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Study Report #4

**The Policy of Fee Retention
and its Implementation in
SNNPR: the experience of
government hospitals**

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Essential Services for Health in Ethiopia

USAID/Ethiopia's primary health sector intervention, Essential Services for Health in Ethiopia-I (ESHE-I) was launched in 1995. It represents a collaborative effort between USAID and the Government of the Federal Democratic Republic of Ethiopia (GFDRE) to (1) increase the use of integrated primary and preventive health care (PPHC) services in Ethiopia; and (2) contribute to the achievement of national sectoral goals, as articulated in the GFDRE's Health Sector Development Program (HSDP).

Mission

The goal of ESHE-I is to create sustainable improvements in the overall health status of Ethiopians by slowing the rate of population growth and by improving the population's access to, and the quality and utilization of health care services. ESHE-I is comprised of policy, budgetary, and institutional reforms; family planning; STI/HIV/AIDS prevention and mitigation; and PPHC service delivery activities in the Southern Nations, Nationalities and Peoples Regional (SNNPR) State, each with the overall aim of strengthening the health service delivery system and thereby creating a demand in the utilization of PPHC services. ESHE-I is structured into four Intermediate Results (IR) focusing on (1) increasing resources to the sector, (2) improving access and utilization of family planning services, (3) HIV/AIDS prevention and control; and (4) strengthened health systems in the SNNPR.

Intermediate result (IR) 1, *"Increased resources dedicated to the health sector, particularly PPHC"*, is a key component that USAID aims to support the implementation of national policies which will increase resources to the sector, the implementation of a Health Care Financing (HCF) Strategy, and promotion of private investment in health care delivery. Also, support for increasing the MOH and RHB capacity for sectoral planning and budget development, relative to the Health Sector Development Program (HSDP). These objectives are meant to be achieved through:

- 1.1 Increased government budgetary allocations to health care, particularly PPHC;
- 1.2 Increased share of public health expenditure covered through cost recovery;
- 1.3 Increased government capacity at central and regional levels for resource; and
- 1.4 Increased private sector investment in health care delivery.

John Snow Inc. (JSI) is the prime contractor for ESHE-I under the USAID/GFDRE bilateral agreement. Abt Associates Inc. is the sub contractor supporting the "health care finance reform" activities constituted under IR1 of ESHE-I. To inform the reform process the HCF Secretariat of the Federal Ministry of Health and the Health Finance team have conducted a series of studies, study tours, analysis and interpretation of the information generated on different aspects of health care financing in Ethiopia. This report is part of a series studies and reports, with the aim of contributing data for policy development and implementation of the HCF strategy.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
ANC	Antenatal Care
CBM	Christian Blind Mission
CRV	Cash Receipt Voucher
D&C	Dilatation and Cure
EC	Ethiopian Calendar
EPI	Extended Program on Immunization
E&C	Evacuation & Cure
ESHE	Essential Services for Health in Ethiopia
FDRE	Federal Democratic Republic of Ethiopia
FY	Fiscal Year
GC	Gregorian calendar
HFR	Health Facility Revenue
HFT	Health Finance Team
HIV	Human Immunodeficiency Virus
JSI	John Snow Incorporated
MCH	Mother and Child Health
MOH	Ministry of Health
NGOs	Non Governmental Organizations
OPD	Outpatient Department
REB	Regional Education Bureau
RFB	Regional Finance Bureau
RHB	Regional Health Bureau
RHCFC	Regional Health Care & Financing Committee
SIM	Swedish International Missionaries
SNNPR	Southern Nations' & Nationalities', & Peoples' Region
SPs	Special Pharmacies
TOR	Terms of Reference
ZFD	Zonal Finance Department
ZHD	Zonal Health Bureau

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1. Introduction

Modern health care system has been introduced to Ethiopia since long time now. Yet, until to date no more than 50 percent of its population has access to health services. Like all other social services, the status of the health care system is a reflection of the overall socio-economic situation where the country stands now -that is - government resources have always been meager while the need for health and other social services has continued to increase.

The emergence of new communicable diseases (such as HIV/AIDS), prevalence of deficiency diseases, and lack of proper planning and resource management have undermined the country's ability to deliver health services. Yet, the demand for health services is still increasing faster than the supply that is made available to meet the former. Moreover, high population pressure has challenged the existing low level of supply of health services prevailing in the country. As a result, the great majority of the rural population has been left without any form of health services.

Thus, the need for additional sources of revenue and improved use of resources to operate the health care system and its services has become more acute than ever before. In view of providing alternative methods of funding the health care system, the Federal Government of Ethiopia has introduced Health Care and Financing Strategy (the Strategy) in 1998.

As part of implementing the Strategy, the Council of the Regional Government of the State of the Southern Nations', Nationalities' & Peoples' Region (SNNPR), has taken a significant initiative, first of its kind in the country, by adopting the policy of fee retention. The policy was supported by another important measure taken by the Council that mandated the Regional Finance Bureau (RFB) to issue implementing guidelines. As a result of the combined policy measures, since the fiscal year 1992EC or July 1999 GC, government hospitals in the Region have been entitled to retain 50% of their collected fee revenue to improve quality of services and to increase availability of essential drugs and equipment at health facilities.

The implementation of the policy has taken effect for over one year and half now, and thus the implications of the new intervention need to be measured. In light of this consideration, the Regional Health Bureau (RHB) of SNNPR, and the Health Care Financing Secretariat at MOH in collaboration with the Essential Services for Health in Ethiopia (ESHE)/John Snow Incorporated (JSI) project have conducted this study on the experiences of fee-retaining public hospitals in the SNNPR.

1.1. Purposes of the Study

The main objective of the study is to assess the experiences of government hospitals that have been allowed to retain 50% of their fee revenues, since July 1999, in the SNNPR following the adoption of the policy of fee retention by the Regional Council. In this regard, the findings of the study are expected to serve as a basis for development of national guidelines for use at health facilities throughout the country.

The Terms of Reference (TOR) provided for the study, having set the background and the rationale behind launching the policy, defines the specific purposes of the study as follows:

- a. To identify the experiences of government hospitals in implementing the new policy of fee retention in terms of collection, retention of fees and utilization of the fees at health facilities over one and half years since July 1999.
- b. To assess the impact of fee retained at health facilities on quality of services and to evaluate management requirements and impacts reflected as a result of the policy implementation.
- c. To contribute towards the development of national guidelines on utilization of fee retained at health facilities in the country.
- d. To obtain baseline information of hospitals experiencing fee collection, retention, and expenditure subsequent to introduction of the new policy.

1.2. Definitions

A number of concepts and terms are used throughout the study report to describe the experiences of government hospitals implementing the new policy of fee retention in the SNNPR. These basic concepts and key terms must be defined for reviewing the findings of the study.

Health Facility Revenue (HFR): all income generated by health facilities from various income-generating activities (user fees, revolving drug funds, private and community/employer based risk sharing schemes, donations, gifts, etc) will be considered as 'health facility revenue' after the necessary arrangements are made.

The HFR shall be additional to government budget, retained and used by the health facility that generates it, deposited in a special account opened by the respective health facility, used to improve the quality and quantity of services, subject for appropriate control and audit by authorized government body as per the new financial regulations.

Fee Revenue: income generated by a health facility from services rendered to patients and sales of drug. The term fee income may also be used interchangeably.

Fee Collection: the process of receiving fees from patients using printed and pre-numbered Cash Receipt Voucher issued to a health facility by the Zonal Finance Department (ZFD) for purpose of collecting fee revenue generated at the facility. The term collection, used alone, denotes the same meaning.

Remittance: the practice of transferring fee revenues collected at health facility and/or any cash balance that has not been used until the end of fiscal period to the accounts of the ZFD. Remittance is imposed on health facilities for two cases: a) fee revenues collected using official receipts of the ZFD, and b) any unused cash regardless of whether the balance not used till the end of the year comes from regular budget or other budgeted sources.

Fee Retention: the practice of keeping all or a portion of fee revenue for use at a health facility without its remittance fully or partially to the ZFD. Alternatively, the word "Retention" may be used to indicate the term.

Retainable Fees: fees calculated at 50% of the preceding year's total revenue that will be paid to a health facility, as an addition to budget allocated from central treasury, subsequent to ZFD's approval of budget request.

Retained Fees: when budget request for retainable fees are approved and subsequently paid to the accounts of a health facility, the fee is said to have been retained at the facility, and hence the term retained fee. Alternatively, the term fee retained may also be used to connote the same meaning.

Withdrawal: commonly used in connection with "retained fees" or "retainable fees", it is the practice of transferring cash to the accounts of a health facility from the treasury at the ZFD in payment of budget requests lodged to the former by the facility.

Release: interchangeably used to connote withdrawal

Government Revenue Accounting System: the system of accounting that prevails in public service sectors and which does not allow the maintenance of separate books of accounts for different activities, such as accounting for fee retention, unless allowed by law.

1.3. Methodology

The definition of the problem, as stated in the TOR, required the gathering of quantitative data related to fee collection, retention, and expenditure patterns in order to compile hospital baseline data for subsequent analysis. Moreover, the need for descriptive information was also equally important as it relates primarily to the operational issues of the new policy. It provides data about how the new policy works at health facilities particularly the actual practice of retention, the impacts of policy implementation, and the lessons that can be learned for its adoption throughout the country, and for development of nation-wide guidelines.

The study used both primary and secondary sources in the course of data collection as its survey instruments. The first instrument, the primary source and which is largely interviews and data collected from the field visits, has been utilized to gather data using the following techniques:

- Interviewing hospital officials including medical directors, administrators, and finance personnel of facilities visited by data collectors and senior members of the study team.
- Observation of service units at health facilities.
- Conduct of rapid survey instrumental for compiling baseline data in relation to fee collection, retention, and expenditures.
- Developed standardized questionnaire on range of topics relevant to the study, and analyzed the data gathered.

The secondary sources of data included written materials related to the theme of the study. In this respect, the content of the Strategy and its relevance to the policy of retention adopted by the regional government has been reviewed in perspective. Beside, the guidelines issued by the RFB to implement the policy of fee retention were examined in

relation to the strategy and the TOR. The Open-ended Questionnaire, list of officials interviewed, the TOR, unofficial translation of the RFB's guidelines and the bibliography of reference materials used throughout the study are annexed to this report.

Although there are eight government owned hospitals in the region that are generally allowed to retain 50% of their fees revenues, only five of them have practiced the new policy during the years 1992 and 1993 EC. Included in this category are Dilla, Wolyta Soddo, Chench, Hosanna, and Mizan Teferi Hospitals. Both survey instruments have been administered in those health facilities to gather qualitative as well as quantitative data in respect of amount of fee collection, fees retained, expenditure, and value of free medical care. While Part I, the main report, presents summarized analysis of the empirical data, which are largely quantitative in nature, the latter part of this report, has also explored the implications of the data to operation of respective hospitals.

The nature of financial and statistical data available at respective hospital has influenced the extent of data analysis through out the report. In many cases, health facilities visited during the study vary in the way in which their financial and statistical records are maintained. Consequently, although the presentation of analysis of these data is made more or less similar, due to the said variation, the style of data analysis may differ among facilities depending up on the nature of data available. For instance, the extent of details concerning data on free-medical care varies from a facility to facility, and so is the analysis. Moreover, in all facilities there was variation in the availability of break down of statistical data. For instance, while data collected in connection with "Major Activity Trend" is broken down in terms of inpatient and outpatient visitors (see part II), the corresponding collections made from both sources are not accounted for separately mainly due to the fact that the existing system of accounting does not break down source of income along these lines. (see Part II and the summary in 1.2.3.).

Moreover, the study team has visited two health facilities in the Region that retain 100% of their fees as opposed to 50% retaining ones: Yirgalem and Arbaminch Hospitals. The visit was arranged as part of the methodology to draw lessons and experience from these hospital. The team has collected qualitative and quantitative data that are relevant to the theme of the study, and has subsequently provided an analysis of the data and their implications to the practice of 50% retaining facilities.

1.4. Organization of the Report

The study report analyzes the data collected, and synthesizes the lessons learned from the health facilities retaining a portion of their fee revenue, and describes opportunities for future development of nation-wide guidelines on utilization of fees retained at government hospitals in the country. The report contains two parts. Part I – Main Report- reflects a summary of experiences of fee-retaining zonal hospitals in the region; emphasizes policy matters; discusses the lessons learned by, among other things, examining the actual practice of fee retention in relation to both the national Strategy and Regional Guidelines; and suggests recommendations for future improvement. Part II of the report explores the unique experiences of each zonal hospital, sets forth analysis of baseline data gathered, and provides additional reading for those interested in any of the hospitals.

Part I
The Main Report

2. Major Findings

The policy of fee retention adopted by the Regional Council was primarily examined in connection with the contents of the guideline provided by the RFB to implement the policy at health facilities in the Region (cf. annex). In this regard, the provisions of the guideline vis-à-vis the Strategy's definition of HFR has been looked at. It should be appreciated from the outset that the Regional Council introduced the policy, and hence the subsequent guidelines before, and in fact independently of the implementation of the Strategy. Consequently, as can be noted later the concept of HFR provided in the Strategy and the provisions of guideline in respect of health facilities' revenue the may not necessarily comply to each other.

Be that as it may, however, based on the RFB's previous experience (which allowed fee retention for schools from initially 75% to 100% currently), the guideline has provided the procedures that need to be followed at health facilities to retain a portion of their fees. Yet, as subsequent parts of the major findings indicate the implementation at ZFD deviated from that provided in the guidelines due to communication gap between the RFB and the ZFD concerning the provisions of the guideline.

2.1. The Strategy and Regional Policy of Fee Retention

The health sector has been characterized with its inability to provide better health services to the population of the country due to mainly financial constraints. The under financing of the health sector suggests the prevalence of low level of government spending on the sector. Yet, the health need of the population has always been increasing while the resources required to meet the demand remained low. In order to provide alternative sources of funding the sector, the Federal Government of Ethiopia has taken a number of significant steps to reform the country's health sector. In this regard, the adoption of the Health Care & Financing Strategy (the Strategy) by the council of Minister's of the FDRE in 1998 is one of the most important measures taken in line with the broader health sector reform initiatives. Thus, the rationale for endorsement of the Strategy, on the part of the government, lies in the decision to remedy these deficiencies by assessing additional sources of financing the health care system.

In this respect, the definition of the HFR as part of the initiatives to identify modalities of financing to establish a financially viable health care system is worth noting. According to item 3.11 of the Health Care & Financing Strategy (MOH, 1998: 6) the HFR is distinguished as follows:

"Health Facility Revenue will be additional to government budget; retained and used by the health facility that generates it; deposited in a special account opened by the respective health facilities; used to improve the quality and quantity of health services; and subject for appropriate control and audit by authorized government body as per the new financial regulation"

HFR refers to all types of fee income that are generated by health facility from users of the facilities who pay something for services rendered to them and include user fees, revolving drug fund, private and community/employer based risk sharing schemes, donations, gifts etc. In any case, the definition emphasizes a number of principles underlying development of guidelines governing the generation and administration of fee revenue. Firstly, fee revenue should be additive and should not replace annual budget allocation. Secondly, perhaps most

importantly, it suggests that guidelines that may evolve to implement the provisions of the strategy with respect to the HFR need to recognize the discretion the Strategy offers to the management of hospitals in terms of retaining, maintaining a separate bank account to deposit collection of fee revenue, and using it to improve quality of services "after the necessary arrangements are made"

The implementation of provisions of the Strategy at all levels of Regional State Governments presupposes the establishment of Regional Health Care and Financing Committee (RHCFC). The Strategy identifies the committee, chaired by the Head of the Regional Council Social Sector, to consist of eight members including the Heads of Regional Finance and Health Bureaus who will be member and secretary respectively. Moreover, the Strategy describes the duties and responsibilities of the committee in regional context. In this regard, item 6.2 of the Strategy, among other provisions, states that the Regional Health Care Financing Committee

"... will design & develop systems appropriate for the region; monitor the implementation of the National Health Care Financing program and amend/adapt the National Health Care Financing procedures and directives to the regional situation; ... ensure the establishment of cost conscious, efficient and effective financial management and accountability within the health facilities."

Although that is the case with the RHCFC, the national Health Care & Financing Implementation Task Force itself has not been functional since the adoption of the Strategy in 1998. In fact, it met twice up to the adoption of the Strategy then. In this regard, a gap is identified with respect to the role of the national Task Force in "policy development and overall monitoring of the implementation" that it must be revitalized towards achieving its expectations. While the national Health Care & Financing Implementing Task Force has lagged behind to implement the Strategy, the government of the Regional State of Southern Nations', Nationalities', & Peoples' Region (SNNPR) has pioneered the adoption & introduction of the new policy of retention by entitling government hospitals to retain 50% of their fee revenue. However, the regional government introduced the new policy with out the benefit of a RHCFC. Consequently, a gap is identified between the provisions of the Strategy with respect to the definition of HFR, on the one hand, and the guidelines issued by the RFB, on the other hand.

This is largely reflected in the contents of the guideline issued by the RFB, which was entrusted by the Regional Council presumably to fill the gap. However, a number of provisions of the guideline do not fully and clearly recognize the concept of HFR defined in the Strategy. It was learned that the RFB has not made reference to the Strategy document in designing and developing the guideline because the Regional Government introduced the policy of fee retention independently of the Strategy. Moreover, even if the Strategy was there, from legal point of view, it wouldn't be consulted for purposes of developing the guidelines on the ground that it (the Strategy) had not yet evolved in the form of law as opposed to the financial administration proclamation, which forbids enforcement of other practices contrary to its provisions. In this regard, the concept of HFR described earlier bears out the foregoing assertion in that "the maintenance of special bank account", for example, is generally un- acceptable under the financial proclamation "unless otherwise provided by law". Yet, the Strategy, in its own right, has not been provided as one of the "laws of the land", and as such not enforceable as much as the proclamation itself. Consequently, the guideline has certain deviations from the stipulations of the Strategy, in subscribing to the

concept of HFR, as the proceeding discussions indicate. The identification of the digression between both documents is very important for couple of reasons: Firstly, it provides an opportunity for improvement of the existing guideline, in one or another form, for future use in the Region and/or elsewhere in the country (as it happened in the SNNPR recently, following the conclusion of a workshop organized to discuss the findings of this study). Secondly, and perhaps most importantly, it sets forth prospects for synchronization of the Strategy with existing laws, such as the Health Fund that is initiated to provide legal framework for the provisions of the Strategy. In any case, the deviations are summarized below:

1. Clarity is one of the major constraints manifested in the two-pages guidelines. One part of it (3.3.) states the provision of couple of alternatives to retention: (a) hospitals are authorized to retain up to 50% of their collections to meet planned & future financial commitments or (b) to immediately use a portion of the daily collection to acceptable extent (presumably up to 50% of the preceding year collection), and remit the remaining balance to the ZFD. The foregoing statements partly subscribe to the concept HFR. Yet, another parts of the guideline such as 2.2 coupled with 3.4 and other subsequent instructions seem to negate the former provision, allowing the ZFD to tighten its grips. The latter instructions lay down requirements of budget preparation, which requires hospitals to submit budget request to the ZFD via Zonal Health Bureau (ZHB). But, most importantly these instructions make reference to provision of Article 5, sub article 1 of the financial proclamation that forbids the use of cash from collections. In that senses, it means all collections should be remitted to the accounts of the ZFD. Almost all heads of ZFD interviewed in connection to the instructions ruled in favor of the latter provisions.
2. Another important component of the strategy and which was ignored in the guidelines is the maintenance of special bank account to which the HFR is deposited. The guideline has made no provision regarding the use of a separate bank account at all. Although retaining to the extent of 50% is by and large allowed, the grip of ZFD on regional finance proclamation is further accentuated by another provision in the guideline that makes a reference to the proclamation. The latter states, "*the RFB may open bank accounts in the name of any public body for deposit of public money and such accounts shall form part of the consolidated fund*".
3. The Strategy states that the HFR will be additional to government budget. An important idea is embodied in this definition-that is-if the HFR will be an add-on to the regular budget it implies that it should be available at the facility for use any time in line with "*relative discretion of hospitals to spend this revenue according to their own need*". (TOR, P.1). More over, by inference, HFR may not be subject to any form of remittance. Yet, another part of the guidelines, i.e. instruction 3.8, indicates that any balance remaining from retained fee must be remitted to the ZFD. This provision does not treat retained fee as "additional government budget" because it enforces the idea of remittance requirements that is peculiar to the regular budget. In this sense, once the remaining unused balances from retained fees are handed over to the ZFD, denying the facility to carry forward the balance

for use in the subsequent year, the fees are no longer additions to regular budget but only form part of the latter.

4. The concept of maintenance of separate bank account and the corresponding statement, in the definition of HFR, that it will be subjected to control and audit logically suggest the need for setup of books of accounts that are different and separate but simultaneously liable for auditing. The guideline's instruction 9.1 is all about "ledger registration", which subscribes to the principles of budgetary accounting system. As may be observed in later parts of the report, the current maintenance of books could not allow the consultant to collect data necessary for measurement of cost recovery due to incomplete nature of financial information common in regular accounting systems.

In summary, the foregoing discussion identifies two approaches to retention. The first mechanism, which the present law supports, proclaims the retained fee revenue during the annual budget appropriation, usually done at the beginning of every fiscal year. In this case, the retained revenue appears as additional part of the regular budget that is separately indicated as additive to the former. Under this arrangement the procedures describe above must be followed. The Region has been following this option to date, and it requires good planning to ensure timely delivery to facilities. As the proceeding parts of this report shall indicate, so far under this mechanism, a lengthy process that resulted in delay of withdrawal of retained fee from the ZFD to health facilities has characterized retention.

The second approach to retention refers to the concept of the HFR in the Strategy. In this regard, the Strategy holds that all revenue generated at health facilities should belong to the facility that generates it. Under this mechanism, health facilities will have to assume control over such resources and utilize them towards improving the quality and quantity of services that the facilities provide. Moreover, the Strategy provides that the HFR should be additional resource to the facilities *"over and above the Government Budget, allocated for public health care delivery"*. (*Health Finance Newsletter, No.1, 1*) The procedure needed to implement this component of the Strategy requires a different arrangement than that is related to the first approach of retention. In this regard, the Strategy maintains the establishment of a separate and special fund *"as a permanent financial resource to be deposited in a special account to be opened by the Ministry of Finance"* (draft proclamation to provide for establishment of Federal Health Fund, article 3). This requires further works to synchronize with existing laws and eventually legalizing it.

2.2. Fee Retention Experiences in the SNNPR

Generally, the implementation of the new policy of fee retention in government hospitals ensues the resolution of the Regional Council that mandated the RFB to develop guidelines governing the administration and utilization of fee retention. Accordingly, the RFB pursuant to the powers vest in it by article 68 of the Regional Financial Administration Proclamation has issued a regulation on "Procedures for Collection & Disposition of Fees and Recording" for use by government hospitals in the region.

As explained in the preceding part, some of the provisions of the guideline particularly instruction 3.3.offers a couple of alternative approaches to retaining fee at a health facility. However, the lack of clarity evident in subsequent stipulations made it an easy prey to

different interpretations of officials of ZFD, who leaned towards the concept of consolidated fund and other provisions of the financial proclamation. Consequently, the ambiguity of the guideline has precluded the implementation of retention from originally expected as the practice took a different form. In this regard, with exception of certain changes in the year 1992EC, the implementation has failed to live up with its expectation in the current year of 1993. As may be observed later, almost all hospitals have not received their 50% share of the fee collected last year until end of May 2001, which was only 4 or 5 weeks away from the end of the fiscal year, due to a lengthy procedural requirements imposed by ZFD, an action which is not provided in the guideline, but largely attributed to ambivalence of the provisions of the former.

