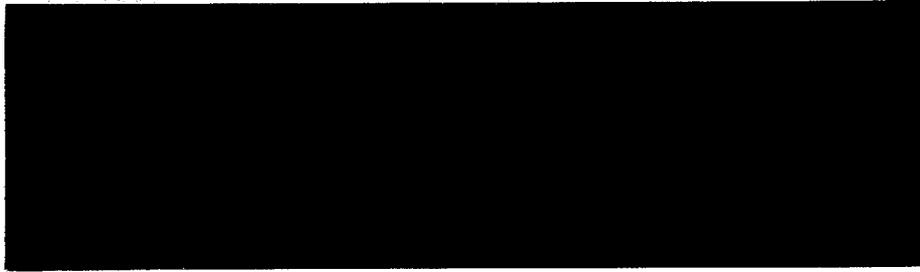


PN-ACA-453

# REPORT



 **BASICS**

PJ-ACA-453

**ASSESSMENT OF THE  
JINJA HOSPITAL  
USER FEE PILOT PROJECT**

November 11-15, 1996

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Peter Ilomo

BASICS Technical Directive: 014-AA-02-024  
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## ACRONYMS

AAR	African Air Rescue
BASICS	Basic Support for Institutionalizing Child Survival
DISH	Delivery of Improved Services for Health Project
MOH	Ministry of Health
ODA	Overseas Development Agency (England)
REDSO	Regional Economic Development Support Office
USAID	United States Agency for International Development

## BACKGROUND

In early 1996, the REDSO/BASICS regional collaboration in health financing assisted the Ugandan Ministry of Health (MOH) and USAID/Uganda's DISH project develop cost sharing guidelines for implementing cost sharing in hospitals.<sup>1</sup> In mid-1996, the DISH project trained Jinja Hospital staff in how to implement the guidelines, and for several months these guidelines were implemented under the general supervision of DISH project staff. The MOH and DISH project requested the assistance of the USAID/REDSO Regional Health Finance Network to assess the guidelines' implementation. If found to be working and appropriate, the guidelines would be implemented in other hospitals throughout Uganda.

During previous visits the Regional Health Finance Network has also assisted the MOH, ODA, and the DISH project develop ideas for expansion of health insurance in Uganda. One of the results of this work is the recent implementation of a hospital-based, pre-paid insurance scheme in Kisiizi Hospital. Another insurance proposal is now being developed by DISH staff and Dan Kraushaar<sup>2</sup> was asked to review the proposal and assist the DISH project in moving ahead on insurance-related interventions in Uganda. In order to facilitate regional sharing of experiences and to assess the capacity of local consultants, Mr. Peter Ilomo, head, Health Finance Implementation Committee, Ministry of Health, Tanzania, accompanied Kraushaar on this visit.

## OBJECTIVES OF THE VISIT

The objectives of the visit were—

1. Assess the implementation of user fee guidelines in Jinja Hospital.
2. Review an insurance proposal prepared by the DISH project and discuss next steps, including the development of a formal relationship with AAR Health Services.
3. Review and develop the consulting capacity of Ilomo, MOH/Tanzania.

## VISIT SCHEDULE

The visit lasted four and one half days. Day one was an orientation for Ilomo. Days two and three were used to assess Jinja Hospital's cost sharing implementation experience, while day four was used to present the findings to Jinja Hospital and MOH senior staff and to carry out informal

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<sup>1</sup> Throughout this report the words "cost sharing" and "user fees" will be used interchangeably.

<sup>2</sup> Dan Kraushaar is the regional health finance advisor for the USAID/REDSO/ESA Regional Network in Health Finance.

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discussions between the DISH project and AAR Health Services visitors.<sup>3</sup> The final morning was used for a meeting between the DISH project, the MOH, and AAR Health Services.

## **USER FEE IMPLEMENTATION ASSESSMENT QUESTIONS**

In assessing the user fee program, we asked the following questions:

1. Are the user fee guidelines being implemented as recommended?
2. How much money is being earned in total? How much of the revenue earned is in the form of cash, waivers, exemptions, absconding or credit?
3. Are collected revenues being spent according to guidelines? Is there evidence of improvements in the quality of care?
4. Is supervision of the system adequate?
5. Based on answers to the above, are user fee guidelines appropriate?
6. Should user fee guidelines be widely implemented throughout Uganda to other inpatient facilities?

## **OUTCOMES OF THE VISIT**

### ***Background***

Jinja Hospital is both a district and a referral hospital, with 500 beds. The user fee program began in August 1992, under the influence of the District Council. In 1996, the DISH project began to help implement and formalize the program through the implementation of guidelines, training, provision of receipts, and supervision.

*Is the management of user fees being carried out appropriately?*

Guidelines for the user fee program were made available to the hospital, and hospital staff were trained in their use. However, the guidelines could not be located in the hospital.

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<sup>3</sup> A copy of the presentation, as well as spreadsheets of expected versus supported revenues, is attached to this report.

The management structure is clear at the district level, where a Hospital Management Committee has been formed, although it seems not to be functional. However, the management structure at the hospital and the role of the MOH are not clear.

The Hospital Management Committee is made up of nine people and has the following roles: 1) advise the hospital on implementing user fees; 2) supervise the program; 3) guide implementors; and 4) inform the public about the program. Although established, this committee never meets to discuss and practice its roles.

At the hospital level, there is a Senior Staff Committee comprised of the medical superintendent, hospital administrator, and nursing officer in charge. The hospital accountant is a co-opted member. This committee, among other things, has the role of discussing the implementation of user fees. Again, however, this committee does not address this program in practice. From discussions with different hospital staff, the decisions related to collection and use of user fee revenue are left to the medical superintendent and chairman of the hospital management committee. The lack of a clear and formal management structure for the user fee program has frustrated hospital staff at all levels.

*Are the user fee guidelines being implemented as recommended?*

### **Bank Accounts, Cash Boxes and Cash Receipts**

The hospital has a user-charges bank account with the signatories being the medical superintendent, mayor of Jinja Town, and the chairman of the district council. All money is to be accounted for and banked before spending. In practice, there is considerable spending before banking.

The hospital has enough receipts, but they are not treated as accountable documents, having been printed by the DISH project for this pilot. There are seven cash collection points, all manned by revenue clerks hired by the district, but paid out of user fee revenue. Each location has a cash box with keys remaining with the revenue supervisor. Normally the revenue supervisor visits the collection points once per day and collects the cash; on weekends and holidays the revenue collection work is done by only a few revenue clerks. No collection is done during the night. Inpatient revenues are collected on the wards by the ward manager who submits revenues each day to the revenue supervisor. There is no central billing office or discharge point as per the guidelines and patient charge sheets are not being used. Payment for ancillary or diagnostic services is done on a pay-as-you-go basis.

The guidelines call for all revenue earned to be accounted for as government revenue. The sum total of revenue earned is equal to money received as cash for services rendered and the value of services provided free of charge due to waivers or exemptions being granted, or through patient absconding or credit given. Each revenue generating department, i.e., lab, x-ray, or inpatient department, should have all fee levels posted and a service register in which all services are

recorded and their value as well as whether cash, credit, waiver or exemption was used or whether a patient absconded. Each department should surrender all its cash each day to the Accounts Office of the hospital and have it recorded in a cash analysis book. At the end of each day, all collected revenue is to be banked by the Accounts Office. Each month each department is to prepare a summary report of the value of all services rendered. This report is to be compiled by the Accounts Office and presented to the hospital and district management. During the visit, we did find that cash payments were being documented in department registers, but the value of waivers, exemptions, abscondings, and credit was not being recorded or reported. There was no debtors book available for us to see.

We did find departmental registers, but few corresponded to the format provided in the user fee guidelines. Few departments had their fees posted, and we found no evidence of any monthly reports being prepared by service departments and no summary reports being prepared by the Accounts Office. Hospital management had not been requesting these reports. Money collected is not regularly banked and is often spent before banking and, indeed, before recording. There was no evidence of the departments or the Accounts Office recording the value of services provided free of charge.

