

*TRAINING OF TRAINERS MANUAL
FOR MUTUAL HEALTH ORGANISATIONS
IN GHANA*

Directed and Edited by:
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Abt Associates Inc

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FOR MUTUAL HEALTH
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PARTNERSHIPS
FOR HEALTH
REFORM
ABT ASSOCIATES INC.

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CONTENTS

| | |
|---|------|
| Acknowledgements | viii |
| Preface | ix |
| Acronyms | x |
| Introduction to training of trainers' manual for mutual health organisations in Ghana | xi |
| | |
| Unit 1 Introducing MHOs | 1 |
| Module 1.1 Introducing MHOs | 2 |
| 1.1.1 Definition, significance and basic principles of an MHO | 3 |
| 1.1.2 MHOs and health insurance | 5 |
| 1.1.3 Types of MHOs | 6 |
| 1.1.4 Services covered by an MHO | 7 |
| 1.1.5 MHO stakeholders | 9 |
| 1.1.6 MHOs' Contributions to health sector | 11 |
| 1.1.7 Major risks that MHOs face | 11 |
| Supporting text #1: Why an MHO is important: The story of Kofi Mensah | 13 |
| Supporting text #2: Basic principles of an MHO | 14 |
| MHO case study: Fandene MHO, Thies, Senegal | 16 |
| MHO case study: The JAS community partners for health, Lagos, Nigeria | 17 |
| | |
| Unit 2 Process of setting up an MHO | 23 |
| Module 2.1 Process of setting up an MHO | 24 |
| 2.1.1 Prerequisites and enabling conditions | 25 |
| 2.1.2 Feasibility study – general environment | 28 |
| 2.1.3 Financial feasibility study | 36 |
| 2.1.4 Setting up a working group | 38 |
| 2.1.5 Contacts with key stakeholders | 39 |
| 2.1.6 Setting up the MHO | 42 |
| 2.1.7 Achieving sustainability | 46 |
| 2.1.8 Summarizing steps in setting up an MHO | 47 |
| Supporting text # 1: Example of a constitution: The mutuelle (MHO) 'And Fagaru' of Thies, Senegal | 47 |
| Supporting text #2: Example of internal rules and regulations of the mutuelle (MHO) 'And Fagaru' of Thies, Senegal | 54 |
| Module 2.2 Membership of an MHO, operations management and organisational structure | 57 |
| 2.2.1 Definition of membership | 58 |
| 2.2.2 Registration procedures | 59 |
| Example of joining an MHO through existing Community-based Groups or Associations | 62 |
| 2.2.3 Advantages and disadvantages of individual, family and group membership | 62 |
| 2.2.4 Procedures for accessing an MHO's services | 63 |
| 2.2.5 MHO operations management | 63 |
| 2.2.6 Organisational structure of an MHO | 67 |
| 2.2.7 Member representation in a large, geographically broad MHO or federation of MHOs | 71 |
| | |
| Unit 3 Costing, setting dues/contribution rates and determining benefits packages | 73 |
| Module 3.1 Costing, setting dues/contribution rates and determining benefits packages | 74 |
| 3.1.1 Choosing the services to be covered | 75 |
| 3.1.2 Different types of contribution and their impact | 76 |
| 3.1.3 How to calculate dues or contribution rates | 77 |
| 3.1.4 The role of an MHO in the implementation of the government's exemptions policy | 85 |

| | |
|---|-----|
| Unit 4 Relations with service providers, payment mechanisms and risk management | 87 |
| Module 4.1 Relations with providers | 88 |
| Introduction | 89 |
| 4.1.1 Associating the service providers with the MHO project from the start | 89 |
| 4.1.2 Relations with different kinds of service providers | 90 |
| 4.1.3 Agreements between MHOs and health care providers | 92 |
| 4.1.4 Negotiations and conflict resolution | 93 |
| Module 4.2 Provider payment methods | 95 |
| Introduction | 95 |
| 4.2.1 Providers incentives and interests | 95 |
| 4.2.2 Payment systems | 96 |
| 4.2.3 Billing methods | 102 |
| Module 4.3 Risk management | 104 |
| Introduction | 104 |
| 4.3.1 Types of risk | 104 |
| 4.3.2 Avoiding risk | 104 |
| | |
| Unit 5 Introduction to the financial management of MHOs | 109 |
| Introduction | 111 |
| Module 5.1 Accounting books | 111 |
| 5.1.1 Entering and managing transactions | 111 |
| 5.1.2 The cash and bank books | 112 |
| 5.1.3 Reconciliation statements | 116 |
| 5.1.4 Register of invoices | 119 |
| 5.1.5 The asset book and depreciation table | 120 |
| 5.1.6 The ledger (or summary) accounts | 124 |
| 5.1.7 The journal | 125 |
| Module 5.2 Financial statements | 127 |
| 5.2.1 The budget | 127 |
| 5.2.2 Preparing to do a budget | 128 |
| 5.2.3 Preparing an MHO annual budget | 132 |
| 5.2.4 The cash plan | 134 |
| 5.2.5 The income and expenditure statement | 135 |
| 5.2.6 The balance sheet | 136 |
| Module 5.3 Cost accounting | 139 |
| | |
| Unit 6 Human resources management | 141 |
| Introduction | 143 |
| Module 6.1 Recruitment and hiring | 144 |
| 6.1.1 Defining tasks | 145 |
| 6.1.2 Preparing job descriptions and specifications | 145 |
| 6.1.3 Determining remuneration/benefit package | 148 |
| 6.1.4 Health and safety | 148 |
| 6.1.5 Recruitment/selection: | 149 |
| 6.1.6 Appointment and placement | 150 |
| 6.1.7 Orientation | 150 |
| Module 6.2 Staff development and training | 151 |
| 6.2.1 Training | 151 |
| 6.2.2 Staff development | 151 |
| 6.2.3 Staff performance appraisal | 152 |
| 6.2.4 Discipline | 152 |
| 6.2.5 Support and supervision | 152 |

| | |
|--|-----|
| Unit 7 Monitoring, evaluation and control in a mutual health organisation | 153 |
| Module 7.1 Monitoring and evaluation | 156 |
| 7.1.1 Definitions | 156 |
| 7.1.2 Indicators of monitoring and evaluation | 158 |
| Module 7.2 Mechanisms of control | 169 |
| 7.2.1 Control of MHO accounts | 169 |
| 7.2.2 Control of MHO management | 170 |
| 7.2.3 Control of MHO benefits/services | 170 |
| Module 7.3 Financial audit | 172 |
| 7.3.1 Basics of a financial audit | 173 |
| 7.3.2 Implementing a financial audit | 178 |
| Module 7.4 Management audit | 186 |
| 7.4.1 Definition and objectives of management auditing | 187 |
| 7.4.2 Norms of management auditing | 189 |
| 7.4.3 Implementing a management audit | 189 |
| 7.4.4 Procedures, techniques and tools | 190 |
| 7.4.5 Evaluation of the effectiveness of the management committee and the board of directors | 191 |
| 7.4.6 Auditing the strategy | 193 |
| 7.4.7 Auditing cash management | 193 |
| 7.4.8 Auditing the record-keeping and archiving systems | 193 |
| 7.4.9 Social auditing | 194 |
| 7.4.10 Auditing of management tools | 194 |
| 7.4.11 Audit report | 194 |
| | |
| Unit 8 Marketing/communication, community mobilisation and participation | 197 |
| Module 8.1 Marketing and communication | 199 |
| 8.1.1 Introduction | 199 |
| 8.1.2 Basic definitions | 199 |
| 8.1.3 Elements of a marketing plan | 200 |
| Module 8.2 Community mobilisation | 204 |
| 8.2.1 Introduction | 204 |
| 8.2.2 Basic definitions | 204 |
| 8.2.3 The community mobiliser: required competencies | 205 |
| 8.2.4 The mobilization cycle | 205 |
| Module 8.3 Methods for community participation | 208 |
| 8.3.1 Introduction | 208 |
| 8.3.2 Definitions | 208 |
| 8.3.3 Interpretations and critical issues | 209 |
| 8.3.4 Approaches to participation | 210 |
| 8.3.5 Participatory methods and tools | 210 |
| 8.3.6 Participatory rural appraisal | 211 |
| 8.3.7 Ensuring participation of different groups | 211 |
| 8.3.8 Recap and summary | 212 |
| | |
| Unit 9 Managing the MHOs equipment and assets | 213 |
| Module 9.1 Managing the MHOs equipment and assets | 215 |
| 9.1.1 Introduction | 215 |
| 9.1.2 Overview of facility and equipment maintenance | 215 |
| 9.1.3 Establish quality standards | 216 |
| 9.1.4 Develop a plan to regularly maintain the health unit facility and grounds | 217 |
| 9.1.5 Identify repairs and improvements | 219 |
| 9.1.6 Equipment inventory | 222 |
| 9.1.7 Equipment inspection and maintenance | 224 |
| 9.1.8 The effect of depreciation | 225 |

TABLES

| | |
|---|-----|
| Table 1.1 Differences between MHOs and other types of health care financing organisations | 6 |
| Table 2.1 Demographic data | 30 |
| Table 2.2 Socio-economic and cultural factors | 31 |
| Table 2.3 Health and epidemiological data | 32 |
| Table 2.4 Political factors, institutional and legislative framework | 34 |
| Table 2.5 Technical information | 34 |
| Table 2.6 Sample of initial data collection | 36 |
| Table 3.1 Different types of contribution | 76 |
| Table 4.1 Payment systems | 97 |
| Table 5.1 Example of an initial MHO budget | 131 |
| Table 5.2 Example of a budget as a financial control or monitoring tool | 138 |
| Table 7.1 Indicators of MHO institutional development, progress or impact | 159 |
| Table 7.2 Indicators of MHO effectiveness in its target population | 161 |
| Table 7.3 Indicators of efficiency of the MHO's service delivery and risk management | 164 |
| Table 8.1 Information campaign to increase MHO membership | 203 |
| Table 8.2 Budget for information campaign | 203 |
| Table 9.1 Procedures for regular maintenance of the MHO | 218 |

FIGURES

| | |
|--|-----|
| Figure 2.1 Becoming a member | 64 |
| Figure 2.2 Example of an identification number | 65 |
| Figure 2.3 Example of a database | 66 |
| Figure 2.4 Organs of an MHO | 67 |
| Figure 2.5 Organisational chart of administrative structure | 70 |
| Figure 2.6 Representational structure of a large mutual organisation or federation of MHOs | 71 |
| Figure 3.1 Cost of pharmaceuticals | 80 |
| Figure 3.2 Consultations (General practitioner/specialist) | 80 |
| Figure 3.3 Hospitalisation costs | 81 |
| Figure 4.1 Alternative contracting models between MHOs and providers | 91 |
| Figure 4.2 Example of an agreement between an MHO and a provider | 93 |
| Figure 5.1 Example of financial transactions | 113 |
| Figure 5.2 Solution: Cashbook | 113 |
| Figure 5.3 Bank book | 114 |
| Figure 5.4 Sample Petty cash layout and worked example | 115 |
| Figure 5.5 Kroye Kuo petty cash book | 116 |
| Figure 5.6 Sample bank reconciliation statement | 117 |
| Figure 5.7 Solution to exercise: Yefre MHO reconciliation Statement | 117 |
| Figure 5.8 Yefre MHO office bank records | 118 |
| Figure 5.9 Yefre MHO bank statement | 119 |
| Figure 5.10 Example of registry of invoices | 120 |
| Figure 5.11 Example of an asset register | 120 |
| Figure 5.12 Yefre MHO assets book, 1997 | 121 |
| Figure 5.13 Fixed installment depreciation | 122 |
| Figure 5.14 Yefre MHO depreciation table, 1999 | 123 |
| Figure 5.15 Diminishing balance depreciation | 124 |
| Figure 5.16 Sample ledger | 124 |
| Figure 5.17 Example of an identification number | 125 |
| Figure 5.18 Sample journal | 125 |
| Figure 5.19 Yefre MHO journal, 1998 | 126 |
| Figure 5.20 Yefre MHO budget, 1998 | 132 |
| Figure 5.21 Example of a budget as a financial control or monitoring tool | 133 |
| Figure 5.22 Example of a cash plan | 134 |
| Figure 5.23 Example of an income and expenditure statement | 135 |
| Figure 5.24 Balance sheet example | 136 |

| | |
|---|-----|
| Figure 5.25 Balance sheet: example 2 | 138 |
| Figure 5.26 Example of a breakdown of costs | 140 |
| Figure 6.1 Basic principles of human resources management | 143 |
| Figure 7.1 Yefre MHO Balance Sheet of 30 June 1999 | 165 |
| Figure 7.2 Yefre MHO Statement of Income and Expenditure,1998 | 167 |
| Figure 7.3 Examples of internal control procedures | 180 |
| Figure 9.1 Example of work plan activities | 221 |
| Figure 9.2 Equipment inventory list | 223 |

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Leaders and selected representatives of existing mutual health organizations in Ghana participated in the workshop for adaptation of this manual to Ghanaian conditions. And as stated elsewhere, the TOT test workshop organized in Akosombo after production of the draft of the manual was co-sponsored by DANIDA Ghana. DANIDA Ghana also contributed to making this manual available by paying for it to be printed.

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PREFACE

The Partnerships for Health Reform (PHR) Project is pleased to present this training of trainers (TOT) manual to our colleagues who will be carrying out the important work of organizing and managing mutual health organizations (MHOs) in Ghana. The manual is the culmination of several years of work by PHR, in collaboration with Ghanaian MHOs, the Ghanaian Ministry of Health, USAID/Ghana, the USAID/Washington Africa Bureau, DANIDA, and the members of the MHO network, headquartered in the *Concertation* in Dakar, Senegal. PHR and all of these partners have been in the forefront of a growing movement, centered in West Africa, of community-based initiatives to increase access to and utilization of basic health services through a new form of financing based on prepayment and risk-sharing. This movement has become increasingly referred to as the mutual health organization approach, or simply as “MHOs” or “mutuelles.”

The MHO movement is an indigenous response to the growing recognition that individuals and communities share the responsibility with governments for insuring health coverage. However, communities also recognize that their members need to access health services whenever they need them, not only when they happen to have cash on hand to pay their share of the cost. The West African response has been spontaneous and has grown remarkably over the past few years. Importantly, this response has preceded the recent recognition in the wider international community of the appropriateness of this approach. The international recognition of the need for prepayment and risk sharing is embodied in the Overview of the World Health Report 2000 (p. xviii):

“In the world’s poorest countries, most people, particularly the poor, have to pay for health care from their own pockets at the very time they are sick and most in need of it. They are less likely to be members of job-based prepayment schemes, and have less access than better-off groups to subsidized services. This Report presents convincing evidence that prepayment is the best form of revenue collection....Evidence from many health systems shows that prepayment through insurance schemes leads to greater financing fairness. The main challenge in revenue collection is to expand prepayment....spreading financial risk for health care, and thus reducing individual risk and the spectre of impoverishment from health expenditures.”

PHR and its partners have pioneered in developing the mechanisms for responsible collection of revenue, in order to spread the risk and thus reduce individual impoverishment. The PHR MHO TOT manual will assist existing and new MHOs to set up and implement their schemes in a way that will contribute to their success and sustainability. These tools will help to quickly replicate the positive experiences of the pioneering MHOs and will thus translate the rhetoric of the World Health Report into reality even as the ink dries on the manual.

Nancy R. Pielemeier, DrPH.
Project Director, PHR

ACRONYMS

| | |
|-------|--|
| AGM | Annual General Meeting |
| ARI | Acute Respiratory Infection |
| CBHI | Community-based Health Insurance |
| CBO | Community-based Organisation |
| CPH | Community Partnerships for Health |
| DHMT | District Health Management Team |
| DRG | Diagnosis-related Group |
| GNAT | Ghana National Association of Teachers |
| GP | General Practitioner |
| GPRTU | Ghana Public Road Transport Union |
| HMO | Health Maintenance Organisation |
| HRM | Human Resources Management |
| IGM | Initial General Meeting |
| IMR | Infant Mortality Rate |
| MHO | Mutual Health Organisation |
| MMR | Maternal Mortality Rate |
| MOU | Memorandum of Understanding |
| NGO | Non-governmental Organisation |
| OPD | Outpatient Department |
| PALM | Participatory Appraisal and Learning Methods |
| PAME | Participatory Appraisal Monitoring and Evaluation |
| PHC | Primary Health Care |
| PHR | Partnerships for Health Reform |
| PRA | Participatory Rural Appraisal |
| PRO | Public Relations Officer |
| RRA | Rapid Rural Appraisal |
| TBA | Traditional Birth Attendants |
| UR | Utilisation Review |
| USAID | United States Agency for International Development |
| VRHA | Volta Region Health Administration |

INTRODUCTION TO TRAINING OF TRAINERS' MANUAL FOR MUTUAL HEALTH ORGANISATIONS IN GHANA

WHY WAS THIS MANUAL PRODUCED?

