision:	
• Staff for user fee program:	N/A
• Implementation of training:	N/A
• Targeted supervision:	N/A

Public and Provider Awareness:	
• Public and provider awareness:	N/A
Community Involvement:	
• Community involvement:	N/A
Monitoring Impact:	
• Revenue Generation:	Yes by facility and provincial departments
• Revenue Expenditure:	No
• Quality of care:	Yes
• Utilization impact:	No

H. Tanzania

Financial and Equity Policies:	
• Cost recovery objectives:	Nominal cost receovery (5-10%)
• Retention of revenue:	100% is retained at the facility
• Additivity to other revenue sources:	Added to current revenue sources
• Protection policy ('safety net'):	Yes
Organizational Policies:	
• Management structure:	It is part of exisiting unit
• Legal or administrative status:	Official, government policy
• Form of user fee program:	Comprehensive fee-for-service
• Bottom-up vs. top-down implementation:	Top-down, regional to district to health center
Fees and Exemptions:	
• Fee type:	Attendance fee and treatment fee
• Fee services (all inclusive fees):	Consultation, laboratory investigation, X-ray, medical exam and certificates, inpatient days, deliveries
• Fee levels: How are fees set?	Fixed specific oriented rates

• Graduated fee:	Yes, increases with the level of care
• Insurance: Any revenue from insurance?	No
• Exemption criteria:	Economic considerations; disease conditions, e.g., TB, polio; immunizations and epidemic disease conditions
• Administration of exemptions:	Social Welfare Department
• Fee adjustment:	Pending
Financial Management:	
• Fee collection system: Standard procedures?	Yes
• Banking systems:	Money is sent directly to National Bank of Commerce
• Recording: What records are kept?	Registers and cash analysis books at all levels
• Reporting: Routine reports?	Revenue collection and expenditure reports
• Audit and oversight functions:	Yes, by Internal Audit Department
• Relationship to government accounts: Communication with counterparts?	Yes
• Interactive systems development:	Yes
Revenue and Expenditures:	
• Expected use of revenue:	Non-capital, non-salary, patient care items of expenditure
• Expenditure process:	Proposed: Hospital Management Committee Approved: Hospital Advisory Committee
Staffing, Training, Supervision:	
• Staff for user fee program:	Facility cashiers, accountant, hospital administrator
• Implementation of training:	Trained the following: Hospital Advisory Committee
• Targeted supervision:	Regional and district medical officer of health

Public and Provider Awareness:	
• Key messages:	Yes
• Provider orientation and information:	Yes, at district and facility levels
• Public Information:	Comprehensive coverage through posters, news media, etc.
Community Involvement:	
• Informal involvement:	Community involved in public awareness campaigns and in planning for spending of revenue
• Formal involvement:	Fee setting, expenditure planning
Monitoring Impact:	
• Revenue generation:	Yes, by individual facility
• Revenue expenditure:	Yes, through Hospital Advisory Committee
• Quality of care:	No
• Utilization impact:	No
Theft, Fraud, Abuse:	
• Sources of losses:	These are clearly known
• Point of collection problems:	None
• Banking and accounting problems:	None
• Expenditure problems:	Not much
Revolving Drug Funds:	
• Revolving drug funds:	N/A
Managing for Success:	
• Key staff:	Are in place
• Performance targets:	Not set
• Monitor performance:	No
• 80/20 rule in priority setting:	Yes

• Spend money to make money:	Yes

I. Uganda

Financial and Equity Policies:	
• Cost recovery objectives:	Nominal cost recovery
• Retention of revenue:	100% facility
• Additivity to other revenue sources:	Yes
• Protection policy ('safety net'):	None
Organizational Policies:	
• Management structure:	By Health Management Committee of Resistance Council
• Legal or administrative status:	No special status
• Form of user fee program:	Fee for service
• Bottom-up vs. top-down implementation:	All levels at once
Fees and Exemptions:	
• Fee type:	Cost per episode
• Fee services (all inclusive fees):	Flat fee for everything
• Fee levels: How are fees set?	Set by Health Unit Management Committee of Resistance Council
• Graduated fee:	At hospital level, a higher fee
• Insurance:	No
• Exemption criteria:	None
• Administration of exemptions:	No administration
• Fee adjustment:	Arbitrary
Financial Management:	
• Fee collection system: Standard procedures?	Yes