When asked about the printed guidelines, the senior hospital administrator remembers seeing them, but could not locate her copy. Many hospital staff remember the guidelines, but we were not able to locate copies within the hospital to see whether they had been used. Many staff were not trained in their use. In short, knowledge of the guidelines was poor and their use all but nonexistent. We feel that the complexity of the guidelines is not beyond the capacity of the staff to implement. The guidelines look theoretically appropriate and doable within the context of Jinja Hospital.

We did have some serious concerns about the roles and responsibilities being carried out by the revenue supervisor. In a proper system, cross checks and controls are needed to assure the safe keeping of all revenue. In this instance, one person has so many roles and functions that cross checks are few and supervision is difficult. This person, for example, prints receipts, issues receipts to departments, collects cash from departments, records cash collected, banks cash collected, completes the daily cash analysis book, keeps banking records, maintains the petty cash, approves expenditures, and records expenditures. Lack of controls and lack of separation of duties is a potential problem for Jinja Hospital.

### **Waivers and Exemptions**

The waiver system is documented in the guidelines. In this hospital there were three people responsible for granting waivers: the personnel officer, the revenue supervisor, and the clerical officer. In the guidelines, the person responsible is the hospital secretary or medical superintendent. All patients must report to these officers in order to obtain a waiver. The procedures for granting waivers are well known to the revenue collectors, but not to hospital staff. There are no posters explaining about waivers or exemptions. Waivers for outpatients are

granted before services are rendered, while inpatients needing waivers are granted them at discharge. The number of waivers granted is very small, not greater than 10 percent of patients.<sup>4</sup>

### **Exempt Patients Include Hospital Staff and Dependents**

The number and type of waivers and exemptions granted and their total value are not being documented or reported, and no waiver targets are set by the hospital contrary to the guidelines.

*How much money is being earned in total and how much is recorded as having been collected as cash or recorded as waivers, exemptions, abscondings, or credit?*

We found that many departments are recording revenue collected as cash, but are not recording routinely all revenue earned. Attached graphs (Appendix C) illustrate the difference between cash reported and revenue earned, indicating that there is significant under-reporting of revenue. Given the extent of allowable waivers and exemptions in the guidelines, the extent of free services may be appropriate, only unrecorded.

We did note considerable under-the-table collection of revenue and unrecorded provision of services. Graphs attached indicate that both services and revenue have varied widely over the past six months. A wild upswing in services provided (and cash collected) occurred between February and April, followed by a subsequent quick decline. This level of variability cannot be accounted for based on changes in morbidity alone and points to conscious manipulation of data recorded by the staff.

The attached spreadsheets (Appendix B) indicate which departments of the hospital are collecting and recording cash received. Note that some departments are not recording it at all. The lab, for example, is not recording all lab tests provided nor all revenue received. The pharmacy provides extensive services, but, based on hospital policy, is not implementing user charges. Since drugs are the one service everyone universally is willing to pay for, considerable revenue is being lost in this department.

In summary, guidelines are not being followed, revenue is being collected as cash, but is often not reported or is under reported, and payments are being made under-the-table. Based on the informal systems operating in the facility, it lends support to our premise that the official guidelines are not beyond the capability of the hospital if the hospital and its staff were serious about implementing them.

*Are collected revenues being spent according to guidelines?*

Ministry of Health user fee guidelines suggest that no more than 50 percent of user fee revenue be spent on staff incentives; the remainder should be spent on those items which improve the

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<sup>4</sup> This is consistent with other studies in Uganda, including that done by Makerere University.

quality of care for patients. In reality, although much of the spending occurs before being recorded, approximately 95 percent of the revenue collected is paid out to staff as salary and wages, incentives, or fees for specialists. By district and hospital policy, all revenue-collecting staff are non-hospital employees whose salaries are taken entirely from user fee revenue. In addition, specialists, e.g., surgeons, receive incentives for providing services in certain hospital departments. These payments are budgeted as "overhead." After "overhead" is calculated, the balance of the funds are budgeted, with staff incentives given depending on an individual's rank in the hospital—higher level staff are given higher incentives. These higher level staff also happen to be those individuals who are responsible for proper implementation of the user fee program and user fee guidelines. Interviews with lower level staff, particularly nurses, indicate that many have not received any incentives for the past two to three months, in spite of the budget indicating that incentives were given. This disparity between what the budget says and what is occurring in reality is troublesome. The fall off in reported hospital attendance and collected revenue is, according to one nurse, the direct result of staff unwillingness to cooperate in implementing the program since they see no direct benefit.

After paying for "overhead," the balance of funds remaining is so insignificant that they would not be able to affect improvements in quality of care. With the exception of one walkway which was paved using user fee revenue, we were unable to locate any other use of cost sharing revenue.

In summary, the user fee program is a de facto staff incentive program for a few hospital employees. The way incentives are distributed affects the implementation of the user fee program and the willingness of staff to follow user fee guidelines. Distribution of collected revenues has in the past and will continue to affect the number and type of services provided by the hospital and the willingness to implement the user fee program in a manner which leads to greater accountability. Guidelines on the use of cost sharing revenue are not being strictly followed.

*Is supervision of the system adequate?*

DISH project staff have made several trips to Jinja Hospital to train hospital staff and supervise implementation of the program. Based on our visit, it was difficult to tell whether these supervisory trips and the training were effective. Hospital employees indicate, however, that they know that this is not a DISH activity, but an activity sanctioned by the MOH. Visits by the MOH have been few since delegation was made to the DISH project. In addition, there is no MOH national policy on cost sharing—each district is able by law to collect fees using the ways and means it sees fit. MOH headquarters has neither the mandate nor the ability (in terms of staff and finances) to implement, monitor, and supervise the cost sharing program. The MOH can only suggest guidelines.

Until national guidelines are in place, supervision from the DISH project or from MOH headquarters is only as effective as the hospitals and districts want it to be. There is no incentive

for hospitals and districts to follow the guidelines or to listen to those supervising the program. As was found in Jinja Hospital, they will implement the program in the way which is in the best interest of certain staff.

### ***General Observations***

There is an accounts section which is headed by a senior accountant. The main function of this section is the record keeping for the recurrent budget provided by the central Ministry of Health. There is no working relationship with the office of the cost sharing revenue supervisor, even though the accounts office had previously dealt with user fee management and accounting. In operation, the user fee program is managed and accounted for separately from all other sources of funds for the hospital.

The virtual separation of management of the user fee program and the accounting of user fee revenue from hospital management is troublesome. Even user fee functions which, according to the guidelines, are direct responsibilities of hospital personnel are now assumed by the revenue supervisor and his staff. Since none of these people are under the control or supervision of the hospital, there is a feeling of distrust and lack of ownership of the program. This, perhaps, is one reason revenues have declined sharply in the recent few months.

*Based on answers to the above, are user fee guidelines appropriate?*

In spite of the fact that only parts of the system are being implemented in Jinja Hospital, we have no reason to believe that the guidelines are inappropriate or too difficult to implement. What is lacking is the incentive to do so. There is, however, the need to closely examine all aspects of the manual to make sure that they are appropriate. The need for and use of the debtors book is one example.

*Should user fees guidelines be widely spread throughout Uganda to other inpatient facilities?*

Based on what we have seen and experienced elsewhere, we feel that the MOH should rapidly expand the implementation of these guidelines to other hospitals in Uganda. With less than 50 percent of revenues accounted for, Jinja Hospital is collecting considerable revenue. If all hospitals begin collecting revenue in this fashion, and if incentives can be found for the proper implementation of the guidelines, extensive revenue can be made available to districts, which is not currently accessible. As the guidelines are more widely implemented a "second generation" manual could be developed if necessary.