Partnerships for Health Reform (PHR) started its work on mutual health organisations (MHOs) in Ghana in October 1997 with a study on the state of the MHO movement in the country and its actual and potential contribution towards financing, delivery and access to health care. Among other things, that study, whose principal findings were later published in a synthesis of similar studies of nine West and Central African countries, concluded that MHOs had a great potential in all countries studied but that the realisation of this potential was hampered by lack of appropriate skills for running insurance-type organisations. Such lack of skill was reflected most clearly in design flaws that characterised many MHOs studied. The study also showed however that most of these flaws could be easily remedied with the right tools and knowledge of best practices in the area of MHOs, particularly in relation to costing, dues and benefits' package determination, marketing, risk management, relations with providers, as well as monitoring and evaluation of MHO activities.

PHR's subsequent MHO programme in Ghana was aimed at encouraging the growth of MHOs by addressing the kinds of issues identified in the earlier study and briefly discussed above. This programme included development of training and management tools as well as technical advice to specific MHO partners. The present manual was the product of the above MHO reflection and analysis and fills an important gap.

At the time that PHR began working on this manual, no tool of this kind existed either in Ghana or indeed in any Anglophone African country to assist communities, individuals or groups wanting to set up, or actually operating, MHOs in those countries.

HOW THIS MANUAL WAS PRODUCED

On the basis of a number of working documents provided by PHR, a workshop (co-sponsored by the Brong Ahafo Regional Health Administration and the Catholic Diocese of Sunyani) was held at Sunyani in the Brong Ahafo Region in July 1999 to review and produce a draft training of trainers' (TOT) manual adapted to Ghanaian conditions. The product of that workshop was further revised and refined by PHR consultants and staff. A test workshop (co-funded by DANIDA's Health Sector Support Office in Ghana) was held at Akosombo in February 2000, at which the revised manual was used for the first time in a live training session. Some suggestions for improvement emerged from this workshop, and again PHR staff and consultants worked to incorporate those suggestions. Finally, the TOT manual was sent to about a half dozen international experts for technical review, and this led to further work by PHR staff to refine and finalise the document for use in Ghana. Only then was the manual judged to be ready for layout and printing.

THE MAIN TARGET GROUPS OF THIS MANUAL

This manual was written principally to address the lack of a comprehensive source of technical knowledge and information to aid MHO promoters, initiators, managers, administrators and staff in setting up, administering, managing, monitoring and evaluation of such organisations. Thus the target groups encompass the leaders and activists of existing MHOs, individuals, NGOs, community leaders, Church and other religious organisations, providers, district assemblies, consultants, etc. who are involved in any of the above areas of MHO life, or who give training and technical advice to such organisations.

Ideally, the trainees would in turn become trainers and therefore be able to impart what they have learnt to others as well. This is indeed the principal objective of any TOT manual. But it is recognised that most people who would turn up for training sessions in the circumstances of Ghana today would be persons more interested in directly applying the skills learnt to setting up, administering and managing MHOs. This target audience is also a legitimate target group and this explains the great emphasis given in the manual to imparting technical information about MHOs and not merely equipping trainees with teaching methodologies on the usual assumption underlying TOT manuals that the trainee already has basic technical knowledge of the subject and needs to know how to impart such knowledge effectively to others. In due course, these latter type of person may become more numerous in Ghana and the manual as designed can be used effectively with both types of audience.

HOW SHOULD THIS MANUAL BE USED?

This manual was designed for training sessions bringing together trainer and trainees. The pedagogic approach and the method of presentation therefore reflect the requirements of such training sessions.

The manual contains nine units each of which is subsequently subdivided into a number of training modules dealing with a specific training theme.

Each unit (or chapter) of the manual begins with a description of the expected learning outcomes, the target group(s) of the unit, the pre-requisites (previous units, knowledge or experience required) for participating in the course, a brief description of the contents, the training methods and finally the teaching materials needed for the unit. In addition, each unit contains essential and extensive technical information to aid the trainer, backed up by technical notes on specific technical points needing further elaboration, practical examples and/or illustrations, case studies, exercises and similar materials to facilitate the teaching.

The basic approach here is that even if the trainer and trainees are from an existing MHO, previous research in Ghana by PHR has indicated that they could benefit from the wealth of technical information about MHO best practices which are contained in this manual. Subsequent experience and investigation have both shown that most immediate beneficiaries of this manual are people who would use the knowledge gained, not principally for training others, but rather to apply in the processes of setting up,

administering, and managing MHOs. This justifies further the heavy emphasis here on imparting technical knowledge and skills as much as, if not more than, training methodologies.

HOW MUCH TIME SHOULD BE SPENT ON EACH UNIT OF THE MANUAL?

Actual training sessions carried out with this manual have led PHR to suggest the following time periods for teaching each of the units of the manual in a satisfactory manner.

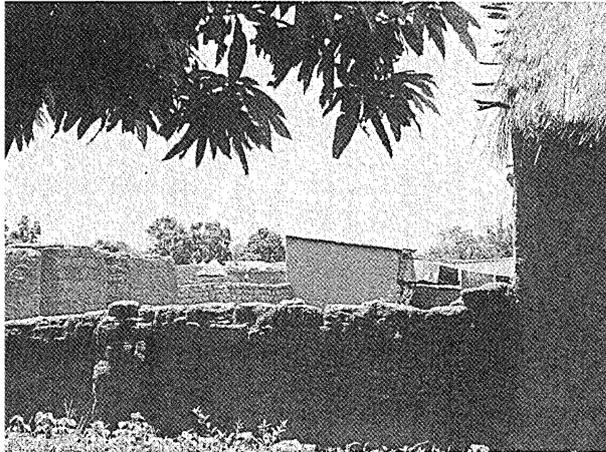
| UNIT NUMBER | UNIT TITLE | RECOMMENDED TIME FOR TEACHING |
|-------------|--|---|
| 1 | Introducing MHOs | Half a day to one day |
| 2 | Setting up, organising and operating an MHO | Two and a half days (includes suggested field trip) |
| 3 | Costing, setting dues/contribution rates and determining benefits packages | Half a day to one day |
| 4 | Relations with service providers, payment mechanisms and risk management | One day |
| 5 | Introduction to the financial management of MHOs | Two and a half to three days |
| 6 | Human resources management | Half a day |
| 7 | Monitoring, evaluation and control in an MHO | Two days |
| 8 | Marketing/communication, community mobilisation and participation | Two days |
| 9 | Managing the MHOs equipment and assets | Half a day |

The full course therefore requires about two six-day weeks of full-time effort to complete. However, there is no reason to have to do the course in one two-week session. Different parts can be done at different times to suit the convenience and work constraints of participants, and this might even be preferable to allow time for participants to practice some of what they have learnt and to return with their enriched experience to tackle more advanced subjects.

UNIT

1

INTRODUCING MHOs



| | |
|---|----|
| Module 1.1 INTRODUCING MHOs | 2 |
| 1.1.1 Definition, significance and basic principles of an MHO | 3 |
| 1.1.2 MHOs and health insurance | 5 |
| 1.1.3 Types of MHOs | 6 |
| 1.1.4 Services covered by an MHO | 7 |
| 1.1.5 MHO stakeholders | 9 |
| 1.1.6 MHOs contributions to health sector | 11 |
| 1.1.7 Major risks that MHOs face | 11 |
| Supporting text #1: Why an MHO is important: The story of Kofi Mensah | 13 |
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| MHO case study: Fandene MHO, Thies, Senegal | 16 |
| MHO case study: The JAS Community Partners for Health, Lagos, Nigeria | 17 |

MODULE 1.1

INTRODUCING MHOs

LEARNING OBJECTIVES

At the conclusion of the module, participants will be able to:

- ◆ Define a Mutual Health Organisation (MHO)
- ◆ State its operating principles
- ◆ List the services it is able to offer its members
- ◆ Identify different kinds of MHOs
- ◆ Distinguish MHO health insurance from other kinds of health care financing
- ◆ Identify the MHO's stakeholders and state their roles
- ◆ Discuss its contribution to the health sector and health policy goals of the country
- ◆ Identify the major risks to which an MHO is exposed

TARGET GROUP

PROMOTERS:

NGOs, trade unions, health institutions both government and mission, welfare groups, churches, credit unions, formal and informal occupational groups and interested individuals, community leaders, leaders of organised groups/associations, credit unions, 'susu' groups, district assemblies, etc.

POTENTIAL MEMBERS:

An MHO

POTENTIAL PARTNERS OF THE MHO:

Health provider staff, local government authorities, government agencies dealing with MHOs such as the Ministry of Health, donors and technical support agencies

PREREQUISITES

TRAINER:

Familiarity with adult learning methods, including participatory approaches

TRAINEE:

Willingness to participate in discussion about the concept of an MHO and to impart the knowledge and skills learnt to others

CONTENT

- ◆ Definition and operating principles
- ◆ Services offered by an MHO
- ◆ Types of MHOs
- ◆ Distinguishing MHO health insurance from other kinds of health care financing organisations
- ◆ Identifying the MHO's stakeholders and their various roles
- ◆ Contribution of MHOs to the health sector
- ◆ Major risks to which an MHO is exposed

TRAINING METHODS

- ◆ Presentation/Discussion
- ◆ Plenary/Discussion
- ◆ Role play
- ◆ Case studies

TEACHING MATERIALS

- ◆ Supporting texts (Participants' Guide and Work Book)
- ◆ Any of the following:
 - ◆ Slides
 - ◆ Flipchart
 - ◆ Overhead projector
 - ◆ Video projector

1.1.1 DEFINITION, SIGNIFICANCE AND BASIC PRINCIPLES OF AN MHO

The first step through which a trainer should lead participants is the definition of an MHO. It may be useful for the trainer to begin by asking participants to mention the various risk-sharing and solidarity mechanisms that exist in their community(ies) for assisting people who face either misfortune or an event that involves expenditure so high that the average person cannot easily defray the costs alone or even save for it. Prompt them by asking what happens in the case of funerals, births, marriages, etc.

Let the participants describe examples of organisations and movements in their localities which are based on the principles of solidarity, mutual self-help and risk-sharing, even if these are not related to health risks.

The trainer should guide the discussion and relate it to such traditional institutions as the 'Abusua Fotoo', 'Abusua Dwatire', 'susu', etc. Gradually lead the participants to think of how these examples could be related to coverage of health risks. A relevant example to illustrate this could be more than the 3,000 social financing schemes a survey found to exist in the Volta Region, more than half of which offer some health care coverage to their members.

Consider next the story of Kofi Mensah (Supporting Text #1). Let one of the trainees read out the story and invite the comments of other participants. Ask how the story illustrates prevailing attitudes towards health risk, compared to the other social risks mentioned above.

Let the participants discuss and list the options available to an average or poor family faced with an unexpectedly high medical bill as a result of a serious illness or accident. The trainer should pose questions to allow the participants to discuss the various implications when the calamity befalls respectively the breadwinner, housewife, school child, and grandparent in the family.

The aim of the foregoing exercise is to introduce the concept of an MHO and its usefulness to participants for whom the notion may be new, although they may already be familiar with similar institutions in the non-health arena. The trainer should continue the discussion on participants' understanding of the concept of an MHO through examples of traditional solidarity organisations drawn from their own experiences.

Based on these discussions, ask a participant to suggest a definition of an MHO. Lead a discussion so that other participants can add to the definition if necessary. Mention the names of different kinds of MHOs in Ghana and others that are popularly known elsewhere, and ask participants to describe the key features of each of these. Write the keywords on the flipchart.

The definition of an MHO should incorporate the following key concepts:

- ◆ Autonomy
- ◆ Not-for-profit
- ◆ Solidarity
- ◆ Democratic decision making and accountability
- ◆ Risk-sharing
- ◆ Social movement

These concepts are defined in the Supporting Text #2. Ask a trainee to read out the text from the Participant's Guide and discuss with participants.

Summarise the participants' discussion and propose the following definition:

An MHO is the generic name for an autonomous, not-for-profit organisation based on solidarity between members and that is democratically accountable to them. Its objective is to improve members' access to good quality health care through risk-sharing based on their own financial contributions. It also aims at improving the lives of members and all citizens and promotes democratic decision making.

The trainer should stress that "mutual health organisation" is a deliberately chosen generic name, because actual organisations may have widely varying names, including purely vernacular ones, for instance, Hwidiem Fe Kuo, Kintampo Teachers' Welfare Fund, Madina Community Partners for Health, and Asokwa Community Health Fund.

PHR field experience has shown that ordinary people can sometimes come up with apt definitions of an MHO or community health insurance if the question is posed to them in the right manner and in the right context.

For example, PHR evaluated the Nkoranza Community Health Insurance Scheme in 1999. The evaluation involved a household survey and focus group discussions. During the course of the latter discussions, the following interesting definitions of community health insurance were recorded.

“A mutual relationship created by people likely to be affected with a common risk, who contribute to a common fund from which a member is relieved in times of the happening of such eventualities” (Yefre insured people).

“A mutual way of living where members contribute to a common fund from which the members are supported in an event of the occurrence of the very calamity (for) which the money was purposely set aside” (Yefre non-insured people).

1.1.2 MHOs AND HEALTH INSURANCE

It should be noted that the term “health insurance” is not included in the definition of an MHO. In practice the majority of MHOs use financing mechanisms based on health insurance principles. In general, the insurance mechanism is the likely to be the most efficient and fair one, enabling poorer people to pool their small contributions so that the most unfortunate among them have access to health care when they need it. It is therefore the mechanism that best satisfies the solidarity and risk-sharing requirements of the MHO definition and is strongly recommended over non-risk-sharing mechanisms such as health loans and simple prepayments.

Nevertheless, MHOs can and do use financing mechanisms other than insurance. An example is the Community Partnerships for Health (CPH) in Lagos, Nigeria which is linked to a network of private primary health care providers. Here, members join the MHO through an existing community association and pay dues to the CPH. These dues are not used to pay the providers for members’ health care, because the dues are just sufficient to cover the administrative costs of the CPH, including health education campaigns and sensitisation work, plus a revolving drugs fund that enables providers to have all the essential drugs available.¹ Rather, the CPH serves two purposes: for the private providers, who practice in a highly competitive environment, the CPH vets clients. And CPH members enjoy a substantial reduction in their bills compared to non-members.

The advantage to the private provider is that the CPH enables them to increase their client base substantially (clients who in all probability would mostly have otherwise gone to the public sector for reasons of cost). The members get the advantage of better quality care at significantly reduced cost. No insurance is involved, at least not in the classical sense, yet this too is an MHO.

¹ Note that there is some risk-sharing if the dues paid by members vary in accordance with their income level, or if it is only the most unfortunate or sick members who benefit directly from the scheme, while the healthy ones do not benefit or do so to a lesser extent.

Table 1 reviews differences between MHOs and other types of health care financing organizations.