2.2.1. The Practice at Hospitals

Hospitals must comply with the following procedures so that the ZFD authorizes withdrawal of "retainable fees" from the treasury. None of these procedures are provided in the guideline, as described earlier. It, therefore, should be clear from the outset that fees are not retained at health facilities in the sense of provisions of the RFB's guideline itself. The following procedures were observed in relation to the actual practice:

1. A plan of action and a detailed budget of expenditure to be paid from retainable amount must be prepared by the hospital, and submitted to ZFD. The expenditure should not exceed 50% of the preceding year's collection of the hospital.
2. The ZFD, following a review of the budget request and ensuring availability of money in treasury, releases the retainable amount to the hospitals. Under this arrangement, the period of withdrawal of the money to the hospitals is at the discretion of the finance department not at the disposal of the former.
3. As hospitals are, first and foremost, required to hand over or deposit 100% of their daily collections to the accounts of the treasury, it is forbidden to use or pay any amount of money out of collections to finance a service unit or cover a budget deficit, nor is it allowed to retain any amount, say for future use, from their collections per se. This practice is in effect in line with the deposit of public money to consolidated fund, which continued, even after the introduction of the new policy of retention. Although that is the case the practice is against provisions of the RFB guidelines.
4. Similarly, no separate bank account is to be maintained by hospitals for purposes of depositing even the approved 50%. The latter in most hospitals remain under custody of the "Main Cash Safe".
5. The hospitals do not have any right to carry forward unused balance from retained fee to subsequent fiscal period, as it must be remitted to the Treasury.

The answers to the questionnaires as well as the series of discussions suggest that the process of budget preparation and submission imposed by the ZFD could not prove effective because the decision to release the retainable fee from treasury took a number of months. For instance, a look into the books of accounts of hospitals indicate that in 1992EC, most of the retainable fee was released towards the end of the year while the request was lodged

relatively earlier. Similarly, in the current year of 1993EC, although the budget request and plan of action of respective hospitals is submitted fairly as early as October 2000, the retainable fee has not yet been released for use in hospitals until the end of the month of May 2001. And, yet it was only one month away from the end of the fiscal year (July 7) for the ZFD to use one of its prerogatives –that is- impose the remittance requirement concerning unused balance from the retainable fee.

In connection with the delay and in the face of possibility of remittance, a member of management of one hospital remarks: *“what is the use of keeping the budget for retainable fees until the end of the year at the ZFD, which will enforce remittance in few weeks time”*. In another hospital, a member of the management committee asks, *“if retention is to be administered in the fashion devised by the ZFD and contrary to the spirit of the Wolkie workshop and the guideline of the RFB, why retention?”* He went on to say, *“The best alternative would have been to increase the annual recurrent budget, and release the fund with monthly regular budget instead of keeping it for a longer time”*. Consistent to these assertions, If the existing practice of keeping retainable fees for longer periods is to continue or if the status quo will not be improved in the short run, hospital management in visited facilities suggest that the ZFD should gradually release the retainable fees along with the monthly recurrent budget so that hospitals will benefit from the fees as early as possible and as planned. In this sense, the monthly recurrent budget will be increased by proportional amount of the total retainable fee earmarked for the year.

With respect to guidelines of the RFB, although hospitals did not receive a copy the guideline, because in most cases a copy made to the ZFD was not sent to hospitals, there are strong evidences that zonal treasury received the guidelines. Yet, against the provisions of the guideline particularly instruction 3.3., the ZFD resorted to old practice of treating fee retention on equal footing with the regular budget due to mainly provision of ambivalent instructions in the latter parts of the guideline. Apparently, therefore, the retention policy is not properly implemented as originally perceived; it rather took a different shape, giving rise to delay in release of fees from the treasury.

The experience of implementing the policy of fee retention did not only deviate from the original perceptions and expectations noted in the TOR, but also from the very guideline of the RFB that was supposed to make changes. Thus, the next logical step would be to share our experience to Heads of RFB and RHB, who are the major stakeholders of the study concerning the experience of implementing the new policy in the SNNPR. The issue was discussed with both officials. It was noted that the problems identified in connection with the implementation of the policy are perhaps attributed to misunderstanding of the guidelines. In this regard, the RFB head promised to send a team to all ZFDs to seek explanation and find out ways to remedy the deficiencies in the future. The Head of RHB holds that, be that as it may, the Bureau has made it possible in creating *“awareness and change of attitude regarding the use of fee revenue at health facilities”* on the part of decision makers. And, he promised that the deficiencies would be corrected, and looks forward to accepting recommendations that improve the status quo.

Yet, the reasons for prevalence of the pitfalls need to be identified so that any proposals meant to rectify them in the future will consider the experiences. The possible explanations for the divergence of the practice from the policy in general, and the guideline of the RFB, in particular, may be summed up as follows:

- a. Officials of the ZFD were more inclined towards their own interpretation, in fact, largely due to lack of lucidity of the guidelines. However, while the guideline had no provisions that are contrary to the finance proclamation, the mere mention of it (the proclamation) in the guideline for other purposes, such as budgeting and budgetary control, was differently construed. Consequently, provisions of the guidelines that were originally meant to allow either retention of cash or the use of cash were wrongly interpreted to allow the continuation of the existing collection and remittance.
- b. The efforts of the RFB was limited only to issuance of guidelines and perhaps should have clarified the contents of the guidelines to all levels of the ZFDs. More seriously, however, the RHB as a major stakeholder and benefiting partner, has failed to organize orientations to hospitals regarding the guidelines.
- c. Last but by no means least, with the exception of Mizan Teferi hospital at Aman town, none of the other hospitals received the guidelines due to either the ZFD withheld, as was often the case or prevalence of staff turnover. This probably stifled the opportunities of hospitals to take their own interpretation of the guidelines to challenge the ZFD of their rights.

2.2.2. Opportunities for Improvement

As elaborated in the preceding part, the implementation of fee retention in all zonal hospitals was distorted or rather took a different & yet undesirable form other than that envisaged in the Strategy document during 1992EC and 1993EC. However, it should be noted that the RHB in collaboration with the RFB have taken commendable measure by issuing a guideline governing administration of retention. They took the initiative in response to the adoption of the policy by the Regional Council. Looked from the vantage point of implementing the regional policy, the issuance of the guideline, meant to streamline implementation of a new policy, is an important step. For that matter, it should be appreciated that, other provisions being constant, the guideline of the RFB subscribes to essential part of the concept of Health Facility Revenue, which reads, "*the Health Facility Revenue will be retained and used by the health facility that generates it*". In recognition whereof, then in its instruction 3.3, the guideline provides the following alternatives in handling retained fee:

1. Hospitals can retain to the extent of 50% of the preceding year collection for use during the fiscal year, or
2. Immediately use cash from daily collections to an acceptable size.

The foregoing provision is a good beginning in terms of its adherence to the concept of facility revenue indicated in the Strategy. In that sense, therefore, it is a potential opportunity in further harmonizing the contents of the guideline to satisfy the requirements of the provisions in the Strategy counterpart in pursuit of realization of the overall goals of the Strategy. In this regard, in the discussion made with the Heads of the RFB, and RHB, the former suggested the following points will be considered in the future in view of further synchronizing the guideline with the Strategy:

1. The provisions available in the financial administration proclamation will be examined. For instance, the Bureau will look into such provisions. "there shall be one consolidated fund into which all public money shall be paid except that otherwise allowed by law". The last statement should be noted in relation to the adoption of the Strategy by Council of Ministers of the FDRE. Article 68 of the regional financial administration proclamation also vests the RFB with the authority to issue guidelines. The possibility of revising the guideline following the experience is very likely.
2. The opening of special account was also discussed, and there is a general consensus between both parties. The study team observed that the Head of RFB is convinced of the important role a retained fee plays in improving quality of services, provided that the system of accountability is in place. Thus, the possibility of having a separate bank account as suggested in the Strategy is promising.
3. The availability of opportunities for improving the status quo is accentuated by the existence of experiences of fee-retaining schools in the region to the extent of 75%, as the Head of the RFB mentioned. The school fees are largely generated from registration of students and other income generating activities initiated by the schools. Previously, there were legal provisions that enforce schools to collect the fees using official receipts of the finance bureau. Nowadays, however, unlike health facilities, the schools retain 75% of their fee revenue without any requirement of 100% remittance to ZFD as a result of arrangement made between the REB and RFB. The schools retain 75% of their fee collections, and remit the remaining 25% to the ZFD along with plan of action and budget proposal for the sum of money they already retained. Alternatively, schools can use up to 75% of their fee, and remit the 25% along with expenditure report prescribed by the ZFD. After the aforementioned practice of retention went for sometime, the Regional Government has now allowed schools to retain 100% of their fees. In this regard, the concept of fee retention at level of facilities is, therefore, not a new concept for the RFB, suggesting, once again, availability of potential for improvement of the guidelines.

2.2.3. Fees Retained at Health Facilities

During the year 1992 EC, the ZFD authorized the withdrawal of retainable fee to hospitals. As it may be observed in latter part of this report, a lion's share of the retained fee was spent on purchase of drugs and medical supplies because during that particular year there was no budget allocation for drugs in the region, although some hospitals benefited from a small quantities of drugs were supplied in kind. As a result, the budget pharmacy was not financed from government budget due to overall shortage of budget in the Region in same year.

Table 1 below summarizes the amount of fee revenue retained at health facilities subsequent to the authorization of the ZFD in 1992 EC, and the budget request lodged to the former for 1993 by the facilities. The amount represents 50% of the total fee income of each health facilities in the preceding year of 1991EC and 1992EC

Table-1: Fee retained at health facilities in 1992EC

No	Name of the Hospital	Amount Retained in 1992EC	Retainable Fees for 1993 EC	Remark
1.	Dilla Hospital	94,694	96,203	
2.	Wolayta Soddo	220,498	171,300	
3.	Chencha Hospital	53,912	61,649	
4.	Hosanna Hospital	212,498	227,158	
5.	Mizan Teferi Hospital- Aman	106,125	83,120 *	
6.	Bonga Hospital			No retention

*Withdrawn and used in 1993

Details of the peculiar experiences of each hospital in relation to collection, retention, expenditure, and impact on quality of services and required management changes are presented in detail in part II of this report. As can be seen from the Table 1, Bonga did not receive the amount of retainable fee from the ZFD not only in the year 1992EC but also in the subsequent year. The ZFD claimed that the idea of fee retention is not recognized in the zone and confirmed that no guideline was received concerning the new policy in both years. The withdrawal of the retainable fees in almost all hospitals was approved towards the end of the fiscal year due to mainly lack of budget in the region.

With regard to the current year of 1993EC, hospitals submitted their budget request in connection with the fee retention as early as October 2000 in most cases. However, for reasons best known only to respective ZFDs, with the exception of the Mizan Teferi Hospital, other hospitals have not received the retainable amount until end of May 2001 from their respective zonal treasury. Mizan Teferi spent 100% of its retained fee for 1993EC on purchase of essential drugs and medical supplies. The hospitals' budget request made in relation to retention of fee for 1993EC is summarized Table 1. The break down of each hospital is presented in part II of the report that explores the unique experience of hospitals.

It should be emphasized that these budget requests for 1993 have not yet been released until the end of May 2001. In connection with the delay, management of the zonal hospitals are concerned about the effects of postponing withdrawal in the face of the fact that few weeks were left for the fiscal period to end, and particularly the procedures for "remitting" the withdrawal back to treasury to take effect. While facility managers do not understand why the delays in withdrawal of the retainable fees, the RFB largely ascribe the problem to financial resource constrains. In this regard, according to an official of the RFB, the major reasons for the delay may be *"attributed to an overall shortage of budget prevailing in the region and partly due to lack of communication between the RFB and ZFD in interpreting the provision of the guideline"*

2.2.4. Pattern of Expenditure

According to the guidelines of RFB, hospitals must comply with budgetary allocations in their disbursement for purchase of products or services. The guidelines, seen from vantage point of budgeting, seem to give a relative discretion to hospitals to allocate retained fees to meet their own needs.

However, it is not clear whether hospitals spend the fee to improve quality of a selected service unit that is directly or indirectly related to patients visiting the facility or to complement deficiencies observed in the regular budget. The guidelines of the RFB do not have any provisions regarding the type of expenditure allowed for retained fees, either. Moreover, a closer look into the kind of expenditure paid from retained fees in 1992 EC (see Table 2, next page) indicate that all hospitals follow their own styles, except for purchase of drugs, which was necessitated by short of budget in the Region during the year.

As can be observed from Table 2, as far as complementing to the deficiencies in the recurrent budget are concerned, a wide variation of allocation of the retained fee is noted. The major reason for this is perhaps the relative discretion given to hospitals in identifying their needs that couldn't be met from the regular budget. Heads of ZFDs in response to the question of limiting the use of retained fees explained that the guideline issued by the RFB "*has no statement regarding the kind of expenditures allowed for retention*". The guideline, they said, has clearly left preparation of budgets at the disposal of hospital, and has no other provisions regarding allowable types of expenses.

Since the launching of the new policy of fee retention, it is only in the year 1992 EC that fees were retained and used for purchase of drugs and other expenses. The retainable fee for the subsequent year 1993 was not released until end of May 2001, and so no report on expenditures.

The Table 2 present the kinds of expenditures paid from retained fee in 1992 EC. In summary, a larger portion of the retained fees was used for purchase of drugs during the year. As a result, hospitals acquired essential drugs & medical supplies to remedy the budget deficiency from extra money provided by retained fees. The experiences of Hospitals vary in the kind of expenditures paid from the fee except for the spending on purchase of drugs. The foregoing assertion suggests that there are no guidelines that identify the kind of expenditure allowed for retained fee. Finally, Table 2 indicate that in both years Bonga Hospital did not benefit from retention at all, although its representatives attended the Wolktie and Awassa workshop on health care financing.

Table-2: Expenditure pattern: 1992 EC

		in ETB									
No	Expenditure Item	Hospitals									
		Hosanna		Dilla		Chencha		Mizan		Wolyta Sodo	Bonga
01	Purchase of Drugs	150,898	71%	47,615	50%	53,912	100%	106,125	100%	191,209	86%
02	Water, light and telephone	10,000	4.7%	21,855	23%						
03	Maintenanc-hospital building	13,000	6.1%	10,000	11%						
04	Maintenance-vehicles	4,500	2.1%							22,923	10%
05	Per diem, transport and labor	10,000	4.7%	10,022	10.5%						
06	Contractual Services	1,100	0.5%								
07	Uniforms & Clothing	5,000	2.4%								
08	Fuel & Lubricant	8,000	3.8%	42	0.5%					7,865	4%
09	Printing & Stationery										
10	Office Supplies & Consumables	6,000	2.8%	5,156	5%						
11	Purchase of Fixed Assets										
	Totals	212,498	100%	5,156	100%	53,912	100%	106,125	100%	221,997	100%

NB: The RFB was not able to allocate budget to finance the budget pharmacy due to general budget problems in the Region.

2.2.5. Collection Procedures and Impacts

The existing collection procedures prevailing in hospitals is predominately based on the principles of government revenue accounting system, which are provided in the financial administration proclamation and the corresponding financial regulation. Accordingly, the following procedures that have been in effect for many years now must be complied with by hospitals, and have not been changed even after the new policy of fee retention:

- Collectors must issue form SA/21/1, an official cash receipt of the ZFDs against the receipt of cash for services.
- Main cashiers use Model 64 to receive the total daily collection from regular collectors.
- The main cashier of the hospitals summarizes the collections using Model 7, and remits the total collection (100%) to the accounts of ZFD.

The procedures for managing retainable fee continued unchanged since the adoption of the new policy of fee retention. As can be noted from the foregoing procedures, collection procedures that existed prior to retention have not been changed even after the new policy took effect. This is largely attributed to the guidelines of the RFB that has not allowed a different arrangement than the existing collection procedures. The continuation of the status quo has not, therefore, required management to make changes subsequent to the on set of the new policy. Consequently, it has not been possible to make analysis of impacts or changes of collection procedures on the amount of fee collection. Under the circumstance; the expectation that retention would provide "greater incentives for hospitals to increase revenue" has largely failed.

There are no indications that suggest increase in collection that may be attributed to the new policy. The only felt impact of the policy most indirectly, in some hospitals, is that

management took new initiatives to increase the total collection in view of boosting the corresponding share of the hospitals. In relation to the foregoing experiences, the empirical data analyzed in Part II of the report for each hospital particularly where there was comparative increase in collections; there are no strong evidences that attribute these changes to the new policy of retention. Be that as it may, however, the policy seems to have positively impacted the attitudes of management at various hospitals. In this regard, as evident in Part II of the report, hospital management in Dilla and Hossana have taken a number of measures to reduce the size of free medical care, apparently out of the perception that the action would eventually contribute to increase in their share of retainable fees. While the direct impacts of these actions remain to be seen in subsequent years, it is clear that such unilateral measures taken by these hospitals to deter the influx of free patients would not attain the desired goal unless the involvement of all concerned parties are involved.

The trend of collection before and after the introduction of the policy is presented in Table-3 below. As one can observe from Table 3, collections of 1992 compared with the preceding year do not indicate rise in fee revenue for most hospitals. The average fee collection for 1992 decreased by 14% when compared with the corresponding collection for 1993. On the other hand, the highest percentage change is recorded in Chench hospital. The change may be attributed to growth in the number of patients that visited the facility during the year. As regards to the trend of collections of the current year, the 9 months data compared as a percentage of the preceding year imply that most hospitals are likely to, at least, meet previous year fee revenue or even more towards the end of the year if the trend continues. Since there are no concrete actions taken by many of them to deter the flow of unauthentic certificates of poverty, the changes in 1992EC as well as the rising trend of current year collections may not be entirely ascribed to the new policy.

Table-3: Analysis of cash collection before and after the introduction of the fee retention policy in ETB

No.	Name of hospital	1991EC (1999)	1992EC (2000)	1993EC (2001)	1992EC Vs 1991EC % changes	9 months collection as % of 1992
01	Woliyta Soddo	527,350	324,785	269,252	- 38.4	82.9
02	Dilla	189,383	192,406	93,274	+ 1.6	48.5
03	Chench	104,107	127,185	119,671	+ 22.17	94.1
04	Bonga	94,405	98,090	56,013	+ 3.9	57.1
05	Mizan Tefferi	212,252	166,619	127,286	- 21.5	76.4
06	Hosanna	424,997	454,317	319,922	+ 6.9	70.4
	Total	1,552,494	1,363,402	958,418	-12.2	70.3
	Average	258,749	227,234	164,236	-12.2	72.3

NB: While statistical data differentiate the number of admissions and outpatient visits, the corresponding records and the accounting system do not segregate the incomes along these lines.

Moreover, the analysis of collection in relation to the new policy of fee retention suggests that the implementation of the policy has a long way towards bringing changes on the amount of collections. In this regard, the decentralization of administration of the retained fees coupled with development of financial management system that ensures accountability, particularly limiting involvement of the ZFDs to control and auditing, are but some of the important measures that may provide management of hospitals with greater inspirations to:

"1.collect existing fees, thereby increasing revenue to hospitals; and 2.use retained funds to improve the quality of services they can offer to fee-paying patients, thereby increasing utilizations, which in turn would increase revenue"(TOR, Background, P.1)

2.2.6. Exemption and Waiver of Fees

The current policy of hospitals as regards exemption and waiver of fee is to provide the following categories of patients and diseases with free medical care:

- Patients that present exemption papers, often referred to as "Certificates of Poverty", from their respective *kebeles*, the lowest local administrative unit. According to managements of hospitals, there is no problem in securing such certificates, even though the process requires patients to apply for a proof up to *Weredas*, and the certificates need to be renewed every six months.
- Staff of hospitals, their spouses and children under 18.
- Employees of the Civil Service that submit official letters from their respective offices will get waiver to the extent of 50% for themselves, their spouses and children under 18.
- Prisoners, street children and other groups of society.
- Cases of tuberculosis & diabetics (supported by national policy) and uterine rupture as well as immunization

There is a strong relationship between collection of hospitals and exemption and waiver of fee. Unless properly managed, the latter may contribute to decline in fee revenue of hospitals and as a result may become detrimental to provision of quality of services for fee retaining facilities envisaged by regional policy.

Data collected in relation to exemption and waiver during 1992EC are analyzed in the Table 4

Table-4: Analysis of free medical care in government hospitals of SNNPR for the year 1992EC
'in ETB

No	Hospital	Value			Patients		
		Total Revenue	Free Care Value	%	Total Patients	Free Patients	%
1.	Wolyta Sodo	324,785	56,882	18	47,866	2,692	6
2.	Chencha	127,185	62,699	49	28,413	4,449	16
3.	Hosanna	454,317	98,237	22	50,323	3,673	7.3
4.	Mizan Teferi	166,569	22,954	14	52,296	1221	2.3
5.	Bonga	98,090	12,006	12	21,294	620	3
6.	Dilla*						
	Total	1,170,946	252,778	22	200,192	12,655	6
	Average	234,189	50,555	22	40,038	2,531	6

*: There were no statistical records that indicate the extent of exemption and waiver due to poor record keeping in 1992 in Dilla Hospital.

According to Table 4, while the percentage of number of free patients seems low in relation to the total number of patients, when these percentages are compared with the corresponding value of free care, they stand as high as 49% of total revenue in some cases. In this regard, while the average percentage of the value of free medical care runs as high as 22%, the related average percentage of number of people treated freely stands as low as 6%. Asked as to why these relative variations prevail between percentages of value of free care and percentage of number of free patients, hospital management in almost all facilities widely hold that they suspect the authenticity of values assigned to free care. One particular case that support the assertion, according to such sources, is that prescriptions for drugs to free-care patients who are admitted to various wards include more than the actually required dosage. the difference between the actual intake of the admitted patient and the prescribed ones is often taken out of the hospital for sale by health personnel else where in the market. The existing practice with regard to distribution of drugs to non-paying patients is not controlled as compared to paying ones. While the existing practice of identifying the poor has limitations as explained earlier, the behaviors of health personnel contribute to decrease in revenue from sales of drugs. Thus, although readers of the study report may make a number of inferences from the foregoing finding, one conspicuous point of relevance to the theme of “retaining fees at government hospitals” is: **the negative impact of increased and uncontrolled exemption on the size of fee revenue, and therefore on quality of services to be delivered by a health facility.** In this regard, therefore, future guidelines should consider addressing exemption and waiver cases not only externally (i.e. where certificates of poverty originate) but also internally where health personnel abuse the privileges free patients for ones benefit.

The observations of this study in relation to exemption and waiver of fee suggest that hospitals took little effort to reduce the influx of “poverty certificates” even after the introduction of the new policy of fee retention. This may be largely attributed to the nature of the practice of retention currently underway in hospitals. As described in earlier part of the study report, the greater involvement of the ZFDs have given hospitals the impression to consider retention as part of the regular budget, denying incentives for hospitals to increase income. However, in some cases, the introduction of fee retention seems to provide hospitals with fresh impetus to deter the flow of certificates of poverty and to increase fee income, thereby increasing their share. In this regard, the experiences of Hosanna, Dilla, and Mizan Teferi set good examples. The management committees of these hospitals took the following measures in view of reducing the impact of uncontrolled free medical care on collections; increasing the fee revenue; and as a result boosting their corresponding share:

- Two of the hospitals, Hosanna & Dilla, have made close consultations with local government bodies –the zonal council & *weredas* in their vicinity – regarding their concern on the procedure for certification of free medical care, and agreed to work out modalities for future handling of the subject.
- All of the three hospitals registered spouses and children under 18 of their employees in order to deny access to other relatives, who are not included in the registration.
- The management of Dilla hospital has begun working closely with the local Civil Service Bureau in a bid to generate what they call “Roster of Employees, their spouses & children under 18” who are eligible for 50% exemption. It was a

common practice to get free certificate from the civil service in Dilla even for remotest member of family.