*Is there a potential future relationship between the Ministry of Health, the DISH project, and AAR Health Services which could lead to insurance options for Uganda?*

Dr. Cowley provided a copy of an insurance concept paper. What is being proposed seems appropriate and doable in Uganda. In order to facilitate implementation, Kraushaar set up an

appointment between Cowley of the DISH project, Dr. Mwesigye, head, Health Finance Program, Ministry of Health, Dr. Muhebwa, MOH Planning Unit, and AAR Health Services (AARHS). The meeting went extremely well. AAR was given the green light to propose ideas for the expansion of health insurance in Uganda, and the DISH project was encouraged to become involved in discussions. Follow-up meetings are being planned. In addition, AAR representatives discussed ideas with Ilomo and a future visit by AAR Health Services to Dar es Salaam to meet with MOH officials is being discussed.

## **GENERAL RECOMMENDATIONS**

1. The MOH should proceed with the definition of a national policy on cost sharing. This policy should outline the roles and responsibilities of all parties concerned, including the role and function of the central Ministry of Health. A core program should be defined and the guidelines adopted as national policy, and the authority to supervise and monitor the program should be given to the MOH. Subsequently, a national program to monitor its implementation should be set up.
2. Since user fees are now being levied by hospitals all over Uganda, we recommend that the DISH project and the MOH proceed quickly to train these other institutions in the guidelines. If necessary, a later version of the manual could be developed which would address needed changes.
3. The management structure of the user fee program must be clear, with the functions of all actors well laid out. Meetings should be documented, guidelines distributed to all pertinent staff, and steps taken to ensure that each institution becomes the "owner" as well as beneficiary of the program.
4. Cash receipts should be accountable documents and treated as cash. They should be controlled by the district or, at least, by the Accounts Office of the hospital. To avoid forgery and abuse, cash receipts should be printed by one printer and a carbon should be used that is double-faced. For sustainability, funds from the user fee program should be used to print receipts.
5. The guidelines for the approval and accounting of waivers and exemptions are appropriate and should be followed. There should be posters advertising their availability. Reports should be prepared on the value of waivers and exemptions granted.
6. With regard to insurance, more formal discussions between the MOH, the DISH project, and AAR Health Services may result in several insurance options which would benefit all parties concerned. Future discussions and proposal development should be encouraged.

## RECOMMENDATIONS FOR JINJA HOSPITAL

1. There is adequate manpower available for the hospital to collect and manage its own cost sharing revenue, obviating the need for an outside revenue supervisor and revenue collectors. This would free up considerable revenue to improve service quality.
2. The hospital's revenue supervisor should have a reduced scope of work with other hospital staff, notably the head of the Accounts Office, being given some of the responsibility for supervising and monitoring the cost sharing program in the hospital.
3. All revenue earned should be accounted for, not just the cash received. Departments should be held accountable for incomplete registers and the monthly reporting in the agreed upon format.
4. Hospital senior management should be given a refresher course in the cost sharing guidelines.
5. Staff incentives should be distributed to all staff, not just a selected few. Incentives should be provided to all staff, particularly those who are responsible for service provision—nurses are in this category. Incentives, however, should be limited to a true 50 percent or less of collected revenues, allowing for quality improvements in the facility.
6. Expenditure plans should be developed and approved by hospital management. If necessary, in order for other staff to understand how revenues are allocated, representatives of all staff should be on an expenditures planning committee.
7. The bank account should be managed by the hospital and its staff. The Accounts Office should be responsible for the program and hospital staff put in charge of collecting, recording, and reporting on collected revenue. There is no need for district staff members to do this work, particularly when the salaries of these staff are taken directly from user fee revenue.

**APPENDIXES**

**APPENDIX A**  
**PERSONS SEEN**

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## PERSONS SEEN

Jinja Hospital            Ms. Anna Wachibe, Senior Hospital Administrator

Other senior and nursing staff of the hospital including members of the Dental Department, Medical Records Department, Laboratory and X-ray Departments, FP department, and others.

DISH project            Dr. Peter Cowley, Health Finance Advisor  
Mr. Festus Kibuuku, Training Advisor  
Dr. Jean Karambizi, Chief of Party, DISH project

USAID                    Mr. Jay Anderson, Chief, Office of Population and Health

MINISTRY OF HEALTH

Dr. Mwisigye, Head, Health Finance Program, MOH  
Dr. Muhebwa, MOH Planning Unit

AAR HEALTH SERVICES

Mr. Derek Oatway, Member of the Board of Directors  
Mr. Njagi Gakunju, Director of Marketing  
Mr. Paul, AAR Uganda

**APPENDIX B**

**JINJA HOSPITAL REVENUE SPREADSHEETS**

**Jinja Hospital Occupied Bed Days by Month, 1996**

Preliminary

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Maternity	Ward 9	Eye Ward	Psych	Physio	Priv A	Priv B	Deliveries	TOTAL BED DAYS
February	438	1,238	913	887	665	1,254	2,111	998	527	31	109	na	na	290	9,171
March	456	813	786	833	844	1,435	2,219	929	487	60	253	323	82	256	9,520
April	327	1,107	813	845	656	1,550	2,664	1,066	417	15	90	86	379	226	10,015
May	492	1,160	1,072	833	738	1,863	2,325	1,074	463	15	80	394	197	172	10,706
June	415	1,259	878	898	665	2,225	2,369	980	379	87	201	405	119	246	10,880
July	423	948	893	1,047	584	2,259	2,393	721	303	91	35	407	85	246	10,189
August	265	972	704	900	531	2,240	2,361	791	323	47	133	282	81	249	9,630
September	136	1,084	651	766	484	2,049	2,704	760	323	95	42	235	91	218	9,420
<b>Totals</b>	<b>2,952</b>	<b>8,581</b>	<b>6,710</b>	<b>7,009</b>	<b>5,167</b>	<b>14,875</b>	<b>19,146</b>	<b>7,319</b>	<b>3,222</b>	<b>441</b>	<b>943</b>	<b>2,132</b>	<b>1,034</b>	<b>1,613</b>	

Some mathematical corrections have been made.

June-Sept	1,239	4,263	3,126	3,611	2,264	8,773	9,827	3,252	1,328	320	411	1,329	376		
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BEST AVAILABLE DOCUMENT

**Jinja Hospital: Fees for IP Services, 1996**

Uganda Shillings per Bed Day

Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Maternity	Ward 9	Eye Ward	Psych	Physio	Priv A	Priv B	Delivery
300	300	300	300	300	300	300	300	300	300	300	10000	1000	3000

Maternity fees come not just from bed day fees. "Earned" fees below include bed fees plus fees from deliveries. This is an underestimate of earned revenue.

**Jinja Hospital: Revenue Earned by Ward by month, 1996**

Preliminary

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Maternity	Ward 9	Eye Ward	Psych	Physio	Priv A	Priv B	Delivery	TOTAL EARNED REVENUE
February	131,400	371,400	273,900	266,100	199,500	376,200	1,503,300	299,400	158,100	9,300	32,700	0	0	870,000	3,621,300
March	136,800	243,900	235,800	249,900	253,200	430,500	1,433,700	278,700	146,100	18,000	75,900	3,230,000	82,000	768,000	6,814,500
April	98,100	332,100	243,900	253,500	196,800	465,000	1,477,200	319,800	125,100	4,500	27,000	860,000	379,000	678,000	4,782,000
May	147,600	348,000	321,600	249,900	221,400	558,900	1,213,500	322,200	138,900	4,500	24,000	3,940,000	197,000	516,000	7,687,500
June	124,500	377,700	263,400	269,400	199,500	667,500	1,448,700	294,000	113,700	26,100	60,300	4,050,000	119,000	738,000	8,013,800
July	126,900	284,400	267,900	314,100	175,200	677,700	1,455,900	216,300	90,900	27,300	10,500	4,070,000	85,000	738,000	7,802,100
August	79,500	291,600	211,200	270,000	159,300	672,000	1,455,300	237,300	96,900	14,100	39,900	2,820,000	81,000	747,000	6,428,100
September	40,800	325,200	195,300	229,800	145,200	614,700	1,465,200	228,000	96,900	28,500	12,600	2,350,000	91,000	654,000	5,823,200
<b>Totals</b>	<b>885,600</b>	<b>2,574,300</b>	<b>2,013,000</b>	<b>2,102,700</b>	<b>1,550,100</b>	<b>4,462,500</b>	<b>11,452,800</b>	<b>2,195,700</b>	<b>966,600</b>	<b>132,300</b>	<b>282,900</b>	<b>21,320,000</b>	<b>1,034,000</b>	<b>5,709,000</b>	
<b>TOTAL</b>															
Jun-Sept	371,700	1,278,900	937,800	1,083,300	679,200	2,631,900	5,825,100	975,600	398,400	96,000	123,300	13,290,000	376,000		

"Earned" maternity revenue includes delivery fees but does not include other earned revenue and so is under estimated here.