TABLE 1.1 DIFFERENCES BETWEEN MHOs AND OTHER TYPES OF HEALTH CARE FINANCING ORGANISATIONS

| | SOLIDARITY OBJECTIVE? (Y OR N) | TYPICALLY FOR- OR NOT-FOR-PROFIT | MANAGEMENT STRUCTURE OR OWNERSHIP | DEMOCRATIC ACCOUNTABILITY TO PARTICIPANTS (Y OR N) | RISK SHARING (Y OR N) |
|----------------------------------|--------------------------------|--|--|--|-----------------------|
| MHO | Y | Not-for-profit | Member owned | Y | Y |
| Community-based health insurance | Y | Not-for-profit | Provider owned, but can be co-managed | N | Y |
| Social health insurance | Y | Not-for-profit | Government, member owned and managed | Y (indirectly through representation in govt. or parliament) | Y |
| Mutual credit | Y | Usually not-for-profit but interest may be charged | Member owned | Y | N |
| Health maintenance organisations | N | For-profit | Owned by shareholders of company | N | Y |
| Health co-operatives | Y | For-profit | Member owned | Y | N |
| Private commercial insurance | N | For-profit | Owned by shareholders of company | N | Y |
| Simple prepayments | N | Not-for-profit | Usually managed by the agency collecting fees, e.g. provider | N | N |

1.1.3 TYPES OF MHOs

Traditional social financing schemes that cover health care costs of members. These may be based on ethnic or village/community social networks. Example: 3000 schemes were found in the Volta Region survey. Frequently these cover a wide range of social risks, primarily funerals, marriages, and births. Health care is added as need arises and may be a systematic benefit with automatic entitlement when certain conditions are met, or simply provided when the need is expressed.

Welfare funds or schemes based on trade unions, work place and occupational associations. Example: The Teachers' Welfare Funds operated by district officers of the GNAT; the GPRTU-based proposed health insurance scheme in the Eastern Region.

Community- or residential-based welfare organisations or NGOs covering health care financing through collective insurance contributions. Example, the proposed Saboba scheme by the Integrated Development Centre, a local NGO.

Co-managed schemes set up and managed jointly by the community and a health provider or providers in the area. Example: The Community Partnerships for Health Schemes in Lagos. After a recent evaluation, the Nkoranza Community Health Insurance Scheme is in the process of implementing proposals for a co-managed structure.

GROUP ASSIGNMENT

After reviewing the four types of MHOs, the trainer, using practical examples, should lead a discussion on the different types of MHO experience that can be found in Ghana and possibly elsewhere in Africa.

Let participants compare and contrast the provider-based community health insurance schemes and democratically run community or NGO-based health organisations, noting similarities and differences. Ask the participants to discuss whether these differences matter and in what way.

In particular, participants should read and discuss the MHO case studies at the end of this unit: the Fandene *mutuelle* in Senegal and the Community Partners for Health schemes in Lagos, Nigeria.

1.1.4 SERVICES COVERED BY AN MHO

Making needed, high quality services available and affordable to its member community is why an MHO exists and how it translates the principle of solidarity into reality on a daily basis. The services offered should correspond to the needs that are felt and expressed by the community; in addition, the MHO must resolve the problem of financing health care. The extent to which the MHO provides such services and is well managed determines its success or failure, as evidenced by the enrollment of new members or the resignation of dissatisfied ones.

But such issues are not always clearly understood or openly expressed at the start of the project. In this case, it is usually necessary to first assist the community to clarify and express their needs clearly, without manipulating or leading them to a pre-defined outcome.

The services offered by an MHO may be summarised as follows:

AFFORDABLE, QUALITY HEALTH SERVICES

With good community organisation, the MHO's activities will encourage attendance at the health centres. The organisation and commitment of members, and the pressure they are able to exert, can encourage or compel health care providers to improve upon the quality of services, especially where performance standards are agreed upon at the beginning.

The kinds of health care services that may be offered by an MHO to its members include:

- ◆ Basic Health Care:
 - ❖ *Preventive and promotional care*, which includes pre- and post-natal consultations, monitoring of healthy nursing infants, vaccinations, family planning, health education and sanitation.
 - ❖ *Curative care*, which includes mainly consultations, nurse care, the provision of drugs and some laboratory tests. Occasionally, minor hospitalisation is added when it occurs in health centres for observation or assisted deliveries.
 - ❖ *Chronic disease treatment*, such as for diabetes, sickle cell anaemia, arterial hypertension, haemophilia and heart disease; coverage may be extended to home.
 - ❖ *Children suffering from malnutrition*, including nutritional recovery using local food.
- ◆ Hospital care: this care includes hospital stays, medical and technical services and drugs.
- ◆ Drugs: for drugs, it is important to determine the list of those, if any, the scheme will not reimburse (for example, expensive brand name drugs upon which patients may insist.)
- ◆ Dental care
- ◆ Eyeglasses
- ◆ Transportation of patients: for example, in emergency situations. The current MHOs in Ghana are based mainly in rural areas where roads are sometimes barely passable and transport is scarce. In some cases, vehicles travel some routes only once or twice a week, on market days. To overcome the transport problem, the Damongo Community Financing Health Insurance Scheme, for instance, operates an ambulance to transport patients to and from the hospital.

NON-HEALTH SERVICES

Non-health services of MHOs could include savings and credit facilities, revenue generating activities, housing and scholarship grants to needy children of members, cash allowances to beneficiaries for births, deaths, and marriages and other agreed purposes.

Furthermore, MHOs could also offer rehabilitative services such as programmes on drug addition, alcohol abuse and mental stress. Still, other services could include resettlement after disasters and reintegration into communities.

GROUP ASSIGNMENT

(It may be best to get group members from the same geographic area)

- ◆ List priority health problems
- ◆ List health problems based on routine health data or feasibility studies
- ◆ List available services

Organise discussion based on the relevance of the health care problems or needs identified and proposed services available to resolve the problems or meet those needs.

In plenary session, ask the rapporteurs of each group to present the results of their work and lead a discussion on the relevance of the health needs identified and the services proposed.

1.1.5 MHO STAKEHOLDERS

MHO stakeholders are groups in the community who have an interest (or stake) in the activities of the MHO and in its success or failure. They would include in the first place, its members, officers, management and staff, the health care providers, any donors or promoters, etc. It is important to identify these possible stakeholders at the very start, in the MHOs' design phase, so that their concerns and interests can be addressed and their active co-operation sought in order to make a success of the MHO. The opposition or even disinterest of a major stakeholder can seriously impede to the progress of the MHO. For instance, in some communities, the active collaboration of the chiefs may be a key factor to achieve a high rate of registration. Ignoring this can be costly, as groups, or individuals who consider themselves slighted or treated with less respect than they deserve can turn into active opponents of the scheme.

Technical note 1.1 summarizes potential MHO stakeholders.

GROUP ASSIGNMENT

Ask participants to list possible stakeholders of an MHO and to describe their roles. Note the answers on the flipchart. Ensure that the following are covered:

- ◆ Members
- ◆ Health providers
- ◆ Scheme managers
- ◆ District assemblies
- ◆ Traditional authorities
- ◆ Other community organisations
- ◆ Donors
- ◆ Technical co-operation agencies

Divide the participants into small groups according to broad areas of origin (village, district, region, etc., depending on the participation in the workshop) and ask each group to discuss the possible role of the stakeholders in the development, promotion and progress of an MHO in their area. Ask each group to report back in plenary.

POSSIBLE MHO STAKEHOLDERS AND THEIR ROLES

1. MEMBERS

Members of the community are the critical link in the MHO equation, as they are the consumers of health services and they can initiate scheme formation and development. They recognise the need for affordable and accessible health care, coming together to pool resources and share the risks of health coverage.

Once empowered with common resources, the community acts to initiate a scheme to protect its collective health and well being in the long term.

2. SERVICE PROVIDERS

The health care professionals treating the members of the MHO scheme are vital to ensuring that the community's health needs are met, and that the standards of care are of sufficient quality to ensure client satisfaction among the scheme membership. Health staff who are trained in MHO principles and protocols and who encourage the community to utilise the health services in an appropriate manner contribute substantially to the success of the MHO scheme. Motivated, well-informed service providers are necessary to ensure that MHO operations are sustainable and well run.

3. MANAGEMENT

Managers have day-to-day responsibility for efficient and effective operation of the MHO. Their most important job is to ensure that MHO resources are spent as the members intended. Their job includes implementation of risk management measures, data management for monitoring costs, internal control measures to prevent fraud, and relations with community members, service providers and administrative staff. MHO management should be transparent, and include regular, detailed reporting to the members.

4. DISTRICT ASSEMBLIES, TRADITIONAL AUTHORITIES, OPINION LEADERS

These are important actors in the community. They may have considerable influence over the behaviour of members of the community or resources that can be tapped by the MHO. It is always vital to try and cultivate the people in these kinds of institutions or of such social standing. This helps the legitimise the MHO and to increase membership. As voices of their communities, district assemblies and traditional leaders may also be bodies with a legitimate claim to representation on MHO management.

5. OTHER COMMUNITY ORGANISATIONS

The MHO does not exist in isolation. As a social movement, it has a vested interest in maintaining active links with other community or social organisations in order to better defend their common interests in a collective manner. Other community organisations may also quite simply serve as units through which people may join the MHO, either as recruiting grounds where the leaders of those bodies are committed to the MHO, or as the base organisations which grant access to the MHO, where membership of the MHO is conditional upon membership of a prior group, or even where this is just an option. Examples include unions, professional organisations, church or religious groups, and cooperatives.

6. DONORS OR OTHER SUPPORT AGENCIES

Donors and technical support agencies may be crucial partners, especially in the initial stages of the MHO, when the need for start-up funding and training may be beyond the resources of the new or proposed organisation. This role often gives such partners a crucial, or even a determining role in the management of the MHO. An MHO that is faithful to its principle of independence will conduct its relations with external partners in a way that does not compromise its freedom of action. Some requirements of donors, such as regular audits and evaluation or accountability, are often consistent with the organisation's own interests and aims, so long as these are not seen as imposed and non-participative, or are not based on criteria which are not shared by the MHO's leaders.

1.1.6 MHOs' CONTRIBUTIONS TO HEALTH SECTOR

MHOs have potential to contribute to health sector goals in various ways, including the following:

- 1. Improved access:** MHOs seek to increase access to health care for those who have some capacity to pay at least the dues of the scheme, but who may not be able to pay user fees for each visit to a health care provider by a family member.
- 2. Improved quality:** People are more willing to pay for higher-quality services. MHO schemes can contribute to this by increasing both the amount and the reliability of community resources mobilised to support local health facilities. The critical importance of good quality care for the success of an MHO cannot be over-emphasised (see the conditions and prerequisites for setting up an MHO in Unit 2).
- 3. Improved efficiency:** MHOs seek to *increase the efficiency in the allocation and use of available resources* through the use of mandatory referral mechanisms to ensure that patients enter and use the health care system at the level most appropriate to their condition, as well as implement essential and generic drugs' policies.
- 4. Equity:** MHOs attempt to make the health sector more *equitable*. Because government subsidies and other funds for health care are dwindling and may not reach a large percentage of the population, many of the poorer populations have little or no access to affordable, quality health care. MHOs can fill some of the gap between those who have health care and those who do not by collecting premiums or membership dues at a time to coincide with the seasonal availability of people's income, which is often related to harvests. MHOs also promote equity by sharing or pooling risk. For example, by collecting resources from both the rich and poor, the healthy and sick and young and old, then using these resources to ensure that the needy, usually the poor, the sick and the old, can get access to good care when they need it. Still, the poorest of the poor might be excluded from this system, given that schemes require at least a minimal payment. The cover for the medical care of this poorest category is an appropriate issue for public policy, especially for authorities who wish to encourage the development of these kinds of community schemes.
- 5. Democratic governance:** MHOs contribute to democratic governance of the health sector by enabling ordinarily people, for the first time, to be able to make an input into allocation decisions of health authorities, negotiating with providers on payment and quality of care and similar issues.

1.1.7 MAJOR RISKS THAT MHOs FACE

There are risks in any new or growing MHO. To prevent the risks from jeopardising MHO viability, some preventive measures should be taken, for "*an ounce of prevention is worth a pound of cure!*"

The major risks to which any MHO that offers services to an entire population may be exposed are the following:

1. Adverse Selection

Adverse selection occurs when persons with a high risk of disease join an MHO in large numbers, and when persons in good health tend not to join. This situation may compromise the MHO's financial viability due to excessively high expenses per member. As opposed to a private commercial insurance system, an MHO cannot select its members, nor may it require each of them to pay dues based on their personal risk. However it may require the minimum registration unit to be the family as a means to minimise risk.

For the same reason, it is advisable to have all the members of a given group join at the same time when an MHO is set up. For example, they may be employees of a business or members of a union, a group, an association or a religious community. The larger the affiliated group, the more the risks covered are distributed over a large number of people.

2. Moral Hazard

Moral hazard is the often-observed tendency by beneficiaries to use the services excessively or more than they actually need to, because they want to “take maximum advantage” of the dues they paid. For instance, an insured person is more likely to go to hospital for a minor headache than a non-insured person.

Moral hazard may also occur through the practice of service providers over-prescribing treatments and drugs. Providers are more likely to provide unnecessary services if they are paid on a fee-for-service basis because the more services they provide, the more money they make. This is probably a bigger danger to the extent that MHOs may not have either the competence or the confidence to monitor this abuse.

3. Fraud and Abuse

An MHO insurance system is open to the dangers of free-riding, that is, providing services to non-members. This may occur through impersonation—giving one's ID card to an uninsured person (relative, friend, etc.)—so that they can avoid paying for their own care.

Dishonest providers seeking to maximise their revenue from MHO members can also perpetrate fraud. It is not unknown for providers to fill in fictitious prescriptions or deliberately claim for services not actually performed.

4. Cost Escalation

The risks of adverse selection, moral hazard, and fraud have caused MHO costs to rise higher than they should. Some rise in costs after launching an MHO is to be expected and is normal since members now have access to services they did not have before. (This makes it important to factor in a higher rate of service use when calculating the MHO's initial budgets than the rate of use that pertained before the MHO was set up.) After this initial rise costs should level off. The risk is when costs rise much faster than expected or continue to rise long after the MHO has been established. Then it is time to look for the possible cause in the above mentioned risks factors, and/or to determine if the benefits package is too generous in relation to the dues or if the MHO is paying for non-covered services.

5. Underestimating Dues

There is a danger, when starting an MHO, of underestimating the dues required to meet the cost of the services to members. Underestimating dues means income does not cover the cost of running the organisation, and the MHO suffers a loss. To avoid losses, costs should be reduced as much as possible, the initial benefits package should be very limited and the MHO could establish limits on utilisation (e.g. a maximum number of 4 visits per person per year).

6. Impact of an MHO's Other Non-health Services

As part of its social function, an MHO may offer a cash allowance during certain events such as birth, marriage or death in keeping with its principle of solidarity. The MHO may also be part of a wider organisation, such as a trade union or credit union, whose management may impose costs that may risk its viability.

GROUP ASSIGNMENT

Ask the participants what risks or potential problems should be anticipated when the MHO is set up. Note the answers on file cards and post them on a notice board for the purpose. Ensure that the following major risks are mentioned:

- ◆ Adverse selection;
- ◆ Moral hazard;
- ◆ Fraud and abuse;
- ◆ Cost escalation;
- ◆ Underestimating dues;
- ◆ Other non-health services offered by a parent organisation of the MHO, or one to which the MHO is affiliated.

Inform participants that possible solutions or ways to minimise these risks will be further discussed in Unit 4, Module 3, on Risk Management.

SUPPORTING TEXT #1: WHY AN MHO IS IMPORTANT: THE STORY OF KOFI MENSAH

Kofi Mensah is a 27-year-old tomato farmer at Nyamebikyere. He crops a five-acre plot of land. He is married with two children: four-year-old Ama and two-year-old Sesa.

Nyamebikyere has a farmers' co-operative society with a mutual health insurance scheme. The premium charged for the mutual health scheme is ₵10,000 per annum.

The co-operative mutual health scheme covers inpatient attendance at the Nyamebikyere clinic. Kofi Mensah is not a member of the scheme.

“You are a strong, hard-working man” said the chairman of the co-operative society to Kofi Mensah, “Why don't you join the mutual health scheme?”

“This is exactly why I won't join the scheme” said Kofi Mensah to the chairman. “I am strong and healthy. The possibility of my getting sick and going on admission is very remote. Moreover when I feel unwell I can go to the local chemical seller whose services are cheaper than the ₵10,000 premium you charge!”

Not long after, Kofi Mensah collapses and starts foaming at the mouth while harvesting tomatoes on his farm. He is rushed to the local chemical seller.