- The experiences of Mizan Teferi with regard to the behavior of its employees are unique. It was a common practice in the hospital for its employees to tell a physician a symptom of diseases that result in prescription of essential drugs, which are sold like hot cakes in the local private pharmacies. According to the Acting Medical Director, prior to 1992 EC drugs taken out for free from hospital pharmacy as a result of this behavior reduced the hospitals' income from sales of drugs. Consequently, hospital management imposed a rather austere measure – that is- *“medical cases of all hospital staff including health personnel to be diagnosed by the Medical Director only”*.

Although the impacts of these measures on collection are not clear, the attempts indicate “change of attitude on the part of hospitals towards fee revenue” that is attributed to the new policy of fee retention. However, a much broader initiatives should be taken to realize one of the key guiding principles stated in the Strategy, and which reads,

“ appropriate measures will be taken to ensure that the poorest people benefit from primary health care through fee exemption, subsidies and or/through instituting community-based risk sharing schemes/insurances/”

In the short run, assessing the possibility of limiting the privilege of exemption to the poor and needy only, and to that effect implementing a viable procedure of screening may reduce the negative impact of providing uncontrolled free medical care on retained fees, and consequently on provision of quality services.

2.2.7. The Experience f Other Hospitals Retaining Fees

As part of its study methodologies, the study team visited Arbaminch and Yirgalem Hospitals, which have been retaining 100% of their fee for many years now. The objective of visit was to learn the experiences of the hospitals in relation to the theme of the study. As far as fee retention is concerned, although the administrative setup of both hospitals considerably vary from the government hospitals that have just begun retaining a portion of their fee recently, there are a number of experiences that could be linked to the subject of the study. The proceeding parts of the report discusses the findings vis-à-vis its relevance to fee retaining government health facilities in the region.

The Yirgalem and Arbamich Hospitals have several years of recorded experience in fee retention. The financial resources of these hospitals are mainly drawn from the following sources:

- Government Regular Budget for salaries of local staff.
- Norwegian Lutheran Mission (NLM) funding for salaries of expatriate staff and a portion of it to finance other part of the running cost.
- Income from patient services and other income generating activities.
- Donation from NGOs such as Christian Blind Mission (CBM).

During the current year, expatriate staffs have been discontinued. However, the NLM and CBM continued to finance supply of drugs and medical supplies and other activities.

The study tour to both hospitals observed that both hospitals have special bank accounts into which fee revenues generated at the facilities are separately deposited, and another bank account into which operating expenses covered by the government are treated. This practice illustrates an instance of synchronizing the policy of retention with existing financial regulations, and hence an opportunity for maintaining separate bank account at health facilities retaining 50% of their fees.

Moreover, both hospitals have modern systems of accounting and financial management that are fully computerized. The accounting systems of both hospitals have been designed to fit with the information requirements of external auditors as well as RFB auditors. This is one of the major learning that is relevant to the study. A good experience of its kind that harmonized the finance proclamation with the realities of a health facility, and in that sense a good precedent for tuning the provisions of the Strategy to the policy of retention.

Moreover, there are cash calculators that set prices for patients on the drug price list and user fees for services given. When a patient comes from either the Outpatient Department (OPD) or an inpatient ward, the calculator calculates the required payment on a form. The calculators, which are more of computer nature, indicate on the same form if the patient is exempted from payment or is a staff. The possibilities of relating this experience perhaps calls for search of funding in the future.

With regard to handling of "certificates of poverty", the hospitals have a different procedures in that provisions of such certificates do not make a patient automatically eligible for free medical care; as a result, he/she must pass what is referred to as, hospital staffs' "*visual determination of whether a patient can not afford the cost of treatment*". The hospital has mandated its administration unit to further screen patients providing certificates of poverty by means of subjective interviews before their papers are accepted. The measure is discriminatory, however as it is not applied at patients seriously sick. This particular experience connotes that health facilities can initiate measures to improve their collections if entrusted to take of administration of their own affairs – merits of decentralization.

Data collected from Yirgalem and Arbaminch hospitals suggest that fee retained at these facilities have been able to cover their running expenses, such as purchase of medicine, food, utilities, cloth & linen and the likes. By and large, when the fee revenues of both hospitals are compared with those retaining 50%, the revenue is higher than what is allocated to operating expenses in other hospitals. This is attributed to the fact that the retention is 100% in the first place, and it is additional to government budget in the real sense. Consequently, as the fee revenues of these hospitals are largely used to cover hospital-running costs, quality is higher and it is attributed to more resources from retention.

The status of fee revenue and expenditure of both hospitals for 1999 are analyzed below:

Table-5: Analysis of fee revenue of Yirgalem and Arbaminch Hospitals for the year 1999
 'in ETB

No.	Description	Yirgalem Hospital		Arbaminch Hospital	
		Amount	% to Exp.	Amount	% to Exp.
1.	Revenue	1,279,710	73.9	1,002,997	103.1
	1.1. Patient payments	1,214,688	70.1	919,547	94.5
	1.2. Other income	27,306	1.6	83,450	8.6
	1.3. Donation	37,714	2.2		
2.	Expenditure	1,732,103		972,907	
	Running expenses*	1,732,103		972,907	
	Residue balance	(452,393)		30,089	

* Non-cash outlays such as depreciation on Transport & Furniture is taken out to limit the measurement to cash items.

The analysis indicates that fee retained at the hospitals particularly revenue from patients payments alone covered 70% and 94.5% of the total running expenses in Yirgalem and Arbaminch hospitals respectively. More over, the total revenues generated including an insignificant portion of other income have paid for 73.2% of the total running expenses in Yirgalem, and 103% in Arbaminch, resulting in Birr 30,089.93 in residue balance (i.e. the excess of income over expenditure). The residue balance for Yirgalem, however, shows a negative balance due to increased spending on other administrative items such as consultancy and supervision, office supplies, and external audit fees, to mention just a few.

The latter finding suggests that the kind of expenditure for retained fee should be controlled in view of channeling scarce resources towards improvement of quality of services. In this regard, expenditures related to hospital overheads such as office supplies, maintenance should be limited to allow increase in fund for purchase of medicines, medical supplies and equipment that are directly related improvement of quality of services.

The observations of the study indicate that experiences of fee retention in both hospitals strongly testify to the significance of combined efforts in financing health facilities. The experiences learned in both hospitals support the provisions of the Strategy regarding diversifying sources of income to health facilities stated in Key Guiding Principles part, and reads as follows:

“apart from increasing government allocation to health, it involves mechanisms that improve other revenue generating sources such as revision of user fees, revolving drugs sales and through various kinds of ...financing schemes.”(HCFS,MOH, 1998,item3.9, 5)

These technical mechanisms should be implemented in all other government hospitals retaining fee, with emphasis on user fee and revolving drug sales, to bring the zonal hospitals at par with these hospitals in some respects, to the say the least.

In conclusion, the experiences of both hospitals further provided the lessons that could be drawn to improve the existing practice of fee retention in government hospitals. In this respect, the following points need to be considered:

- i. The merits of decentralization of administration of fee retention at health facilities offer increased revenue and utilization.
- ii. Health facilities can run their own system of financial management and accounting efficiently if provided with excellent design, manual and training. The accounting and financial management systems installed in both hospitals are carefully designed to meet requirements of both management as well as government portion. Moreover, accounting and financial management manuals support the systems, and personnel staffs are well trained to operate the system effectively
- iii. Factors that skew fee revenue negatively, such as free certificates, could be reduced to manageable extent.

2.3. Implications on Quality and Management of Services

One of the objectives of the new policy is to provide additional source of income to health facilities so that the latter can improve the quality of services provided to patients. The survey instruments included questionnaire items focused on how the quality of services provided to patients is impacted, and if there are changes in management of the services as a result of the policy intervention. As may be observed in latter parts of this section, the policy has positively impacted the provision of the services by providing additional financing to cover shortage of drugs and medical supplies, provision of water supplies and water lines, maintenance of x-ray buildings to improve outputs, and so on. However, the new policy has not required management to introduce changes mainly because the administration of the fees retained at health facilities is made to fit in with the existing practice of managing the fees.

2.3.1. Impact on Quality of Services

The assessment of impact of retained fees on quality of services provided to patients largely involves qualitative information. However, managements of hospitals that had the benefit of additional funding from fees retained in 1992EC hold that the products or services acquired with the assistance of fee retained have contributed to the smooth operation of their hospitals to a certain extent.

In 1992 EC, due to the overall macro economic situation that prevailed in the country and particularly general scarcity of budget in the Region, the government was not able to allocate budget for acquisition of drugs and medical supplies at all. Consequently, a larger portion of fees retained at hospitals, in some cases to the extent of 100%, was spent on purchase of essential drugs. During the year, the retained fee compensated the deficit and provided extra money that was not possible by any other means including the regular budget allocation. In this regard, the impacts of retained fees are felt in hospitals in the sense of covering the deficit in drug budget. The budget pharmacy would have run out of essential drugs and medical supplies, if it had not been supplied with new stocks of vital and life-saving drugs acquired from retained fee. Consequently, managements of zonal hospitals hold that service of hospitals were made effective in terms of providing essential drugs to visiting patients and consumable medical supplies to physicians. In some hospitals where Special Pharmacies (SPs) exist, hospital management agrees to the positive role the retained fee played during the year. In that sense, management believes, the additional financing to the budget pharmacy

secured from retained fees not only provided additional supply of drugs to patients, but also considerably reduced the load on the SP resulting from shortage of supplies. In this respect, the statement in the TOR that fee retained at facilities "*can be retained and is consequently available to finance efforts to increase availability of essential drugs and equipment*" has been achieved.

During the fiscal year 1992, all hospitals benefited from retained fees in terms of acquiring essential drugs and increasing availability to visiting patients. However, as can be seen from part II of this report, which explores the unique experience of each facility, hospitals were not able to improve the quality of a selected service unit from among observed and deserving attention. That may be largely attributed to the fact that during the year because of lack of budget allocation to the pharmacies, efforts could not be shifted to improvement of selected units, in the face of a pressing shortage of essential drugs.

Another contribution of fee retained at facilities to provision of services related to patients is the use of the fund to improve water supply in certain hospitals; certain, because many of the hospitals used the fund for purchase of drugs to a larger extent for reasons explained earlier. In this regard, the actions taken by Hosanna and Dilla hospitals are worth mentioning. One of the major problems of the hospitals was the line of water supply to which both were linked. Both hospitals used to have access via a busy reservoir in town that they were facing constant shortage of water supply. Besides, one of the hospitals was able to buy extra water tankers that were linked to the main pipeline to eventually augment storage & supply of water. By and large, since the introduction of the new policy, with extra funding from retained fees the hospitals managed to acquire sufficient supply of water, which has considerably enhanced provision of range of services.

Dilla and Hosanna hospitals managed to maintain the building of some part of service giving units, x-ray rooms in the former case, and medical ward in the latter. The maintenance of the building has, among other things, improved x-ray outputs that suffer poor quality due to perforated premises, according to hospital sources. Moreover, the use of money from the regular budget for generators is generally not allowed because allocation to electricity is often provided from the government budget. In Chenchu and Hossanna hospitals, the additional money secured from retained fees has enabled them to operate their alternative generators during the year.

In 1992EC, the adoption of the new policy particularly fee retained in the year, although faced with procedural hurdles, has also provided hospitals with additional money to complement budget deficit. As result, managements of hospitals, hold that fee retained during the year gave them the flexibility of budget re-allocation in which case under financed budget lines were identified and eventually financed from retained fee. Yet, since the rationale for adoption of the new policy is "*to improve quality of services at hospitals and to increase the availability of essential drugs and equipment,*" spending from retained fee to complement budget deficiencies should be limited to a reasonable extent.

In the current year of 1993EC, the ZFD has not approved withdrawal of the fee retained for the year from the treasury until end of May 2001, thereby leaving no data concerning retention. Consequently, this part of the study could not be analyzed.

2.3.2. Management Requirements & Impacts

The managements of hospitals in all zones have not yet felt the need for making changes in association with management of retained fees. The major reason is involvement of government accounting system made possible as a result of the guidelines issued by the RFB concerning the administration of the fees. The method of collection and disposition of fees have been framed to fit with the existing sets of procedures governing the use of public fund. Thus, since the practice of fee retention, in its present form, has not called for a different arrangement in assessment of collections and handling of fees, the impacts of the new policy in terms of changes in management cannot be apparently noted.

With respect to any management changes that could be made in hospitals that would serve to increase fee collection and to improve the quality of services, members of management of the various hospitals suggest that the following measures should be taken:

- a. The administration and utilization of fees should be practiced in accordance with the provisions of the Strategy document on health care financing learned during the Wolktie workshop given in February 2001 to participants drawn from zonal hospitals.
- b. The administration of retained fees should be decentralized allowing more autonomy to hospital management, and doing away with lengthy procedural requirements imposed by the Finance Bureau.
- c. A clear guideline preferably consistent with provisions of the Strategy document that empower hospitals to retain fees and deposit such fees in a separate account should be developed and implemented.
- d. In order to increase collections of the hospitals, guidelines that are capable of strictly screening poverty certificates and identification of patients should be imposed. This requires the involvement of the Regional Council and administrative units at all level.
- e. Enhance the skills of hospital management through capacity building programs, and allow extra incentive from retained fees to hospital health personnel, who are also the key actors in the delivery of quality of services.

3. Conclusions and Recommendations

3.1. Conclusions

Although the government of the State of the SNNPR has pioneered the introduction of the new policy by entitling government hospitals to retain 50% of their fee revenue, it took the initiative without simultaneously making the necessary preparations for orientation and sensitization of the procedures governing the implementation of the policy.

By and large, the measure is commendable, as it has brought about changes on the attitude of policy makers in the Region regarding retention. Although the problem discussed so far is at technical level, the introduction of the new policy suggests that policy makers at the Region have recognized the importance of fee retention. However, consequences of absence of organizational support such as the RHCFC have been felt in the implementation of the policy taken on by the regional government. In light of this, the gap identified between the provisions of the Strategy with respect to definition of the HFR on the one hand, and the guidelines issued by the RFB concerning implementation of the new policy on the other hand, may be attributed to absence of such organizational setup. Besides, lack of communication between the RFB that originated the guideline and the ZFD regarding the guidelines coupled with the capacity to understand the contents of the guideline have contributed to the gap between the Strategy and RFB's guideline.

Evidently, a closer look into the contents of RFB's guideline confirms that the RFB made no reference to the Strategy at all. According to RFB Head, the Bureau failed to consult the Strategy due to largely lack of institutional setup that could either provide it with the Strategy or other terms of reference to develop the guideline. Moreover, the council mandated the RFB to develop the guideline without any point of reference. Under the circumstances, the Bureau resorted to adopt a guideline formerly developed for fee-retaining schools in the region. The guideline of the RFB would have better reflected the concept of HFR if the RHCFC had been there to either provide the Strategy as a point of reference or most importantly to discharge one of its duties & responsibilities stated in the Strategy, *"ensure the establishment of cost-conscious, efficient and effective financial management and accountability within health facilities"* (HCFS, MOH, item 6.2.,9.15)

Consequently, while some part of the guideline subscribes to the concept of HFR as defined in the Strategy, it has failed to recognize other aspects of the concept. As discussed earlier, the guideline allowed health facilities to retain their fee revenue in the sense of the Strategy. In this regard, it provided couple of alternatives to retention of fees: *"hospitals can retain to the extent of 50% of the preceding year collection for use in the current fiscal year or immediately use cash from daily collections to an acceptable size."* (Item 3.3., RFB, *Guideline,p1*). However, the guideline has omitted the other important elements of the concept such as maintenance of "special bank account". Besides, it has imposed remittance of the remaining balances from retained fees, denying health facilities to use the money for subsequent year. The latter provision of the guideline, apart from challenging the concept of HFR as being "additional to government budget", considers the retained fee as part of the regular budget. In the sense of the foregoing assertion, the practice becomes against one of provisions in the concept, which reads, *"...and used by the health facility that generates it"* (HCFS, MOH, 1998, tem 3.11,P6)

Although the guideline allows retention of fees in the manner described above, its implementation at the ZFD level has taken a different shape. Among the practices of the ZFD, two important actions are not supported by the guidelines: firstly, health facilities are required to remit their fee collection in its entirety to ZFD, and secondly, wait for quite longer time until the retainable fees are paid, in most cases towards the end of the fiscal year. While the former action may be largely attributed to lack of clarity of the guidelines, it is not clear why withdrawals are often delayed. As explained earlier, while some provisions of the guideline clearly allow retention, others provide reference to the financial proclamation. It was learned that repeated reference to the latter has caused ZFD officials to lean towards old practices. Moreover, since separate books of accounts are not allowed to account for transactions related to fees retained and used at the facility, officials at ZFD ruled in favor of those provisions of the guideline that refer to the finance proclamation.

Consequently, the practice of retention has been, by virtue of lack of clarity of the guideline, framed to fit in with the existing administration of government revenue accounting system. These systems impose a number of procedures discussed previously: do not allow flexibility of using the fees retained at facilities; forbid the use of special accounts unless differently arranged; and do not tend to consider retained fee as additional to government budget due to the fact that booking requirement for retained fees is identical to that of recurrent budget, and most importantly remittance of unused balances from retainable fees is exercised at year-end.

With respect to impacts of the policy implementation on the size of collection, the data analyzed in connection with trend of collections suggest that with the exception of increase in certain hospitals, a majority of the hospitals has shown either marginal increment or decline in the size of their collections. Under the circumstances, it would be difficult to attribute the increase to the policy only. Similarly, there have not been changes on collection procedure since the policy implementation took effect because the provisions of the guideline of the RFB with regards to collection procedures do not require different arrangement. The implementation of the policy has, however, brought about change of attitude on the part of hospital management. As a result, some hospitals have introduced measures targeted at reducing uncontrolled inflow of poverty certificates mainly out of the conviction that the actions would contribute to increase in total collection, and hence in their 50% share. Although the effects may not be measured in the short run, the action is a reflection of impact of the new policy. Yet, despite efforts to control the external factors, hospitals are also facing acute problems internally with respect to behavior of some of their health personnel as the discussion of Exemptions and Waivers indicates. Thus, development of national guidelines governing utilization of retained fees should also consider control mechanism that can possibly boost the size of retained fees not merely focus on aspects of utilization.

The practice of retention in the first year of its implementation has contributed to increase availability of essential drugs in all hospitals and covered major maintenance of service units despite the delays caused on the part of the ZFD in releasing the retainable fee. If the delays and other rather lengthy procedural requirements can be done away with or improved, the policy implementation can support provision of quality of services in the future.

3.2. Recommendations

The recommendations of the study, suggested below, emanate from two basic reflections. The first reflection, perhaps the most important, may be the goals of the Strategy. In this

regard, the Strategy, among other things, identifies, *"increasing absolute revenue to the health sector; and promoting sustainability of financing"*. More over, in pursuit of the realization of the goals, the Strategy will *"allow local retention and use where the community will play a vital role in the management of fund"*. The second reflection relies on the outcomes of the study and the observations made therein regarding experiences of government hospitals "retaining fee" in the SNNPR as to the conditions that are required to prevail within health facilities if the Strategy were to achieve the goals entrusted, in general, and policy of retention in the region in particular.

The observations discussed in this study report, therefore, point out to the fulfillment of the following conditions in the short run, particularly recommendations 1-5, in the Region so that the experiences could be basis for improvement in the region and major learning to other regions:

1. The role of the National HCFS Implementing Task Force should be revitalized to undertake its major duties and responsibilities of "overall initiation, implementation and monitoring of the HCFS" to fill the gap that emerged since 1998. Alternatively, a different organizational requirement should be sought at Federal level for implementation of the Strategy if revitalization of role of the Task Force is not possible.
2. The RHCFC should be established to fully harmonize the current practice of retention with Strategy.
3. The policy intervention initiated by the Regional Council requires wide sensitization and transparency of guidelines developed to implement the policy must be ensured among stakeholders at all levels. In this respect, the guidelines of the RFB must be communicated to all stakeholders such as the ZFD and health facilities that should be sensitized as to the policy and concomitant guidelines issued thereof.
4. Although the composition of the RHCFC covers all relevant sector bureaus, the terms of reference provided for the committee, suggest that its establishment alone is not enough. Meanwhile, due to the current structural changes in Federal as well as Regional State Governments, the social sector, which heads the RHCFC, is eliminated from the structure, thereby suggesting the need for considering replacement of the chairmanship. In any case, the overall capacity of the committee need to be strengthened to discharge duties and responsibilities provided in the strategy, such as, *"development of appropriate systems for the region, adapting national health care financing procedures and directives to regional perspective, development of cost conscious, efficient financial management and accountability in the regions."* Thus, depending up on availability of resources, it is suggested that the following requirements be met if the experience of the SNNPR are to be consolidated and subsequently replicated in sustainable manner elsewhere in the country:
 - An institutional setup, preferably an autonomous office having its own legal personality, need to be established at Regional level with which health facilities implementing fee retention communicate and receive close technical

and administrative support to implement the Strategy. An office with defined line functions is the only channel closer to health facilities than the committee, as the latter without such organizational form failed to live up with their expectations in many instances. The size and life of the office can be limited depending on resources.

- The technical capacity of the committee to discharge the duties and responsibilities stated at the Strategy cannot be assured by membership from sector bureaus alone. It should be supported by an institutional setup having the necessary personnel staff to ensure proper implementation of the policy of retention. Personnel with expertise skill on health and finance should be either hired or seconded from available staff at Regional Bureaus for marginal payment on existing salary, often in the form of salary top up, depending on how resources are available to implement the strategy.
5. The provisions of the Strategy related to the use of Health Facility Revenue should be harmonized with relevant financial administration proclamations; and guidelines evolving in effect thereof should allow autonomy to hospital management and must limit the intervention of the RFB to auditing and inspection. One possible way of doing this is to establish the Health Fund, which requires a separate institutional setup to manage additional sources of income to health facilities. Moreover, the Fund provides legal framework for the provisions of the Strategy, thereby laying the basis for its synchronization with the financial administration proclamation. In this regard, the guidelines issued by the RFB, setting a good precedent, should be further streamlined to fit with a number of provision of the Strategy discussed in the report, particularly in light of establishment of the Fund. In specific terms and given the experiences of the SNNPR, the following items should be considered in the development of national guidelines meant to implement the health fund
- In the sense of the RFB guidelines, health facilities should be authorized to retain fees to allowable extent, remitting the balance to the ZFD. In this case, expenditure reports will follow later. Alternatively use cash from their daily collections to an acceptable level, and remit the balance along with expenditure reports to the ZFD. In either case, the only requirement will have to be plan of action.
 - Health facilities should be allowed to open special bank account into which the allowed fee retention is deposited. This account will be separate from the recurrent budget account. This arrangement will avoid restrictions of financial proclamation related to the use of consolidated fund.
 - Existing procedures that impose remittance requirements on fee retained should be avoided so that fund can be available at facilities for use any time. If remittance requirements on balances from retained fees are done away with, cash will always be available for use at facilities, and hence the arrangement will ensure that fees retained at facilities are additional to government, in the real sense.