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### Jinja Hospital: Reported Cash Revenue from Occupied Bed Days by month, 1996

Preliminary

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Maternity	Ward 9	Eye Ward	Psych	Physlo	Priv A	Priv B	TOTAL REPORTED REVENUE
June	53,800	231,600	92,700	79,900	0	1,443,500	623,700	28,700	57,000	0	0	558,000	303,000	3,471,900
July	74,500	275,900	124,000	95,700	0	1,572,600	668,500	45,300	80,500	0	0	1,112,000	405,000	4,454,000
August	53,600	249,200	85,900	90,700	0	1,269,900	585,800	23,100	83,900	9,800	0	656,000	173,000	3,280,900
September	26,300	207,500	106,400	83,400	0	1,002,000	619,900	51,300	82,900	25,200	16,000	584,000	129,000	2,933,900
October	34,400	182,600	95,400	71,600	0	938,900	593,600	110,000	74,200	6,000	0	107,000	151,000	2,364,700
<b>TOTAL</b>	<b>242,600</b>	<b>1,146,800</b>	<b>504,400</b>	<b>421,300</b>	<b>0</b>	<b>6,226,900</b>	<b>3,091,500</b>	<b>258,400</b>	<b>378,500</b>	<b>41,000</b>	<b>16,000</b>	<b>3,017,000</b>	<b>1,161,000</b>	
June-Sept	208,200	964,200	409,000	349,700	0	5,288,000	2,497,900	148,400	304,300	35,000	16,000	2,910,000	1,010,000	

### Jinja Hospital: Percent Variance between revenue earned and cash reported from occupied bed days, by month, 1996

Preliminary

[(actual / expected)\*100]

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Maternity	Ward 9	Eye Ward	Psych	Physlo	Priv A	Priv B	Ave variance Reporting units
June	36%	67%	29%	32%	0%	258%	51%	9%	41%	0%	0%	14%	154%	52%
July	60%	73%	47%	36%	0%	236%	46%	15%	71%	0%	0%	27%	340%	58%
August	42%	88%	32%	29%	0%	187%	40%	11%	92%	36%	0%	16%	204%	52%
September	33%	71%	50%	31%	0%	149%	43%	22%	86%	179%	40%	21%	159%	48%
October	84%	56%	49%	31%	0%	153%	41%	48%	77%	21%	0%	5%	166%	54%
<b>TOTAL</b>	<b>65%</b>	<b>90%</b>	<b>54%</b>	<b>39%</b>	<b>0%</b>	<b>237%</b>	<b>53%</b>	<b>26%</b>	<b>95%</b>	<b>43%</b>	<b>13%</b>	<b>23%</b>	<b>309%</b>	
June-Sept	43%	75%	40%	32%	0%	208%	45%	14%	72%	54%	10%	20%	214%	53%

Ave variance excludes private wards A&B, wards 5, psychiatric and physiotherapy.

**ESTIMATED OUTPATIENT FEE REVENUE EARNED BASED ON ADJUSTED UTILIZATION AND ESTIMATED FEES**

Jinja Hospital 1996, by month

	OPD	OPD Surgery	Acupunc	ANC	GYN	ENT	EYE	Dental	OP GR A&B	MED	Physio	Psych	TB	Child ward clinic	FP New	FP revisit	XRAY	Minor theatre	Major theatre	Csection	Female steril	Lab tests	Transfus-ions	TOTAL SERVICES		
June	496,000	83,430	277,150	1,759,000	103,000	361,530	487,190	80,340	389,340	211,150	158,125	0	0	1,867,500	0	0	0	0	0	0	0	0	0	0	6,273,755	
July	537,000	101,970	233,450	2,076,000	210,000	174,070	703,490	115,360	290,480	254,410	272,500	0	0	2,294,375	9,450	48,825	1,530,000	1,088,950	2,950,950	148,320	13,390	1,046,250	280,160	0	14,387,380	
August	420,500	69,010	134,550	1,526,000	181,000	391,400	634,460	109,180	234,840	354,320	75,000	0	0	4,843,125	5,250	31,500	2,115,000	1,189,850	3,028,200	189,520	10,300	1,122,750	383,160	0	16,848,735	
September	392,500	95,790	144,900	1,684,000	142,000	364,620	706,580	94,780	432,600	457,320	111,250	0	0	1,399,375	0	0	1,215,000	957,900	2,857,400	226,800	0	891,000	292,520	0	12,266,115	
October	391,500	117,420	115,000	1,920,000	219,000	282,220	716,880	250,290	222,480	311,060	72,500	0	0	1,439,375	0	0	0	0	0	0	0	0	0	0	0	6,057,725
<b>TOTAL</b>																									55,833,710	

**ACTUAL REPORTED REVENUE**

Jinja Hospital 1996, by month, by department

	OPD	OPD Surgery	Acupunc	ANC	GYN	ENT	EYE	Dental	OP GR A&B	MED	Physio	Psych	TB	Child ward clinic	FP New	FP revisit	XRAY	Minor theatre	Major theatre	Csection	Female steril	Lab tests	Transfus-ions	REPORTED REVENUE	
June	1,642,500			1,001,600			57,000	49,500	18,000						50,500		280,000						43,000		3,122,100
July	1,979,000			1,138,600			80,500	76,500	135,000		64,300				52,500	0	457,000						25,000		4,008,400
August	1,805,800			1,537,500			63,900	75,000	123,000		69,000	9,800			33,500		647,000						16,000		4,300,300
September	1,643,800			1,271,000			82,900	82,500	149,000		18,000	25,200			58,000		145,000						76,000		3,529,400
October	1,870,000			1,437,300				52,500	117,000		38,000				37,000		420,000						47,000		3,618,800
<b>TOTAL</b>	8,740,900	0	0	6,386,000	0	0	304,300	316,000	542,000	0	177,300	35,000	0	0	231,500	0	1,929,000	0	0	0	0	0	207,000	0	16,869,000

**PERCENT VARIANCE [(Reported Revenue/Expected Revenue) \* 100]**

	OPD	OPD Surgery	Acupunc	ANC	GYN	ENT	EYE	Dental	OP GR A&B	MED	Physio	Psych	TB	Child ward clinic	FP New	FP revisit	XRAY	Minor theatre	Major theatre	Csection	Female steril	Lab tests	Transfus-ions	TOTAL SERVICES	
June	331%	0%	0%	57%	0%	0%	12%	62%	5%	0%	0%	ERR	ERR	0%	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	50%
July	369%	0%	0%	55%	0%	0%	11%	66%	48%	0%	24%	ERR	ERR	0%	556%	0%	30%	0%	0%	0%	0%	2%	0%	0%	28%
August	429%	0%	0%	101%	0%	0%	13%	69%	52%	0%	79%	ERR	ERR	0%	638%	0%	31%	0%	0%	0%	0%	1%	0%	0%	26%
Sept	419%	0%	0%	75%	0%	0%	12%	66%	34%	0%	14%	ERR	ERR	0%	ERR	ERR	12%	0%	0%	0%	ERR	9%	0%	0%	20%
October	427%	0%	0%	75%	0%	0%	0%	21%	53%	0%	52%	ERR	ERR	0%	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	63%
<b>TOTAL</b>	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	ERR	