“Oh Kofi, I am sorry I cannot diagnose your condition to sell you any medicine. I do not even have the expertise to provide such service. Please go to the Nyamebekyere clinic,” said the chemical seller.

At the clinic, Kofi’s blood pressure is taken and is found to be very low. He is diagnosed as suffering from chemical poisoning from insecticides he used on his crops. He is given intravenous infusions and drugs to treat the poisoning and the service charge including treatment cost comes to ₵300,000.

“Where can I get such an amount?” moaned Kofi Mensah.

His wife, Abena, goes to her uncle for help. “I cannot be of help, I am at the moment thinking about how to pay the school fees for my two children”. “You know school re-opens next week” said the uncle. “Why don’t you go to Egya Kodwo, the money lender? He may be able to assist”.

At Egya Kodwo’s premises: “Oh I have heard of your husband’s predicament. Have my sympathy. Can I be of any help?” asked Egya Kodwo, the moneylender.

“Yes” replied Abena, “we need a loan of ₵300,000 to defray my husband’s medical expenses”.

“Hmm, you know money palaver these days. I can help if you provide a collateral and the rate of interest is 100 percent per annum” said Egya Kodwo. “I usually accept fixed properties as collateral but in your case, since Kofi Mensah is a friend and a good person, I may accept his tomato farm as collateral for the loan” continued Egya Kodwo.

SUPPORTING TEXT #2: BASIC PRINCIPLES OF AN MHO

AUTONOMY

To be autonomous implies independence from external pressures in the functioning of the MHO. Each MHO exists on its own and is not obligated to any other external institution or government agency, provided it operates within the law. An MHO is also autonomous by having its own rights and responsibilities.

It should be free to set up its own rules and regulations with the approval of its members. It should be free to select services, determine utilisation and where to access services.

Autonomy enables flexibility for it and enables it to adapt to suit local conditions.

It allows quick decision-making in terms of setting dues, payment of bills and dealing with complaints.

Autonomy also implies the ability to negotiate with service providers and other authorities in the interest of its members.

NOT-FOR-PROFIT

An MHO is an association that belongs to all the members. It does not have outside shareholders or owners who distribute surpluses or profits from its operations.

Instead, any surpluses made are either reinvested in the organisation or used to improve or add to existing services for all members. Example: In Zimbabwe, the Engineering Medical Fund sets aside a sum of money from its annual surplus to look after members who have contracted AIDS.

Usually the rules of an MHO stipulate that surpluses should be used to build a reserve fund up to a certain level to withstand times of adversity before being put to other uses.

Not-for-profit does not mean that the MHO should not respect sound financial and business principles in its operations or seek to achieve efficiency, avoidance of waste or misuse of resources. This is to be stressed, as there is a tendency to believe that not-for-profit means not paying attention to efficient resource use and stringent business principles.

Trainers should also stress the fact that general attitudes towards public property and social services are that these don't belong to anyone and can be misused at will, but this should not be encouraged in the MHO.

SOLIDARITY

Solidarity in a Ghanaian context is the expression of empathy with the more disadvantaged without expectation of direct reciprocal obligation from the recipient at the time of giving. However the giver is assured of reciprocity in the future if he/she also becomes disadvantaged or is in need. It is different from charity because giver and receiver are bound together in a complex relationship of equals having social rights and obligations toward one another.

Contributions are the same for everyone or according to income but utilisation is according to need only.

Examples are the basic principles on which local formal and informal welfare/benevolent associations are based. Many clubs, such as ladies' clubs, market women's associations, work place clubs, social clubs, ethnic clubs, old boys' and old girls' clubs, and old age group clubs, are formed for social and economic support among members in time of need (birth and naming ceremonies, funerals, weddings, etc).

DEMOCRATIC PARTICIPATION

This principle means that:

- ◆ Members enjoy freedom of association without any form of discrimination on the grounds of ethnicity, religion, gender or political affiliation
- ◆ Equal rights and responsibilities for members in decision-making with no member "bossing" another
- ◆ Active participation, in that members may, if necessary, be grouped into gender groups, peer groups etc., to discuss issues exhaustively and freely before decisions are taken or arrived at
- ◆ Members have equal votes

- ◆ A decentralised structure to facilitate active participation in decision making whenever the size of the organisation attains a certain level or operates over a wide geographical area.

TRANSPARENCY AND ACCOUNTABILITY

This requires:

- ◆ Openness in all aspects of the MHO's work and management
- ◆ Checks on cheating, fraud and embezzlement are in place
- ◆ Records on income and expenditure are rigorously maintained
- ◆ Accounts are audited on a regular basis
- ◆ Mutual trust exists between members and management to increase confidence
- ◆ Non-technical language is used so that lay persons can participate meaningfully in discussions or decisions, and the translation of technical documents into simpler language or local vernaculars to facilitate comprehension.

SOCIAL MOVEMENT

The MHO, as an active organisation of individuals linked together by common interests to whom it is democratically accountable in all areas, forms part of a larger social movement to improve the lives of members and all citizens to promote democratic participation in decision making. It works on the above principles of autonomy, not-for-profit, democracy, accountability and solidarity to advance the interests of members and seeks active partnerships with women's associations, trade unions, credit unions and other groups that aim to empower citizens to take responsibility for crucial aspects of their lives.

MHO CASE STUDY: FANDENE MHO, THIES, SENEGAL

K *KEY FEATURES:*

- ◆ Thies, pop. 250,000 is a region mainly Christian and of the Sereer ethnic group
- ◆ Served by a regional public hospital and Catholic-run district hospital
- ◆ Catholic Hospital a promoter (but *not* owner) of MHOs since late 1980s
- ◆ First MHO set up in 1989, in village of Fandene
- ◆ Initiated by local priest from village together with villagers
- ◆ MHO made up exclusively of people from village
- ◆ 2,500 beneficiaries; about 90 percent of village population
- ◆ Structures: executive committee, board of directors and general assembly of all members
- ◆ Executive committee made up of educated people living in village as farmers or running other local enterprises
- ◆ Services: only hospital admission and emergency evacuation (surgery excluded)
- ◆ From start, hospital agreed to offer 50 percent reduction on prices to MHO members
- ◆ 50 percent includes services not covered by MHO
- ◆ Dues charged at CFA100 (c. €700) per person per month for all family members

RISK MANAGEMENT TOOLS:

- ◆ MHO's cover fixed at maximum 15 days of admission
- ◆ Later reduced to 10 days due to:
 - ❖ Hospital discount being reduced to 35 percent
 - ❖ Analysis showing that average hospital stay was eight days
- ◆ MHO pays all of patient's bill to hospital, and then recovers member's portion afterwards directly from member
- ◆ Waiting period of 18 months
 - ❖ To accumulate sufficient funds for paying bills and
 - ❖ Pay caution fee of CFA500,000 to hospital
- ◆ Hospital charges MHO flat amount per hospital day for each member admitted
- ◆ Payment method a vital gain obtained from Catholic hospital
 - ❖ Important for risk management
 - ❖ MHOs know maximum costs for each admitted member
 - ❖ Only risk is longer hospital stays for members
 - ❖ But having clearly supportive provider mitigates this risk

IMPACT OF FANDENE'S SUCCESS:

- ◆ Made Fandene a model for MHOs in Thies region and elsewhere
- ◆ Other villages began to copy this example wholesale
- ◆ Only modifying later on basis of experience
- ◆ Example of second MHO in region which did not cap its cover and collapsed
- ◆ Pioneering example eased path for later MHOs
- ◆ New ones copied constitution and rules and regulations
- ◆ Created management tools such as members' registers and accounting books that now are available to others
- ◆ Risk management tools plus support of hospital also available
- ◆ Showed it was possible to set up and run MHO with members' resources, not external funding

MHO CASE STUDY: THE JAS COMMUNITY PARTNERS FOR HEALTH, LAGOS, NIGERIA

BACKGROUND AND OBJECTIVES

Since 1995, six urban communities in Lagos are being assisted by USAID's BASICS project with technical advice, training and equipment to undertake Community Partners for Health (CPH) projects, with a view to reducing infant and child deaths and generally improving the quality of lives of children in the communities. The communities involved are Ajegunle, Amukoko, Lagos Island, Lawanson (Surulere), Makoko and Mushin. They shared certain features: though urban in location, they were deprived communities that had rural characteristics where their key health problems were concerned. Both the Jas CPH (Mushin) and the Lawanson CPH (Surulere) were started in December 1995, after sensitisation workshops animated by BASICS officials.

CPHs have eight specific objectives, nearly all of which are quantifiable²:

- ◆ To reduce by the end of 1998, the number of children under five years and pregnant mothers falling ill and dying from malaria
- ◆ To reduce the number of children under five years having diarrhoea and dysentery and dying from dehydration
- ◆ To reduce the number of children falling sick with cough and dying from acute respiratory infections
- ◆ To increase the immunisation coverage of children under two years old and ensure availability of effective quality vaccines
- ◆ To increase the demand for and the availability of modern child spacing/family planning services
- ◆ To increase the level of awareness of partner organisations and the community on the incidence and control of HIV/AIDS and sexually transmitted diseases
- ◆ To ensure that the project is self-sustaining to maintain its improved capacity and services, and
- ◆ To strengthen and expand the role of female decision making among members of the project and community.

This approach of defining specific objectives for the MHOs has several advantages, including a basis upon which to design benefits packages and to develop work plans, budgets and periodic evaluations.

DESIGN, ORGANISATION AND MANAGEMENT

The CPHs undertake to achieve the above objectives through partnerships between interested private health facilities (for profit or not-for-profit) and community-based organisations, with the emphasis on utilising existing community resources to solve child survival problems. Funding is obtained from membership dues, donations and support from members of the community.

There is a governing board of trustees, which manages the CPH and is elected by CPH members for five-year terms. In practice, the board is made up of leaders and representatives of both providers and community-based organisations (CBOs). The board has all executive powers and is responsible for “planning, implementing, supervising, monitoring, and evaluating programme activities of the Association including financial accountability and sustainability of the Association”.³

A Memorandum of Understanding (MOU) sets out the terms of the partnership and provides the framework for the collaborative effort to solve the community’s leading child health problems. Two MOUs are involved: one MOU sets out the relationship, duties and obligations between BASICS and the CPH; another sets out those between the health provider(s) and the CBOs.

There are two essential aspects to the CPH. The first is the health self-financing part, described as a “pre-paid/mutual fund”, which seeks to mobilise resources from the community via the CBOs to strengthen the financial capacity of the health facilities and

² From Memorandum of Understanding between BASICS-Nigeria and Jas Community Partners for Health. These objectives are incorporated into the MOUs and Constitutions of all the Community Partners for Health.

³ Constitution of the Lawson Community Partners for Health, p. 6.

to provide and improve access to quality care for members of the community. The second part is the managed care committee, which brings all participating health facilities together in a committee that meets regularly to ensure uniform quality and pricing of health care.

The health objectives of the CPHs are achieved through a subsidised health scheme, described as “a kind of health insurance under which the community can refer a patient to the hospital for treatment with a promise to pay within two weeks if the patient defaults”.⁴ Each member registers at a participating hospital or clinic near where they live. On registration, a member receives a “participatory card” containing the name, address, hospital number and CBO of the member. The dates and times of clinic attendance are also recorded in the card but no passport picture is affixed.

The following description of how the Jas CPH works to attain its health objectives illustrates the basic principle underlying the operation of all the CPHs.

THE JAS CPH

After preliminary sensitisation sessions in October and November 1995, a meeting was held between Jas Medical Services (a private local clinic in Mushin area), BASICS officials, and eight CBOs on 12th December 1995 to launch the Jas CPH. The founding members were the following:

- ◆ Jas Medical Services
- ◆ Holy Trinity (Anglican) Church, Mushin
- ◆ Bosby Private School, Ilasamaja
- ◆ Oladeinde – Coker & Environs – Landlord/Residents Association
- ◆ Alfa-Nda Welfare Association
- ◆ Foursquare Gospel Church Ilasa II
- ◆ National Union of Road Transport Workers Union (NURTW), Ilasamaja branch
- ◆ Kayode Native Doctor, Itire Road
- ◆ Kingdom Christian Ministry

By 1997, the participating CBOs had increased to 13. The new groups are: OSA Residents Association, Christ Gospel Apostolic Church, Ahoememogbe Ishan Women’s Social Club and Health Care Association of Igbehin Residents. No reliable figure for the total membership of these organisations was available, but an estimate by the chairman of the CPH put this at over 10,000 members. Many of the members of these organisations are involved in informal sector economic activity – such as petty traders (probably the predominant economic activity especially among the women members), vulcanisers, battery chargers, mechanics, drivers of public transport (taxis and mini-buses), carpenters, hairdressers and tailors.

Jas Medical Services, which also serves as the secretariat for the CPH, is a primary health care (PHC) clinic which provides preventive and promotive health services (including family planning, immunisation outreach, promotion of breast feeding, health education, etc.), and curative care (including obstetrics and gynaecology services). Diagnostic services are contracted out to a private laboratory. It has nine in-patient beds

⁴ See the Lagos *Guardian* newspaper of 2nd June 1997, “Unsung community effort to secure the child’s future”, p. 13.

(seven adult and two child beds) and a total staff of 12 (distributed as following: two medical doctors, six qualified nurses and four auxiliary staff (two cleaners and two receptionists). An outside auditor comes monthly to do the books.

The CPH staff and governing board consists of a chairman, vice-chairman, secretary, vice-secretary, treasurer, the chair of the Women's Empowerment Committee, an advisor (an elderly retired educationist), financial secretary plus the ex-officio members (representatives and leaders of the CBOs). In addition, there is a fund-raising committee, a youth wing and an ambulance committee (which manages the operation of the ambulance/hearse of the CPH).

At one of the first meetings of the CPH, the partner organisations (i.e. the CBOs and the Jas Medical Services together) met and identified the key health problems of the community. These were defined as:

- ◆ Malaria
- ◆ Diarrhoea
- ◆ ARI (acute respiratory infections)
- ◆ Lack of potent vaccines
- ◆ Fevers
- ◆ Family planning services
- ◆ Health education

In addition, it was felt that the issues of women's empowerment, sustainability of the CPH and democracy and governance were of such importance that they deserved attention. Some strategies for dealing with these problems were also agreed on. For instance, for malaria, it was accepted that regular clean-up campaigns to remove stagnant water (the breeding place of the malarial parasites) and clean up streets and gutters would be undertaken. Each CBO is responsible for mobilising its members, while Jas and BASICS help with sensitisation campaigns to explain the importance of the clean-up exercises. Environmental sanitation materials and implements (such as wheel barrows, shovels, garden forks, rainboots, gloves, etc.) are made available by BASICS as part of its assistance package.

To improve the stock of vaccines and drugs, a financing scheme was devised, which works like this: Each individual member of the CPH pays a participating fee (annual dues) of 100 naira (about US\$1.20) for an adult, 70 naira (about US\$0.85) for adolescents and 50 naira (about US\$0.60) for children under 12 years. This is used both to run the CPH secretariat and to buy essential drugs (defined as generic ones required to treat the common ailments identified by the community and listed above). In effect, some of the dues are used to constitute a revolving fund for drug purchases.⁵

To achieve its objectives for health improvement and access extension, additional novel and interesting features have been built into the design of the scheme. If a member's health problem falls among the key health problems identified by the community at the start, that member is entitled to 50 percent discount on their health bill (including drugs) if properly referred by the leader of his/her CBO. (In this way, CBOs are playing an important community health and PHC role.)

⁵ It is not known to what extent the drugs budget is subsidised by other bodies such as donors, but the participation fees certainly seem to be rather modest in relation to the real costs of drugs in particular.

Furthermore, a co-operative credit society that is open to all members has been started by the CPH. There are currently (October 1997) 138 members of the co-operative (from 11 founding members in February 1997) and each member saves either 100 naira or a multiple of this amount every month, after paying a once-only registration fee of 100 naira. The highest contributor currently pays 3000 naira (US\$36.59) per month.

Eighty percent of the total savings times two are available to the member (after a minimum of six months of regular savings) as a loan if he/she so wishes (at interest of 10 percent). The other 20 percent is held back as health savings, to which interest (at 5 percent) is added at the end of the year, but this is not ordinarily available for withdrawal except either when the member is resigning from the CPH, or when the member or a family member is ill. In the latter case, an interest-free loan can be obtained from the health savings to help pay the hospital bill.