- Lengthy procedural requirements involved to get the retainable fees paid to the accounts of the facilities should be avoided. In this regard, the ZFD should be contented with expenditure reports and plan of action, as long as its right to audit the report is reserved any time.
 - Separate books of accounts should be maintained to account for transactions related to retained fees. It will only require little modifications to the existing system of accounting, such as maintenance of codes of accounts, and ledger or register book, keeping the current payment voucher and receipt vouchers. The proposal simplifies reporting and auditing requirement. Besides, it will lay down the basis up on which modern system of accounting is established in the future.
6. **In the long run**, if the existing level of retention will be increased to 100%, the situation will require a different arrangement than proposed above. In this regard, an efficient and effective system of financial management and a corresponding system of accounting and reporting will have to be studied and developed. The system, among other things, should be capable of generating financial reports for all sources of financing such as fee retention, government budget, donor fund and providing information to all stakeholders. In this regard, the learning generated from Arbaminch and Yirgalem hospitals sets a good example. Specifically, **if resources allow**, the new system will have the following features:
- Booking for transactions will be based on source of finance: government budget will be separately accounted for based on the existing practice, while sources from fee retention and donor fund will be differently treated.
 - Transactions related to fee retention and donor fund will be treated under cash basis double entry where a different receipt voucher, payment vouchers, charts of accounts, etc are maintained.
 - Except for government portion, the involvement of ZFDs on the other set of books will not exist, and shall be subject to external auditing only.
 - The system related to fee retention will have to be supported by a procedural manual and training. The existing staff, if provided with manuals and training, can handle cash-basis double entry.
7. The realization of one of the goals of the Strategy, “increasing absolute revenue”, to the health sector calls for not only identifying additional sources of finance but also minimizing factors that are detrimental to existing hospital revenue. Thus, forthcoming national guidelines concerning fee retention should devise mechanisms that contribute to increase fee revenue from sources existing at facilities. In this regard, the following points, including recommendations 8 & 9 below, need to be considered in the **intermediate future**.
- A viable procedure of screening that ensures the poor and only the poor benefit from free medical care should be worked out. The formulation of the procedures requires a much wider institutional intervention preferably integrated and involving the regional government at all levels, health

facilities, and other stakeholders. Much broader initiatives of this kind can sustain the series of measures health facilities have taken to deter the influx of poverty certificates (see 5.2.6. of the report for details of experiences of health facilities).

- A system of internal control that is primarily directed to control the behaviors of health personnel and other hospital employees should be developed if the revenue from sales of drugs will benefit health facilities, and contribute to increase in their total fee revenue. The system review should pay due attention to existing procedures of prescribing and distributing drugs to free-care patients admitted to medical and other wards to ensure that drugs prescribed are used for intended purposes only. Moreover, only medical directors should diagnose cases of hospital staff in order to control another form of abuse by hospital. (see 5.2.6. of the report for details of experiences of health facilities).
8. The experiences learned from Abrabminch & Yirgalem Hospitals suggest that 100% retention of fees at health facilities raise quality of services. The fees entirely retained at these facilities are additional to government budget in real terms, and spent to ensure availability of drugs and improve status of service units and acquire medical supplies. Thus, diversifying source of income to health facilities, as is the case at both hospitals, in terms of revising user fee, introduction of the drug revolving fund and other financing mechanisms stated in the Strategy will eventually contribute to provision of quality of services at health facilities.
 9. The pattern of expenditures of most hospitals indicates that some portion of retained fees is spent to cover regular budget deficits. In the interest of increasing quality of services, the size of this spending should be limited procedurally to ensure that more money is available from the retained fees to purchase drugs, medical supplies and improve selected services units.

Part II
Experiences of Zonal Hospitals

4. Experiences of Zonal Hospitals

This part of the report explores the unique experiences of government hospitals that have been allowed to retain 50% of their fee revenue since 1992. It is a detailed version of what has been discussed in the main report, particularly as it pertains to the experience of each facility covered under this study. The style of presentation is, by and large, similar although, where there is a variation in type of available data, the analysis may differ.

The first part of the coverage for each hospital begins with a description and analysis of background information pertaining to types of services, activity trend and the likes. This is followed by analysis of category of data gathered in respect of collections, retention of fees, expenditures, waiver of user fees, and the likes. Moreover, qualitative information obtained in connection with impacts of the policy on quality of services and management requirements has been analyzed in detail.

4.1. Dilla Hospital

Dilla Hospital is located in Gedeo Zone of the SNNPR at the town of Dilla, which is 90 kilometers from Awassa, the Regional capital. A missionary group known as Swedish International Mission (SIM) initially established the hospital at what is now old building in 1949 EC, which is located few meters away from the current building. The current hospital was officially re-opened in 1979EC by the previous government as one of government hospitals in the area.

Demographic indicators of the hospital suggest that the hospital renders health services to a total population of 73,449 residing in Gedeo Zone. More over, people residing in neighboring zones such as Oromia and Southern part of Sidama Zone are served in addition to the population in its catchments area. The hospital is also used as referral hospital from clinics and health posts in and around the catchment area although serious cases are referred to Yirgalem Hospital.

According to the current organizational setting, the Medical Director is responsible for the overall day -to-day management of the Hospital, and supervises three units: Matron Office, Health Services Unit, and Administration & Finance.

4.1.1. Type of Services

a) Outpatient and inpatient services

Currently, Dilla Hospital provides outpatient services focused on provision of emergency examination, general examination, dental services, health education, family planning, antenatal & post-natal care, and Extended Program on Immunization (EPI). Its 81 bed hospital renders inpatient services to patients admitted to medical & pediatrics ward as well as deliveries, Evacuation & Cure, Dilatation & Cure; conducts surgical procedures & treatments, and pre operative and post operative cares.

The range of services provided includes laboratory tests (parasitology, hematology, etc), radiological services, optical and surgical facilities including, major and minor surgery. In

addition to antenatal clinics, the hospital conducts other preventive services such as health under-five- year clinics, sanitation, health education and family planning on daily basis.

b) Beds and health personnel

There are 81 beds, the allocations of which are, 30 beds in medical ward (out of which 6 are TB ward), 20 surgical and 15-pediatrics wards. According to survey conducted in 1993 EC, figures indicate that the hospital currently employs 8 physicians (of which 1 is specialist), 19 nurses (6 of them specialized), one pharmacist, three pharmacy technicians, three laboratory technicians, three x-ray technicians, twenty health assistants, two sanitarians, two dental technicians, and one optical assistant.

c) Activity trend

Table 6 (next page) indicates the trends in major activities of the hospital. Data were available for 12-month period (July 1999 to June 2000, on the number of outpatient visits, admissions, major operations, and laboratory tests. The hospital's statistics officer confirmed that there is no under-registration of users visiting the facility due to strict procedures of compilation of activity records on daily basis. A look into table 6 suggests that the total number of outpatient visits for last year (1999/2000) indicates that 21,841 patients attended the hospital's care, i.e. an average of 1820 patients per month, 61 patients per day.

Table-6: Major Activity Trend

Month	OP Visits	IP Admissions	Major Operation	Lab. Tests	IP/OP	Tests/OP
July 99	2,499	235	26	401	0.09	0.16
Aug.99	2,100	162	29	468	0.08	0.22
Sept.99	1,884	85	11	502	0.05	0.27
Oct.99	1,994	81	5	765	0.04	0.38
Nov.99	1,508	214		305	0.14	0.20
Dec.99	1,622	190		293	0.12	0.18
Jan.00	2,021	227		550	0.11	0.27
Feb.00	2,016	144		249	0.07	0.12
Mar.00	2,124	186		653	0.09	0.31
Apr.00	1,328	102		313	0.08	0.24
May.00	898	85	29	258	0.09	0.29
June.00	1,847	83	6	321	0.04	0.17
Average/Mo	1,820.08	149.5	8.3	423.25	0.08	0.23
Total/year	21,841	1,794	106	5078		

The average number of admissions per month was 150 or approximately 5 per day. An estimated total number of admissions per year are 1,794. The hospital conducts 8 operations per month. The number of laboratory tests per month is approximately 423 or 14 tests per day. Taken all together, the total number of visitors of the facility during the year, for major activities alone, as percentage of the catchment's population suggests that 40 % of the population attended the hospital's care. These statistics reveal that by standards of rural hospitals, the hospital is highly active and probably functioning near capacity, which should stand at 45-50% of catchment's population attending care.

Table 7 shows that the ten most common reasons for visiting the outpatient facility are mostly preventive in nature and include: malaria pneumonia, intestinal diseases, URTI, and gastrointestinal diseases.

Dilla is located in malaria endemic zone that is why the highest number of cases is registered as malaria during the year. In a bid to reduce the number of infections, the hospital management has launched a continuous program in which health education on malaria is given to the local community. More over, spray of DDT has been used to control the spread of the disease.

Table-7: Ten Most Frequent Diagnoses for Outpatient Visits to Dilla

No	Disease or Diagnosis	Code	Number of Patients per month
1	Malaria	37.1	1,315
2	URTI	87	1,038
3	Pneumonia	90	887
4	Intestinal Parasite	43.9	810
5	Gastroenteritis's	104.2	510
6	G.U.S.	114.6	507
7	Accidents	147.3	470
8	Infections of skins	121	330
9	GE	104.1	286
10	Bronchial asthma.	66.1	261

Inpatient facilities appeared crowded, and probably need to be expanded to accommodate increase in demand resulting from improved quality of services if investments on facilities are annually and gradually made from the amount of money hospitals retain. Analysis of the most frequent reasons for hospitalization provides valuable information on the type of focus that hospitals should make to improve health facilities from retention.

Table-8: Ten Most Frequent Diagnoses for Hospitalization in Dilla Hospital

No	Disease or Diagnosis	Code	Number of Patients/month	Bed-day
1	Bronchial pneumonia	90	198	991
2	Malaria	37.1	154	858
3	Parasitic Disease	43.9	126	688
4	Gastroenteritis's	104.2	108	849
5	Abortion	118	104	219
6	G.E.	104.1	97	200
7	TB	001	87	1,633
8	Pyrexia of unknown origin		84	474
9	Disease of GUS	114.6	68	476
10	Bronchial Asthma	66.1	45	682

Table 8 provides data on the number of discharges, average length of stay, and death rates per ward for four months the year 1999/2000. From Table 8 one can see that the bed turnover rate is highest for the Pediatrics Ward (36.8) followed by OB/Gyn Ward (36.37). Occupancy rates are highest for the pediatrics ward (152%) in the year compared to 60% in the surgical ward.

Table-9: Inpatient Care in Dilla Hospital

Ward	Beds	Discharge	Bed Turn over	Bed Days	ALOS	Deaths	Death Rate
1	2	3	4 = 3/2	5	6 = 5/3	7	8 = 7/3
Medical	30	510	17	3,925	7.69	19	0.03
Surgical	20	150	7.5	1,834	12.22	1	0.006
Pediatrics	15	552	36.8	2,820	5.10	10	0.01
OB/Gyn	16	582	36.37	1,447	2.48		
TB							
Others							
Total	81	1,794	97.67	10,026	27.49	30	0.04
Average	20.25	448.5	24.41	2506.5	6.89	10	0.02

*Given and compiled from hospital statistics

The Average Length of Stay (ALOS) was 6.89 days in the hospital, with the highest in the surgical ward (12.22 days), followed by the medical ward (7.69 days), and pediatrics (5.10 days). The Ob/Gyn ward has the shortest length of stay of 2.48 days. Death rate was the highest in the medical ward as high as 19 cases in the year

4.1.2. Fee Retention Experiences

a) User fees

There has been an established practice of price setting for long time now' which continued to date without almost any change. The user fee is not available in a standardized way in the sense that although prices are set for certain services such as advance payments for admission, laboratory and x-ray services, the fees for many other services is determined by the particular service unit rendering it, taking into account the inputs used.

In the current practice, the unit cost of a service unit is either not clearly stated or entirely unknown. The system does not allow for such practice. Apparently, therefore, costs of inputs are determined by rule of thumb or arbitrarily in the sense that there are no standardized costing systems with respect to the various fees.

b) Budget preparation

The amount of money to be retained is subject to budgetary control in as much as the regular budget is. In this regard, the hospital was required to prepare budget for the amount of money to be retained based on the annual collection of the preceding year. Accordingly, during 1992EC, the hospital submitted its plan of action, and the corresponding budget of expenditures to be paid from the amount of retention.

However, the amount had not been transferred from the zonal finance department until end of June 2000 (i.e. the end of the fiscal period). Similarly, during the current budget year of 1993EC, although the hospital submitted the budget of expenditures calculated at 50% of 1992 EC collection, the zonal finance department did not transferred the eligible amount of retention until May 2001. In both years, the hospital was not able to use money from collections. Instead, all collections must be first deposited to the accounts of the zonal finance bureau. Only up on submission of budget will then the latter release the amount of money to be used from collection. This procedure is similar to that of administration of

recurrent budget, and delays in transfer of money had caused considerable problems on timely use of the amount of money retained.

Hospital administration complains that the current handling of retention is not actually retention because it does not allow the hospital to retain and use money as and when required.

More over, any amount left is to be appropriated by the zonal finance department at the end of the year in the form of remittance, leaving no authority for the hospital management to carry forward balance to subsequent year to accommodate any changes.

c) Collection procedures

Existing procedures

An examination of the system of accounting and record keeping prevailing at the hospital reveals that the system is completely based on government revenue accounting systems. As part of this system, therefore, the collection procedure is designed to ensure compliance with the requirements of the government's budgetary & revenue accounting system. Other guidelines pertaining to retention of fees are not given to the hospital. Accordingly, collection of hospital revenues regardless of whether such revenue are generated from patient services or sales of drugs are subject to the following procedures:

- Daily collectors receive cash against issuance of pre-numbered and printed official receipts provided by the local Finance Bureau for purposes of collecting revenue generated at the health facility. The official receipt is known as SA/21/1.
- The main collectors receive collections from daily collectors against issuance of Model 64, another voucher prescribed by the Finance Bureau for use in the hospital with the purpose of clearing the debts of collectors.
- The handover (remittance) to the local Finance Bureau is finally concluded following presentation of Model 7 (summary of income collected) by the hospital main cashier. The Finance Bureau confirms the receipt of the collection by issuing Model 64 (another official receipt of the Finance Bureau).
- The same pattern of collection is also used with respect to 50% paying-patients, and collection in settlement of services given on credit basis to government agencies in Dilla.

The existing collection procedure requires the hospital to deposit 100% of the income generated at facility to the accounts of the local Finance Bureau. That is mandatory. There is no separate bank account maintained by the hospital to which collections are deposited.

Similarly, a different arrangement that is consistent with government revenue accounting is used to determine the amount of money to be released as a "retention" – that is through the process of budget application described in 3.2. above.

Collection procedures and impact

There have not been many changes on collection procedures following the introduction of the fee retention policy due to continuation of requirements to comply with the procedures of the zonal finance department, as described above.

However, since the introduction of the retention policy, the management of the hospital seems to get motivated to take some actions to either increase the size of the collection or mitigate factors that contribute to decline of hospital revenue. This largely emanates from the management's belief that increase in total revenue is directly proportional to growth in size of the corresponding 50% share of the hospital. Accordingly, in a bid to achieve the consideration, the hospital has taken the following actions to control provision of services to non-paying patients:

- The adoption of a two- stage checking of poverty certificates, by the Administration Office and the Registrar, has begun to reduce the influx of forged certificates. In a short survey made by the hospital to selected kebeles and woreda to check the authenticity of poverty certificate after service are fully given suggest that none is forged. Although the finding doesn't guarantee if only the needy are served, the practice happens to avoid the use of forged poverty certificates.
- Conducted series of meetings with administrators of kebeles on limiting issuance of poverty certificates to only the needy and the poor. Although the immediate impacts of this action are not apparent, it may influence kebeles to make serious considerations in the future.
- Formal registration of families of staff members was made at the hospital. Accordingly, spouses and children under 18 are registered. This practice has totally deterred relatives of hospital staff from getting free services.
- As regards to 50% paying patients working with Civil Services, the zonal health bureau, following a notice from the hospital, has sent circulars requesting officers of respective Offices to maintain record of spouses and children under 18, and to releases official letters to hospitals only after confirming that beneficiaries are authentic. More over, the civil service department and the hospital are working closely to produce a roster of civil servants, their spouses and children under 18. It is hoped that this part of the paying patient will also come to line in the future.
- As described above, the collection procedures have not been changed since the advent of the new policy of fee retention. Consequently, the impacts of these changes on the amount of collection cannot be inferred.

Collections –comparative analysis

Although the idea of fee retention is introduced, its administration in practice has been tuned to the existing collection procedures, and budgetary control the zonal finance

department imposes on the hospital. Thus, as described above, the introduction of retention policy hasn't, in effect & directly, brought about any changes in fee collection procedures. However, the perception that increase in the total income results in proportional change on the share of the hospital income has, as mentioned above, motivated the hospital to take some more control measures. These control mechanisms, which are considered by hospital since advent of retention, seem to bring about some changes in the amount of annual collections, although one can't conclusively attribute it to the policy.

Thus, while prior to July 1999 figures indicate that revenue generated in 1991 EC from patient service and drug sales, as compared to 1990EC, decreased by 18% and 25% respectively, as can be seen from table 10.

Table-10: Fee Collection Prior to the New Policy

No	Type of Fee	Code	'in ETB		
			1990EC	1991EC	% Decrease
01	Patient Services	1513	46,737	38,470	18
02	Sales of Drugs	1512	196,974	150,913	25
	Total		243,711	189,383	

On the other hand, the post-retention period is characterized by slight increase in the income from patient services by 38%, although there was a 7% decrease in the sales of drug. The decrease in the sales of drugs was caused by free issuance of drugs to prisoners and street children that attended the hospital during the year.

The extent of free drugs made available to prisoners and street children during the year 1992 EC, according to hospital records amounts to Birr 29,475.50. Both categories of beneficiaries are different than the other free-patients who are required to bring certificates from kebel. Thus, the event can be considered as unique in the sense that prisoners and street children cannot be accommodated under the control mechanisms adopted by the hospital. The amount of revenue generated from drug sales would have risen by nearly 12% had it not been for the free drug issued to the prisoners and street children. Hospital management suggests that prison administration need to maintain a separate budget for treatment of people under its custody to enable the hospital recover costs associated with free treatment of prisoners. Table 11 indicates the pattern of collection after the introduction of the new policy.

Table-11: Fee Collection after the New Policy

No	Type of Fee	Code	'in ETB			
			1991EC	1992EC	% Change	1993EC upto March '01
01	Patient Services	1513	38,470	53,258	+38	32,472
02	Sales of Drugs	1512	150,913	139,147	-8	60,802
	Total		189,383	192,406		93,274

There are no exact records on the amount of money forgone by way of free treatment in the year 1992 EC because the Hospital was not maintaining statistical records. However, figures for 9 months period of the current fiscal year (July '00 to March '01) indicate that the value of free service provided to patients proved financially "poor" including prisoners stands at Birr 45,034.07 which is nearly 50% of the total revenue for 9 months, suggesting that the claimed "mechanisms", have a long way to prove effective.

Special bank account

Although the Strategy document clearly states the need for opening of special bank account into which the amount of collection or retention is deposited, the hospital has not yet been allowed to open the account. Instead, the current practice requires the hospital, first of all, to deposit 100% of its collection, and secondly, to comply with budgeting procedures to get released, the 50% share of the hospital.

d) Retention practice

As one of its provisions, the guideline issued by the RFB allows hospitals to directly retain money from their daily collections which shall “ not exceeding 50% of total collection of the preceding year, and describes procedures for reporting the retained amount and the remaining balance of collection. However, the management of Dilla hospital confirmed that it did not receive the guideline. Instead, it received a circular from the zonal finance department, which instructed the hospital to prepare expenditure budget not exceeding the preceding year’s collection.

The current practice of retention in the hospital indicates that the following steps similar to administration of recurrent budget should be followed:

- Based on the preceding year’s collection, a plan of action, and a corresponding budget of expenditure not exceeding 50% of such collection will have to be prepared and submitted to the zonal finance department.
- Up on approval of the zonal finance department, the amount of money to be used as a “retention “ is then released depending on availability of funds at the department.
- The hospital is forbidden to use any amount of money from its collections either to supplement budget deficit or improve quality of a selected service unit, for the hospital is instructed to deposit 100% of its collection.
- Similarly, no separate bank account is be maintained by the hospital for purposes of depositing even the approved 50% which must be under the custody of the main cashier.
- The hospital doesn’t have any right to carry forward unused balance to subsequent fiscal period. The zonal finance will have to appropriate it at year-end count and audit in the form of remittance.

During the fiscal period 1992 EC, although the hospital satisfied the requirements of the ZFD, in terms of early submission of its action plan & budget, the latter was not able to release the amount of money supposed to be retained until the end of the fiscal year. Hospital management complains that the delay on the part of the ZFD in releasing the fund in time has caused considerable problem in allocation of the retained amount, and there was rush for fear of appropriation by the latter.

For the fiscal year 1993 EC, although the hospital submitted its action plan and budget to the ZFB as early as October 2001, the retention has not been released until the end of May 2001. According to the hospital management, the ZFB promised to release it as soon as fund is available at the department. And, yet only one month is left for the entire fiscal period to end, without using the retention. Table 12 (see next page) indicates the amount of money released from the ZFD as retained fee for 1992Ec, and the budgetary allocation as well as the request lodged for 1993 EC.

It is not clear whether hospitals use the retained amount to complement deficit in the recurrent budget or use the money for improving the quality of a selected service unit. There is no a clear guideline to that effect as this is reflected in Table 12 which mixes budgeting for recurrent expenditure and purchasing on drugs and fixed assets to service units.

Table-12: Amount of Fee Retained 1992 EC & Budgeted Request for 1993EC

No	Description	in ETB		
		Fee Retained	Budgeted	%
1	Fiscal Year 1992 EC			
1.1	Fee Retained: at 50% of 1991 revenue	94,691		
1.2	Budgeted Expenditures			
	1.2.1. Electricity & Water Consumption		21,855	23.08
	1.2.2. Purchase of Fixed assets		5,156	5.45
	1.2.3. Wages, Per diem allowance, laborer		10,022	10.58
	1.2.4. Purchase of Drugs		47,615	50.28
	1.2.5. Maintenance of x-ray rooms & other wards & buildings		10,000	10.56
	1.2.6. Fuel & Lubricants		42	0.05
	Totals for 1992EC	94,691	94,691	100
2	Fiscal Year 1993 EC			
2.1	Fee Retained: at 50% of 1992 revenue	NIL		
2.2	Budgeted Expenditures for 1993			
	2.2.1. Electricity & Water Consumption		20,000.00	
	2.2.2. Purchase of Fixed assets		10,000.00	
	2.2.3. Wages, Per diem allowance, laborer		15,000.00	
	2.2.4. Purchase of Drugs		40,000.00	
	2.2.5. Maintenance of x-ray rooms & other wards & buildings		11,000.00	
	2.2.6. Miscellaneous		203	
	Totals for 1993EC	NIL	96,203	

As can be observed from Table 12, the amount of money released for retention in 1992EC has been 100% used during the last month in which it was received (June 2000, the end of the fiscal period); while 1993EC no retention was made till the end of May despite a budgetary request. A slight growth in the amount of money to be retained in 1993EC as compared to that of 1992EC is observed, suggesting that the hospital management has a long way to increase the amount of total collection, and hence its corresponding share of 50%.

e) Expenditure pattern

The process of budgeting to expend from retained fee seems to be at the discretion of hospital management. It is noted that almost all the budget lines in the hospital are covered

under the recurrent budget although it may not be sufficient. It is, therefore, logical to hold that a larger portion of the amount of money allowed to be retained at health facility level need to be spent in improving selected service units, while a relatively smaller amount be allocated to cover budget deficit. However, although the guideline issued by the RFB did not reach the hospital, it does not at all specify the pattern of expenditure from retained fee.