• Banking systems:	No
• Recording: What records are kept?	Cash analysis books, service registers
• Reporting: Routine reports?	No
• Audit and oversight functions:	Depends on the district; most do not
• Relationship to the government accounts: Communication with counterparts?	None
• Interactive systems development:	No
Revenue Expenditure:	
• Expected use of revenue:	50% salary supplement 30% drugs 5% capital development (community and prevention) 15% health unit management
• Expenditure process:	Proposed: HUMC and medical officer in charge of facility Approved: Resistance Council
Staffing, Training, Supervision:	
• Staff for user fee program:	Hospital cashier, health unit staff
Public and Provider Awareness:	
• Key messages:	No
• Provider orientation and information:	No
Community Involvement:	
• Informal involvement:	In some districts
Monitoring Impact:	
• Revenue generation:	By individual facility and, at times, at district level
• Revenue expenditure:	Yes
• Quality of care:	No
• Utilization impact:	No

Theft, Abuse, Fraud:	
• Source of loss:	No
• Point of collection problems:	Yes
• Banking and accounting problems:	Yes, HUMC is changing the system to stop
Revolving Drug Funds:	
• Revolving drug funds:	None
Managing for Success:	
• Key staff:	In place in some facilities
• Performance targets:	None

J. Zimbabwe

Financial and Equity Policies:	
• Cost recovery objectives:	Nominal cost recovery plus strengthened ref system
• Retention of revenue:	100% central accounts/Treasury
• Additivity to other revenue sources:	No
• Protection policy ('safety net'):	Yes
Organizational Policies:	
• Management structure:	Part of existing unit
• Legal or administrative status:	Official, government policy
• Form of user fee program:	Health services, fee-for service
• Bottom-up vs. top-down implementation:	In place at once at all levels where relevant
Fees and Exemptions:	
• Fee type:	Variable service fee, card fee
• Fee services (all inclusive fees):	Flat fee for everything
• Fee levels: How are fees set?	Opinion of program officials
• Graduated fee:	Yes, higher at referral hospital

• Insurance:	No
• Exemption criteria:	Below a certain income; type of illness
• Administration of exemptions:	No administration, some keep records
• Fee adjustment:	Three adjustments since 1980
Financial Management:	
• Fee collection system: Standard procedures?	Yes
• Banking systems:	At commercial banks
• Records: What records are kept?	Yes
• Reporting: Routine reports?	No
• Audit and oversight functions:	Yes, internal/external audits
• Realtionship to government accounts: Communication with counterparts?	Yes, reports go to districts, who in turn submit to province
• Interactive systems development:	Yes, accounting instructions
Revenue Expenditure:	
• Expected use of revenue:	All goes to Treasury
Staffing, Training, Supervision	
• Staff for user fee program:	Existing clerical staff
• Implementation training:	No, only ministry circulars, ministerial statements
Public and Provider Awareness:	
• Key messages:	Ministry statements to the press, and advertisements
• Provider orientation and information:	Circular
• Public information:	Notices at hospitals
Community Involvement:	
• Community involvement:	Public awareness campaign

Monitoring Impact:	
• Revenue generation:	Yes, has to be remitted to the Treasury by a gi date monthly
• Revenue expenditure:	No
• Quality of care:	Very recently
• Utilization impact:	No
• Cost of cost sharing:	Study done. Current fees well below the cost c the service. No assessment to compare revenu collected with collection costs.
Theft, Abuse, Fraud:	
• Source of loss:	None
• Point of collection problems:	None
• Banking and accounting:	No problems
Drug Revolving Fund:	
• Selection of drugs:	Health professionals decide
• Demand-based supply system:	Management problems exist
• Quality assurance:	System exists
• Accountability	This is a problem area
Managing for Success:	
• Key staff:	Are in place in most cases
• Performance targets:	None
• Monitor performance:	None, but systems will be in place soon
• 80/20 rule in priority setting:	Not applied

V. COUNTRY ACTION PLANS

A. Botswana

The first plan of action is to work with policy makers and politicians, to convince them of the importance of introducing fees for service. This can only be done if discussions on issues of sustainability and efficiency in the delivery of health care is brought forth.