The clinic's gain in this respect, and therefore its ability to offer the 50 percent discounts in the appropriate cases, stems from the virtual elimination of bad debts (a big problem before the CPH) and the greatly increased numbers of patients they now attend to daily.

To explain this more succinctly, then, if a member or a dependant falls ill, the concerned person or his/her relatives must first obtain a referral slip from their CBO leader. This slip entitles the patient to treatment at Jas Medical Services clinic even if they have no means of immediately paying the bill. (They will also not be asked for a deposit before being treated, which a non-member is required to do.) The patient has two weeks to pay after the treatment, and the leader of the CBO makes sure of this. In case of default, money can be withdrawn from the member's 20-percent health saving to pay the bill.

To illustrate further by means of an example, suppose the normal or full health care bill of a person is 1000 naira (about US\$12). The amount actually billed to a member of the CPH will be 500 naira (about US\$6) or half that of a non-member if the ailment falls within the 10 major health problems identified by that community. If the ailment is not in the priority list, they have to pay the full amount. But even in this latter case members have recourse to the health savings of the co-operative. If they have been saving the minimum of 100 naira for six months, they will be able to borrow 120 naira (about US\$1.5), representing 20 percent of their total savings of 600 naira (just over US\$7). As far as the savings aspect is concerned, therefore, there is no solidarity between members.

These savings are also available for use in the case of further referral from Jas to, say, Lagos University Teaching Hospital.

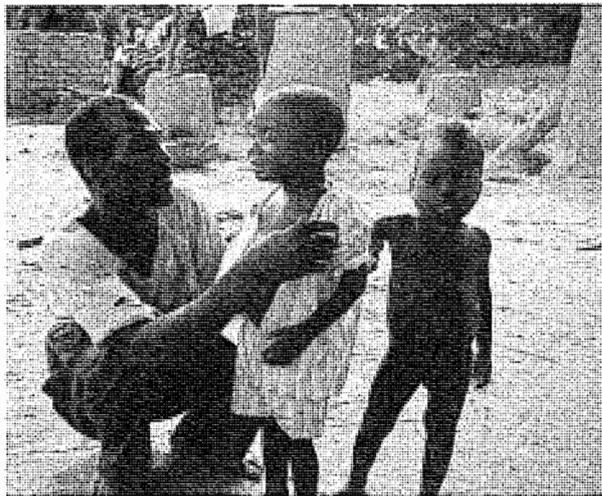
Quality improvements in health care for the community are obtained through the greater interaction between hospital staff and users, especially in the context of regular meetings of the CPH and other elected bodies. The governing board of the CPH meets the third Wednesday of every month, while the General Meeting of all members takes place every three months. In addition, the co-operative society holds meetings twice a month. Sensitisation, health education and clean-up campaigns further bring providers and community members together frequently, all helping to cement a partnership to tackle the health and problems of the community.

In the case of Jas CPH, obviously the Managed Care Committee is simply notional since there is only one provider. However, interviews with users showed that they perceive significant improvements in quality of care at Jas clinic since the CPH was set up. For instance, the attitudes of staff are reported to be much better and waiting times have shortened with more staff employed from the increased revenues made possible by the CPH. Even the Chief Medical Officer, who lives in the community himself, is said to be much more approachable than before.

UNIT

2

PROCESS OF SETTING UP AN MHO



| | |
|--|----|
| Module 2.1 PROCESS of setting up an MHO | 24 |
| 2.1.1 PREREQUISITES AND ENABLING CONDITIONS | 25 |
| 2.1.2 FEASIBILITY STUDY – GENERAL ENVIRONMENT | 28 |
| 2.1.3 FINANCIAL FEASIBILITY STUDY | 36 |
| 2.1.4 SETTING UP A WORKING GROUP | 38 |
| 2.1.5 CONTACTS WITH KEY STAKEHOLDERS | 39 |
| 2.1.6 SETTING UP THE MHO | 42 |
| 2.1.7 ACHIEVING SUSTAINABILITY | 46 |
| 2.1.8 SUMMARIZING STEPS IN SETTING UP AN MHO | 47 |
| SUPPORTING TEXT # 1: EXAMPLE OF A CONSTITUTION: THE MUTUELLE (MHO) 'AND FAGARU' OF THIES, SENEGAL | 47 |
| SUPPORTING TEXT #2: EXAMPLE OF INTERNAL RULES AND REGULATIONS OF THE MUTUELLE (MHO) 'AND FAGARU' OF THIES, SENEGAL | 54 |
| Module 2.2 MEMBERSHIP OF AN MHO, OPERATIONS MANAGEMENT AND ORGANISATIONAL STRUCTURE | 57 |
| 2.2.1 DEFINITION OF MEMBERSHIP | 58 |
| 2.2.2 REGISTRATION PROCEDURES | 59 |
| 2.2.3 ADVANTAGES AND DISADVANTAGES OF INDIVIDUAL, FAMILY AND GROUP MEMBERSHIP | 62 |
| 2.2.4 PROCEDURES FOR ACCESSING AN MHO'S SERVICES | 63 |
| 2.2.5 MHO OPERATIONS MANAGEMENT | 63 |
| 2.2.6 ORGANISATIONAL STRUCTURE OF AN MHO | 67 |
| 2.2.7 MEMBER REPRESENTATION IN A LARGE, GEOGRAPHICALLY BROAD MHO OR FEDERATION OF MHOS | 71 |

MODULE 2.1

PROCESS OF SETTING UP AN MHO

LEARNING OBJECTIVES

At the conclusion of the module, the participants will:

- ◆ Know the procedure to be followed in setting up an MHO
- ◆ Be able to advise on or help set up a viable MHO

TARGET GROUP

MHO initiators and promoters

PREREQUISITES

Completion of Unit 1 “Introducing MHOs”

CONTENT

- ◆ Prerequisites
- ◆ Preparation of general feasibility study
- ◆ Preparation of financial feasibility study
- ◆ Setting up a working group
- ◆ Preliminary contacts with key partners/stakeholders
- ◆ Setting up the MHO
- ◆ Achieving sustainability

TRAINING METHODS

- ◆ Plenary session
- ◆ Group assignment
- ◆ Individual assignment
- ◆ Role play
- ◆ Presentation
- ◆ Case study or data collection field trip

TRAINING MATERIALS

- ◆ Flipchart
- ◆ Plus any of the following:
 - ◆ Slides
 - ◆ Overhead projector

- ◆ Video projector
- ◆ File cards

SUPPORTING TEXT

Participants' Guide and Work Book

2.1.1 PREREQUISITES AND ENABLING CONDITIONS

A GENUINE NEED AND EXPRESSED PRIORITY

The MHO will primarily provide a solution to financial barriers to health care access for its members. This financing problem is the first justification for setting up an MHO. In order for the targeted population to feel a genuine need for the MHO, it is necessary that the MHO not merely meet a real need—in this case, funding members' health care—but the need must be considered a priority, and be expressed as such. This requirement is not always met when the project is launched. In this case, it is important to help the people clarify and express their needs without generating them artificially.

EXISTENCE OF SOLIDARITY LINKS AMONG FUTURE MEMBERS

Solidarity is an essential factor in all mutual aid groups. As seen in the preceding chapter, solidarity is the very basis of an MHO. Solidarity links necessary for setting up an MHO may stem from a number of situations: people belonging to the same village or neighbourhood, workers in the same company, members of a social group or association, etc.

PEOPLE'S CONFIDENCE IN THE PROJECT'S INITIATORS

Potential members of a future MHO must have confidence in the project's initiators so that they will entrust their dues to the embryonic organisation. Therefore, the previous relations between potential members and the project's initiators are important factors in evaluating the possibility of establishing an MHO. For instance, were the initiators previously involved in some failed projects in the locality? Had any of them ever embezzled the funds of a community group, club, or society? What is their general reputation? These questions are important in assessing confidence or lack of it in the initiators.

PEOPLE'S CONFIDENCE IN THE CONCEPT

People's confidence in the project will also depend on past successes or failures in the same area or in similar experiments, such as service co-operatives, savings and loans and credit unions. These must be analysed to determine the feasibility of the plan to set up an MHO and to identify the approach to be used.

The MHO idea is new in the country and it takes time for new ideas to be accepted. Care must therefore be taken to win the confidence of the leadership of the target groups, including traditional and political authorities, the clergy, associations and other organised groups. It is usually in the initiators' interest to make contact with the authorities at an early stage.

This requirement is not to be taken in isolation, but with other requirements such as confidence in the initiators. Care must be taken to avoid rash action. Sensitisation and consultation are therefore very essential. Communication of the concept must be clear, consistent and understandable by the target groups.

FAVOURABLE GOVERNMENT POLICY

There should at least be no laws prohibiting the freedom of association. But government can be even more proactive in promoting MHOs using national health policies. For instance, health sector reforms promoting autonomy of health institutions (therefore enabling them to negotiate meaningfully and contract with MHOs), reinforcing the managerial (especially financial and accounting) skills of provider staff, and policies to promote quality assurance and accreditation of provider institutions, would all be helpful to the development of MHOs.

Equally government has a responsibility to ensure the health care access of the poorest (those who have no income, the targets of the 'paupers fund' of government). Also, more broadly, national policy will be required to ensure equity such as between MHOs in rich and poor regions of the country (through subsidies for those in poorer regions, for instance), and between MHOs with disproportionately bad risks—not from bad scheme designs but from the demographic character of their target groups—and those with very good risks (this last problem could be addressed through risk equalisation funds, for instance).

QUALITY HEALTH CARE SERVICES

An MHO must provide a range of health care services that meet the principal needs of members. An MHO usually arranges for services to be provided to its members by existing health centres, public hospitals or health professionals—physicians, nurses, physical therapists, etc.—in the private sector operating on their own.

Empirical evidence, has demonstrated decisively that, while service quality is not the only criterion on which to judge an MHO, successful MHOs tend to be those formed around health institutions with a reputation for good quality care. This factor is frequently ignored by promoters associated with public authorities. MHOs tend to be most successful in locations where high-quality services already exist, and the MHO is formed to help members gain financial access to those services.

However, the absence of good quality health services does not preclude consideration of an MHO. What is important is that from the start, the MHO must be seen as part of the solution to the quality problem, e.g. through negotiations with health authorities and making funds available for quality improvements. For instance, people may not like some health care centres because they periodically have shortages of prescribed drugs or because they may not always treat patients appropriately. Often these shortcomings relate to employee salary levels and motivation, the condition of equipment and supplies, etc. If so, a determination must be made as to whether the MHO will be able to solve these problems, such as making available more cash to purchase prescribed drugs, or to provide incentives to motivate staff.

The MHO may establish its own health centre or hospital only if there are no service providers located near the community able to provide quality services (perhaps with assistance from the MHO). If these services exist but are far too costly, medical institutions under MHO management may also be considered.

Health centres or hospitals set up at the initiative of the MHO must have a legal status that is separate from the MHO because their management and operation are not similar. It is important to clearly separate the income and management of each organisation, and not to confuse the responsibilities of their respective managerial units.

This will prevent one of the structures from experiencing difficulties due to poor management of the other.

In summary, it should also be remembered that, if the MHO is established where no prior good quality care is available, its medium-to long-term viability will not be assured unless it makes a positive impact on quality health care. An MHO should always endeavour in these situations to improve the quality of care delivered at the health care institutions as a tangible benefit to members (shorter waiting time, less over-crowding, better staff attitudes, drug availability, etc.) This may be achieved through negotiations with the health care authorities and through the additional funds that it can make available to the health institution.

SOCIO-ECONOMIC FACTORS

Steady employment gives people financial resources which, while not sufficient to cover the cost of health care individually, may enable them collectively to defray costs through dues, based on the solidarity expressed between those who are ill and those who are well. The existence of other economic development projects or schemes that improve the revenues of the population facilitates the introduction of a mutual financing system for health services, especially in rural areas. In fact creation of an MHO does require a minimum economic level and would be extremely difficult, if not impossible, in an extremely impoverished community.

GROUP ASSIGNMENT

Ask the participants to answer the questions below. Supplement the answers if necessary, and give detailed comments on each component based on the following text.

FEASIBILITY OF SETTING UP AN MHO

Question 1: *What are the prerequisites and/or favourable conditions for setting up an MHO?*

A number of factors determine the feasibility of an MHO, and ensuring its smooth operation and optimal results: These are mainly:

- ◆ Existence of a felt need for financing health care
- ◆ People's confidence in the concept itself
- ◆ Favourable government policy
- ◆ Solidarity links among future members
- ◆ Confidence in the project's initiators
- ◆ Availability of quality health services
- ◆ Favourable socio-economic development in the region or locality
- ◆ Co-operation of all key stakeholders.

Question 2: *Divide the factors into two categories: those factors that are essential (prerequisites) to the establishment of an MHO and those that, though not essential, can promote (enable) the establishment of an MHO and even influence, its eventual success or failure.*

PREREQUISITES

- ◆ Existence of a felt need for financing health care
- ◆ Existence of solidarity links among the future members
- ◆ Confidence in the project's initiators

ENABLING FACTORS

- ◆ Availability of quality health services (essential for eventual success but may also be promotional)
- ◆ Dynamics of socio-economic development in the region or locality
- ◆ Co-operation of key stakeholders
- ◆ People's confidence in the concept
- ◆ Favourable government policy

Question 3: *What preliminary work needs to be done when an MHO is to be set up?*

PRELIMINARY WORK

Activities to be performed before organising and setting up an MHO include:

- ◆ General feasibility study of the MHO
- ◆ Consensus building among stakeholders through
 - ❖ Public seminars,
 - ❖ Sharing results of feasibility studies,
 - ❖ Establishing a working group,
 - ❖ Holding a workshop for working group,
 - ❖ Identifying sources of funding.

During the preliminary work, it is important for the project's initiators, especially if they are sponsors from outside the area, to co-operate closely with local people to obtain their opinions, and for local people to state their needs and identify the steps to be taken.

2.1.2 FEASIBILITY STUDY – GENERAL ENVIRONMENT

The feasibility study is an important stage in setting up an MHO. In addition to determining the feasibility of establishing the MHO, it is a baseline for future evaluations and monitoring of the programme.

2.1.2.1 DATA COLLECTION

The first step in conducting a feasibility study is conducting an investigation of the general environment in which the MHO is going to operate. Data collection will be used to:

- ◆ Assess the community's needs for the proposed scheme;
- ◆ Determine the legal and organisational structure;
- ◆ Determine a benefits package
- ◆ Establish prices and dues
- ◆ Ensure that the required quantity and quality of health services are or will be available, (i.e. from hospitals, health centres, clinics, drug stores)
- ◆ Design promotional strategies
- ◆ Evaluate growth potential

The main goal of the feasibility study is to ensure that community members will join the scheme and that it will be financially sustainable.

The data will also be used to monitor and evaluate the impact of the MHO on the community (improving access to health care and the general health status, etc.), by comparing it to data collected after the MHO is operating. The kinds of data to be collected will be determined by the objective of the initiators and promoters of the MHO. The data will enable questions such as the following to be easily answered:

- ◆ Are there quality services available in the area?
- ◆ Is there an access problem?
- ◆ Is there unmet demand for health services because there are not enough facilities or appropriate services?
- ◆ What are the priority health problems of the target population?
- ◆ What health services should be covered by the MHO?
- ◆ How much can the target group afford to pay?
- ◆ What is a realistic level of dues for viability?
- ◆ What are likely administrative, transport, training, etc. costs associated with running an MHO?
- ◆ What sources of support are available?

Some information may be easily obtainable; other data may not be strictly relevant for the MHO (e.g. a small MHO in a locality accessible by foot and run only by volunteers need not spend an inordinate amount of time trying to figure out its likely administrative costs). In some cases, and especially for potentially large MHOs with significant data needs, it may be cost effective to engage a consultant to collect types of data that are not readily available and thus require relatively sophisticated data collection techniques.

With the above qualifications regarding the extent of data needs in mind, the MHO promoters should attempt to collect as much information as possible as described in Tables 2.1 - 2.5.