A closer look at table 13 (see next page) suggest that in 1992EC, about 66% of the retained amount was spent on purchase of drugs, fixed assets to wards, and maintenance of x-ray room, the remaining 34% was spent to cover deficit in regular budget such as electricity & water, wages, per diem allowance, and laborers. The spending meant to cover regular budget deficit is relatively high, and may have impact on provision of quality of services at health facilities. As much as possible the regular budget requirements must be financed from government budget allocation in order to make more funds available for purchase of drug and medical supplies. The allocation of 50% of the retained fee on purchase of drugs was made to the budget pharmacy. The hospital management was forced to spend half of the retained fee on the drug because the hospital ran out of drugs and that there was no budget at all for drugs during the year 1992EC.

During the on going fiscal year of 1993, although the retainable amount is not yet released by the zonal finance department, a look into the pattern of budgeting for expenditures followed by the hospital suggest that the budget pharmacy is taking the lion's share, i.e., about 42%. However, the consultant's another reliability check into the budget books suggest that there is budget for drugs. More over, except for 21% allocation for apportioning building to accommodate the eye clinic and pharmacy room, 37% of the retainable amount is still to be expended to cover regular budget deficit. If the latter continue for years to come, the possibility of putting emphasis on improving quality of service unit will be questioned. Table 13, next page, indicates the budgeted pattern of expenditures to be made from retainable amount.

Table-13: Expenditure Pattern for 1992EC & Budgeted for 1993 E.C

'in ETB

No	Description	Amount Expended In 1992EC	%	Budgeted* Expenditure 1993	%	Remark
1.	Electricity & Water Consumption	21,855	23.08	20,000	20.79	
2.	Purchase of Fixed assets	5156	5.45	10,000	10.39	
3.	Wages, Per diem allowance, laborer	10,022	10.58	15,000	15.59	
4.	Purchase of Drugs	47,615	50.28	40,000	41.5	
5.	Maintenance of x-ray rooms & other wards & buildings	10,000	10.56	11,000	11.43	
6.	Fuel & Lubricants	42	0.05	203	.22	
	Totals for 1992EC	94,691	100	96,203	100	

*Budgeted Expenditures from Retainable fee -1993EC. These budgets have not been released to the accounts of hospitals until end of May 2001.

f) Exemption and waiver

The policy of the hospital as regards exemption and waiver states that a number of categories are covered in the scheme. A larger portion consists of patients with poverty certificates, prisoners, street children, TB patients, and spouses & children hospital staffs are exempted. Waiver of fees are applied to patients that present official letters from the Civil Service, and are allowed up to 50% of the fee as a waiver.

Due to poor record keeping, there were no statistical records that indicate the extent of exemption and waiver during the year 1992 EC in Dilla Hospital. The hospital attempted to improve its statistical unit during the year 1993 EC. Consequently, we were able to collect data on exemption and waivers for the nine months of the current fiscal period. Accordingly, figures for the period spanning 9 months, July 2000 to March 2001 suggest that the total value of exemption and waiver amount to Birr 45,034.07, accounting nearly 50% of the total collection for the period. In fact, the hospital has adopted certain control mechanisms described in earlier parts of the report for Dilla hospital. However, the value of exemption and waiver indicated above suggest that unless all parties involved in the issuance of certificates closely work with the hospital, it will continue to contribute towards declining of collections, and hence the spending of the hospital from retention.

4.1.3. Impact on Quality of Services

The evaluation of impact of the retained fee on quality of services is not easy because the nature of information involved is predominately qualitative in nature. Yet, hospital management believes that the products or services acquired with the assistance of fee retained have positively impacted the quality of services provided to patients directly or indirectly. Patients were able to get medicines bought from 50% of fee released to the hospital as retention in 1992EC. During the year there was no any budget allocated to the pharmacy from the recurrent annual budget at all. The retention provided additional money that was not possible by any other means. Thus, the fee indirectly made the hospital service more effective by providing essential and other drugs available to patients. Had it not been for the retention fee, it wouldn't have been possible to provide medicines to patients in a situation where there was no budget allocation at all.

Moreover, water supply to the hospital, which was one of the major problems to date, has been solved to some extent from fee retention. The hospital was able to buy extra water tankers that were linked to the main pipeline to augment storage and supply of water. The laboratory and x-ray rooms were ill equipped with old and obsolete furniture that new ones are bought from retained fee replaced furniture that was out of use. Besides, expenses paid for renovation of the x-ray room, have improved the quality of x-ray outputs that was previously exposed to external inputs caused by perforated wall.

Further more, the hospital become clean and attractive than it was before as a result of the retained fee from which payment of per diem and/or wages to cleaners, and gardeners was made. By and large, the retained fees of the fiscal year have directly or indirectly contributed to improvement of quality of health services rendered to patients by making supply of drugs or medicines, adequate supply of water possible; maintaining perforated x-ray rooms to give better output, and providing the benefits of clean hospital environment. Finally, the availability of fund from the retained fee has given the hospital management

with the advantage of flexibility in supplementing the regular budget deficit that may have indirect impact on quality of hospital services.

The amount of retainable fee for the year 1993 EC has not been released until the end of May 2001 to the hospital from the zonal finance department although the hospital submitted the required budget to the latter. Thus, where there is no retained fee, it is not possible to make impact assessment.

4.1.4. Management Requirements and Impacts

The current practice of retention does not allow hospitals to retain 50% of their fee collection for potential utilization. It does not empower hospital management to immediately use funds from collection, either. In fact, both alternatives have been provided in the guideline issued by Regional Finance Bureau. For reasons best known only to zonal finance department, the process of retention has been tuned to existing practice of recurrent budget. The latter requires the fulfillment of a number of requirements including 100% deposit of hospital collection to zonal finance department accounts, and as described in earlier part of this report to lodge budget application.

Dilla hospital is not unique in this regard. The procedures of collection, handover of collections, budgeting, budget request for withdrawal of retention fee, and all other activities pertaining to the administration and utilization of retained fees have been made to stick to the existing procedures. The way hospitals organize collection, and methods of disposition of such fees are consistent with the requirements of finance regulations. Moreover, there were not any changes in the assessment, collection and handling of fees since retention was allowed. Consequently, the existing practice of retention has not required the hospital management to make any changes in relation to fee retention. Looked from management requirements and impacts perspectives, the current handling of retention has not required management to introduce a different arrangement.

The hospital management has suggested a number of issues that need to be addressed in view of increasing collection of fee and improve the quality of services delivered, which are indicated below:

- The administration and utilization of fees should be practiced in accordance with the provision of the Strategy document learned during the workshop given in Wolktie sometime in February 2001. The lengthy and time wasting process of handing over all collections and lodging separate request for withdrawal from retained fee must be avoided.
- A clear guidelines preferably consistent with provisions of the strategy document that empower hospitals to retain fees and to deposit such fees in a separate account should be implemented to allow hospitals use the fund fairly during or before a fiscal year expires.
- Hospitals should be given relative discretion in the administration and utilization of retained fee for either improving a given service unit or complementing budget deficit. The role or degree of intervention of the zonal

finance department should be limited to recognition of budgets pertaining to retained fees, and proper auditing.

- In order to increase the collection of the hospital, strict screening and control over patients that are eligible for exemption and waiver should be imposed. This requires the involvement of Regional Council and administrative units at all level.
- Enhance the skills of hospital management through capacity building programs, and allow extra incentive from fee retained to hospital health personnel, who are the key actors to provision of quality of services.
- Strict control over the use of drug, and avoid drug wastage.

4.2. Wolyta Sodo Hospital

A missionary group known as SIM established the hospital at a lower level health facility in 1938 EC. It had 45 beds for admission, and provided outpatient service on a range of facilities. In 1967 EC, the management of the SIM developed the capacity of the hospital to own a new building comprising almost all wards and services currently provided by the hospital. Since 1970EC(1978), the administration of the hospital has fallen under the government that financed capital and recurrent budget requirements of the hospital.

The demographic conditions of the hospital suggests that the catchment or assigned population stretches to 1.5 million, covering almost all woredas of the densely populated Wolyata Zone. There are clinics, health centers and health posts from which patients are referred to the Hospital. Besides, self-referred people come to the hospital to get a better service.

The organization structure of the hospital suggests that the Medical Director supervises a number of service units organized in the form of Departments and include Matron, Pharmacy, X-ray & Laboratory. The Administration & Finance Department, comprising offices of the Registrar, Budget & Accounts, Property Administration and Personnel Services, are also under the supervision of the Medical Director.

4.2.1. Types of Services

a) Outpatient and inpatient services

The outpatient unit of the hospital renders a number of services including Antenatal Care (ANC), Mother and Child Health (MCH) medical emergency treatment, surgical emergency treatment (minor), dental clinics, ophthalmologic care, psychiatric care and managements, and diabetic and TB follow-up clinics. The inpatient services are focused on internal medical services for severely and chronically ill patients, major elective surgery for both gynecological and surgical patients as well as medical and surgical care for children.

The hospital offers laboratory tests (phraseology, hematology, etc), x-ray, endoscopies, ultra sound, radiological services and other services. Besides, health education is provided every morning to all hospital visitors including patients and their families. The education focus on sanitation, family planning and HIV /AIDS.

b) Beds and health personnel

The distribution schedule of the total number of 133 beds available in the hospital indicates that 84 beds are allocated to the medical ward, and surgical ward at 42 beds to each ward, accounting for 63% of the total. The pediatrics ward, and OB/Gyn ward have 29 and 20 beds respectively. The figures for 1993 suggest that hospital is staffed by 7 physicians (of which 1 is specialist), 34 nurses (6 specialized nurses), one pharmacist, two pharmacy technicians, three laboratory technicians, two x-ray technicians, one sanitarian, two anesthetists, and 53 health assistants. Hospital management holds that the hospital is under staff given the size of the assigned population.

c) Activity trend

The data collected for 12 months period (July 99 to June 00) to indicate the trend of hospital activity is analyzed and summarized below under table 14. During the year a total number of 44,767 outpatient visitors received health care, which means 3731 patients a month or an average of 125 per day. The hospital admits 259 patients per month or 9 per day approximately, that gives to an estimated 3,099 number of admissions per year. Similarly, the number of laboratory tests during the year stand at 20,690, i.e., approximately 1724 per month. The statistics reveals that the hospital is probably functioning near capacity. Besides, if the hospital

Table-14: Major Activity Trend

Month	OP Visits	IP (Admissions)	Major Operation	Lab. Tests	IP/OP	Tests/OP
July 99	4,854	266	81	1,266	0.05	0.26
Aug.99	4,771	274	109	2,416	0.06	0.51
Sept.99	3,968	266	67	1,167	0.07	0.29
Oct.99	2,963	232	71	1,084	0.08	0.37
Nov.99	3,393	275	60	990	0.08	0.29
Dec.99	3,007	271	-	63	0.09	0.02
Jan.00	4,285	258	100	2,301	0.06	0.54
Feb.00	2,981	242	89	2,207	0.08	0.74
Mar.00	3,679	238	73	2,031	0.06	0.55
Apr.00	3,401	264	72	2,029	0.08	0.60
May.00	3,208	275	76	3,109	0.09	0.97
June.00	4,257	238	111	2,027	0.06	0.48
Average/Mo	3730.58	258.25	82.64	1724.17	0.07	0.47
Total/year	44,767	3,099	909	20,690		

is allowed to retain a larger portion or all of its income to improve the quality of its services, the flow of people to the hospital will increase given the reputation it has established to date.

The number of discharges, average length of stay, and death rates for each active ward is presented in table 15 spanning 6 months period (January 2000 to June 2000).

Table-15: Inpatient Care in Wolyta Sodo Hospital

Ward	Beds	Discharges	Bed Turn Over	Bed Days	ALOS	Deaths	Death Rates
1	2	3	4=3/2	5	6=5/3	7	8=7/3
Medical	42	359	8.5	5,296	14.8	56	15%
Surgical	42	390	9.3	8,825	22.6	22	5%
Pediatrics	29	292	10.1	4,025	13.8	43	14%
OB/Gyn	20	474	23.7	3,351	7.1	12	2%
TB	-	-			-	-	
Others	-	-			-	-	
Total	133	1515	-	21,497	-	133	
Average	33.3	378.8	12.9	4,299.4	14.6	33.3	9%

The highest length of stay was recorded in the surgical ward i.e. 22.6 days with an overall hospital average length of stay of 14.6. This is followed by medical ward (at 14.8), and pediatrics (at 13.8). The OB/gyn ward has the shortest length of stay. The average length of stay has implications on cost of providing care, and if the costs are accurately determined, the hospital may consider recovery of costs when retention of fee is allowed at 100% in the future.

The analysis indicates that the bed turn over rate is high for OB/Gyn ward (23.7), although the least ALOS is recorded, followed by the pediatrics ward. As regards to death rates, the average for the hospitals stands at 9% of discharges, while the medical and pediatrics ward being with highest percentage of 15% and 14% respectively.

4.2.2. Fee Retention Experiences

a) User fee

The user fee set when the hospital was established is still functioning to fee patients for services provided although the fees for certain service units was slightly changed. In Wolyata Sodo hospital, the user fee is uniformly provided in schedule form for a service unit that levies it, and the cashier that collects it. This arrangement has made it simple to account for services that are freely provided for patients. In many visited hospitals except for certain services, the fees vary because the service units rendering service determine the fee taking the inputs into account.

On the other hand, the sales of drugs from the budget pharmacy are determined at 25% margin of purchase prices. Since the amount of money collected from sales of drugs is fully handed over to the zonal finance department, and as long as the amount of margin is not retained at hospital level, it is not still clear whether the margin is shared.

b) Budget preparation

The hospital submitted the budget of expenditure to be paid from retainable fee set at 50% of the preceding year's collection. The retainable amount was released in three consecutive installments in 1992EC from February 2000 to June 2000. Compared to other hospitals, Sodo hospital benefited in terms of relatively timely release of the retainable amount.

However, the retainable amount for 1993⁴ EC has not been released until end of May 2001 despite the fact that the hospital submitted a detailed budget as early as November 2000. Hospital management is concerned with such a delay, and commented that the hospital may run out of time in terms of acquiring services on time with in the next one month (i.e. June is end of the budget year). In the sense of the forgoing actions of zonal finance department, management questioned, "what is the use of releasing retainable amount towards the end of fiscal period to just re-appropriate it on the 30th of Sene (June) because it is the practice of the zonal finance department to appropriate any unused balance.

c) Collection procedures

Existing procedure

The role of regulations of the zonal finance department is highly pronounced as regards collection. The following procedures, which have been in place for many years now, must be complied with if the hospital would get the fund released, and haven't been changed even since the introduction of the retention fee:

- Collectors must issue form SA/21/1, an official cash receipt of the zonal finance department, against receipt of cash.
- The main cashier makes use of Model 64 to receive the total daily collection from daily collectors.
- The main cashier of the hospital summarizes the collections using Model 7, and remits the total collection (100%) to the accounts of the zonal finance department.
- The procedures described above must also be complied in collecting cash from 50% paying patients as well as settlement of credit sales to customers such as Blatie Agricultural Ent., EELPA, Tobacco Plantation, and the Central Prison of Sodo.

According to the procedures described above, it is mandatory for the hospital to deposit all of its collections to the account of the zonal finance bureau. The hospital is not allowed to retain 50% of the total fee from collection nor the use of separate bank account.

Collection procedures and impacts

The collection procedures described above have been operational for many years now. The promulgation of the regional finance proclamation, which is more or less similar to the federal version, reinforced these procedures and are applicable at all levels.

The outcomes of the field visits particularly the interviews and data collection conducted in Sodo Hospital reveal that the collection procedures have not been changed even after the introduction of the new policy retention. The procedures of the zonal finance department require the hospital to comply with these procedures. In this regard, booking for collections and for withdrawals is made using the existing system of government accounting system, which is predominately single entry.

Since the collection procedures have not been changed after the advent of the new policy of fee retention, it was not possible to get concrete data to make analysis of impacts or changes on the amount of collection.

Collections –comparative analysis

Table 16 below compares the amount of collection prior to introduction of the new policy of fee retention. As can be seen from table 16 there has been a decrease in the total fee earned in 1991EC as compared to 1990EC due to provision of free services to financially "poor"

patients. Hospital management complains that it has not been possible to identify the poor from those who can afford to pay for medical services because poverty certificates are loosely issued from keels or wereda administration units.

Table-16: Fee Collection Prior to the New Policy

'in ETB					
No	Type of Fee	Code	1990EC	1991EC	% change
1	Patient Services	1513	312,723.35	315,118.50	1
2	Sales of Drugs	1512	224,788.15	212,231.96	6
	Total		537,511.50	527,350.46	2

The introduction of the new policy, as explained earlier, has not brought about any changes on the procedures of collection during 1992 when retention was allowed. Consequently, the amount of collection has not been changed in 1992 as compared with 1991EC, it was rather characterized by a decrease in the total income by 38%. As can be seen from table 17 below, collection from patient services has decreased by 14%. According to hospital management the, the decrease is caused due to continued influx of poverty certificates. Similarly, the collection from drug sales drastically dropped by 75% in 1992EC as compared with 1991EC because there was no budget for drugs during 1992EC, and there was no additional financing to the budget pharmacy as was in 1990 and 1991.

Table-17: Fee Collection After the New Policy

'in ETB					
No	Type of Fee	Code	1991EC	1992EC	% Change
01	Patient Services	1513	315,118.50	272,553.90	(14)
02	Sales of Drugs	1512	212,231.96	52,232.05	(75)
	Total		527,350.46	324,785.95	(38)

Table 17A below compares the amount of collection of the 9-month period of the year 1993 with the same period of the preceding year. The new policy of fee retention is being practiced during both years. There is an increase of the total collection by 16% during 1993 when it is compared with the collection of same period in 1992. However, there are no clear evidences to link the increase in the collection to introduction of the fee retention because the current administration of the latter has not yet motivated management to take local initiatives to increase the amount of collection.

Table-17A : Fee Collection After the New Policy

'in ETB					
No	Type of Fee	Code	July – March 2000	July – March 2001	% Change
01	Patient Services	1513	197,868.15	243,763.55	
02	Sales of Drugs	1512	33,360.50	25,489.35	
	Total		231,228.65	269,252.90	+16

Special bank account

Despite the provisions of the Strategy that allows hospitals to open separate bank accounts into which income generated at health facility deposits are made, Wolyta Soddo hospital, like others, has not yet opened that separate accounts. It is, instead, required to handover all of its

collections to zonal finance department directly, and follow the procedures of the recurrent budget administration to get what is known as "retainable amount" form the former.

d) Retention practice

The current practice of retention in the hospital indicates that a circular issued from the zonal finance bureau governs it. In this regard, the hospital management must comply with the following sets of procedures:

- A plan of action and a detailed budget of expenditures to be paid from retainable amount should be prepared by the hospital, and submitted to the zonal finance bureau. The expenditure shall not, however, exceed 50% of preceding year's collection.
- The zonal finance department, after a review of the budget request & ensuring availability of money, releases to the amount of money to be retained by the hospital. The period of withdrawal to the hospital is at the discretion of the finance department not at the facility that generated the income.
- As the hospital is, first and foremost, required to hand over or deposit 100% of its daily collections to the accounts of the zonal finance department, it is not at all allowed to use any amount of money to finance a service unit or cover a budget deficit.
- Similarly, no separate bank account is to be maintained by the hospital for purposes of depositing even the approved 50%.
- The hospital doesn't have any right to carry forward unused balance to subsequent fiscal period. The zonal finance will have to appropriate it at year-end count and audit.

Although the hospital submitted its action plan and the corresponding budget to ZFD as early as September 1999, the latter was not able to release the first installment of retainable amount until January 2001. In fact, compared to other hospitals, the Wolayta Sodo hospital relatively got the advantage of early funding in terms of release from the ZFD. Table 18 presents the series of installments of retainable fee released from the ZFD.

Table-18: The Amount of Fee Retained for 1992 EC

No.	Description	'in ETB Amount
1.	First installment, January 2000	82,000.00
2.	Second installment, March 2000	80,000.00
3.	Third installment, June 2000	60,000.00
	Total	222,000.00

For the fiscal year 1993 EC, although the hospital submitted its action plan and budget to the ZFB during November 2000, the retention has not been released until the end of May 2001. Management describes the current practice of retaining fees as totally different from those explained in the Wolkite Workshop, and one that is characterized by long process of applying for budget, and delay in getting the budgeted retention released from the Zonal finance

department. For instance, the budget requested for 1993EC has not been released despite the fact that the application was lodged as early as November 2000.

Table 19 (next page) indicates the amount of money to be released from the ZFD as retained fee, and the budgetary allocation as well as the request lodged for 1993 EC. According to table 19 the budget for year intends to spend 85% of the retainable amount in improving the quality of a number selected service units by purchasing badly needed instruments. If the allocation is implemented, almost all active wards of the hospital will be benefiting from the retainable amount. The remaining 15% is to be spent for acquisition of a computer with printer and deck for use as teaching aid. This spending is also indirectly related to improvement of quality of health services of the hospital.

Table 19: Budget Request for 1993 EC

No.	Description	Qty	in ETB	
			Unit Price	Total Amount
1.	Intensive Care unit			
	1.1. Oxygen Concentrate	2	32,000.00	64,000.00
	1.2. Beds	10	350.00	3,500.00
	1.3. Suction Machine	10	510	5,100.00
2.	Medical, Surgical & Pediatrics Wards			
	2.1. Section Machine	1	6,500.00	6,500.00
	2.2. Blood Pressure measuring unit	2	510	1,100.00
	2.3. Oxygen Concentrate	1	32,000.00	32,000.00
	2.4. Screen	5	350	1,750.00
3.	Outpatient Service Unit			
	3.1. Toscope	10	325	3,250.00
	3.2. Ophtratoscope	10	450	4,500.00
	3.3. Blapaptratus	10	510	5,100.00
4.	Teaching Aid & Physicians Services			
	4.1. Computer & Printer	1	23,000.00	23,000.00
	4.2. Television Deck	1	2,000.00	2,000.00
	Total			171,300.00

According to the hospital management, the ZFD promised to release it as soon as fund is available at the department. And, yet only one month is left for the entire fiscal period to end, without using the retention. Although there is no clear guideline regarding spending from retainable amount, one can readily infer from, the table of allocated budget, that the management of Wolyta Sodo hospital is committed to improve the quality of service units which are directly related to the patients.

As can be observed from tables 18 & 19 above, the retainable amount for current year of 1993 when compared with that retained in 1992 shows a decline by 22%. The situation is attributed to a sharp decline of total collection of 1992EC to the tune of 38% as compared to the preceding year collection. A closer look into the pattern of allocation of budgets in both years indicate that a lion's share of the budget allocation of 1992 went to finance the budget pharmacy because there was no regular budget to the pharmacy. In 1993EC, however, 85% of the allocation is intended to equip the service units with essential equipment and instruments. The pattern is quite encouraging if the zonal finance department releases the required amount of retention in time to enable the hospital management take the most out of the new policy.

e) Expenditure pattern

The amount of spending from retainable amount must follow the budget allocation submitted to the zonal finance bureau. Accordingly, in 1992EC, the budget allocation apportioned into purchase of drugs, which was not at all available from the regular budget, and to supplement budget deficit.