The goal is to provide adequate services, and put systems in place so that money can be collected: the concept of "making hay while the sun still shines." This can be done through regional collaboration on subject matters such as:

- management of cost sharing,
- financial management, especially by countries who are ahead in cost sharing initiatives, and
- monitoring and evaluation.

B. Ethiopia

The first draft document on cost sharing in Ethiopia is completed and a conference is to be conducted shortly for technical people. The input provided by experts (REDSO) will be crucial in the implementation phase. Once acceptance is granted by the government, a second conference will be conducted at the policy level.

At the third stage, a concept of cost sharing familiarization amongst the providers of health services will be implemented. At this point, lessons learned from the Regional Collaboration Network will be taken into consideration.

The problem identified when implementing cost sharing is that this concept will lead to less revenue generation for the central government, and more revenue for the district and provincial levels.

The idea of health care insurance and managed care may seem feasible for region 14 but may not work in other regions.

C. Ghana

Improve the financial management systems including:

- revenue and expenditure control;
- target setting;
- monitoring and evaluation on a continuous basis;
- design systems of information flow and implement them at regional, national, and district levels; and

utilization.

Other goals:

- Further studies to show utilization behaviors (by ASE).
- Find ways to protect the vulnerable groups.
- Look at other determinants of utilization.
- Improve the quality of care.
- Policy.
- Review the guidelines to address implementation problems.
- Use the Regional Collaboration Network program as a resource pool.

D. Malawi

- Health care financing and cost sharing specifically are in the "dating" phase

- The policy makers need:
  - commitment from political leaders to implement, hence, the examples from the regior can be useful for convincing Malawi policy makers.
  - continued advocacy: Cost sharing should be a choice rather that "the only hope."

- Beginning to work on "systems," e.g., HIS, staffing workload survey, quality assurance, and community participation.

- Prepare IEC for cost sharing.

- Compile experiences from the mission and private sectors within the country.

- Continue to explore alternative financing schemes since cost sharing and insurance schemes a not universally appropriate.

- Experience other financial initiatives, e.g., Bamako Initiative, IGA's -IV fluid production.

- Principle of managed care, particularly in rural areas.

E. Mozambique

- Review of cost recovery project in accordance with the experience gained at this conference (from other countries), adapting it to the specifications of our own country.

- Exchange experiences with Kenya in this field. Use Kenya Health Care Financing Program's technical assistance team and Secretariat to initiate cost sharing in Mozambique.

Through the regional health financing network, invite consultants to enhance the program, especially to diversify the activities in health insurance.

F. South Africa

South Africa is in the process of health care financing reforms. Policies for health care financing are in the process of development. No clear direction is in place. The government is presently examining national health insurance as a way of financing primary health care.

The implementation of user fees has also been considered as an option for health care reform. However, questions that arise from this option are:

> Question of equity of distribution of health care. Who gets exempted? Historically, South Africa has provided services based on racial lines, therefore, reform will have to be slow, and on-going.

The first major health summit is to be conducted in October 1995.

G. Tanzania

The country has only recently looked at cost sharing as an option in health care financing. Tanzania hopes to learn from the Kenya experience and follow their footsteps when implementing cost sharing within the health care system.

Tanzania hopes to draw upon the Regional Collaboration Network for assistance for health care reform within their country.

H. Uganda

Belief:

There is a reason to reward staff for improved health services and facilities.

One must address the issue of decentralization. Cost sharing in Kenya is significant, although is highly centralized.

Policy:

- Decentralization to the local committee level is essential, especially to observe health charges issue.
- Political influences should be down to the district level.
- There should be regular consultation and integration with the NGOs and donor agencies.
- Permanent cost sharing Secretariat among the government staff is highly recommended.

Need for increased quality of staff and health services delivery.