20

**OUTPATIENT UTILIZATION - Jinja Hospital 1996, by month**

	OPD	OPD Surgery	Acupunc	ANC	GYN	ENT	EYE	Dental	OP GR A&B	MED	Physio	Psych	TB	Child ward clinic	FP New	FP revisit	XRAY	Minor theatre	Major theatre	Csection	Female steril	Lab tests	Transfus-ions	TOTAL SERVICES
June	992	81	241	1759	103	351	473	78	63	205	253	74 NA		2888										7661
July	1074	89	203	2078	210	169	683	112	47	247	438	99 na		3871										10588
August	841	67	117	1526	181	380	816	108	38	344	120	70	3029	7429	5	60	423	231	186	48	10	499	186	16520
September	785	93	126	1684	142	354	688	92	70	444	178	37	46	2239			243	188	172	55		398	142	8170
October	783	114	100	1920	219	274	898	243	38	302	116	66	78	2303										7250
Est % under reporting	0%	3%	15%	0%	0%	3%	3%	3%	3%	3%	25%	3%	3%	25%	5%	5%	25%	3%	3%	3%	3%	50%	3%	50168

**OUTPATIENT UTILIZATION ADJUSTED FOR UNDER REPORTING**

**Jinja Hospital 1996, by month**

	OPD	OPD Surgery	Acupunc	ANC	GYN	ENT	EYE	Dental	OP GR A&B	MED	Physio	Psych	TB	Child ward clinic	FP New	FP revisit	XRAY	Minor theatre	Major theatre	Csection	Female steril	Lab tests	Transfus-ions	TOTAL SERVICES	
June	992	83	277	1,759	103	382	487	80	85	211	318	76	0	3,735	0	0	0	0	0	0	0	0	0	0	8,547
July	1074	102	233	2,078	210	174	703	115	48	254	545	102	0	4,589	9	98	383	219	197	37	13	898	140	12,021	
August	841	69	135	1,528	181	391	634	109	39	354	150	72	3,120	9,288	5	83	529	238	202	47	10	749	192	18,943	
September	785	98	145	1,684	142	385	707	95	72	457	223	38	47	2,769	0	0	304	192	177	57	0	594	146	9,123	
October	783	117	115	1,920	219	282	717	250	37	311	145	68	80	2,879	0	0	0	0	0	0	0	0	0	7,924	
																								58,558	

**OUTPATIENT FEE SCHEDULE BY OUTPATIENT SERVICE TYPE**

**Jinja Hospital 1996, by month**

	OPD	OPD Surgery	Acupunc	ANC	GYN	ENT	EYE	Dental	OP GR A&B	MED	Physio	Psych	TB	Child ward clinic	FP New	FP revisit	XRAY	Minor theatre	Major theatre	Csection	Female steril	Lab tests	Transfus-ions
FEE	500	1000	1000	1000	1000	1000	1000	1000	8000	1000	500	0	0	500	1000	500	4000	5000	15000	4000	1000	1500	2000

**APPENDIX C**  
**PRESENTATION MATERIALS**

## **WAIVER AND EXEMPTION SYSTEM**

- Should be granted by someone other than Revenue Supervisor.
- Hospital staff should be educated on importance and existence of system.
- They are a right; therefore, posters explaining their existence are needed.
- Hospital staff should follow procedures.
- The number, value and targets for waivers and exemptions should be known.

## **COST SHARING POLICY**

- MOH needs to develop a national user fee policy but allow local implementation.
- The policy will:
  - be drawn from National Health Policy
  - state why user fees are needed and role of individual actors
  - explain objectives of user fees.
- Lack of clear policy leaves decisions to individuals and implementation may lose direction.

## **MANAGEMENT AND ORGANIZATIONAL STRUCTURE**

- The role of MOH and management structure of Jinja Hospital is unclear.
- The management structure IS clear - The Hospital Management Committee exists.
- Recommendations:
  - Roles must be made clear
  - Senior Staff Committee should include key actors needed for successful implementation.
  - The Hospital Management Committee should meet regularly.

## **BANK ACCOUNTS AND CASH RECEIPTS**

- The bank account is operated by both District Council and Hospital.
- Recommendations:
  - The account should remain a separate account.
  - More hospital signatories should be added.
  - Cash receipts should be printed by one printer and be handled as accountable documents.
  - Use user fee revenue to print receipts.
  - The Hospital Administrator should supervise.

## **EXPECTED VS REPORTED REVENUE**

- Reported revenue is only about 50% of expected revenue
- There is evidence of considerable, sanctioned, under-the-table payments.
- “Unofficial” fees demanded by hospital employees are likely many times greater than “official” fees.

## **CASH INCENTIVES FOR STAFF**

- Financial incentives from user fee revenue consume up to 95% of reported fees.
- Incentives in practice are likely many times larger due to direct and unofficial payments demanded by staff.

## **UTILIZATION OF SERVICES**

- Inpatient and outpatient fees and utilization have recently risen and then dropped.
- Utilization is significantly under-reported by certain departments including physiotherapy, x-ray and laboratory.

## **ACCOUNTING, REPORTING AND RECORDING**

- Hospital management seems unaware of appropriate recording and reporting requirements.
- Few departments are reporting in a manner which allows for adequate control of the program.
- The Accounts Office is not involved in the user fee program.

## **RECOMMENDATIONS: ACCOUNTING**

- Institute departmental reports detailing all revenue EARNED.
- The Accounts Office should compile monthly summary reports.
- Hospital management should ask for and study prepared reports and supervise their compilation.

## **RECOMMENDATION: FEES**

- Fee schedules should be posted and followed.
- Unofficial fee collection should be stopped.
- Receipts should be used whenever fees are collected.

## **SEPARATION OF DUTIES**

- Key functions should not be vested in any one person:
  - approving waivers and exemptions
  - collecting revenue
  - banking and bank reconciliation
  - purchasing
  - reporting and recording
- More responsibility should be given to various hospital staff.

## **ARE THE SYSTEM APPROPRIATE**

- We were unable to evaluate the appropriateness of systems since few are being implemented by the facility.
- Systems are not being implemented for reasons other than their appropriateness.

## **EFFECT ON THE POOR**

- There is no evidence to suggest that the poor are being denied care due to implementation of user charges.
- All classes of patients seem willing and able to pay if services are available.

## **IS REVENUE BEING MAXIMIZED?**

- Reported revenue is low and dropping
- Unofficial revenue is high and unrecorded.
- Issues exist in how the program is managed and how collected funds are used.

## **ARE PROGRAM OBJECTIVES BEING ACHIEVED?**

- The user fee program is a de facto income enhancing project for hospital staff.
- There is little evidence of improved quality of services due to the appropriate use of collected revenue.
- This situation is unlikely to change in the future.

## **SHOULD THE PROGRAM BE EXPANDED?**

- There is no reason not to expand the program to other hospitals as rapidly as possible.
- At the same time, policy and management issues need to be addressed.
- Expansion efforts should use existing manuals and guidelines.

## **WHERE IS REVENUE LOST?**

- Drugs could be one of the major sources of user fee revenue.
- People are willing to pay for drugs if they are available.
- We recommend charging a fee per drug.
- Along with this, waivers should be more aggressively implemented.