Collecting these types of data should be a continuous activity in order to keep abreast of the changes and evolution in the health sector and to continuously monitor the MHO's environment, and measure its achievement and impact on the community.

TABLE 2.1 DEMOGRAPHIC DATA

| WHAT DO I NEED TO KNOW? | WHERE CAN I GET IT? | WHAT DO I NEED IT FOR? |
|---|--|---|
| Population size (service area) and growth rate | Census (national, regional or local government entity) Health facilities Other sources | Used to set target population and to estimate the number of potential members. |
| Average family size and number of households | Census (national, regional or local government entity) Health facilities Other sources | Used to estimate the number of potential members; this is an important factor in deciding whether registration will be conducted on an individual or family basis and determines the resulting revenue. The statistics can also be used to evaluate adverse selection (if average number of registered family members is lower than average number of family members for the total population). |
| Breakdown of target population by age group and sex | Census (national, regional or local government entity) Health facilities Other sources | Different age groups have different health needs. Knowing potential members by age group and sex will help identify each group's major health needs and usage rates, and their costs. |
| Composition of household heads by age group and sex | Census (national, regional or local government entity) Health facilities Other sources | Generally, the primary marketing efforts will focus on the family head (who makes the financial decisions); knowing the age breakdown and sex of household heads will help identify which communication tools to use for which group, since not all groups respond to the same arguments. |

TABLE 2.2 SOCIO-ECONOMIC AND CULTURAL FACTORS

| WHAT DO I NEED TO KNOW? | WHERE CAN I GET IT? | WHAT DO I NEED IT FOR? |
|---|--|---|
| People's economic activities (employment, etc.) | Census (national, regional or local government entity) Health facilities Other sources, e.g. statistics department | Helps promoters select most effective and appropriate communication channels to reach the target group and provides a basis to evaluate levels and seasonal availability of income. |
| Inflation rate | Ministry of Finance Statistics department | Used to estimate costs for financial projections. |
| Income levels breakdown, and seasonal availability | Baseline survey Government census or other surveys | Used to estimate the purchasing power of the target population. |
| Types of current and past community organisations (number of organisations and percentage of target population that belongs to these organisations) | Community leaders Government entities Previous social studies Previous surveys Other sources | Will define if the scheme can use such groups to attain its goals (membership, marketing, etc.) and whether community members already have a culture of joining solidarity groups. |
| Literacy rate | Census (national, regional or local government entity) Health facilities Previous surveys Other sources | Will define the types and level of sophistication of communication channels that will be used. |
| Norms, customs and religious beliefs | Discussions with community leaders Observation Other sources | Will define the level of acceptance of insurance organisations, health seeking behaviour and the communication channels the target group trusts most. |
| Most widely used communication channels (radio, television, person-to-person, etc.) | Research Baseline survey Other sources Consult companies and organisations advertising to same | Defines which communication channels are most widely accepted and consulted to decide which ones to use to convey messages. |

TABLE 2.3 HEALTH AND EPIDEMIOLOGICAL DATA

| WHAT DO I NEED TO KNOW? | WHERE CAN I GET IT? | WHAT DO I NEED IT FOR? |
|--|---|---|
| Identify the different participants involved in health (who provides services, who receives them, who pays) | Survey of different health providers Ministry of Health and other health-related organisations | All the stakeholders (providers, community members and other groups) should be identified for potential support: marketing; technical and financial assistance; favour community ownership of the project; etc. |
| <p>Analyse local health delivery system (health map):</p> <ul style="list-style-type: none"> ▲ <i>Basic health status</i> (IMR, MMR, mortality/morbidity rates per disease) ▲ <i>Health facilities</i> (Distribution and level of technology or sophistication of equipment of medical institutions and other care providers; quality of care in different facilities, types of health services provided) ▲ <i>Drugs</i> (consumption, distribution system, costs, generic drug policies) ▲ <i>Inpatient care</i> (admissions per year, average length of stay, bed occupancy rates) ▲ <i>Outpatient care</i> (utilisation, prices) ▲ <i>Public health infrastructure</i> (water, sanitation, nutrition) | <p>Health providers Ministry of Health and other development organisations (e.g. NGOs) Donors</p> | Used to identify community health needs and service availability, and to estimate costs. This data is essential to estimating costs for the financial feasibility study. |
| Take into consideration the population's perception of care providers (in terms of quality, etc.) | Baseline survey | Used to select providers (in the case of schemes that are not provider-based) and to design benefits packages and marketing campaigns. |

TABLE 2.3 HEALTH AND EPIDEMIOLOGICAL DATA (CONT.)

| WHAT DO I NEED TO KNOW? | WHERE CAN I GET IT? | WHAT DO I NEED IT FOR? |
|---|---|---|
| Current spending patterns on health care | Baseline survey, health care providers, Ministry of Health, other sources | Used to assess affordability and need for MHO scheme. |
| Determine the costs and quality of care (compared with those offered in neighbouring regions) | Independent survey of health providers (including visits) Administrators of hospitals, clinics, etc. Government entities (Ministry of Health) Organisations involved in health (e.g. NGOs) Past studies | Used to estimate costs and select health care providers . Could tell you if some villages /groups/ individuals would prefer to go to other providers rather than those proposed by the scheme. |
| Identify the procedures of financing and running medical institutions | Administrators of hospitals, clinics, etc. Government entities (Ministries of Health, Finance, Decentralisation, etc.) Organisations involved in health (e.g. NGOs) Past studies | Used to estimate costs and select health care providers. The knowledge of such procedures is an asset during negotiations with member groups or entities that may provide services under contract. |
| Study health financing initiatives Completed, in process or planned | Administrators of hospitals, clinics, etc. Government entities (Ministries of Health, Finance, Decentralisation, etc.) Organisations involved in health (e.g. NGOs) Past studies | Used to identify potential sources of assistance and challenges, and to gain general awareness of the current status and development plans in the sector. |

TABLE 2.4 POLITICAL FACTORS, INSTITUTIONAL AND LEGISLATIVE FRAMEWORK

| WHAT DO I NEED TO KNOW? | WHERE CAN I GET IT? | WHAT DO I NEED IT FOR? |
|--|---|---|
| Verify existence of any legal requirements for organisations such as MHO schemes | Ministry of Health or other government institution Insurance organisations Department of Social Welfare Registrar General's Department | May be necessary to gain the right to conduct business, recognition and access to resources. The existence of a law specific to MHOs is not essential. An MHO may have another legal status, such as that of a co-operative or a not-for-profit welfare association or a company limited by guarantee. |
| Opportunities for outside assistance (governmental and other organisations, technical and financial) | Ministry of Health NGOs and other organisations Donors | Necessary to access resources and assistance. |
| The government's health policy, in particular its user fees and health care financing policy, and exemptions and subsidies | Ministry of Health Local health providers District assembly | To assess the extent of the need for the MHO and possibilities for coverage for the poor by government or other agencies |

TABLE 2.5 TECHNICAL INFORMATION

| WHAT DO I NEED TO KNOW? | WHERE CAN I GET IT? | WHAT DO I NEED IT FOR? |
|---|--|---|
| Background information on managing health insurance organisations: ▲ Risks: adverse selection, moral hazard, cost escalation risk ▲ Membership: family or individual ▲ Payment mechanisms: co-payment, third-party payer system, reimbursement, etc. ▲ primary versus secondary health care coverage ▲ provider payment methods: budget, capitation, fee-for-service, etc. | Ministry of Health, NGOs and other organisations Publications (USAID, WHO, etc.) Other MHO schemes Training seminars | Used to gain technical knowledge in managing insurance organisations and related risks, and to learn from past experiences. |
| Study of other MHO schemes (visits, reports, etc.) | Ministry of Health, NGOs and other organisations Publications (USAID, WHO, etc.) Other MHO schemes | Used to learn from past experiences and identify opportunities for guidance. |

GROUP ASSIGNMENT

DISCUSSION TOPIC

On the flipchart, present the main components of the general environment that must be analysed in order to design a viable MHO. Ask the participants to add to them if necessary:

- ◆ Demographic factors,
- ◆ Socio-economic and cultural factors,
- ◆ Health factors,
- ◆ Institutional and legislative framework,
- ◆ Political factors,
- ◆ Technical factors,
- ◆ Other issues

For each of these factors, ask the participants to indicate the information they will need for the context study.

FIELD TRIP

If possible, divide the participants into four groups and assign each group an area of data collection according to the topics in Tables 2.1 - 2.4. The groups topics will be as follows:

Group 1: Demographic features (see Table 2.1)

Group 2: Socio-economic and cultural data including macro-economic environment (see Table 2.2)

Group 3: Health and epidemiological data (see Table 2.3)

Group 4: Political features, institutional and legislative framework (see Table 2.4)

Organise a field trip for them into the surrounding community where they will attempt to collect information as if they were investigating the feasibility of setting up an MHO. Let them report their findings in plenary and lead a discussion emphasising the difficulty or ease of collecting the types of data.

The following instructions could be distributed to the groups to facilitate data collection:

Your task is to collect data concerning the relevant features of the community you are visiting, according to your group's assignment. Refer to the Table corresponding to the topic of your group. You will identify and meet the key informants who are able to give you the data you require. You have to decide on appropriate data-gathering techniques (interview? documents? focus/discussion group? etc.).

You will give a written report of your visit, describing:

1. The methodology (sources and methods of collecting the data)
2. Are there independent ways of verifying the data you obtained?
3. An assessment of the reliability or otherwise of the data you have collected. How much confidence should you put into the information gathered, assuming you were using it to design a scheme for the community?
4. An appreciation of the ease or difficulty of getting the information.

5. If you had more time, how could you have improved either the quality or method of collecting the data?
6. Would you consider it necessary to put in safeguards in designing your scheme (if so which?) to protect it against the possible consequences of bad quality data, assuming you had to rely on this data for designing your scheme?

If the data collected are of reasonably acceptable quality, they may also serve as basis for designing exercises on costing, the determination of benefits packages, calculation of dues and aspects of financial management to do with budgeting and financial feasibility studies (Units 3 and 5).

Table 2.6 presents a list of data that could result from a data collection field trip.

TABLE 2.6 SAMPLE OF INITIAL DATA COLLECTION

- ▲ Population of 100,000 farming community
- ▲ Hospital treated 58,361 outpatients in 1998 (43,566 at the hospital and the rest in community clinics)
- ▲ 11,909 patients were admitted for inpatient care in 1998
- ▲ Hospital has 180 beds in 6 wards
- ▲ Causes of morbidity for 5 year olds and over are in order of importance: malaria, pulmonary tuberculosis, pneumonia, immunosuppressive syndrome, trauma, diarrhea, dysentery, congestive cardiac failure
- ▲ 46 percent of the community belong to various local welfare associations and professional/occupational organisations
- ▲ 1 outpatient visit per member per year
- ▲ Cost per outpatient visit – 2500 cedis
- ▲ Members requiring inpatient care – 6 percent per year (including deliveries)
- ▲ Median cost per inpatient stay – 100,000 cedis
- ▲ Membership mix – Children: Adults 1:1
- ▲ Average family size: 5.9 individuals

2.1.3 FINANCIAL FEASIBILITY STUDY

The preceding section described the feasibility study to test the general environment for which an MHO is being considered. This section discusses a second type of feasibility study integral to the decision of whether to establish an MHO: The financial feasibility study assesses whether, and under what financial conditions, the MHO can be viable. It assesses financial needs, sources of possible funds, and the cost to provide the health care services that will be covered by the MHO, the revenues that are needed and can be expected. This also forms part of the baseline study.

The determination of costs must start with identifying the health services or benefits package to be provided to the members. The previous study of the general environment will have provided data for choosing the priority health needs to be financed, although a final decision on the benefits' package is not possible until consultations have been held with potential members, culminating in the initial general assembly. To the costs of the

benefits package must be added estimated administrative and overhead costs, equipment finance required, and a margin of safety as well as a reserve fund provision.

Typically, costs of health services will be higher than may be estimated from the feasibility survey, due to the fact that financial access is increased by the MHO and thus people tend to use the services more intensively than when they were not insured. For this reason, 15-20 percent should be added to the utilisation figures obtained from the survey; or the overall costs increased by about 10 percent as a margin of safety. The reserve fund provision is to ensure that the MHO will be able to withstand unforeseen rises in its operating costs, e.g. an epidemic.

The results of the financial feasibility study enable the MHO initiators to calculate membership dues or contribution rates. These are obtained by dividing total cost by potential membership.

The amount of dues arrived at will serve as a determining factor as to whether to seek external funding, and if so how much. It is always best to cover operating costs of providing health services exclusively from dues, and to reserve external subsidies for investment and equipment expenses. A study of the general environment should indicate the amount of dues that potential members can afford to pay.

The results of a financial feasibility study serve as a guide in preparing the first budget of the MHO, which should then be projected over at least the next four years to see how the MHO expects to fare by its fifth year of operation. These budget projections are presented to the first general meeting. The first budget when monitored and evaluated will serve as a guide for subsequent budgets.

Budgeting requires carrying out the following procedures with information gleaned from the following sources:

- ◆ Estimating the number of probable members (members and beneficiaries)—from census, district assembly
- ◆ Determining the services covered by an MHO—from minutes of Initial General Meeting (IGM)
- ◆ Evaluating the frequency of use of services covered—from health providers, hospital, district assembly
- ◆ Estimating the MHO's operating costs including administrative costs—from MHO, other MHOs
- ◆ Calculating the amount of dues necessary for financial balance—from the above sources
- ◆ Preparing a summary table for the budget

The discussion above has outlined the financial feasibility study. The actual preparation of such a study, however, can only be done after completing Unit 3 “Costing and Setting of Dues and Determination of Benefits Packages”, and Unit 5 “Introduction to Financial Management”.

The following are parameters required for preparing the first budget

1. Outflows

- ◆ Target population
- ◆ Geographical coverage (area)

- ❖ Personnel (human resources)
 - ❖ Package and cost of services
 - ❖ Estimate demand of health services
 - ❖ Hospital records
 - ❖ Baseline survey
 - ❖ Comparative studies with other Communities (MHO)
 - ❖ Administrative structure
2. Parameters for preparing cash inflows (income)
- ❖ Potential number of members
 - ❖ Income level of potential members and seasonal availability of income
 - ❖ Subscriptions from potential members
 - ❖ Registration fees
 - ❖ Opportunities for outside assistance (where applicable)
3. Services
- ❖ Most frequent diseases
 - ❖ Morbidity rate (incidence rate according to type of disease)
 - ❖ Number of cases of illness per year
 - ❖ Number of admissions (hospitalisation) cases
 - ❖ Drug consumption
 - ❖ Prescription habit of prescribers
 - ❖ Coverage of chronic illnesses
4. Cost of service
- ❖ Pricing for medical procedures
 - ❖ Operating cost
 - ❖ Average length of stay
 - ❖ Estimate of average annual inflation
 - ❖ Type of specialist services available
 - ❖ Level of technology or sophistication of equipment
 - ❖ Introduction of co-payment:
 - Payment for part of total cost of certain services by the scheme and the member
 - Payment of the cost for first week of stay
 - ❖ Ceiling (maximum refund or coverage level) per member, per disease, per year

2.1.4 SETTING UP A WORKING GROUP

Once a feasibility study has indicated that an MHO is a viable project initiators should set up a working group to meet with the key stakeholders to prepare the setting up of the MHO. (Note that sometimes it may be more useful to set up the working group at an earlier stage, to involve its members in the feasibility study and thus enhance the acceptability of the results by building a consensus as early in the set up process as possible. The initiators need to make a judgement about this.)

The working group will meet with the community to be served and prepare the basic documents that will be submitted to the Initial General Meeting they will convene. There should be a workshop for the members of the working group to familiarise them with the setting-up process and the various aspects of the organisation and operation of an MHO.