Implementation:

- Uganda accepts cost sharing shift from flat fee as gate-keepers to fee for service.
- Fee and expenditure involved at a facility level.
- Health unit management committee trained and restricted (spirit of volunteerism).
- Incorporate operational forms that are useful.
- Implement credit systems (that are not presently in place).

I. Zimbabwe

- Through the conference, "'Managing Cost Sharing,'" the first plan of action will be to:
  - Prepare a report on ideas presented at the conference (within the next two months);
  - Try and implement user fees (for practical purposes) and strengthen referral systems.
- Since the administrative costs are high and revenue collected is low, a study should be condu to identify where the flaw is.
- Existing policies have to be modified or changed, in regard to revenue collection. The existi policy does not allow for the retention of any revenue at the district level.
- There needs to be strong collaboration between the committee of multi-disciplinary member order to identify need in all areas.
- Presently, the government is looking into a national health insurance policy for Zimbabwe. I addition, managed health care plans seems to be viable for the country, and should be addres

VI. PARTICIPANTS' PROPOSED CHANGES TO THE COST SHARING MANUAL

1. Accounting procedures for recording and managing user fees should be included (maybe in a profit and loss account).
2. Highlight need for fairness of fees (question of equity).
3. Section on patient care: used as a ready indicator of input of quality of care (process, outcom and structure).
4. Index should be detailed.
5. Concerns about legal framework need to be emphasized.

6. Add acronyms.

7. Concept of volunteerism should be addressed.

8. Include more suggestions on staff incentives to motivate staff to participate more fully in the cost sharing program.

9. Concept of fairness should be stressed in fee setting -- pages iii and 15 of manual.

10. There should be a full section on quality of care and patient satisfaction.

VII. WHERE DO WE GO FROM HERE?

Richard Sturgis, REDSO health policy advisor, in his closing remarks, indicated that a regional network would enhance collaboration among various African countries. He also stated that REDSO would act as a resource office for countries seeking information on health financing.

Recommendations made by the participants include:

- Visits to countries that have experience in a particular area, e.g., decentralization (Uganda, Ghana).
- Regional meetings to address a few critical issues, e.g., financial information systems, health information systems, and national health insurance schemes.
- Help to coordinate donor activity in health care financing.
- Create a network to improve sharing of reports of significant studies, sharing technical assistance needs, etc.
- Need to sensitize policy makers on the usefulness of this regional collaboration and to encourage visits to other countries

The network will be accessible through each country's USAID mission.

VIII. MANAGING COST SHARING - CONFERENCE EVALUATION

Conference Evaluation

1 = Poor 5 = Excellent
No. Of Participants = 17

		1	2	3	4	5	Total	Average
1.	Overall rating	0	0	1	8	8	17	4.4
2.	Sessions: quality, content, presenter							
a.	Conference overview	0	0	1	9	7	17	4.4
b.	Health financing alternatives	0	1	2	9	5	17	4.1
c.	History of health financing in Kenya	0	0	3	8	6	17	4.2
d.	Policy issue in cost sharing	0	0	3	8	6	17	4.2
e.	Implementation of cost sharing	0	0	4	11	2	17	3.9
f.	Management	0	0	0	15	0	15	4.0
h.	Fee setting	0	0	3	11	3	17	4.0
I.	Expenditure	0	2	8	4	3	17	3.5
j.	Quality of care	0	0	6	10	1	17	3.7
k.	Monitoring and evaluation	0	0	4	5	8	17	4.2

Aspects of the conference that were useful:

- fee setting
- financial management
- implementation
- printed material
- field trips
- cost sharing management
- group discussions
- sharing of experience

Cost Sharing Manual:	Yes	No
Have you had a chance to read the manual?	13	4
Do you think it is useful in your work?	17	0
Was it clearly written?	17	0
Are there any changes/additions you would like?	See list in section VI	

Regional Collaboration:	Yes	No
Are you aware of the USAID regional collaboration. Which began last year?	5	12
Have you visited the Kenya Health Care Financing Program?	4	13
Would like to visit the program	16	1 Not Yet

What would you like to see?

- National insurance fund
- Implementation to lower level
- Financing family planning programs
- Management cost sharing
- Data base systems
- MOH involvement

When would you like to visit?