A closer look at table 20 below suggests that in 1992EC, about 86% of the retained amount was spent on purchase of drugs, while the remaining 14% was spent to complement budget deficit. The allocation of more than 85% of the retained fee on purchase of drugs was made to the budget pharmacy. The hospital management was forced to make such huge spending from retained fee on the drug because the hospital ran out of drugs and that there was no budget at all for drugs during the year 1992EC. The bulk of drugs and medical supplies purchased were duly received by the hospital as evidenced by the receiving voucher.

Table-20: Expenditure Pattern for 1992EC

No	Description	Amount Expended	%	Remark
1.	Purchase of Drugs to Budget Pharmacy	191,209.49	86	
2.	Fuel and lubricants	7,865.97	4	
3.	Maintenance of vehicles	22,923.74	10	
	Total	221,999.20		

During the on going fiscal year of 1993, although the retainable amount is not yet released by the zonal finance department, as explained earlier the pattern of budgeting for expenditures followed by the hospital suggest that the largest share of is assigned to improve a number of service units. As mentioned earlier, the amount of money to be released from zonal finance department as retainable fee for 1993EC has not been released until the end of May 2001, which is only one month ahead of the end of the fiscal period. Hospital management complains of the danger of putting off the release of fund up to the end of the fiscal year, and went on to emphasize that the hospital may run out of time to acquire the budgeted equipment and services.

f) Exemption and waiver

The right of access to free medical care expressed in terms of exemption and waiver of fee is identified when poor patients present certificates of poverty from their respective kebeles. The children under 18 and spouses of hospital staff are also part of this category. Besides, waiver of fee to the extent of 50% of the value of the medical care is also allowed to members of the civil service up on submission of eligibility certificates to the hospital.

In view of examining the impacts of exemption and waiver on the total amount of collection and so on retention, certain data were collected from the hospital statistical department. However, the limitation of the data lies in the accuracy of value of free medical care assigned to type of care provided. The record on exemption and waiver was firstly not up dated, and most importantly for many types of care the exact value of care was not assigned until it was request for our review. As a result, the summary below may understate the value of free medical care provided during the 1992EC and 9-month period of 1993EC.

The number of free patients in 1992EC was 2,692, amounting to an estimated value of Birr 56,882.61 or 18% of the total revenue collected for the year. The value of free medical care during the 9-month period of 1993 as a percentage of the period's total collection stands at 21% provided to 2,496 patients. The number of free patients for 9 months period of 1993EC is only slightly lower than the total of the preceding year. Thus, since it is not uncommon for people to obtain poverty certificates with out actually being poor, and the hospital alone cannot effectively deter such influx; the number of free patients is likely to increase.

Table 21: Analysis of Free Care: 1992 EC and 9-month period of 1993EC

No	Description	Total Revenue	Free Care Value	% of Free Care	Total Number of patients	Number of free patients	'in ETB % of free patients
1.	1992 EC (July 99 to June 00)	324,785	56,882	18	47,866	2,692	6
2.	1993 EC (July 00 to March 01)	269,252	55,436	21	37,951	2,496	7

4.2.3. Impact on Quality of Services

As far as impacts of inputs from retained fee on quality of services of Wolyata Sodo Hospital are concerned, the analysis may be relevant to the year 1992EC only for no acquisition of products or service was yet made in 1993EC. During the year, 86% of the retained amount was spent on purchase of drugs to the budget pharmacy to which there was no budget allocation from the government side. Although there is a special pharmacy established under Bamako Initiative, it cannot alone satisfy patient demand for essential and other drugs. Thus, the additional financing to the budget pharmacy secured from the retained fee not only provided supply of drugs to patients, but also considerably reduced the load on the special pharmacy by making the medical supplies available.

The adoption of the new policy of fee retention, although shackled with tedious procedural requirements, has also provided the hospital with additional money to complement budget deficit. As a result, two budget lines that were under funded by the regular budget were financed from 50% fee retained. These were maintenance of vehicles and fuel and lubricants budget lines.

The amount of retainable fee for the year 1993 EC has not been released until the end of May 2001 to the hospital from the zonal finance department although the hospital submitted the required budget to the latter. Consequently, analysis of impact of retained fee on quality of services is not possible where there is no retained fee.

4.2.4. Management Requirements and Impacts

Under the current practice, the organization of collection, disposition of fee and administration of retained fees are all framed to fit with existing procedural requirements of government accounting system. Consequently, the continuation of dominance of the system has not allowed the management of Wolyta Sodo hospital to make changes with respect to the new policy of retention.

By and large, the impression of the hospital management concerning the policy is that policy implementation has not taken effect because administration of fee is still under control of the zonal finance department that limited the discretion of the hospital to formulating budgets. Moreover, under the circumstances, there have not been any changes in the assessment of collection and handling of fees even since retention was allowed. Consequently, management requirements and impacts have not yet been felt in relation to retention.

However, in view of implementing the new policy of retention, and hence, increasing fee and improving the quality of services, the management of Wolyta Sodo has suggested that the following actions be taken.

- The hospital must be allowed with relative discretion and autonomy to retain and administer the retained fees.
- The discretion of the hospital should be subject to auditing and inspection by appropriate health, finance and other government bodies.
- The health personnel of the hospital are integral parts of the greater initiative launched to improve the quality of service at a health facility. Thus, the new policy of retention should also make due consideration on the incentive part of it.
- The spirit and intentions of the Wolktie workshop on health care financing should be implemented in light of allowing autonomy of retaining and administering self generated revenue.
- For better outcomes, guidelines on implementation of the new policy of retention must be drawn and communicated to health facilities that will be responsible for generation and utilization of the fee revenue.

4.3. Chench Hospital

Chench hospital is one of the oldest rural hospitals established in 1960. The setting remained same until 1995 when it was expanded to include additional building that host four major departments: internal medicine, OB/ Gyn., surgery and pediatrics ward.

Demographic indicators suggest that the hospital is expected to serve more than 150,000 people of Chench Worda and its environs. There are only few number of health stations and posts from which patients are referred to the hospital.

The Office of the Medical Director is the highest decision making body in the hospital, and is supported by a management committee for implementing decisions. The office supervises matron and administrative units.

4.3.1. Types of Services

a) Outpatient and inpatient services

The outpatient service is primarily focused on provision of emergency examination, medical, surgical and pediatrics, ANC/MCH, health education family planning, antenatal & post natal care, and EPI services. The 120 – bed inpatient unit cover all these services to patients admitted to the wards and deliveries ESC, DSC as well as minor and major operations. Its also offers laboratory and X-ray services.

b) Beds and heath personnel

The total number of 120 beds available in the hospital are allocated into medical ward 50, surgical 30, pediatrics 20, and OB / Gyn. 20. Currently, the hospital employs 2 physicians, 8 nurses, 1 pharmacy technician, 2 lab technicians, 1 X-ray technician and 10 health assistants. Hospital management holds that Chench hospital is under staffed and not functioning fully.

c) Activity trend

Table 22 presets trends in major hospital activities. The number of total outpatient visits for 12 months (July 99-June 00) was 27,996 patients or 2333 monthly average. Data were also available on the number of admissions, major operations, and laboratory tests. The average number of admissions per month is 35. i.e. an estimated total number of admissions per year are 417. The hospital conducts 19 major operations per year. The number of laboratory tests per month is approximately 901 or total of 10,822. The statistics reveals that the hospital is not functioning at full capacity because people prefer to refer themselves to Arbaminch hospital for better services. If financing from retention is continued, the hospital management intends to up-grade and improve selected service units to attract patients in the future.

Table 22: Trends in Major Activities in Chench Hospital

Month	OP visits	IP Admissions	Major operations	Lab tests	IP/OP	Tests/OP
July 99	2,645	39	-	810	0.01	0.30
August 99	2,659	34	-	748	0.01	0.28
Sept. 99	710	28	-	999	0.03	1.40
Oct 99	2,421	27	-	959	0.01	0.39
Nov. 99	1,258	53	-	775	0.04	0.61
Dec. 99	1,633	32	-	670	0.01	0.41
Jan. 00	2,627	41	-	1,171	0.01	0.44
Feb. 00	2,863	34	-	969	0.01	0.33
March 00	2,701	33	6	926	0.01	0.34
April 00	2,207	44	5	966	0.01	0.43
May 00	2,915	20	7	875	0.00	0.30
June 00	3,357	32	1	954	0.00	0.28
Average/Month	2,333	34.75	4.75	901.83	0.01	0.45
Total/year	27,996	417	19	10,822	0.15	5.51

Data on the number of discharges, average length of stay and death rates per ward for the first six months of 1999/2000 are presented in table 23. From table 23; one can see that the bed turnover rate is the highest in medical ward, which are 3.3. The pattern of bed turnover in other wards less than 1:1, indicating preference of the local community being shifted in favor of neighboring Arbaminch Hospital. As regard to the average length of stay, it is apparently in medical ward (where bed turnover is the highest) and 9.02, followed by surgical and Pediatrics ward represents of 8.3 and 7.8 respectively.

Table-23: Analysis of in patient care Chench Hospital (July 99- December 99)

Wards	Beds	Discharges	Bed turn over	Bed days	ALOS	Death	Death rate
1	2	3	4=3/2	5	6=5/3	7	8=7/3
Medical	50	163	3.3	1470	9.02	4	0.02
Surgical	30	13	0.4	107	8.23	-	-
Pediatrics	20	10	0.50	78	7.80	1	0.00
OB/Gyn.	20	13	0.6	33	2.54	-	-
Others	-	-	-	-	-	-	0.00
Average	30	49.75	1.2	422.00	6.389	2.5	0.02
Total		199	4.8	1,688	27.59	5	0.02

4.3.2. Fee Retention Experiences

a) User fee

The management committee of the hospital in consultation with zonal health department set prices of various service units taking into account experiences of other hospital. This was necessitated following the re-organization of the hospital in 1995. The selling prices of drugs however, is mark-up to 25% margin on the cost price.

b) Budget preparation

As part of the requirements of the zonal finance department, the hospital submitted the budget of expenditure to be paid from retainable fees in both years. This is one of the

requirements that must be satisfied by the hospital so that the zonal finance department can allow withdrawal of the retention. In 1992 E.C, the budget request was released towards the end of June (the final month of the budget year) although the request and corresponding action plan were presented some time before. Similarly, the withdrawal of the retainable fee for 1993 E.C has not been in effect until end of May 2001.

c) Collection procedures

Existing procedures

The procedures of collection drawn for handling of fees in government entities are still operational. No separate arrangement has been made ever since the introduction of the policy of retention. In this respect, the following series of procedures are currently being practiced by the hospital:

- An official receipt voucher, known as SA/21/1 and issued by the zonal finance bureau, is used to collect service fee and sale of drugs.
- The daily collectors hand over their collections to the main cashier, and in doing so, use another official voucher, model 64 and (model 7 income summary).
- Finally, the zonal finance bureaus receive the total fee collected by the hospital against issuance of consolidated version of model 64.

These procedures, which are used during daily collection from paying patients on the counter, are also applicable when cash is received in settlement of credit services and 50% paying patients. Moreover, under the foregoing procedures, hospitals are required to remit 100% of their collections to zonal finance department, and are forbidden to use or retain there from.

Collection procedures and impacts

The existing procedures of collection continued to date. A different arrangement has not been introduced since the advent of the new policy, either. Consequently, there have not been changes on collection procedures observed.

The persistence of the existing procedures even after introduction of the new policy left management with the perception that retention of fees is only a different addition to existing regular budget that is subjected to similar procedures. Therefore, since there are no changes on the procedures of collection, a corresponding impact on amount of collection cannot be analyzed.

Collections, – comparative analysis

A comparative analysis may be needed to contrast the money collected before and after the new policy is introduced to prove the non-existence of changes explained earlier. However, due to lack of information for the year 1990EC, the analysis for the period prior to the policy could not be made.

After the introduction of the money retention policy, there seems to be a relative increase in money collected from patients, comparing 1991EC collections with 1992EC. According to the Table 24, 18% increase in the total fees was observed in the current year as compared to that of the preceding year. However, there are no strong evidences to link the increase to the policy because there is no corresponding action taken by management and that were meant to boost fee revenue. The Table 24 shows comparative analysis of collection in 1991EC and 1992EC, the period during which policy of fee retention is introduced.

Table-24: Fee collection after the new policy

No.	Type of fee	Code	in ETB		
			1991 E.C	1992 E.C	% charge
01	Patient service	1513	25,891.45	23,234.17	(10)
02	Sales of drugs	1512	78,216.20	103,951.33	25
	Total		104,107.65	127,185.50	18

The Table 25 compares the total revenues earned in 9 months of 1993EC with the total fee revenue of 1992EC. Fees from sales of drugs during the current year seem to achieve the target met last year (1992EC), i.e. 100% of sales of the preceding year has been met in only months time during the current year. During the year, 94.1% of the entire fee revenue was met in 9 months period during the year, and probably may exceed the figure if the trend continues in the future.

Table-25: Fee collection After the new policy

No.	Type of fee	Code	Total income in 1992	in ETB	
				July- March in 1993	% Compared with total 1992
01	Patient service	1513	23,234.17	15,278.50	65
02	Sale of drugs	1512	103,951.33	104,393.37	100
	Total		127,185.50	119,671.87	94.1

According to the Medical Director, the supply of brought forward from last year and bought from retained fees together with current year budget increased the supply, and so the sales, implying that the increase may not be attributed to the new policy.

Special bank account

The Chench hospital didn't maintain a separate bank account because it was not allowed to deposit the cash collected; rather, it is required to remit the total collection to the treasury of the Wereda Finance Department .

d) Retention practice

Like the experience of other hospitals, Chench hospital is required to comply with sets of procedures of the Wereda Finance Department. The procedures are summarized below:

- A budget must be prepared for retained fee, and submitted to the wereda finance department. The amount of the budget should not exceed 50% of the preceding year collection, as a rule.

- After receiving the budget request, approval for withdrawal from treasury is subject to availability of money at the treasury.
- Any cash collected from the activity of the hospital must be totally remitted to the zonal finance bureau, and no cash payment must t be made from collected amount.
- Maintenance of separate bank account is not allowed for purposes other than the recurrent budget.
- The balance remaining at the end of every budget year from the retained fund will have to be remitted, and shall not be carried for ward to the next budget year.

Chencha's ZFD ensured the compliance of the hospital to the procedures described and released the amount of retention to the latter for the fiscal year 1992EC. The Table 26 indicates the amount of fee retained at Chencha Hospital in 1992EC.

Table-26: The amount of Fee Retained for 1992

No.	Description	'in ETB 1992 E.C
01	50% of 1991 collection	53,912.89
	Total	53,912.89

The amount of retention set for 1993 at 50% of the preceding year has not been released to the hospital until the end of May 2001 despite the compliance on the part of the hospital to the sets of procedures imposed by the ZFD. As part of the requirements, hospital management presented its budget for the current year to the former, see Table 27, as fairly early as October 2001.

Table-27: Budget request for 1993 E.C

No.	Expenditure title	Code	'in ETB 1993 E.C (July 2000- March 2001)
01	Per diem, labor cost	6202	15,400.00
02	Printing and advertising	6203	3,000.00
03	Vehicle repair	6205	11,446.00
04	Utilities	6301	4,903.00
05	Education supplies	6303	200.00
06	Fuel & lubricants	6305	12,000.00
07	Stationary	6306	3,000.00
08	Supplies	6307	12,000.00
	Total		61,649.00

The intention of spending in Chencha hospital as the budget suggest is entirely on supplementing budget deficit. The guideline of RFB does not indicate the type of expenditure allowed for retained fee. Consequently, hospitals are often confused as to the use of extra funding from retained fees. Chencha's move to spend the budget for 1993EC to the extent of 100% on administrative overheads with out considering to improve quality of a give service unit is one good example of the need to develop a guideline not only on collections but also disbursements.

e) Expenditure pattern

The fee retained at the hospital in the year 1992 was totally spent for the purchase of drugs. This implies that there was no money budgeted by the government for the purchase of drugs in the year as described in earlier part of the report.

The Table 28 shows the expenditure for retained fee in the year 1992 in Chench hospital. However, in the year 1993, the money requested for retention has not been released and expended at this particular facility that analysis on the pattern of expenditures could not be possible.

Table-28: Expenditure pattern for the year 1992 E.C

No.	Description	Amt. Expenditure	%	'in ETB	
					Remark
1.	Purchase of drugs	53,912.89		100	
		53,912.89		100	

f) Exemption and waiver

As in other hospitals, the following categories of patients are entitled to receive medical care freely:

- A patient providing poverty certificate from the local administrative unit in the area.
- Hospital staff, their spouses and children.
- War veterans and prisoners

In an attempt to evaluate the impact of free medical care on amount of collection the following data were collected for 1992EC analyzed in Table 29.

Table-29: Analysis of free medical care for 1992

Description	Patients	Free Patients	% of free patients	Total Revenue	'in ETB	
					Free Care value	% of Free Care
Yearly Total	28,413	4,499	16	127,080.80	62,699.83	49
Average/month	2,368	371	16	11,552.73	5,224.99	45

During the year under consideration, the value of free medical care provided to patients that account for only 16% amounts nearly 50% of the hospital's fee revenue. The Medical Director describes the flow of certificates alarming because even those who can afford to pay for treatment often submit such certificates. He suggested that unless strict control is imposed it will continue to contribute towards declining the revenue of the hospital

3.3.3. Impact on Quality of Services

The amount of fee retained for 1992EC was entirely spent on purchase of drugs mainly because there was no budget allocation for purchase of drugs from the recurrent budget. According to the Medical Director, there are a number of service units that deserve

improvement if additional funding was available to the hospital. Yet, during the year the hospital was forced to allocate the scarce resources generated from retained fees to purchase of drugs. The action was effective in terms of supplying essential and life saving drugs to patients. In that sense, the impacts of the policy are positively felt. However, as mentioned earlier, the number of service units deserving improvement remained unchanged due to shortage of additional or regular budget funding. Worse still, the budget requirement have not been released for the year 1993 EC, as a result of which the hospital can not be said to have benefited from the retained fees, and so no impact on quality of services.

4.3.4. Management Requirements and Impacts

The current management practice of the Chenchu hospital is the same as it used be even after the introduction of the new policy of retention. In this regard, the methods of collection and disposition of fees prevailing in the hospital have not been changed since the advent of the new policy. Consequently, the situation has not required management to make changes with respect to assessment, collection, and handling of fees since the retention was allowed.

With respect to any management changes that could be made to increase collection and improve quality of services, the management of the hospital suggests that the following actions must be taken:

- The intentions of the Wolktie workshop must be implemented and the hospital should be autonomous in administering the fees to be retained at the hospital.
- Guidelines governing administration of the fees as well as financial management related to should be prepared, a system installed, and staff members trained.
- The problem of free patients should be addressed in regional perspective including lower level administrative units with which the hospital communicates.

4.4. Hosanna Hospital

Hosanna Hospital was constructed in June 1980 at 8,914.30 sq.mts of land at total cost of Birr 4,832,817, raised from the local community. The hospital building consisting of a number of rooms for various uses has ground plus three stairs. The hospital started operation in 1984 with limited number of rooms and manpower, and has now undergone transformation in terms of manpower, organizational setup and delivery of health services.

According to hospital figures, the demographic conditions of the hospital suggests that the catchment area is estimated to provide health service for a total population of 1,100,000 to 1,200,000 drawn from the four wereda of Lemo, Missa, Sorro, and Badawacho. A number of clinics, health centers and health posts around the vicinity of the hospital often make referrals to the Hospital.

The organization structure of the hospital shows that the Medical Director supervises a number of service units organized in the form of Departments and include Matron, Pharmacy, X-ray & Laboratory. The Administration & Finance Department, comprising offices of the Registrar, Budget & Accounts, Property Administration and Personnel Services, is also under the supervision of the Medical Director.

4.4.1. Type of Services

a) Outpatient and inpatient services

The outpatient service unit offers MCH (IPI, ANC,FP, HE), delivery, minor and major operation as well as Gyn/OB operation, eye examination, psychiatry patient examination, and dental examination. The inpatient services admit different kinds of patients to medical, surgical, pediatrics, and Gyn/OB wards. The hospital offers laboratory tests (phraseology, hematology, etc), ophthalmology, radiological services and other services. More over, antenatal service , health education, and other preventive service are offered daily.

b) Beds and health personnel

The hospital has 186 beds distributed to all wards, 82 in the medical ward, 30 in the surgical, 50 in pediatrics ward, and 24 in OB/Gyn ward. Based on 2001 figures, the hospital employs 15 physicians (3 of them specialists), 41 nurses(4 of specialized), 1 pharmacist, 4 pharmacy technicians, 7 laboratory technicians, 5 x-ray technicians, 1 psychotherapist nurse, 33 health assistants, and 1 sanitarian.

c) Activity Trend

According to Table 30 below during the year a total number of 46,538 outpatient visitors received health care, which means 3878 patients a month or an average of 129 per day. The admission rate indicates 315 patients per month or 11 per day approximately, which is estimated 3785 numbers of admissions per year. Likewise, the number of laboratory tests during the year stand at 23,942, i.e., approximately 1995 per month. The information suggests that the hospital is almost functioning near capacity.

Table-30: Major Activity Trend

Month	OP Visits	IP (Admissions)	Major Operation	Lab. Tests	IP/OP	Tests/OP
July 99	1,973	256	87	891	0.13	0.45
Aug.99	2,273	352	-	1,935	0.15	0.85
Sept.99	3,962	182	19	1,863	0.05	0.47
Oct.99	5,593	384	59	2,101	0.07	0.38
Nov.99	3,663	352	62	2,110	0.10	0.58
Dec.99	4,191	320	67	2,035	0.08	0.49
Jan.00	3,652	288	79	2,383	0.08	0.65
Feb.00	4,513	384	50	2,070	0.09	0.46
Mar.00	3,717	416	105	2,083	0.11	0.56
Apr.00	4,183	222	56	2,020	0.05	0.48
May.00	4,472	296	60	2,113	0.07	0.47
June.00	4,346	333	85	2,338	0.08	0.54
Average/Mo	3,878.17	315.42	66.27	1,995.17	0.09	0.53
Total/year	46,538	3,785	729	23,942	1.06	

Hospital management looks forward to using retention to accommodate more demands if 100% retention of collections is allowed. As the only referral hospital in the zone, there are a large number of influxes of people from the neighboring Kembata zone.

The number of discharges, average length of stay, and death rates for each active ward is presented in table 31 spanning 6 months period (January 2000 to June 2000). According table 31, the highest length of stay was recorded in the medical ward i.e. 9.7 days with an overall hospital average length of stay of 8.5. In terms of ranking, this is followed by pediatrics (at 9.5), and surgical (at 8.03). The OB/gyn ward has the shortest length of stay, i.e. 6.8. The average length of stay has implications on cost of providing care, and if the costs are accurately determined, the hospital may consider recovery of costs when retention of fee is allowed at 100% in the future.

Table-31: Inpatient Care in Hossana Hospital

Ward	Beds	Discharges	Bed Turn Over	Bed Days	ALOS	Deaths	Death Rates
1	2	3	4=3/2	5	6=5/3	7	8=7/3
Medical	82	499	6.09	5,296	14.8	56	15%
Surgical	30	180	6.0	8,825	22.6	22	5%
Pediatrics	50	501	10.02	4,025	13.8	43	14%
OB/Gyn	24	261	10.88	3,351	7.1	12	2%
TB	-	-	-	-	-	-	-
Others	-	-	-	-	-	-	-
Total	186	1,441	-	21,497	-	133	-
Average	47	360	32.99	4,299.4	14.6	33.3	9%

The analysis suggests that the bed turn over rate is high for OB/Gyn ward (10.9), followed by the pediatrics ward to the tune of 10.02. The medical and surgical wards relatively indicate least bed turnover, with 6.09, and 6.00 respectively. With regard to death rates, the average for the hospitals stands at 7% of discharges, while the medical stands at 9% followed by the pediatrics ward equivalent to the average, i.e. , 7%.