2.1.5 CONTACTS WITH KEY STAKEHOLDERS

2.1.5.1 CONTACTS WITH HEALTH CARE PROVIDERS

It is important for the MHO to meet early-on with the health care providers who will serve MHO members. Reasons for meeting include the following:

- ◆ To seek further assurance of the availability, quality and cost of health care;
- ◆ To see what additional improvements may be required to make the MHO proposal attractive;
- ◆ To assess the attitude of health care providers regarding the MHO and to suggest necessary quality improvements;
- ◆ To sensitise the providers to the concept and importance of the MHO;
- ◆ To seek the commitment of health care providers to the MHO and their possible involvement in setting it up and getting the community to accept it and have confidence in it;
- ◆ To negotiate on the prices and quality of care to be provided and the payment methods between the MHO and provider(s);
- ◆ To arrange a preliminary training session for staff of the health care provider on the principles and functioning of the MHO (see the Introductory Module and “Relations with providers” module).

Sometime soon after the Initial General Assembly, the MHO executives should contact the providers to arrange a training session for its staff on the ‘MHO and the Providers’.

GROUP ASSIGNMENT

Ask the participants why it is necessary to communicate with health care providers before the MHO is set up. Make sure their list includes the reasons enumerated in the technical discussion above.

2.1.5.2 CONTACTS WITH DISTRICT ASSEMBLY

If the MHO is a district or community scheme, the district assembly should be approached regarding its financial and other support for:

- ◆ Equipment supplies, etc.
- ◆ Offices
- ◆ Dues for the poorest MHO members from the Poverty Alleviation Fund

Such support should not be allowed to compromise the autonomy and independence of the MHO by subjecting the organisation to political control. This should be emphasized during the meetings.

2.1.5.3 CONTACTS WITH POTENTIAL MEMBERS

The meetings with potential MHO members are to serve the following purposes:

- ◆ To inform them about the plan to set up an MHO:
 - ❖ Its philosophy
 - ❖ Its general goals
 - ❖ Its advantages and disadvantages
 - ❖ Its method of management, etc.
- ◆ To obtain their viewpoints on the project and its method of implementation
- ◆ To jointly identify specific goals
- ◆ To prepare a preliminary action program.

2.1.5.4 GROUP ASSIGNMENT

To enable participants to prepare for the contacts that they will have with the various stakeholders—in particular with potential MHO members—they should perform the following role play exercise. The exercise assigns a variety of stakeholder roles, including both MHO supporters and opponents, and asks participants to convince opponents of the value of supporting and joining the MHO.

ROLE PLAY

Hand out the role-play guidelines (see below). Explain to the participants that the purpose of the role play is to train themselves to convince potential members that there are valid reasons for setting up an MHO and that it is in their interest to join.

This exercise sets up a framework for discussing both sides of the issue during which the assimilation of the MHO's basic principles and the differences with other payment systems are verified.

Using these guidelines, share out and explain the following roles:

- ◆ Members of the district health management team (DHMT)
- ◆ Hospital administrator or medical assistant in charge of the local health centre
- ◆ Agricultural director/director of education or headmaster
- ◆ The village chief
- ◆ Assembly man or woman
- ◆ Women leaders
- ◆ Youth representatives
- ◆ Unit committee chairperson

Without the first group knowing about it, designate:

- ◆ A group of convinced villagers;
- ◆ A group of opposing villagers.

Assign observers for different roles played:

- ◆ A committee draws up the agenda and opens the meeting
- ◆ The committee runs the meeting, one person gives the floor to others
- ◆ The participants intervene based on their roles, and they may criticise, support and/or ask questions
- ◆ Ask the observers to comment on what they observed

ROLE PLAY EXERCISE

First Group:

- ◆ Draw up agenda for the meeting
- ◆ Choose chairperson
- ◆ Open the meeting by stating the aims of the meeting and issue at hand – to accept or reject the MHO idea proposed by the working group as the solution to their health care problems. Explain the general proposal based on a feasibility study – to cover hospital admission at 80 percent and outpatient services at 50 percent of cost for a proposed premium of 6,000 cedis per person, but all subject to approval by members in a General Assembly.
- ◆ Open the floor for contributions.
- ◆ Designate some people to note every criticism and try to answer every point. You should discuss the likely objections and questions and have some answers ready.
- ◆ When the head of the opposing people starts to argue for guarantees against cheating, or for an oversight committee, the chairperson should accept this on behalf of the group, and propose to include the most vocal opponents on such a committee. When you hear a suggestion that a similar scheme is working in another village, suggest to send a delegation to find out how they started and what you can learn from them.

Second Group (convinced villagers)

- ◆ Designate an informal leader (influential person)
- ◆ Two persons support the general idea by narrating experiences suffered by community members (relatives or friends).
- ◆ Another person relates the idea to some traditional practices.
- ◆ Choose two or three people to listen to the arguments of the opponents and respond to each point-by-point (agree where the objection is genuine but point out why this initiative may be different from what he/she imagines or has seen before e.g. no one in the village can run away with monies meant for our health knowing that if somebody dies due to lack of care he will always be blamed for those deaths; point out that this group will be truly controlled by members and suggest an oversight committee made up of the sceptical or opposing people to check all abuses and report back to the general assembly). Discuss the likely objections and have some answers ready.
- ◆ A woman should close by arguing about how she heard another village started an MHO sometime ago and it has been working successfully and reducing the burden on families.

Third Group (not convinced)

- ◆ Designate an informal leader who is influential but not radically opposed (level-headed and respected).
- ◆ A person opposes the idea as representing another tax on top of all else.
- ◆ Another attacks the integrity of the working group.
- ◆ Ask about what happened to past contributions for other development projects.
- ◆ Use experience of private commercial insurance to show the dangers (lawyers' fees, cheating, long delays before reimbursement) etc.

- ◆ Another person should point out that the working group never invited him to join their group because they knew that he could see through their phony idea. The person should argue that s/he is no fool: look, we all know hernia operation costs 90,000 cedis, so how can you believe somebody who tells you that he can handle your hernia operation for only 6,000 cedis? Don't you see that there is a trick? Do you remember the Pyram scheme – this is exactly the same kind of trick!
- ◆ Others should ask genuine questions: if I pay this money and I don't fall sick but my relative falls ill, can I let him benefit instead? What happens if I keep paying and never fall sick? If I die can my children inherit my membership? Etc.
- ◆ Eventually as your questions are answered by the convinced villagers, or working group, the leader should begin to urge the radical opponents to consider the possible benefits, and give the MHO a try. Especially they should immediately take up the challenge to set up the oversight committee which will check all the activities of the management and executive. Ask for guarantee that the oversight committee will only report to the General Assembly and not be under the control of the management, that they will have the power to call for an audit of the accounts if they are not satisfied. If this is given, then you will be prepared to accept the idea, but warn them they should expect close scrutiny and no monkey business.

Observers

- ◆ Observe the three parties and comment on what you have seen and heard.

2.1.6 SETTING UP THE MHO

2.1.6.1 THE INITIAL GENERAL MEETING

Once the decision has been made to set up the MHO, the working group should carry out the following activities prior to the initial group meeting:

- ◆ Preparation of draft constitution
- ◆ Writing of draft rules and regulations
- ◆ Preparation, revision or validation of the first budget (taking account of any new information, changes in any of the underlying assumptions or parameters and better knowledge of the population's preferences and capacities since the feasibility study)
- ◆ Preparation of the IGM's agenda
- ◆ Announcement of the IGM
- ◆ Holding the IGM

PREPARATION OF A DRAFT CONSTITUTION

The rules that pertain to the MHO's goals and operation are set forth in the constitution, which determines the rights and duties of members and officers. The constitution also establishes the procedures that guarantee democratic and integrated operations (management units to be established, their composition, responsibilities, etc.). Once the IGM approves the constitution, it becomes the collective contract between the members and their MHO.

Since constitutions are often written in technically complicated language, it may be advisable to prepare for members attending the IGM a simplified version of the draft. This is also a requirement for participatory democracy.

PREPARATION OF DRAFT RULES AND REGULATIONS FOR MEMBERS

Certain provisions that pertain to the practical operations of the MHO are not indicated in the constitution but rather in the rules and regulations of the MHO. They cover issues, such as documents to be provided when a member registers for the first time or accesses services, the content of membership cards, requirements to be considered as a part of the member's family, etc. Every member of the MHO should be given a copy of the rules and regulations.

An operating procedures manual should be prepared for the MHO administrative staff. It is also necessary to produce a document of rules and regulations specifically for the providers.

PREPARATION OF THE FIRST BUDGET

Using the data collected in the general environment and financial feasibility studies, a draft budget is to be prepared in accordance with the constitution and rules and regulations submitted to the IGM. It should include a proposal for a schedule of dues. As noted earlier, the budget should include a "safety margin," since health care utilisation tends to rise dramatically after an MHO is established, and the financial barrier to access to health care has been lifted. (The situation prior to the creation of the MHO is generally under-use of care.) Dues should not be raised in the middle of a fiscal year or during the first fiscal year, all things being equal, so that member confidence is not shaken.

The safety margin will be all the more necessary if dues are to be collected annually, especially in rural areas, and since the country's economic and financial situation is likely to remain uncertain due to inflation. The budget should be balanced and include a provision for the obligatory reserve fund that is required in every case for good management (see Units 3 and 5).

THE INITIAL GENERAL MEETING

The working group should invite to the IGM those people who wish to immediately join the MHO. If from the outset the MHO covers a broad geographical area, the group should invite the representatives of the different localities. The purpose of the meeting, as its name indicates, is to officially create the MHO by giving it legal status. The meeting approves the constitution.

As a minimum, the agenda should include the following points:

- ◆ Appointment of persons to run the meeting (chairperson, secretary and recorder)
- ◆ Presentation and approval of the constitution, the rules and regulations and the first budget (setting the amount of dues and benefits offered)
- ◆ Election of the various units: Board of directors, Control/Watchdog of Oversight Committee, etc.

The officers will ensure that the discussions and elections take place appropriately, and that the minutes of the meeting are correctly recorded. The session chairman will introduce the draft agenda which is to be adopted after changes are made (if any). The various items on the agenda will be presented and discussed before a vote is taken.

The meeting is also required to establish the various organs charged with starting up and promoting the MHO. To this end, it elects the members of the Board of Directors and the Control/Watchdog or Oversight Committee etc. (See Organisational Chart in 2.2.6)

The members attending the meeting pay their registration fees immediately, if this was not done previously. However, registration fees may be paid shortly thereafter if desired.

FOUNDING MEMBERS

Founding members are those who attend the IGM, approve the constitution and the rules and regulations, and comply with the ensuing commitments within the time frames stipulated by the meeting.

IGM MINUTES

The executives appointed at the IGM will immediately prepare minutes of the meeting. The minutes list the names of those attending, the date and place the MHO was established, the names and titles of the various officers and, finally, a description of the proceedings of the meeting. The minutes will be submitted to the members for approval at the next General Meeting.

These different documents may need to be sent to administrative authorities for recording in accordance with the regulations for registering the MHO.

2.1.6.2 REGISTRATING AN MHO

IMPORTANCE OF REGISTRATION

1. The registration gives the scheme the status of a legal entity, separate from its members and initiators. It gives it the capacity to enter into contracts (i.e. with the providers, donors etc.)
2. An NGO can sue and be sued. The initiators and the Board of Directors and Executive Committee members are legally not personally liable for their actions in the course of their official duties. The registered scheme is personally liable.

The directors names in the registration forms must be the directors for the scheme. However, if the director(s) change after the scheme has taken off, there will be the need to inform the Registrar-Genera's Department about the change. Normally, a resolution from the general assembly of the scheme to the effect that the Board or a member of the Board is changed is required.

3. The registration also enables the scheme to operate within the confines of the law as required under the Companies Code, i.e. preparation of annual accounts, keeping of minimum books of accounts, auditing of annual accounts by external auditors.

PROCEDURES FOR REGISTRATION

1. Get the registration forms from the Registrar-General's Department, Accra.
Note: Registration forms for Company Limited by Guarantee are appropriate in this case.
2. Fill the forms
 - a. Set out NGO's objectives
 - b. Name the directors of the NGO

c. Give the particulars of the auditor for the NGO. (Note: Previously this was not a requirement for the Registration of an NGO. Now it is.)

In getting the auditor, it is advisable to explain to him the objectives and the not-for-profit status of the NGO, which is dedicated to the welfare of the target group. (This may help in fixing his fees.)

Write formally to the auditor and get a written response from him for your file and also attach same to your registration forms to the Registrar-General.

3. Present the forms for registration.
4. After registration and a certificate has been issued to the NGO, apply to the Department of Social Welfare for registration as an NGO. Remember to attach a copy of the Registrar-General's Certificate to the application to the Department of Social Welfare.
5. After the issuance of the Certificate from the Department of Social Welfare, send another application to the Internal Revenue Service (with copies of the certificates from the Registrar-General's Department and the Social Welfare Department) to request for tax exemption.

GROUP ASSIGNMENT

Question 1

Ask the participants to list the items found in a constitution.

Note the answers as they are given on the flipchart and add to them (if necessary), referring to the following suggestions:

- ◆ the MHO's name and headquarters;
- ◆ its purposes;
- ◆ the services it plans to offer;
- ◆ requirements for joining and coverage of dependants;
- ◆ procedures for setting dues, especially the amount;
- ◆ procedures for electing members of the board of directors;
- ◆ rules for running the MHO that are not stipulated by public laws or statutes;
- ◆ disciplinary code;
- ◆ procedures for revising the constitution;
- ◆ arbitration;
- ◆ powers of key organs and management personnel (spending powers, to take on liabilities, hire and fire, etc.)
- ◆ independent audit or financial oversight committee

Question 2

What is the importance of an MHO's constitution?

Provisions regarding the goals and operation of MHOs are defined in the constitution. They determine the rights and obligations of members and officers and establish the procedures that govern operations and the various organs to be set up (their composition, powers, etc.)

On the one hand, the constitution is the collective contract between the members and their MHO; on the other hand, it serves as a reference in relations between the MHO and third parties, for example, with the government, health care providers with which contracts are made and non-members who may wish to join, etc.

Question 3

What is the difference between the constitution and the rules and regulations?

Note the answers on the flipchart and then summarise them.

The rules and regulations supplement the constitution by indicating a number of provisions about the practical operations of the MHO that are not stated in the constitution.

INDIVIDUAL ASSIGNMENT

Ask the participants to read the example constitution and the rules and regulations at the end of this module and to determine the differences and complementarities between the two.

Ask the participants to present their conclusions to the group.

2.1.7 ACHIEVING SUSTAINABILITY

In order to be sustainable, an MHO must fulfill the following requirements:

- ◆ Good organisation and well trained and capable management
- ◆ Quality of services
- ◆ Information and training of members
- ◆ Good risk management techniques (see major risks in Units 1 and 4)
- ◆ Sound financial management (Unit 5)
- ◆ Good human and material resources management (Units 6 and 9)
- ◆ Establishment of an efficient system of monitoring and evaluation (Unit 7)
- ◆ Income-generating activities should be promoted to improve income levels of members and their capacity to pay their dues
- ◆ Community mobilisation and participation, and marketing of MHO services (Unit 8)

GROUP ASSIGNMENT

Hand out file cards to the participants and ask them to write down what they believe are the requirements to properly operate and sustain an MHO. Collect the papers and post them as they are completed on a wall or other suitable place for the purpose. Requirements should include those listed above. Discuss the proposals and use those the participants approve. Arrange the cards and identify the main requirements.

Wrap up the workshop and go around the table to allow the participants to express their level of satisfaction with the workshop.

2.1.8 SUMMARIZING STEPS IN SETTING UP AN MHO

Close the module. Using the flipchart, briefly indicate all the steps of the process of setting up an MHO.

- ◆ Study of the general environment to identify problems and their priority
- ◆ Feasibility/baseline study
- ◆ Consensus building among stakeholders through:
 - ❖ Public seminar
 - ❖ Sharing results of feasibility studies
- ◆ Establishing a working group
- ◆ Workshop for working group
- ◆ Contact with providers and district assembly (may be useful in exploring avenues of initial support and especially the payment of dues for poorest people by the assembly from its poverty alleviation fund)
- ◆ Meeting for information of the MHO's potential members
- ◆ Preparation of the constitution and the rules and regulations
- ◆ Preparation or validation of the first budget
- ◆ Holding the initial general meeting

SUPPORTING TEXT # 1: EXAMPLE OF A CONSTITUTION: THE MUTUELLE (MHO) 'AND FAGARU' OF THIES, SENEGAL

I – Preamble

Article 1

An MHO named AND FAGARU has been established in Thies.