- October 1995
- January 1996
- After 2 years
- Next year
- Not sure

	Yes	No
Has the Kenya Health Care Financing Project visited you?	3	14
Would a visit be useful?	10	Not yet

If yes, how would it be useful?

- To convince MOH of positive aspects of implementation
- To help the country with actual working problems
- Technical assistance
- Help set up better financial systems
- Assist with cost sharing problems
- Part-take in implementation phase

How best would the regional collaboration work?

- Periodic meetings
- Regular conferences, such as this one
- Exchanging information, have an up-to-date newsletter

IX. CONFERENCE AGENDA

Day/Time	Session Topics	Presenter
Monday		
08:30	Tea and registration	Sophia Ladha/ Sharmi Bhalla
09:15	Objectives and homework	Stephen Musau/ Shairoz Nathoo
09:30	Welcome and introductions	Ibrahim Hussein/ Ray Kirkland
10:00	Opening Address	Hon J. Angatia, Minister for Health
10:30	Tea	
11:00	Conference overview: Review of health financing alternatives and reasons for introducing cost sharing	Dan Kraushaar
11:45	History and overview of Kenya cost sharing program	Ibrahim Hussein
12:15	Brief overview of other countries cost sharing programs	Sam Munga
13:00	Lunch	
14:00	Policy issues in cost sharing	Ibrahim Hussein
14:30	Other country experiences: * Ethiopia experiences on policy	Hailemariam Redda
14:40	Implementation: Resources needed, development, preparation, systems, phasing, role of nurses.	David Collins/ Theodora Bwire
16:00	Other country experiences: * Implementation issues in Tanzania	P. Mmbuji
16:10	Open discussions and sharing of country experiences	Mary Kilonzo
17:00	Close	

Tuesday		
08:00	Fee setting: Which services, what types of fees, how much, protecting the vulnerable	David Collins
09:00	Group discussions on fee setting	David Collins
09:30	Other country experiences: * Fee setting in Uganda * Protecting the vulnerable in Zimbabwe	 R. Basaza L. Manambara
10:00	TEA	
10:15	Management: Levels, roles and responsibilities, supervision, motivation, resources needed.	Sam Munga
11:15	Other country experiences: * Cost sharing management in Ghana	 D. Osei
11:30	Financial management: Recording, controlling, reporting, managing for success.	Stephen Musau Mary Kilonzo
12:30	Group discussions on financial management	Stephen Musau
13:00	LUNCH	
14:00	Other country experiences: * Financial Management systems in South Africa	 G. Karim
14:15	Expenditure: planning, spending	Patrick Itumbi
14:45	Other country experiences: * Spending of cost sharing funds in - Uganda - Mozambique	 R. Basaza M. Ndimande
15:00	Quality of care, patient and public information: Ways to improve quality of care, information mechanisms.	Theodora Bwire
15:45	Other country experiences: * Botswana on quality of care	 G. Moalosi
16:00	TEA	

Wednesday	FIELD TRIP	
	Group I - Embu District Hospital and Ruiru Health Center	Kenneth Mureithi
	Group II - Nakuru District Hospital	Sam Munga
Thursday		
08:00	Report on field trips	Kenneth Mureithi
08:30	Monitoring and evaluation: Revenue generation use of funds, quality, utilization, vulnerable groups	Dan Kraushaar
09:30	Group discussions on monitoring and evaluation	
10:00	Results of Kenya surveys on impact of cost sharing	Sam Munga
10:30	TEA	
10:45	Other country experiences: * Ghana on evaluation of cost sharing program	D. Osei
11:00	Country action plans	Mary Kilonzo
12:00	Presentation of country plans	Mary Kilonzo
13:00	LUNCH	
14:00	Regional collaboration - discussions and plans	Richard Sturgis/ Dan Kraushaar
15:00	Closing.	I. M. Hussein