4.4.2. Fee Retention Practices

a) User fee

The hospital management committee composed of the Heads of Departments, the Administrator, and Medical Director set the prices for all services at the time of establishment of the hospital. The schedule of user fee determined in a such a manner was dispatched to all service units of the hospital including the cashier's office. Compared with experience of other hospitals, the user fee of Hosanna hospital seems standardized in terms of its availability uniformly. The user fee is more or less similar to other hospitals. However, the hospital management committee made certain changes on the user fee on selected services in 1995. More over, as part of the total collection, sales of drugs from the budget pharmacy has been made at 25% of the purchase price.

b) Budget preparation

In compliance with the requirements of the zonal finance department, Hosanna hospital submitted its budget for use from collection, and got the fund released during 1992EC after it was withheld for a long time.

However, the retainable amount for 1993 EC has not been released until end of May 2001 despite the fact that the hospital submitted a detailed budget as early as November 2000. In order to compensate for delays, Hosanna hospital and the zonal finance department were in a sort of unofficial agreement that allowed keeping handover of hospital collection until the budget is released. The arrangement gave the hospital certain relief in 1992 to pay for badly needed products or services or to complement certain budget deficits. However, the arrangement was short lived as the zonal finance department reinstated its grips on procedural requirement regarding handling of collected fees once again.

As result of withholding of the retainable fund until end of May 2001, which is only one month away from the end of the fiscal period, the hospital may run out of time in terms of acquiring services on time with in the next one month (i.e. June is end of the budget year). In this regard, hospital management asks why they were requested to provide budget proposal, if there are no enough money to pay.

c) Collection procedures

Existing procedure

In spite of the introduction of the new policy of retention, collection procedures acted long time ago, as part of mandatory requirements of the government accounting system, continued to this time. These procedures are described below.

- Collectors must issue form SA/21/1, an official cash receipt of the zonal finance department, against receipt of cash.
- The main cashier makes use of Model 64 to receive the total daily collection from daily collectors.

- The main cashier of the hospital summarizes the collections using Model 7, and hands over the total collection (100%) to the accounts of the zonal finance department.
- The procedures described above must also be complied in collecting cash from 50% paying patients as well as settlement of credit sales to customers such as Blatie Agricultural Ent., EELPA, Tobacco Plantation, and the Central Prison of Sodo.

According to the procedures described above, it is mandatory for the hospital to deposit all of its collections to the account of the zonal finance bureau. The hospital is not allowed to retain 50% of the total fee from collection nor the use of separate bank account.

Collection procedures and impacts

The continuation of the procedures described above has made booking for collections and for withdrawal to be processed using the existing government accounting system. There are certain requirements of the zonal finance department with respect to collection and disposition of fees. The hospital must, first and foremost, remit its collections to zonal finance department. Secondly, only up on submission of budgets are then the latter releases the retainable amount for use in the hospital.

The respondent's reply to the interviews and questionnaires suggests that the collection procedures have not required management to make changes even after the introduction of the new policy of retention. Since the collection procedures have not been changed after the advent of the new policy of fee retention, it has not been possible to make analysis of impacts or changes on the amount of collection.

The only felt impact of the new policy is that management of the hospital took a new initiative to increase the total collection in view of boosting the corresponding share of the hospital. In this regard, the zonal council was consulted with collection status. The zonal council circulated detailed instruction on certification of financially indignant people. It is premature to analyze the impacts of these actions on the collection.

Collections – comparative analysis

Table 32 below compares the amount of collection prior to introduction of the new policy of fee retention. As can be seen from table 32 there has been a decrease in the total fee earned in 1991EC as compared to 1990EC. Hospital management attributes the decline to provision free medical care.

Table-32: Fee Collection Prior to the New Policy
in ETB

No	Type of Fee	Code	1990EC	1991EC
01	Patient Services	1513	343,217	319,282
02	Sales of Drugs	1512	117,337	105,714
			460,554	424,997

The introduction of the new policy, as explained earlier, has not brought about many changes on the procedures of collection during 1992 when retention was allowed. Consequently, the amount of collection has not been changed in 1992 as compared with 1991EC, although there

was a marginal increment by 7% in the total collection. As can be seen from table 33 below, collection from patient services has shown slight growth by 12% while the collection from drug sales dropped by 9% in 1992EC. Thus, the marginal increment in the total income by 7% cannot be attributed to the new policy or to initiatives taken by the zonal council. There are no strong evidences that justify the situation.

Table-33: Fee Collection After the New Policy

'in ETB					
No	Type of Fee	Code	1991EC	1992EC	% Change
01	Patient Services	1513	319,282	358,691	+12
02	Sales of Drugs	1512	105,714	95,625	(9)
			424,997	454,317	+7

Table 33A below compares the amount of collection of the 9-month period of the year 1993 with collections of the preceding year. The new policy of fee retention is being practiced during both years. During the 9 months of 1993 nearly 77% and 48% of last years collection are met from patient service and sales of drugs respectively. However, there are no clear evidences that suggest if the total collection for the year will surpass the target met last year because the local initiatives have long way to go to make differences. Besides, unless current administration of the fee retention is changed, the hospital management may not be motivated to bring about changes.

Table-33A: Fee Collection After the New Policy

'in ETB					
No	Type of Fee	Code	1992EC Collection	July – March 2001	% of 1993EC collection to 1992
01	Patient Services	1513	358,691	274,917	77
02	Sales of Drugs	1512	95,625	45,004	48
			454,317	319,922	

Special bank account

Despite the provisions of the Strategy that allows hospitals to open separate bank accounts into which deposit of income generated at health facility is made, Hosanna hospital, like others, has not yet opened that separate accounts. It is, instead, required to handover all of its collections to zonal finance department directly, and follow the procedures of the recurrent budget administration to get what is known as “retainable amount” form the former.

d) Retention practice

The implementation of the new policy of fee retention is different from that envisaged in the strategy document. The latter declares that income generated at health facility shall be retained and deposited into a separate bank account for use by it. The current practice, however, requires hospitals to comply with sets procedures of zonal finance department.

1. Based on the collections of the preceding year, hospital management must prepare and submit a budget of expenditure payable from retainable amount to the extent of 50% of such collection along with a detailed plan of action.

2. The zonal finance department shall then authorize withdrawal of retainable fee from treasury up on approval of the budget. The approval for withdrawal is subject to availability of fund, and often takes a long time.
3. Under the current arrangement, hospital management is not authorized to retain a portion of the collections (i.e. 50%). Similarly, it is forbidden to pay for certain services from the collection. Yet, the guidelines issued by the Regional Finance Bureau have provisions for both arrangements.
4. The hospital shall not maintain a separate bank account for purposes of depositing the approved 50%. The amount should remain in the Main Cash Safe until the end of the fiscal period, when the ZFD appropriates any left over available in the Safe in the form of remittance.
5. It is not possible for the hospital to carry forward unused balances to subsequent fiscal year. Retained fee, but not yet used, for one or another reason until the end of fiscal period is subject to ZFD's appropriation or remittance to its account.

The hospital submitted its budget for 1992EC fairly early. However, it received the lump sum of retainable amount towards the end of May 2000 indicated in the table 34

Table-34: The Amount of Fee Retained for 1992 EC
in ETB

No.	Description	Amount
1.	Lump sum withdrawal	212,498
	Total	212,498

Hospital management found the process of lodging applications and waiting for approval of ZFD time consuming that the practice should be changed to encourage hospital autonomy. The budget request for the current year of 1993EC was lodged in early days of December 2000. Yet, the ZFD has not released the retainable fund until the end of May 2001. If withdrawal is allowed, the hospital will have only one month left to use the budget. The details of the budget application submitted for approval of the local finance department during the year is indicated below.

Table-35: Budget Request for 1993 EC

No.	Description	Total Amount	%
1	Water, light, telephone & other utilities	20,000	8.8
2.	Per diem, transportation, loading & unloading	5,000	2.2
3.	Maintenance- Hospital Building	30,000	13.0
4.	Maintenance – Vehicles	10,000	4.4
5.	Purchase of Drugs & Medical Supplies	133,000	59.0
6.	Fuel oil – 4 generators & vehicle	10,000	4.4
7.	Stationery & office supplies	1,000	0.2
8.	Fixed Assets Purchase	8,158	3.6
	Total	227,158	100

From the budget request one can see that the highest allocation is made to purchase of drugs and medical supplies, accounting for 59% of the total budget. 13% of it is also earmarked for

maintenance of hospital building. The remaining 28% is reserved to supplement regular budget deficit. As the regular budget allocation covers almost all budget lines, the request suggests that the hospital may not often run the facility from government financing alone.

Moreover, the pattern of budgeting suggests that it is not clear if hospitals use the retained fee to supplement shortages in the regular budget or to improve the quality of service units. There is no clear guideline governing the use of retained fee as it is apparently seen in the allocation above where, except for drug part, the rest of the fee is intended for covering deficit observed in the regular budget of the hospital.

e) Expenditure pattern

In 1992EC, fee retained at Hosanna hospital was primarily used to purchase drugs, and to supplement regular budget deficit. The regional government was not able to finance the budget pharmacy of the hospital due to overall regional shortage of budget in the year. Consequently, 71% of the retained fee, which is the lion's share, was spent to purchase of essential drugs and medical supplies. Table 36 below presents the pattern of expenditure paid from retained fee in the year 1992EC.

Table-36: Expenditure Pattern for 1992EC

'in ETB				
No	Description	Amount Expended	%	Remark
1.	Water, light, telephone & utilities	10,000.00	4.7	
2.	Per diem, transport, loading & unloading	10,000.00	4.7	
3.	Maintenance- Hospital Building	13,000.00	6.1	
4.	Maintenance – Vehicles	4,500.00	2.1	
5.	Contractual Services	1,100.00	0.5	
6.	Purchase of Drugs & Medical Supplies	150,898.68	71.0	
7.	Uniform & clothing	5,000.00	2.4	
8.	Fuel oil – 4 generators & vehicle	8,000.00	3.8	
10.	Stationery & Printing	4,000.00	1.9	
11.	Office supplies & Consumables	6,000.00	2.8	
	Total	212,498.68	100	

The shortage or lack of budget for purchases of drugs & medical supplies from the recurrent government account was a general problem of the region in 1992. For that reason, spending a larger portion of the retained fee on acquisition of essential drugs and supplies is justified. Besides, a new line of water facilities that connected the hospital reservoir to the major source of water supply was acquired from retained fee during the year. The new line relieves the hospital from dependence on supply of busy lines that are shared with the rest of the town. The improved water supply has considerably facilitated the operation of the various service units of the hospital. Although a greater part of the retained fee is used for activities that are directly related to provision of improved services to patients, it is noted that about a quarter of the retained fee is still used to supplement or cover regular budget deficit that must have been met by the regional government so that retained fees can be spent fully on service units of the hospital.

The budget request for 1993EC submitted for approval of ZFD has not yet been withdrawn from the accounts of zonal treasury. Although that is the case, the pattern of intended

expenditure as indicated in Table 36 suggests that like the previous year the emphasis is on acquisition of purchasing drugs and covering budget deficit. It is not clear why the hospital cannot select at least one service unit among those deserving attention for improvement. Hospital management ascribes the tendency to absence of clear guidelines governing the use of retained fee.

f) Exemption and waiver

According to the current practice, patients eligible for exemption and waiver of service fee are identified up on submission of certificates of their inability in terms of financial problems to pay for medical care. It has been difficult for management to identify the really needy and poor, as it is not uncommon to get poverty certificates. Moreover, hospital staffs, children under 18 and their spouses and members of civil service are exempted to the extent of 100% and 50% respectively.

Analysis of free medical cares provided to eligible patients in the year 1992EC is provided in the Table 37 for a period of 12 months (July 99 to June 2000). One can see from the Table 37 that the hospital forgone about 22% of the annual revenue to provide free medical care to patients, who may not be certainly poor.

Table-37: Analysis of Free Care: July 1999 – June 2000

Month	Revenue	Free Care value	%	Total number of patients	Number of free patients	% of free patients
July 99	34,063	17,245	50	2,229	120	5.4
Aug.99	22,708	19,686	87	2,625	128	4.9
Sep.99	11,606	10,317	89	4,144	410	9.9
Oct.99	12,186	5,628	46	5,977	450	7.5
Nov.99	14,894	6,095	40	4,015	380	9.5
Dec.99	38,744	3,538	9	4,511	270	6.0
Jan.00	51,645	6,274	12	3,940	320	8.1
Feb.00	59,512	2,426	4	4,897	345	7.1
Mar.00	43,095	7,589	17	4,133	330	8.1
Apr.00	39,784	4,777	12	4,405	250	5.7
May.00	47,967	7,076	14	4,768	370	7.8
June 00	78,108	7,580	9	4,679	300	6.4
Total	454,317	98,237	22	50,323	3,673	7.3
Average	50,479	8,186	16.2	4,194	306	7.3

The value of medical care provided to 3,673 patients amounts to Birr 98,237.35, i.e., approximately Birr 8,186.44 per month. Although the number of free patients accounts for 12% of the total patients, the value of exemption appeared to be as high as 22% of the total revenue. That is largely attributed to severity of diseases treated, and the longer time it took to provide the care to patients. The proportion of value of free care appeared to increase in the first quarter of the year, accounting for 89% of the total revenue for the last month in the quarter. The pattern was, however, changed in the second quarter and remained relatively stable in subsequent quarters. The trend suggests that the initiatives the hospital took in collaboration the zonal council to deter influx of poverty certificates seem to bring about certain changes, although it has a long way to make a difference.

4.4.3. Impact on Quality of Services

The fee retained at Hosanna Hospital in 1992EC was largely spent on purchase of essential drugs and medical supplies, and acquisition of a new line of water supply. The spending on both inputs alone accounts for 76% of the total fee retained in the year. During the year, there was no budget for drugs and medical supplies. The budget pharmacy would have run out of essential drugs and medical supplies, if it had not been supplied with new stock of drugs acquired from retained fees. As a result, the hospital's services were made effective in terms of providing essential drugs to visiting patients, and consumable medical supplies to physicians.

Moreover, one of the major problems of the hospital was the line of water supply to which it was linked. It was not directly connected to town sub station reservoir. It rather used to have access via a busy reservoir in town that it constantly faced shortage of water supply. Since the introduction of the new policy, however, with extra funding from retained fee the hospital managed to acquire an abundant supply of water, which has considerably enhanced provision of range of services. Furthermore, the availability of extra money from retention has enabled management to be flexible in identifying and funding budget lines that were under financed by the regular budget.

As regards to the impact of retained fee for 1993, the earmarked budget has not yet been withdrawn from ZFD until end of May 2001 despite submission of the budget request in early December 2001. Consequently, the extent of changes brought about on services of hospital cannot be analyzed.

4.4.4. Management Requirements and Impacts

Hospital management has not yet felt the need for making changes in association with management of fee retention. The major reason is involvement of government revenue accounting system in administration of retained fee. The method of collection and disposition of fees have been adjusted to fit with the existing sets of procedures governing the use of public fund as described in earlier parts of this submission. Thus, since the existing practice has not called for a different arrangement in assessment of collection and handling of fees, the impacts of the new policy in terms of changes in management cannot be noted. In view of changing the status quo and taking the most out of fee retained, the management of the hospital urges all concerned government bodies to take the following actions:

- Implement the provisions of the strategy with respect to retention of fee, and orientations of the Wolkitie workshop on health care financing strategy in Ethiopia.
- Decentralize the administration of retained fee and do away with the tedious procedural requirements imposed by the Finance Bureau.
- Issue clear guidelines on collection, deposit of collection, withdrawal and definition of the use of retained fee: improving service units versus complementing budget deficit.

4.5. Mizan Teferi Hospital – Aman

The Mizan Tefferri hospital was established in May 1979 E.C. with the help of the European Economic Commission (EEC), and the World Red Cross Association (WRCA). It continued to provide health services to the local community until the government had taken total control of the hospital in 1986 E.C. Since that year the government was responsible for allocation of running and capital expenditures. The hospital services a population of 375,382 people in the Bench-Maji Zone, the Keffa-Sheka zone. It also treats patients from Chene Woreda and the Dimma refuge center.

The organizational structure of the hospital shows that the Medical Director is the head of the technical staff and the administration staff of the hospital. The former includes physicians, nurses, laboratory technicians and health assistants, while the later is composed of auxiliary personnel in the finance and administration division, auditors and other supporting staffs.

4.5.1. Types of Services

a) Outpatient and inpatient services

The hospital gives a wide range of outpatient services : MCH (consisting the sick-baby clinic), OPD, emergency clinic, psychiatric unit, ophthalmic unit, STD's clinic and the TB & Leprosy clinic. Moreover, health education given to patients and visitors every day on HIV/AIDS, malaria and other communicable diseases. Inpatient services are provided in all wards: pediatrics ward, surgical and gynecological ward as well as minor and major operating rooms.

Other services offered by the hospital include family planning program by the MCH department, the ANC, the EPI and the sick-baby services carried on daily basis. There are also some other services rendered by the hospital in the town – that is - inspection of food and drink inspection in the town by sanitarians of the hospital, and the out-reach EPI program held once a week and health education in the hospital and in some other sectors.

b) Beds and health personnel

The hospital equipped with a total number of 72 beds, where 15 beds are allocated to the medical ward, 15 beds to the surgical ward, 19 beds in the pediatrics ward, 15 beds in the OB/ Gyn. ward and 8 beds for the TB ward.

Figures for 1993 EC point out that the hospital employs 5 physicians, 10 nurses (of which 3 are specialist nurses), a senior and a junior pharmacy technicians. More over the technical staff includes 3 laboratory technicians, 2 X-ray technicians, 26 health assistants, 2 sanitarians, 2 junior nurses and 5 health officers. There are no physiotherapists in the hospital. The medical director explained that the hospital needs to be staffed with additional health personnel.

c) Activity trend

In the year 1992 E.C, the hospital gave service to 50, 391 outpatients as indicated in Table 38. The average member of patents received every month therefore is an almost 4,199, that is

140 patients a day. On average, the hospital admits 159 patients a month or 6 patients a days, totaling to 1, 905 patients a year. The laboratory service given by the hospital to patients in the year totals 6,690, on average 558 patients a month. The medical director stated that due to lack of funding other than the regular budget, and lack of qualified health personnel. the hospital could not meet the ever increasing demand for treatment. The trend in major activities is presented in the Table 38.

Table-38: Major Activity Trend

Month	OP visits	Admissions	Major Operations	Lab. Test	IP/OP	Tests/ OP
July 99	4,731	320	9	500	0.07	0.11
Aug. 99	4,653	129	12	598	0.03	0.13
Sept.99	4,650	201	2	540	0.04	0.12
Oct. 99	2,278	107	2	583	0.05	0.26
Nov. 99	3,742	139	10	577	0.04	0.15
Dec. 99	3,193	170	11	493	0.05	0.15
Jan 00	6,268	146	-	524	0.02	0.08
Feb. 00	4,579	141	-	532	0.03	0.12
March 00	4,191	126	-	608	0.03	0.15
April 00	4,440	173	-	596	0.04	0.13
May 00	3,244	108	-	564	0.03	0.17
June 00	4,422	145	-	575	0.03	0.13
Average / mo	4,199.25	158.75	7.67	557.50	0.04	0.14
Total /Year	50,391	1,905	46	6,690	0.46	1.7

With increased funding from fee retention and other sources, the hospital may improve the provision of quality services if additional personnel are recruited

The number of discharges, average length of stay, and death rates for each active ward is presented in table 39 spanning 6 month period (Jan. 00 to June 00)

Table-39: Inpatient Care in Mizan Tefferi Hospital

Ward	Beds	Discharge	Bed turn over	Bed days	ALOS	Deaths.	Death rate
1	2	3	4=3/2	5	6=5/3	7	8= 7/3
Medical	23	395	17.17	2,288	5.79	27	0.07
Surgical	15	134	8.93	1,041	7.77	6	0.04
Pediatrics	18	251	13.94	1,266	5.04	16	0.06
OB/Gyn	15	286	19.07	1,063	3.72	4	0.01
Average	17.75	266	14	1,414	5.58	13.25	0.05
Total	71	1,066	59.11	5,658	22	53	0.18

The surgical ward had the highest length of stay, of 7.77, with an average of 5.58 days. It is followed by the medical ward with 5.79 days, the pediatrics ward with 5.04 days and lastly, the OB/Gyn with only 3.72 days. According to the medical director, the hospital may increase the services with quality the amount is retained fully and other sources are added to the funding mix.

As regard to death rated rates, the medical ward is the highest with 27% and pediatrics follows with 16% ,while surgical and OB/Gyn are 6% and 4% respectively. The bed turnover ratio is the highest in the OB/ Gyn ward although it had the lowest ALOS.

4.5.2. Fee Retention Experiences

a) User fee

The schedule of fees previously established as user fee is still used up to present day, with no conspicuous changes even though little change was made to prices of some of the services. The hospital collects fee from the services it renders. However, all staff members, personnel of governmental bodies, soldiers are free from any fees. Thus, unless the user fee is increased or free treatment is reduced to a manageable extent, increase in fee revenue with the existing user fee is remote.

b) Budget preparation

As with other health facilities, the Mizan Teferi is also required to submit plan of action and budget expenditures for retained fee. In this regard, the hospital has fulfilled the requirements of the ZFD for both years, as a result of which it is an exceptional hospital in the region in terms of the retaining fees in 1992EC and 1993EC. This attributed to the fact that the hospital received a copy of the guideline of the RFB, which was not available in other hospitals.

c) Collection procedures

Existing procedure

The cash collection process is regulated by the rules of the zonal finance department that drew sets of procedures concerning handling of fees .

- Collectors issue form Model AS/21/1, as an official cash receipt of the zonal finance department when they receive cash.
- The main cashier issues model 64 when receiving the total daily collection from daily collectors.
- Using the model 7 as a summary of collections, the main cashier of the hospital remits 100% of the fee revenue to the zonal finance department.

The procedures described above must also be compiled in collecting cash from 50% paying patients, as well as settlement of credit sales given to government bodies.

The hospital is required to deposit all of its cash collections to the treasury of the ZFD. It is not allowed to retain 50% of the total fee from collection or to maintain a separate bank account, either.

Collection procedures and impacts

There have not been any changes in administration of collection of fees since the introduction of policy because of the persistence of government revenue accounting system described earlier. The guidelines of the RFB continued to predominately treat the method of collection and disposition of fees in accordance with finance proclamation. Thus, the new policy of retention has not brought about any changes on the collection procedures of the hospitals.

Thus, the impacts of changes, resulting from the policy, could not be reflected on the amount of collection as the proceeding analysis will show.

Table 40 below indicates analysis of the amount of cash collected before the policy of retention was introduced for two consecutive years. It can be noted from Table 40 that the amount of fee earned decreased in the year 1991, compared with the just preceding year. The medical director ascribes the decline to provision of uncontrolled free care that persisted to date.

Table-40: Fee Collection Prior to the New Policy

No.	Type of fee	Code			'in ETB
			1990 E.C 1997/98 G.C	1991 E.C 1998/1999G.C	% age Charge
01	Patient services	1513	72,251	64,677	(10)
02	Sales of Drugs	1512	191,581	147,574	(23)
	Total		263,832	212,252	(20)

The post – retention period is also characterized by incessant decline in fee income as the Table 41 evidently indicates.