## **INPATIENT**

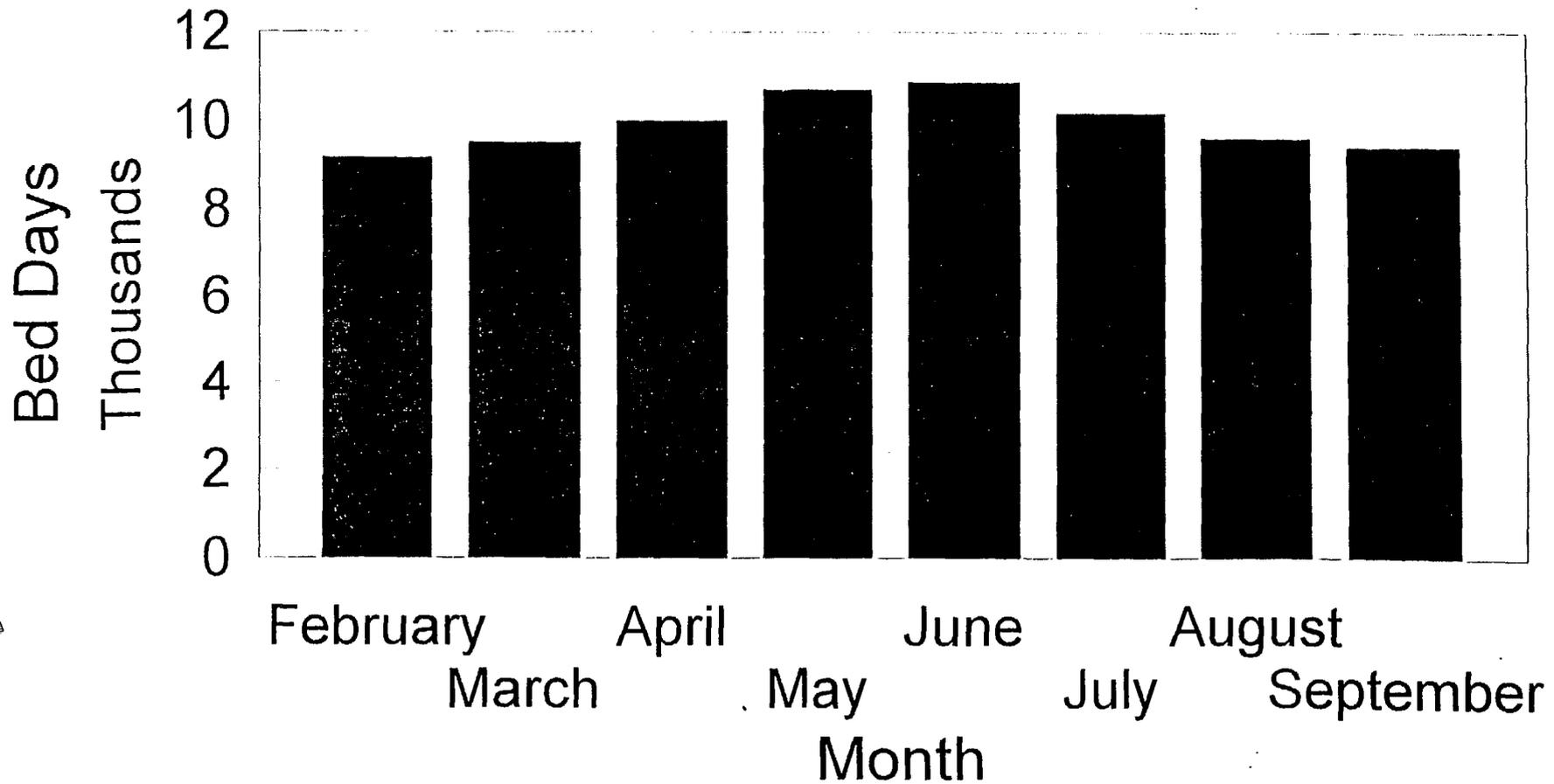
- Most Efficient Collectors
  - Ward 2
  - Ward 6
  - Eye Ward
- Least Efficient Collectors
  - Ward 4
  - Ward 9
  - Physiotherapy

## **OUTPATIENT**

- Most Efficient Collectors
  - Family Planning
  - ANC
  - Dental
- Less Efficient Collectors
  - X-ray
  - Eye
- Least Efficient Collector
  - Lab

# Adjusted Total Bed Days

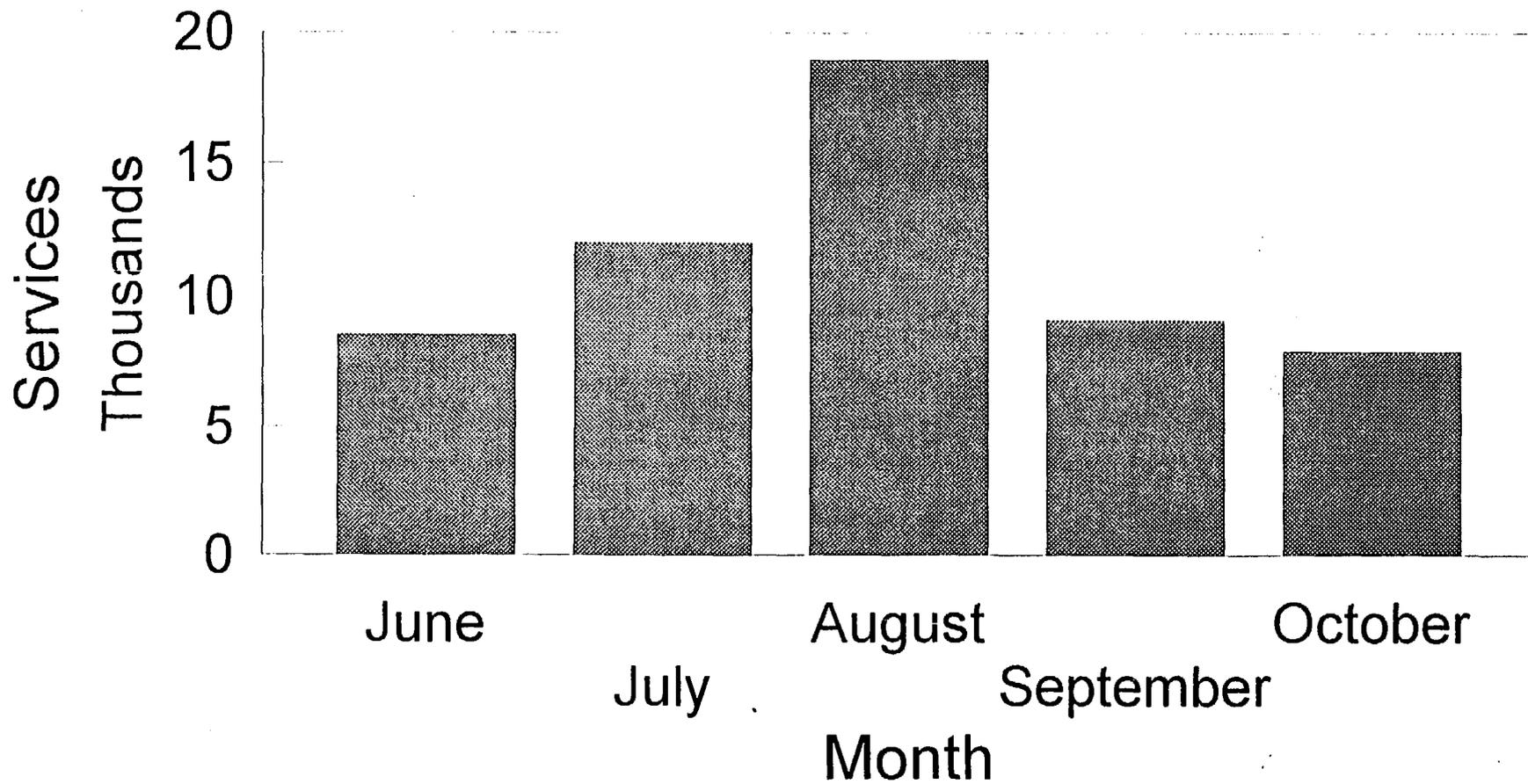
Jinja Hospital (by month, 1996)