APPENDICES

APPENDIX A

Participant Contacts

Name	Title & Organization	Contact Address
BOTSWANA		
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ETHIOPIA		
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Hailemariam Redda	Administrator St. Paul Hospital	PO Box 1172 St. Paul Hospital, Ethiopia Off Tel: 131648 Contact: Dr. Meseref Sheferaw
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GHANA		
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KENYA		
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Mary Mueni Kilonzo	Economist KHCFS	PO Box 30016 Nairobi, Kenya Off: 717077 ext. 45198 Hom: 603003 Fax: 719308 Contact: P. Secretary
Daniel Kraushaar	Chief of Party KHCFP	PO Box 41869 Nairobi, Kenya Fax: 02 719308 Internet: [d Kraushaar@.gn.apc.org]
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Richard Sturgis	USAID/REDSO/ESA	Po Box 30261 Nairobi, Kenya

MALAWI		
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MOZAMBIQUE		
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Filomena Eduardo Zimba	National Director Ministry of Health	PO Box 264 Maputo, Mozambique Off: 425497 Hom: 743964 Contact: Financial & Admin Directorate
SOUTH AFRICA		
Goolam Karim		
Fezile Makiwane	Coordinator Health Care Financing Department of Health	PO Box 409 Kelvin, 2054, South Africa Off: 012-3120889 Hom: 012-3446006 Fax: 012-3231980 Contact: Dr. O. Shisana
TANZANIA		
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Peter Mmbuji	Cost Sharing Implementation Committee	PO Box 9083 Dar-es-Salaam, Tanzania Off: 255-51-23955 Contact: Dr. A. Kimambo

UGANDA		
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David Collins	Director of Health Financing Program Management Sciences for Health	165 Allandale Road Boston, MA-02130 USA Off: 617-524-7799 Fax: 617-524-2825
ZIMBABWE		
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APPENDIX B

Planning & Assessment Guide
For
User Fee Programs

(Oct '94, J. Quick, MSH)

Country: _____
Name of User Fee Program: _____
The following is an outline of the key issues and options for user fee programs.

1. Financial & Equity Policies

1.1 Cost recovery objectives - What are your cost recovery objectives:
- ☐ nominal cost recovery: minimal fee (5 -10% real costs)
- ☐ partial cost recovery: full or partial cost of drugs
- ☐ partial cost recovery: significant portion of all costs (e.g., 20-50%)
- ☐ recovery of all operating costs: replacement cost of drugs, salary costs
- ☐ recovery of full costs: all operating costs + capital costs
- ☐ other objectives: _____

1.2 Retention of revenue - What percent is retained at each of the following levels:
- _____ Central accounts/Treasury (The law of the Treasury)
- _____ Ministry of Health headquarters account
- _____ District Account
- _____ Facility
- _____ Community
- _____ Other:

1.3 Additivity to other revenue sources - Does user fee **add** to current revenue sources or **substitute** for central Treasury, donor, or other funds? Is user fee revenue deducted from Ministry allocations in national budgeting decisions?

_____

1.4 Protection policy ("safety net") - Are there specific categories of patients, illnesses, or services which are exempt as a matter of national policy? (Details to be provided in Section 3, below.)

_____
_____

2. Organizational Policies

2.1. Management structure - How is the user fee program managed and directed?

- ☐ part of an existing unit: _____
- ☐ part of a new unit: _____
- ☐ other: _____

2.2. Legal or administrative status - What is the legal or administrative status of the user fee program and the revenue raised by the program?

- ☐ no special status, but no problem created by this
- ☐ no special status, but this causes operational problems
- ☐ official, accepted government policy
- ☐ legal notice
- ☐ law/act of parliament/Presidential decree
- ☐ other: _____

2.3. Form of user fee program - What type of user fee program do you currently have? (Tick all that apply)

- ☐ comprehensive fee-for-service systems (charges for most services)
- ☐ revolving drug funds
- ☐ community-based systems (e.g. Bamako Initiative)
- ☐ other: _____

2.4. Bottom-up vs. top-down implementation - In what order have user fees been introduced at the following levels of the health system? (1=first level to charge, 2=second level, etc., write "nc" if not charging.)