Table-41: Fee Collection after the New Policy

No.	Type of fee	Code			'in ETB
			1991 E.C	1992 E.C	% age Charge
01	Patient services	1513	64,677	53,135	(18)
02	Sales of drugs	1512	147,574	113,484	(23)
	Total		212,252	166,619	(22)

The Mizan Tefferi hospital, like any other hospitals visited by the consultant, has not opened a separate bank account.

d) Retention practice

A circular issued from the zonal finance department totally governs the current retention practice. There are certain procedures that must be complied by the hospital so that the ZFD releases the amount of retention to the hospital.

- The approval for withdrawal of fee retention is subject up submission of budgets pertaining to expenditures for retained fees. The hospital should fulfill this first requirement.
- The collections of the hospitals should be remitted to the accounts of the ZFD 100% and intact. In this respect, no cash is to be paid out from collections.
- Other than the regular budget account, no separate account is maintained by the hospital.
- Any unused balance from retained fee is subject to remittance to the treasury of the ZFD at the end of the year.

Mizan Teferi Hospital is exceptional in terms of receiving the money earmarked for retention in both years. The amount of money retained by the hospital account for Birr 106,125.16 and Birr 83,120.31 for 1992EC and 1993EC respectively. The decline in the amount of retained fee in 1992EC is attributed to decline in the total collections of the preceding year, which is the base year for calculating the amount of fee.

e) Expenditure pattern

There was only one expenditure item for the amount of fee retained in the hospital in 1992EC and 1993EC. 100% of the retained amount for both years, which stands at Birr 106,125.16 and Birr 83,120.31, has been spent for acquisition of essential drugs and medical supplies. The medical director explained that in 1992EC the allocation was necessitated by scarcity of regular budget to the pharmacy. In 1993EC, however, due to repeated change of management personnel, the time for submission elapsed with out making concrete plans for improvement of other services. The lately appointed medical director decided in favor of using the fund for purchase of drugs and supplies.

f) Exemption and waiver

The current practice indicates that patients eligible for exemption and waiver of service fee are identified up on submission of certificates of their inability in terms of financial problems to pay for medical care. It has been difficult for management to identify the really needy and poor, as it is not uncommon to get poverty certificates. Moreover, hospital staffs, children under 18 and their spouses and members of civil service are exempted to the extent of 100% and 50% respectively.

Analysis of free medical cares provided patients in the year 1992EC is provided in the Table 42. One can see from Table 42 presented next page that the hospital forgone about 14%% of the annual revenue to provide free medical care to patients, who may not be certainly poor.

Table-42: Analysis of Free Medical Care

							'in ETB
No	Period	Total patients	Free patients	% of fee patients	Total revenue	Free-care value	% of free value
1	(July 99 to June 2001)	52,296.00	1,221	2.33	166,569.9	22,954.64	13.78

Although the percentage of free patients stands at only 2.33 %, the amount of money that was forgone by the hospital is as high as 14% of the total revenue earned.

4.5.3. Impact on Quality of Services

The amount of fee retained at the hospital in both years has been spent on purchase of drugs and medical supplies. It was not possible to select a service unit and invest a portion of the fee to improve the quality of the service due to repeated shuffling of management. In terms of increased availability of essential drugs, the impacts of the retained are felt, particularly during 1992EC when the regular budget was unable to finance supply of essential drugs and supplies. Thus, patients benefited from increased supply of medicines financed by retained fee.

4.5.4. Management Requirements and Impacts

Management of Mizan Teferi Hospital has not yet felt the need for making changes in relation to administration of fee retention. The major reason being persistence of government revenue accounting system. In this regard, the method of collection and disposition of fees have been adjusted to fit with the existing sets of procedures governing the use of public fund as described in earlier parts of this submission. Consequently, the impacts of the new policy in terms of changes in management cannot be noted. In view of changing the status quo and taking the most out of fee retained, however, the management of the hospital suggests the following measures be taken for total improvement:

- Implement the provisions of the strategy with respect to retention of fee, and orientations of the Wolkitie workshop on health care financing strategy in Ethiopia.
- Decentralize the administration of retained fee and do away with the tedious procedural requirements imposed by the Finance Bureau.
- Issue clear guidelines on collection, deposit of collection, withdrawal and definition of the use of retained fee: improving service units versus complementing budget deficit.

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List of Persons Contacted/Interviewed

Arbaminich Hospital

Dr. Degu Jerene, Medical Director
Ato Tekle Eyasu, Main Cashier

Bonga Hospital,

Dr. Meju Damtie, Medical Director
Ato Alemu Woldemariam, Hospital Administrator
Ato Kinfé Ambo, Budget & Accounts

Chencha Hospital

Dr. Terefe Tadesse, Medical Director
Ato Assefa Dessalegn, Hospital Administrator
Ato Ermias Zekarias, Budget & Accounts Head

Dilla Hospital

Dr. Kibru Beza, Medical Director
Ato Negussie Shenkutie, Hospital Administrator
Ato Degu Werres, Budget & Accounts Head

Hossana Hospital

Dr. Yohannes Mengesha, representing Medical Director
Ato Legesse Gonnore, Hospital Administrator

Mizan Teferi/Aman Hospital

Ato Mesfin Temesgen, Health Officer, Acting Medical Director
Ato Atnafu Gurasha, Hospital Administrator
Ato Wutie Semela, Budget & Accounts Head

Regional Finance Bureau, Awassa

Ato Getachew Hamussa, Head Regional Finance Bureau

Regional Health Bureau, Awassa

Dr. Estifanos Birru, Head of the Regional Health Bureau
Dr. Zeleke Gobie, Deputy Head of Regional Health Bureau

Annex:1 Terms of Reference

Retaining Fees at Government Hospitals in SNNPR: Implications on Quality and Management of Services?

Assignment

These Terms of Reference apply to the assignment of a team leader who will conduct a study in Ethiopia on “retaining fees at government hospitals in Southern Nation’s, Nationalities and Peoples Region (SNNPR): Do they improve quality and management of services?” The study is proposed by the IR1 team of Essential Services for Health in Ethiopia (ESHE)¹ Project, Regional Health Bureau (RHB) of SNNPR and the Health Care Financing Secretariat, Ministry of Health, Ethiopia.

Background

As of Fiscal Year 1992 (Ethiopian Calendar) or July 1999 (Gregorian Calendar), government hospitals in the SNNPR have been entitled to retain fifty percent of their fee revenue (while remitting the remaining amount to the finance bureau). At the same time, the Regional Council has given hospitals relative discretion to spend this revenue according to their own needs. Previously, legal policy mandated that this money be sent in its entirety to the finance bureau. However, now in the SNNPR region, fee revenue can be retained in facilities and is consequently available to finance efforts to improve quality of services at hospitals and to increase the availability of essential drugs and equipment. The kinds of expenditures allowed for the retained fee revenue are spelled out in general terms in a set of guidelines that were issued at the onset of the implementation of this new policy.

The rationale behind the Regional Council’s decision to allow fee retention by regional hospitals is based upon its expectation that retention would provide greater incentives for these hospitals to collect existing fees, thereby increasing revenue to the hospitals; and use retained funds to improve the quality of services they can offer to fee-paying patients, thereby increasing utilization, which, in turn, would increase revenue.

Objective

The subject of this research is the experience of the hospitals in implementing this new policy of fee retention during the last one and half fiscal year. Besides it will help to get baseline information of hospitals experiencing fee retention, contribute towards the development of guidelines on the utilization of retained fees to impact on quality of services, and assess the required management adjustment to properly manage the retained fees.

Expected outputs

The study should come up with a comprehensive report of the experience of fee retention in SNNPR, guidelines on utilization of those fees, guidelines on the required adjustments in management, and some reflections on the implications of fee retentions on quality. These outputs should then be presented and discussed in a regional workshop.

The study is expected to last during a maximum of two and half months from the signature of contract for consulting services.

¹ The ESHE, financed by USAID, Intermediate Result #1, is addressing the financial component of the health sector strategy by four result areas: increased public allocations, increased cost recovery, capacity building to improve budgeting and budget utilization and increased private investment.

The research results should assist the regional government in determining how closely the program is achieving its goals, what modifications, if any, might need to be made, and what kinds of technical assistance or added staff may be needed to assist the hospitals to implement it effectively. If the results of hospitals' experience in fee retention prove to be positive, it is anticipated that they will be allowed to keep up to 100% of their own fee income, and the program may be extended to facilities at lower levels of the system.

These fees would continue to be extra budgetary, as they are now, meaning that the amount collected would not affect the budget levels to be assigned to the hospitals. The research results are likely to give us some concrete data with which to estimate and to predict the future impact of additional increases in fee retention, as well as the impact experienced so far. It may well show that the regional hospital system will have realized a net increase in resources allocated to the hospitals.

The following results are expected:

1. An inception report should be delivered within two weeks from signature, outlining the approach to be used as well as the timing of activities.
2. A mid-term report should be delivered within one and half months from signature stating the status of progress, encountered obstacles and possible changes of the study plan.
3. A draft final report should be delivered within two months from signature, presenting the full text as proposed by the consultant.
4. A final report should be delivered within two weeks from receipt of comment to the draft final report by the IR1 team.
5. The final report should be combined with a proposed agenda for a one-day regional workshop as mentioned above.

Scope of activities

The consultant services to produce the expected outputs should encompass, but not necessarily be restricted to, the following activities:

1. The study team leader should work in close collaboration with IR1 team of the ESHE project and the RHB of SNNPR.
2. The inception report should be worked out in close collaboration with the IR1 team and SNNPR RHB.
3. The study team leader should subcontract support staff and other services necessary to deliver the expected outputs on time.
4. The research approach to be used will be twofold: first, consultants will interview hospitals medical directors, administrators and finance managers about all relevant aspects of their recent experience with collection, retention, and expenditure of fees. Second, they will design and administer a short survey instrument having the purpose of collecting standard hospital data related to fee collection, retention, and expenditure under the new regional regulation. These should include all hospitals in the region.
5. The study team leader should present the final report at a workshop to be arranged by the IR1 team in collaboration with the RHB.

Time frame

The study should be conducted within a start date at the latest by 1st March to a final report date at the latest by mid May, 2001

Implementation Requirements

Two domestic consultants one with a health financing background (health economist or financing specialist) and one with a background in design, implementation, and evaluation of methods for managing improved quality standards in hospitals. The staff of the Secretariat, RHB will provide technical and administrative support as required.

Research Questions

Fee Collection and Retention:

- What amount of money has been collected in fees by the hospitals?
- How do these amounts compare with those of past years?
- Have fee collection procedures been changed in order to accommodate any changed needs due to the new fee retention policy?
- If so, how have they been changed and what impact have these changes had on the amount collected?
- How much of the fee revenue has been retained at the facilities?
- Expenditure of Retained Fees:
- How much of the retained amounts have been spent so far?
- What products and/or services have been purchased and in what quantities?

Impact on Quality of Services:

- How have these products and/or services impacted, if at all, the general (and specific) level of quality of services made available to patients visiting the facility?
- Has the hospital attached fees to any of these products or services if directly or indirectly provided to patients?
- If so, how much of the cost has been recovered in the process?

Management Requirements and Impacts:

- Have the hospitals made management changes in association with fee retention?
- How have the hospitals organized collection and disposition of the fees?
- What have been the major changes in the assessment, collection, and handling of fees since retention was allowed?
- Are there any management changes that could be made in the hospitals that would serve both to increase fee collection and to improve the quality of services delivered?

Annex: 2 Open-ended Questionnaires

Retaining Fees at Government Hospitals in the SNNPR

1. General Information

Name of the Hospitals _____
Town/Locality _____
Woreda _____ Zone _____

2. Background Information

2.1 **General:** Describe the brief history of the hospital including data of establishment, partnership of other parities etc.

2.2 Describe the demographic conditions of the hospital such as catchment or assigned population

2.3 Describe the Hospital Current Organization Structure

2.4 Are there other hospitals and/clinics in the vicinity? Is the Hospitals used as referral hospital for the cathcment are?

3. Baseline Hospitals Data: Health Facility Aspects

3.1. Total number of Beds _____ indicate details below

- In Medical Ward _____
- In Surgical Ward _____
- In Pediatrics Ward _____
- In OB/Gyn Ward _____
- In TB Ward _____

3.2. Indicate the number of rooms covered for the following functions

- Registration _____
- Waiting Rooms _____
- Examination Rooms _____
- MCH _____
- OR _____
- Delivery Room _____
- Sterilization Room _____
- Dispensary/Pharmacy _____
- Store _____
- Kitchen _____
- Laundry _____
- Administraion & Finance _____
- Other (Specific) _____
- _____
- _____
- _____
- _____

3.3. Indicate the type of services the hospitals offers

3.3.1 Outpatient Services _____

3.3.2 Inpatient Services _____

3.3.3 Other Services such as antenatal clinics, and how often are theses services offered?

3.3.4 Other preventive services _____

3.4. Number and type of Hospitals Staff by Profession

Physicians: MD _____ Specialists _____
Nurse _____ Specialized Nurse _____
Pharmacy technicians _____
Laboratory technicians _____
X-ray technicians _____
Physiotherapists _____
Health Assistants _____
Sanitarians _____
Others (specify) _____

3.5 Indicate the most frequent diagnoses for outpatient visits to the hospital during year 2000?

No.	Disease or Diagnosis	or Number of Patients /Month (average)	Remark or Code
-----	----------------------	---	----------------

3.6. Explain the nature of the diseases in terms of preventive and curative?

3.7. Describe the then most frequent diagnoses for Hospitalization?

No.	Disease or Diagnosis	Number of Patients /Month (average)	Bed day	Remark or Code

3.8. Any other comments /opinions concerning the status of the products /services offered by the hospital

Name of the Respondent _____

Title _____

Major Duties _____

4. Baseline Hospital Data: Financial Management Aspects

4.1. How are prices set? Is the use of cash calculators in palace? Or is it manual ? Please describe the situation

4.2 How is exemption from payment identified?

4.3 Indicate the user charge for services given? How much does a user pay for a given service? Please state the user charge schedule below:

4.4 Are patients admitted to the inpatient wards required to make advance payments ? Yes

_____ No _____

4.5 If, yes, indicate the amount for the following

Delivery	Birr _____
Pediatric Ward	Birr _____
Surgical Ward	Birr _____
TB Ward	Birr _____
OB /Gyn Ward (if different from Delivery)	Birr _____

4.6 Indicate the price list of hospital for the following services where applicable?

4.6.1 Outpatient Department

Consultation fee during working hours Birr _____
Consultation fee during extra hours Birr _____
Medical Board Paper Birr _____
New Card Birr _____
Attendance paper Birr _____
Autopsy statement Birr _____
Statement Birr _____

4.6.2 Admissions

Admission Fees Birr _____
Major Operations Birr _____
Minor Operations Birr _____
Infusion fluids Birr _____
D + C Birr _____
Cesarian S. (Incl. all) Birr _____
Uterus rupt. WF Birr _____
Bed and food/day/adults Birr _____
Bed, Pediatrics Ward Birr _____
Bed, Ped Wards advance Birr _____
Venflons Birr _____
Abortion (/E+C) Birr _____
Sterilization (all) Birr _____
Normal Delivery Birr _____
Others (Specify) Birr _____
Birr _____
Birr _____
Birr _____

4.6.3 Minor Surgery

Foley, chest drain, trichiasis op Birr _____
Wound suture, inclusion (L+D), toothe extr. Biopsy Birr _____

4.6.4 Laboratory

Hb, SR Stool 7 Urine micro, Bloodslide Birr _____
WBC, Dff. Count Blood Sugar, trombocytes Birr _____
Blood Chemistry, ordinary Birr _____
Widal, Weil-Felix, Chemistry (emergency) Birr _____
Transfusion , cultural tests Birr _____

4.6.5 X-ray

Ordinary Examinations Birr _____
X-ray Examination with contrast Birr _____

4.6.6 Other Examinations

Anoscopy	Birr _____
Urethro-Cystoscopy	Birr _____
Diagnostical Gastoscopy & branchosocopy	Birr _____
Therapeutical Gastoscopy & branchoscopy	Birr _____
Colonoscopy	Birr _____
ECG	Birr _____
Sonography	Birr _____
Sonography W/Pucture	Birr _____
Pregnancy	Birr _____
VORL	Birr _____
RF	Birr _____
Rotavirus	Birr _____
Others (Specify)	_____

4.7 . Is the accounting system of the hospitals single entry i.e a practice consistent with government budgetary accounting or a different system introduced?

4.8 Describe the fee collection procedure that has been applicable before the introduction of the new policy of fee retention?

4.9 How are these procedures changed since the introduction of fee retentions of 50 % in 1992 EC?

4.10 If collection procedures are changed since the advent of the new policy of fee retention, describe the impact of these changed procedures on the amount collected?

4.11. What amount of money has been collected in fees by the hospital? (Please give summary of out form # 01)

4.11.1. Since introduction of fee retention

Code	Type of Fee	Fiscal Years		Remarks
		1992 1999/2000	EC 1993 up to Megabit (2000/2001, March)	

4.11.2. Before introduction of fee retention

Code	Type of Fee	Fiscal Years		Remarks
		1990 1997/1998	EC 1991 (1998/1999, March)	

4.12. How much of the fee revenue has been retained at the facilities?

No	Type of facility	Amount Retained	
		1992 EC	1993 EC

Any opinions / comments as regards retaining fees at facility

4.13. How much of the retained amounts have been spent so far? (please give summary of our form # 02)

No	Code	Expenditure title	Fiscal Year			
			1992 1999 /2000	EC	1993 Megabit (2000/2001, up to March	EC

4.14. Describe any particular products and / or services that have been purchased ? Specify the quantity also? _____

4.15.State the number and qualification of accounting division or section of the hospitals _____

4.16 Who conducts auditing of the books of accounts of the hospitals? How often in a year

4.17. Has the hospital maintained a separate bank to deposit retained fee?

a. If Yes, state the bank account number _____

b. If No. explain why? _____

4.18 Explain authorization procedures for payments made by check and by cash

4.19 Explain the deposit procedure adopted by the hospital

5. Baseline Hospitals Data: Impact on Quality of Services Aspects

5.1. How have the new policy of fee retention impacted the products and / services of the hospital? Explain the general or specific level of quality of services made available to patients visiting the facility?

5.2. Does the hospital attach or attribute these products / services directly or indirectly provided to patients to the fees? Explain and, if yes, how much of the cost has been recovered in the process

5.3. Any comments on linkage between retained fees & quality of services

6. Baseline Hospital Data: Management Requirements Aspects

6.1. Has the management made any changes in relation to fee retention? Explain if there are changes caused by the new policy.

6.2. Explain the organization of collection of Fees

6.3. Explain the disposition of fees

6.4. Describe the major changes in the assessment, collection and handling of fees since retention was allowed.

6.5. Explain if there any management changes that could be made in the hospital to increase fee collection.

6.6. What changes should management make to improve the quality of services?

6.7. Any further comments on management aspects of the fee?

7. Baseline Hospitals Data: Free Care in the Hospital

7.1. State the policy of the hospital in treating patients freely. State categories

7.2. How much is foregone by way of revenue because of retention? Give comparative figures of at least 2 to 3 years?

7.3. Explain how retention of fees in 1992 EC and 1993 EC improved the quality of services of your hospital. Please give concrete examples of improvement in quality of service.

Annex:3 Fee Retention Directive

A Directive for the Collection, Utilization and Accounting of the Revenue of Hospitals.

When the finance bureau, in order to implement the Financial Administration Proclamation of Region, it has been stipulated in article 69 of the Proclamation, that it can issue a directive. Therefore, on the basis of the stipulation made and that as regards the collection, utilization and accounting of the revenue to the hospitals, it has issued this directive.

1.Revenue

The revenue of hospitals means, a revenue collected from

- The sales of drugs
- From laboratory sample investigation
- X-ray
- Senography
- From hospital beds, and from others which are related with medical treatment and from the payment of non medical services and goods collected through the hospitals.

2.Budget preparation

- 2.1 When the Council of the Region approved the budget of 2000, it has allowed hospitals to utilize from the correct revenue they collected during the previous budgetary year and not exceeding 50 % from their revenue of the current budgetary year. Therefore on the basis of the authority conferred by the Region to the Finance Bureau, the bureau has authorized the budget, and since the percentage of the comparison of the expenditure budget authorized must be expressed in terms of numbers, the budget department of the basis of the 1999 hospitals revenue report that will be submitted to it, shall inform the amount of the budget authorized to use from their revenue in 2000.
- 2.2 Starting from the next budgetary year, in accordance with the provision of the financial administration proclamation and regulation of the Region hospitals must submit the revenue they collect and the expenditure budget that they want to utilize from their revenue through the zonal health departments to the zonal finance department.

3.Revenue Collection and Revenue and Expenditure Accounting

- 3.1 Hospitals shall take the receipt number G/H/21/1, which they use for the collection of revenue from the finance department office.
- 3.2 Hospitals shall record the revenue they collected under receipt number G/H/21/1 with relevant revenue account category.
- 3.3 Hospitals, by analyzing the revenue they collected under receipt number G/H/21/1, together with the second copy of the receipt with model 16A, and that from the money they utilized or they will be utilizing under expenditure account category, 6431 they must submit to the finance department, the operational expense requisition form G/BW/11/2 and the amount of money that they should transfer in cash, and that

thereafter, they will receive model 34. They shall record the account under 4020, as an expenditure amount.

- 3.4 When the finance department receives from hospitals an operational expense requisition under expenditure account category number 6431 and a cash payment, it having analyzed the sum of the two under model 16 and that it having ascertained that it is equal with the total of the second copy of form GH/21/1 and by approving the operational expense submitted to it and by receiving the cash payment and that for the total revenue it shall give model 64. It shall record the account under 4020 payment revenue account.
- 3.5 In accordance with the articles mentioned above the total amount of the operational expense submitted by the hospitals during the 2000 budgetary year and which they utilize under 6431 expenditure account category and the operational expense which will be approved by the finance department should not exceed 50 % of the total revenue that the hospitals during the previous budgetary year submitted to the finance department.
- 3.6 The hospitals shall take a revenue receipt number GH/21/1 which was approved by the finance department for the operational expense requisition form GBW/11/2 and they shall record the account under 4011. Under this revenue account they shall record the money which they utilize from their revenue and or money which they shall use and record the expenditure documents under expenditure accounts.
- 3.7 The finance department office shall record the approved operational expense under 6431 expenditure account category as an expenditure. It shall made a deduction in the ledger.
- 3.8 If the hospitals from the revenue they collect during the budgetary year and therefore if they have not utilized the revenue budget authorized for them up to the end of the budgetary year and therefore, the authorized budget in stead of being expended shall be paid back to the finance bureau.
- 3.9 Concerning the Recording of Ledger.
4. For the budgetary year of 2000, hospitals and the finance department offices, in order to make sure that the correct revenue of the previous years of hospitals and which is paid to the finance department office 50 % under 6431 and therefore, by having an expenditure account category on top of the authorized budget that the operational expense which is requested and approved periodically and therefore to make sure that it does not exceed the amount of the authorized budget they shall control the ledger by making a deduction.
5. Staring from the next budgetary year hospitals and finance department offices on the basis of the authorized expenditure budget making sure that the expenditure budget does not exceed the ceiling shall approve payments. As regards the budget execution they shall control their ledgers by making deductions.

Seal:- The Southern Nations Nationalities and Peoples Regional State The Bench Magi Zone Administration Finance Department.