Source: Jinja Hospital

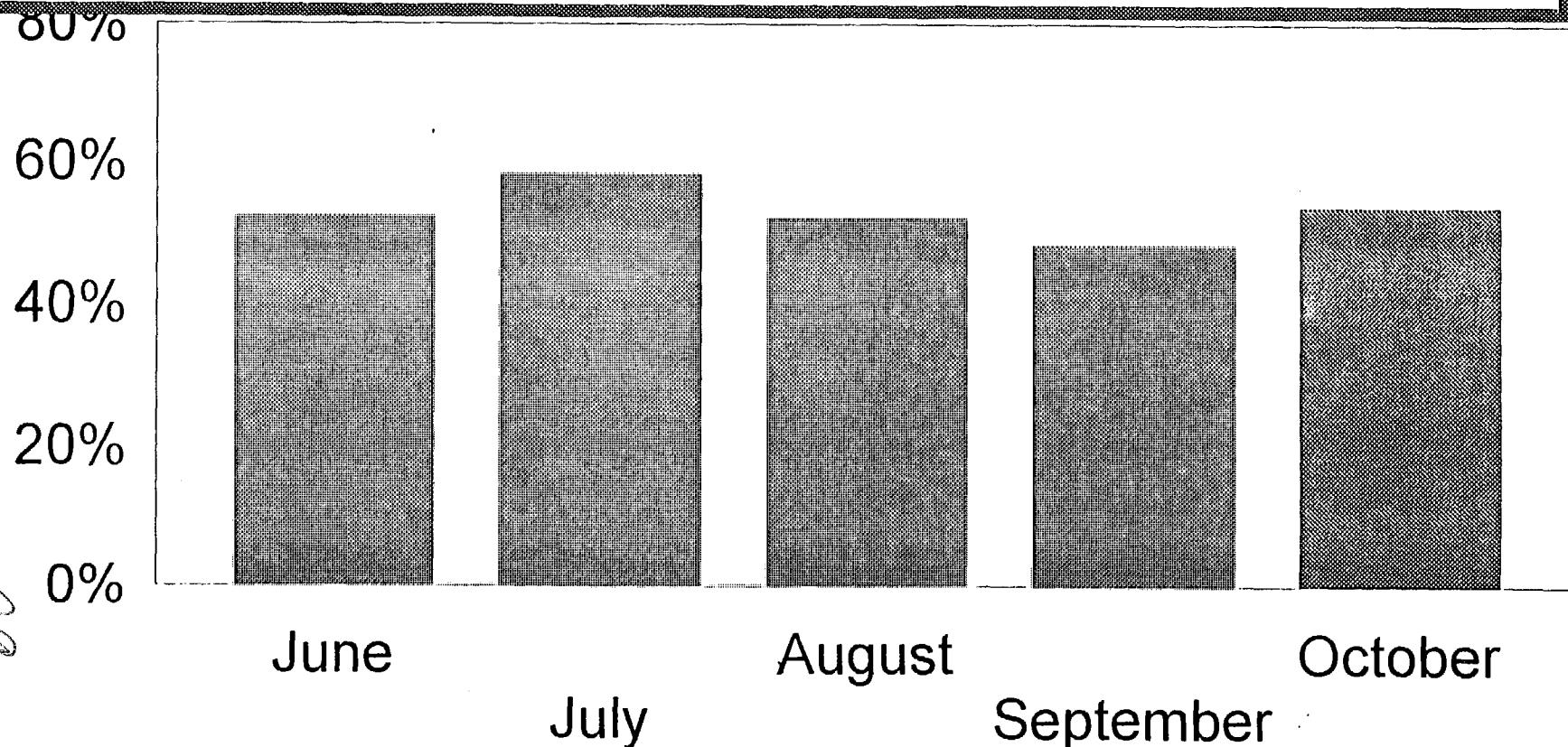
# Adjusted OP Utilization

Jinja Hospital, by month, 1996



Source: Jinja Hospital Medical Records

# Revenue Reported as Percent Of Revenue Earned

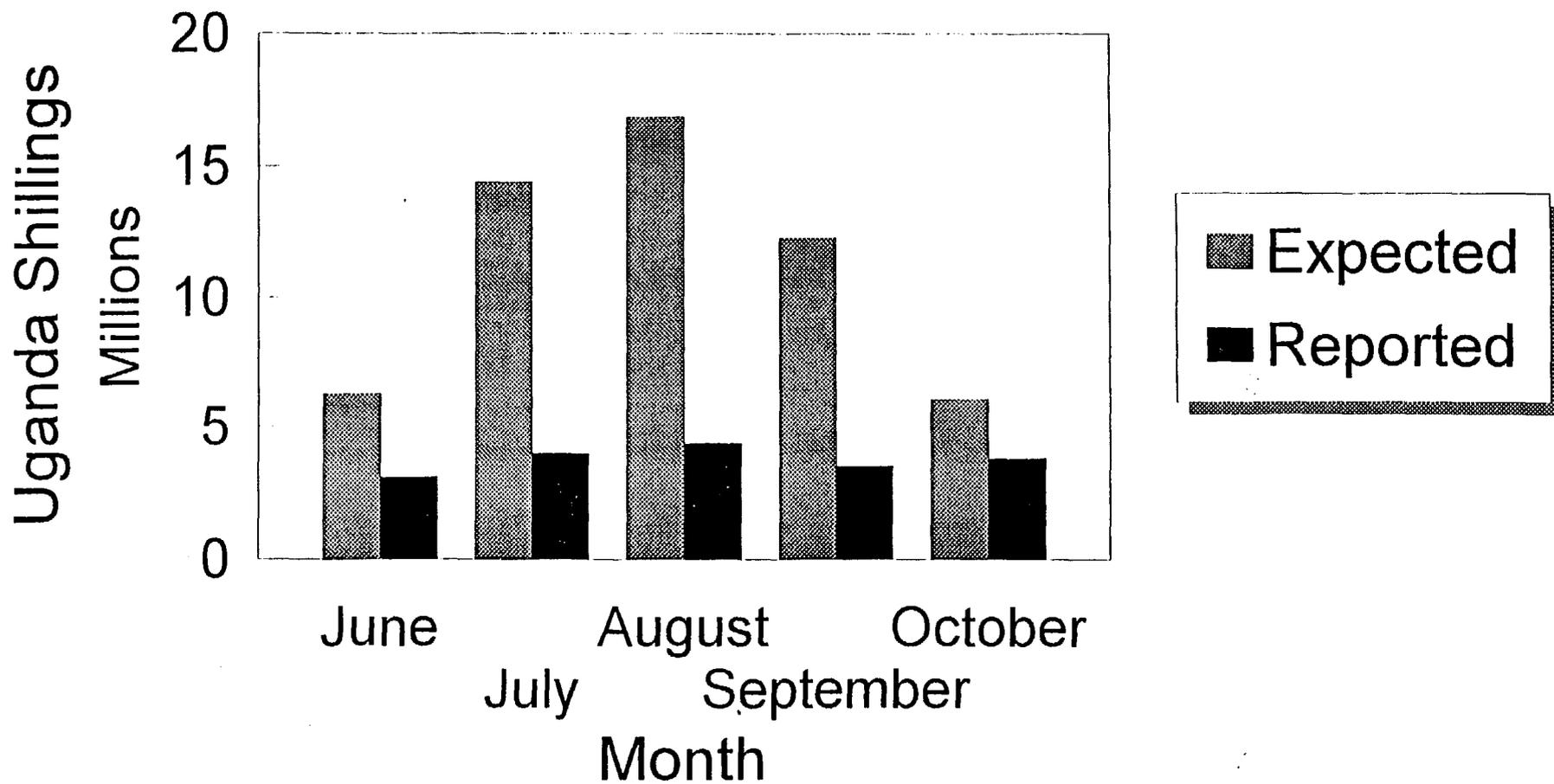


Source: Jinja Hospital (by mo, 1996)