- _____ community level (CHWs)
- _____ dispensaries (lowest level health facility)
- _____ health centers
- _____ district/first level hospitals
- _____ referral hospitals

3. Pricing & Exemptions

3.1. Fee types - Which types of fees have been implemented?

- ☐ card fee (covers fixed time period)
- ☐ attendance fee (covers all costs for one visit)
- ☐ flat service fees (fixed amount for each service - e.g., consultation, drugs, lab)
- ☐ variable service fees (variable amounts for each service, depending on true cost or complexity of service - e.g., special lab tests cost more than simple tests)
- ☐ other: _____

3.2. **Fee services** - For which of the following major services are fees charged:

- ☐ consultation
- ☐ drugs (take-home)
- ☐ x-ray investigations
- ☐ immunization
- ☐ inpatient days
- ☐ minor surgery
- ☐ physical therapy
- ☐ laboratory investigations
- ☐ injections
- ☐ medical exams & certificates
- ☐ family planning services
- ☐ major surgery
- ☐ deliveries
- ☐ mortuary
- ☐ other: _____

3.3. **Fee levels** - How are fees set? (Cost-based, willingness to pay approach) Are fee levels based on:

- ☐ actual calculated cost of providing the service
- ☐ cost plus percentage mark-up or minus a subsidy discount
- ☐ opinion of program officials
- ☐ comparisons with private or NGO/mission sectors
- ☐ other: _____

3.4. **Graduation of fees** - Are fees graduated? That is, does the level of fee vary by the level of facility so that the same service will cost more at higher levels? If so, in what ways do fees vary?

_____

_____

3.5. **Insurance** - Is any revenue received from insurance? If so, how much of total revenue comes from insurance?

_____

_____

3.6. **Exemption criteria** - Are there specific criteria for exempting certain patients, illnesses or services? If so, what are these criteria?

_____

_____

3.7. **Administration of exemptions** - How are exemptions/waivers administered? Who decides and what records are kept?

3.8. **Fee adjustments** - How often are fees adjusted? How are fee adjustments decided?

_____

_____

4. **Financial Management Systems**

4.1. **Fee collection system** - Are there standard procedures and rules for collection of revenue' there standard collection points in the hospital?

_____

4.2. **Banking system** - Where is revenue banked? How accessible are banks? Do the banks pr regular statements? Do accounts earn interest?

_____

4.3. **Recording** - What records are kept at *individual health facilities*? Service registers? Cash analysis books? Other records? What records are kept at the district level?

_____

_____

4.4 **Reporting** - Are routine reports required from facilities? If so, what are the reports? How are they submitted?

_____

_____

4.5. **Audit and oversight functions** - Is the program regularly audited? Are audits done at the national level? district level? facility level? Who performs the audits?

_____

_____

4.6. **Relationship to government accounts** - Does the user fee program have regular communications with counterparts at each level in the government accounting administratic (e.g., district accountant, provincial accountant, chief accountant)? What types of interacti are there?

_____

4.7. **Interactive systems development** - How have these financial systems been developed? Are financial management systems standardized in the form of an operations manual? Have the systems been modified based on experience with implementing the systems?

_____

5. Revenue Expenditure

5.1. **Expected use of revenue** - Based on the rules regarding retention of revenue (section 1, above), are there specific rules regarding the use of revenue. For each item below indicate with a **E, P, D, or F** whether expenditure on those items is **Encouraged, Permitted (but not encouraged or discouraged), Discouraged, or Forbidden.** Also indicate what percent of revenue is used for each item (if known).

E, P, D, F	%	
_____	____	regular salary payments
_____	____	salary supplements
_____	____	drugs
_____	____	medical supplies
_____	____	painting & building maintenance
_____	____	patient transport/ambulance
_____	____	staff transport (e.g., supervision)
_____	____	health educations or other preventive services
_____	____	capital development project - community & prevention
_____	____	capital development project - hospital & other services
_____	____	other: _____

5.2. **Expenditure process** - Who must be involved in proposing expenditure made with user fee revenue? Who must approve expenditure?

Proposing: _____

Approving: _____

6. Staffing, Training, Supervision

6.1. **Staff for user fee program** - Which staff are the most involved in supervising and in operating the user fee program? Has it been necessary to hire additional staff?

Primary staff responsible for user fee program: _____

_____

Additional staff hired for user fee program: _____

_____

6.2. **Implementing training** - What training has been provided to various groups? That is, wh been trained? On what topics? For how many days/weeks?

Who? What topics? How long? (days/weeks)

6.3. **Targeted supervision** - Who is involved in supervision of the user fee program at each lev How often are supervision visits made? Is there a supervision checklist?

_____

7. **Public and Provider Awareness**

7.1. **Key messages** - Have key messages been identified for informing providers and the public about user fees?

7.2. **Provider orientation and information** - Have any of the following activities occurred to orient and inform providers about user fees:

- ☐ district-level workshop with facility in-charges
- ☐ facility level meetings with staff (all staff)
- ☐ user fee newsletter
- ☐ other: _____

7.3. **Public information** - Have any of the following efforts been made to inform patients and t public?

- ☐ posters
- ☐ meetings with local leaders
- ☐ radio announcements
- ☐ morning lectures at health facilities
- ☐ other: _____

8. **Community Involvement**

8.1. **Informal involvement** - Have community members been involved in:

- ☐ public awareness campaigns
- ☐ advising on program development
- ☐ advising on the collection and use of revenue
- ☐ other: _____

8.2. **Formal involvement** - Is the community involved in:
- ☐ fee-setting
- ☐ determining or advising on who receives waivers/exemptions
- ☐ ensuring accountability
- ☐ participating in expenditure planning
- ☐ helping to generate capital (e.g., for revolving drug funds)
- ☐ other: _____

8.3. **Mechanisms of community involvement** - If involved, is the community involved through:
- ☐ voluntary committees, boards or other bodies
- ☐ officially established committees, boards or other bodies
- ☐ village committee
- ☐ facility committee
- ☐ district committee
- ☐ other: _____

9. **Monitoring Impact**

9.1. **Revenue generation** - Is revenue generation routinely monitored? By individual facility? By district? By source of revenue?

_____

9.2. **Revenue expenditure** - Is revenue expenditure routinely monitored? If so, how? Is there a breakdown by type of expenditure?

_____

9.3. **Quality of care** - Is quality of care periodically assessed? If so, how?

_____

9.4. **Utilization impact** - Is the impact of user fee on utilization routinely monitored? If so, how?

_____

9.5. **Cost of cost sharing** - Has an assessment been made of the cost of collecting user fees in comparison with the amounts of revenue collected?

_____

Additional Considerations

1. Theft, Fraud, Abuse

1.1. **Source of losses** - Are the sources clearly known for losses due to theft, fraud or abuse?

_____

1.2. **Point of collection problems** - Is theft at the point of collection a problem? What steps are being taken to counter this threat?

_____

1.3. **Banking and accounting problems** - Are funds lost through the accounting and banking process? How much is lost this way? What steps are being taken to counter this threat?

_____

1.4. **Expenditure problems** - How much is lost through fraudulent procurement with user fee revenue? What steps are being taken to counter this threat?

_____

2. Revolving Drug Fund (RDF) Issues

2.1. **Selection** - Are drugs chosen only for public health reasons or also considering provider preferences? Or patient preferences?

2.2 **Capitalization** - How have capital requirements for the RDF been calculated? Are they sufficient to ensure a steady supply of drugs?

2.3. **Demand-based supply system** - Is the supply system sufficiently well-managed to ensure regular supply based on actual demand? (Pull versus push system)

2.4. **Quality assurance (appearance as well as reality)** - Is there a dependable quality assurance system? And are there mechanisms to ensure that patients receive drugs in proper packages packages which to the patient justify the price paid?

2.5. **Accountability for drugs versus revenue** - Are accounting procedures adequate to ensure th drugs dispensed are balanced against revenue collected?

2.6. **Effect on rational drug use** - Is the effect of drug fees on rational drug use regularly assessed?

3. **Managing for Success**

3.1. **Key staff** - Are key staff in place?

3.2. **Set performance targets** - Does each facility have realistic collection performance targets?

3.3. **Monitor performance** - Is progress measured against performance targets?

3.4. **Use 80/20 rule for setting priorities** - Are most efforts going in to collections at services with the highest revenue-potential?

3.5. **Spend money to make money** - Is user fee revenue being used to make improvements or other changes which would increase revenue collections?