# Expected vs Reported Revenue

50

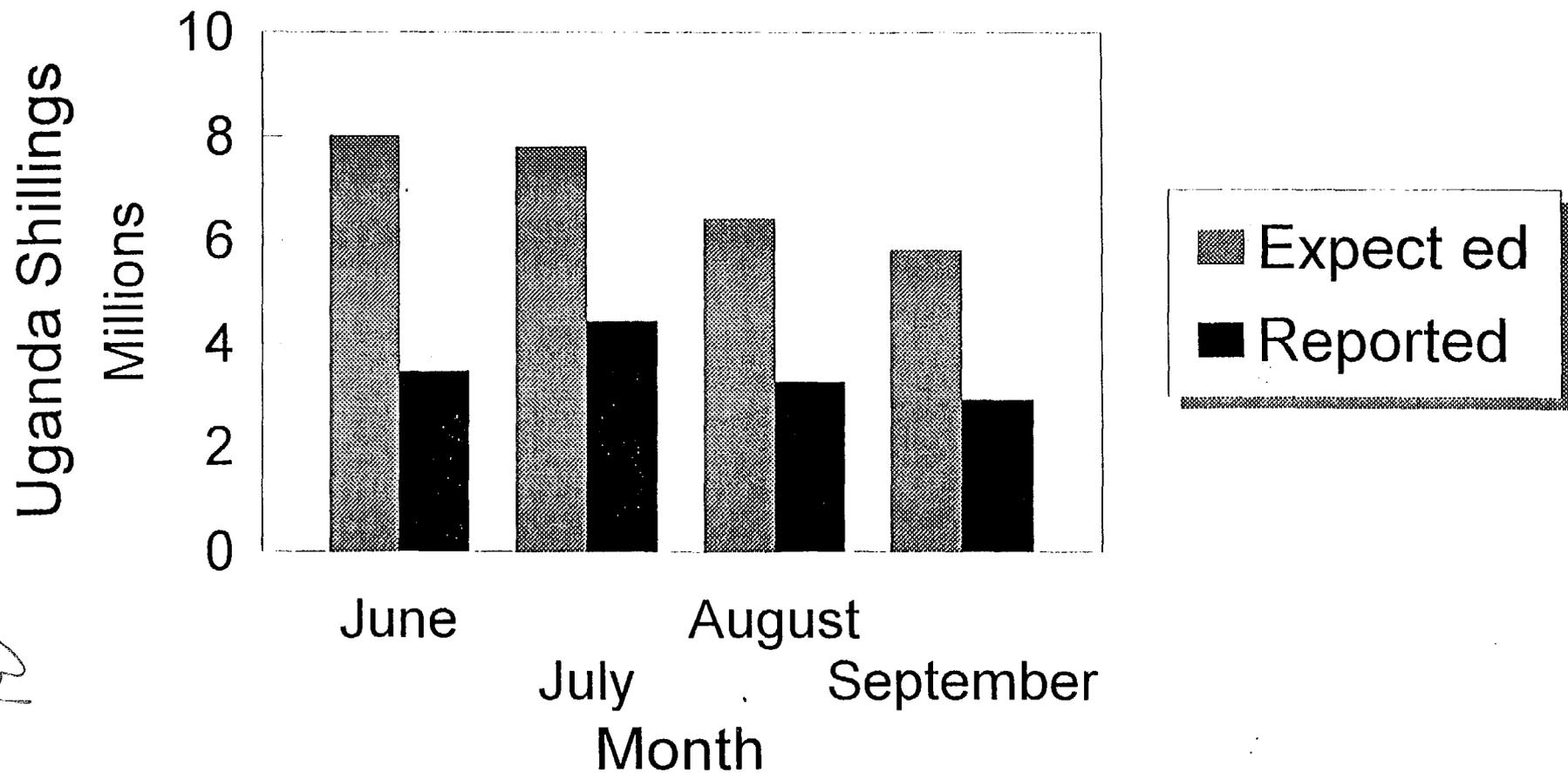
OP Services, Jinja Hospital (by month, 1996)



Source: Jinja Hospital

# Expected vs Reported Revenue

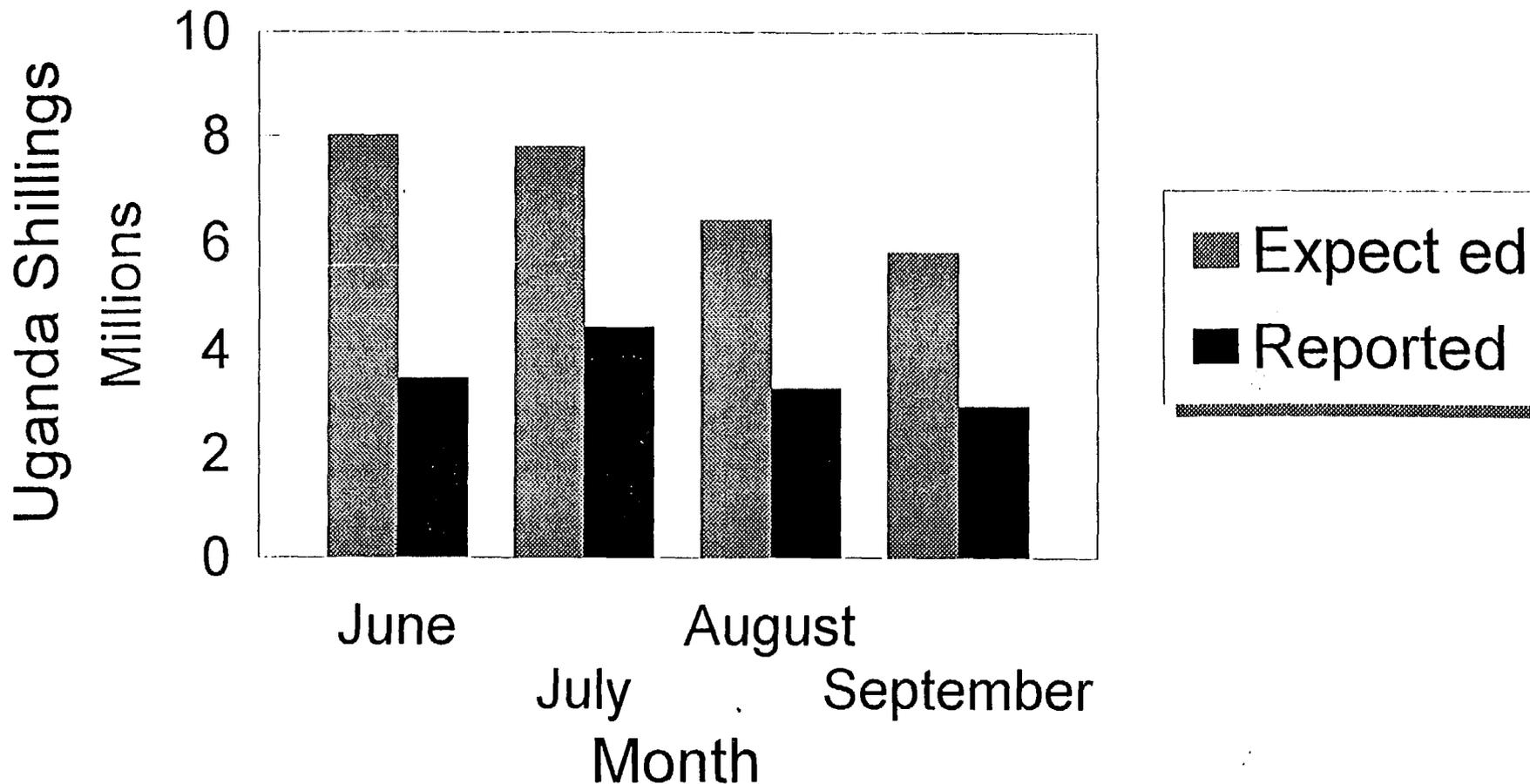
IP Services, Jinja Hospital (by month, 1996)



Source: Jinja Hospital

# Expected vs Reported Revenue

IP Services, Jinja Hospital (by month, 1996)



Source: Jinja Hospital