II – Purpose

Article 2

The objective of the MHO is to provide access to health care for its members as needed.

III – The member

Article 3

The MHO is open to all persons residing in Thies without discrimination related to sex, ethnicity, class, political or religious convictions.

Paragraph 1

Membership is acquired by the payment of the registration fee.

Paragraph 2

All new members are obliged to observe a 6-month waiting period during which they shall regularly pay their dues without benefiting from the services offered by the MHO.

Paragraph 3

Membership is lost through:

- ◆ resignation,
- ◆ exclusion,
- ◆ dismissal,
- ◆ death, in which case the spouse can request the transfer of the membership card to his/her name without any cost.

Article 4

The member can have as beneficiaries:

- ◆ spouse(s),
- ◆ children,
- ◆ any other person under his/her responsibility.

Restrictions related to the number and age of beneficiaries can be determined by the Internal Rules and Regulations.

IV – Administration

Article 5

The organs of the MHO are:

- a) The General Assembly
- b) The Board of Directors
- c) The Management Committee
- d) The Control Committee

Article 6

The General Assembly is composed of all members who are up-to-date in their subscriptions. It is the supreme organ of the MHO. All other organs act on the authority invested by the General Assembly.

It meets for ordinary and extraordinary sessions.

Article 7: Ordinary General Assembly

It meets once a year and is convened by its Chairman.

It discusses:

- ◆ the moral and financial reports,
- ◆ the report of the Control Committee.

It approves or rejects:

- ◆ the profit and loss account,
- ◆ the balance sheet.

It sets or revises the following:

- ◆ dues,
- ◆ registration fee,
- ◆ the list of services offered.

It ratifies:

- ◆ contracts and contract modifications,
- ◆ the exclusion of members.

It votes:

- ◆ the nomination or dismissal of administrators,
- ◆ the nomination or dismissal of members of the Control Committee.

Paragraph 1: Quorum

- ◆ A quarter of its members should be present at the ordinary General Assembly for its proceedings to be validated.
- ◆ If there was not a quorum, a second General Assembly convened 15 days after with the same agenda can take valid decisions without regard to the number of members present.

Paragraph 2: Decision-making

- ◆ Decisions are made by a simple majority, i.e. half of the members present plus one vote.
- ◆ In case of a second ballot, the Chairman has a casting vote.

Article 8: The Extraordinary General Assembly

It is convened under the following conditions:

- ◆ Constitution,
- ◆ joining a union or withdrawal,
- ◆ fusion or scission,
- ◆ for urgent and/or serious issues which cannot be adjourned to the next ordinary general assembly,
- ◆ dissolution.

The general assembly is convened by any of the following:

- ◆ The Chairman of the Board of Directors,
- ◆ The members of the Control Committee,
- ◆ The management,
- ◆ Any member on the basis of a petition signed by a quarter of registered members.

The General Assembly discusses matters on its agenda.

Paragraph 1

The required quorum for proceedings to be validated is three-quarters of registered members. If there was no quorum, a second assembly can legitimately proceed with a majority of three-fifths.

Paragraph 2

Decisions at the extraordinary general assembly are made by a two thirds majority. In case of adjournment because the required majority was not attained, a second assembly can legitimately decide by a simple majority.

Article 9: General Assembly of Delegates

For reasons related to the need for a greater participation of members in the decision-making process, the agenda shall first be discussed at the each district level (sectoral general assemblies), and the delegates nominated according to a quota determined by the Internal Rules and Regulations shall represent the different sections of the MHO at the General Assembly of Delegates.

Article 10: The Board of Directors

The MHO is managed by a 15-member Board of Directors. The administrators should be:

- ◆ of Senegalese nationality,
- ◆ of age,
- ◆ without any criminal convictions.

The Board of Directors is generally responsible for the administration and management of the MHO. To this effect, the General Assembly delegates all its authority to the Board except those expressly reserved for the said General Assembly.

The Board of Directors is especially responsible for the following:

- ◆ elaborating projected accounts,
- ◆ ensuring the correct execution of the budget,
- ◆ ensuring adherence to statutory rules and regulations,
- ◆ ensuring a balance between subscriptions/expenses and consequently proposing the readjustment of the dues rates, registration fees and the list of services offered,
- ◆ examining the draft agreements and contracts to be signed with other organisms,
- ◆ electing the members of the Management committee,
- ◆ filling in the posts of administrators left vacant due to dismissal, resignation or death until the next General Assembly and provided the proportion does not exceed one-third of the administrators.

It meets at least once every three months.

Paragraph 1

The administrators are responsible individually and jointly as is the case for any embezzlement and management errors committed during their term.

Paragraph 2

The duties of an administrator are incompatible with that of:

- a) an employee of the MHO,
- b) an auditor.

Besides, they cannot have stakes, either directly or indirectly, in companies with which the MHO deals with.

Paragraph 3

A third of the Board of Directors is renewed at each ordinary general assembly. The out-going third is re-eligible.

Article 11: The management committee

The Board of Directors elects, among its members, a management committee to whom authority will be given to ensure the daily management of the MHO.

The committee is composed of:

- ◆ The Chairman / possibly Vice-Chairman
- ◆ The Secretary General / possibly Deputy Secretary General
- ◆ The Accountant

The committee meets once a month.

Article 12: The Chairman

- ◆ Is the moral personality of the MHO
- ◆ Chairs the meeting of the Board, Management Committee and General Assembly
- ◆ Authorises expenditures
- ◆ Signs all receipt or expenditure vouchers
- ◆ Signs all agreements, contracts or conventions between the MHO and third parties
- ◆ Presents the report of the Board of Directors to the General Assembly
- ◆ Represents the MHO in litigation

The Vice-Chairman stands in for the Chairman in the absence of the latter.

Article 13: The Secretary General

- ◆ Prepares the minutes of meetings
- ◆ Prepares correspondences (projects and other matters)
- ◆ Prepares and distributes notifications at the request of the Chairman
- ◆ Manages the archives

The Deputy Secretary General supports and stands in for the Secretary General if the need arises.

Article 14: The Accountant

- ◆ Receives dues and member registration fees and delivers receipts
- ◆ Keeps the receipts and expenditure books up to date
- ◆ Submits to the Chairman for signature and countersigns all payment or receipt vouchers
- ◆ Keeps the cash and bank books up to date
- ◆ Makes payments
- ◆ Presents the financial situation to the Board of Directors
- ◆ Presents the financial report to the General Assembly

Paragraph 1

The Accountant is obliged to put at the disposal of the internal and external control committees:

- ◆ all monies and cashbook for control,
- ◆ savings accounts books and bank statements,
- ◆ invoices, proformas and vouchers,
- ◆ and any other document they may demand.

Paragraph 2

The non-observation by the Accountant of his/her obligations to the control organs as stipulated in Paragraph 1 of Article 14 will expose the Accountant to sanctions determined by Law.

Article 15: Management

The MHO is managed by its management committee. The latter can in turn delegate its authority to an administrator or a person (outside of the Board of Directors or even the MHO) chosen for his/her competence.

This manager is entrusted, under the responsibility of the management committee, with the management of the MHO and particularly the management of relations with health providers.

- ❖ Through powers conferred by the Chairman, he issues at the request of a member, a letter of guarantee after ensuring:
 - ❖ that the member is up-to-date with his subscriptions,
 - ❖ that the member is not subject to a waiting period,
 - ❖ that the member was referred in accordance with the conditions determined in the Internal Rules and Regulations.
- ❖ Verifies the invoices received from health providers and submits them to the Chairman for payment.

Article 16: The Control Committee

The Control Committee is composed of three (3) members nominated by the General Assembly. The Control Committee covers the areas of administration and management of the MHO:

- a) At the administrative level
 - ❖ Ensures that meetings are convened and held in accordance with the statutory rules and regulations
 - ❖ Ensures that the rules and internal regulations are applied
 - ❖ Particularly ensures the respect of MHO principles:
 - equity
 - non exclusion.
- b) At the management level
 - ❖ Regularly verifies the imprest
 - ❖ Verifies the morality and the veracity of expenditures
 - ❖ Carries out a book and a physical inventory of the equipment
 - ❖ Verifies the accounts and deposits made (bank, post office, savings)
 - ❖ And, generally, verifies the MHOs assets
 - ❖ Presents a report to the General Assembly

The members of the Control Committee have wide investigating powers within the context of their mission.

Administrators and managers are obliged to make available any document or information they may judge necessary.

Members of the Control Committee are also empowered to convene an extraordinary general assembly should they discover, during their mission, anomalies or management errors that deserve to be brought to the attention of the members.

The Control Committee is also empowered to receive and look into grievances presented by the members.

V – Financial dispositions

Article 17: The MHOs resources

The MHOs resources are composed of:

- ◆ dues,
- ◆ registration fees,
- ◆ fines,
- ◆ fund-raising,
- ◆ donations,
- ◆ subsidies.

The MHOs expenditures are:

- ◆ health care bills,
- ◆ operating costs,
- ◆ training costs,
- ◆ subscription to unions and federations.

Article 18

The funds accumulated during the waiting period constitute the reserve fund and shall be deposited into a special account.

Budget surpluses are paid into the reserve fund which can be used partially to balance the budget during exceptional periods of over-consumption of health care services due to an epidemic, without however going below the safety margin of 75 percent of the initial amount.

Article 19

In the case where the reserve fund is being utilised below the safety margin of 75 percent of the initial amount, the Board of Directors is obliged to:

- a) suspend the agreement signed with the health care provider,
- b) propose the appropriate measures to rescue the MHO,
- c) convene an extraordinary general assembly to approve the rescue plan.

Article 20

The MHOs working capital is composed of the contributions collected during the fiscal year and should balance the expenditures (health care bills, management costs, etc.).

VI – Headquarters

Article 21

The MHOs headquarters are located at the Ndèye Ngoné Touré building on Avenue Léopold S. Senghor, P.O. Box 3055. Tel. & Fax 951.47.69. Email: graim@enda.sn. These headquarters can be transferred.

VII – Dissolution

Article 22

In the case of dissolution, after auditing of the accounts, the MHOs assets shall be donated to another MHO, union or federation of MHOs

SUPPORTING TEXT #2: EXAMPLE OF INTERNAL RULES AND REGULATIONS OF THE MUTUELLE (MHO) 'AND FAGARU' OF THIES, SENEGAL

I – Generalities

Article 1

The MHO covers the following districts:

- ◆ The MHO And Fagaru is open to the entire population in Thies without any discrimination.

II – Registration fees, dues, sanctions

Article 2

The registration fee is set at: 2.000 F (Two thousand francs). A membership card is delivered upon payment of the registration fee.

Article 3

Subscription is set at 300 francs per month for each member and for each beneficiary. It is payable monthly and in advance, latest the 10th of each month.

Article 4

In the case of non-payment of dues by the 10th of the month, the member and his/her beneficiaries shall not benefit from the MHO's services.

Article 5

After payment of arrears, the member shall observe a one-month penalty before re-benefiting from the services offered by the MHO.

III – Services offered, coverage

Article 6

The MHO offers the following services to its members:

- ◆ Primary Health Care at health centres which have signed agreements with the MHO;
- ◆ Hospital admissions for a maximum of 10 days at Saint Jean de Dieu Hospital.

Article 7

Access to primary health care at the health centres that have signed agreements with the MHO is subject to the presentation of an up-to-date membership card.

Article 8

The MHO shall issue letters of guarantee, subject to the following conditions:

- ◆ Dues are up-to-date for all the persons registered on the membership card;
- ◆ Member is not subject to a waiting period or a penalty;
- ◆ Presentation of a hospital ticket issued by the physician of the registered medical centre or any other medical officer registered with the MHO;
- ◆ Payment of a deposit set at 10.500 F

Article 9

The MHO member (or a member of his family) admitted for a greater number of days than statutorily covered by the MHO, or benefiting from hospital services which require a financial contribution on his/her part, is obliged to:

- a) sign an acknowledgement of a debt (IOU),
- b) sign a commitment to repay the debt in accordance with a schedule of payment negotiated with the management.

Article 10

The non observation, by the member, of the commitments stipulated in Article 9 shall result in the suspension of services offered by the MHO without prejudice to legal action undertaken by the MHO against the member.

IV – Delegates

Article 11

Delegates shall be nominated on the following basis:

- ◆ equal representation: two from each district
- ◆ proportionate: 1 for every 50 members

They are responsible for the collection of dues and delivery to the central bureau. They represent their districts during the General Assembly of Delegates and ensure that information and decisions are relayed from the base to top management and vice versa.

They elect administrators within themselves.

Article 12

The selection criteria for delegates and for the MHO officials in general should take into account:

- ◆ probity,
- ◆ competence,
- ◆ availability.

V – Administrators

Article 13

Administrators are individually and jointly responsible as is the case of embezzlements or management errors committed during their term.

Members of internal and external control committees shall determine the individual or joint responsibilities of the administrators.

Article 14

The Chairman and the treasurer cannot be close relatives or in-laws. The same applies to the Chairman and the manager.

Article 15

Temporary or permanent proxy should be legalised by the competent administrative or judicial authorities.

VI – Management ratios

Article 16

- ◆ The Miscellaneous management costs/Receipts ratio is set at five percent (5 percent)
- ◆ The Reserve fund ratio: provision for six months of average management costs

MODULE 2.2

MEMBERSHIP OF AN MHO, OPERATIONS MANAGEMENT AND ORGANISATIONAL STRUCTURE

LEARNING OBJECTIVES

At the conclusion of the module, the participants will:

- ◆ Know the procedures for joining an MHO and accessing its services, and
- ◆ Understand the problems caused by admitting certain categories of persons

TARGET GROUP

- ◆ Initiators
- ◆ Members of the Board of Directors and other organs
- ◆ All members if feasible; otherwise all community representatives

PREREQUISITES

Basic knowledge of an MHO's principles and characteristics

CONTENT

- ◆ Membership
 - ◆ Beneficiaries (member and dependants)
 - ◆ Special cases
 - ◆ Registration fees
 - ◆ Dues
- ◆ Procedures for joining
- ◆ Procedures for accessing services offered by an MHO
- ◆ MHO operations managements
- ◆ Organisational structure

TRAINING METHODS

- ◆ Presentation
- ◆ Plenary session (work and wrap-up)
- ◆ Role play
- ◆ Teaching materials
- ◆ Flipchart
- ◆ Hand-outs
- ◆ Overhead projector

Present the purpose of the module to the participants and answer any questions they may have for clarification.

SUPPORTING TEXT

Participants' Guide and Work Book

2.2.1 DEFINITION OF MEMBERSHIP

Explain to the participants that a “member” is someone who belongs to an MHO, who promises to abide by the rules that govern its operation, and to pay his/her dues. A member may make a certain number of persons directly dependent on him/her for utilising an MHO's services. These people are called “dependants.”

DEPENDANTS

It is important to accurately identify the standards that define dependant status, because the number of eligible dependants may have a substantial financial impact on the MHO. Defining dependants is a sensitive decision that depends on local customs. Generally, certain members of the MHO member's family may be eligible for the MHO's services by paying additional dues. Potential dependants include:

- ◆ Spouse(s);
- ◆ Children up to a certain age (if they are students, the age limit is often higher);
- ◆ Official orphans (wards).
- ◆ Elderly parents, aunts, uncles etc.

One option is to consider family members to be dependants only if they are financially dependant on the MHO member. If a spouse or child works on his own, or becomes an employee and thereby earns an income, that person is no longer a dependant and should register separately with the MHO.

Certain evaluation difficulties may arise, for example, for a young single man who continues to live with his parents after he reaches a certain age. In such a case, the general meeting must resolve such a problem.

For cases of polygyny, it is considered that the number of families equals the number of wives. Therefore, dues are paid for a member with a dependant just as they are paid for each wife.

There is almost always the touchy issue of parents. Their status should be carefully reviewed since these are elderly people whose health care needs are usually greater than those of the average population. In most cases, they are considered as a separate family and must pay their own dues.

To the extent possible, the status of dependants must be certified by official documents.

In summary, the procedures for accepting applicants should be discussed taking local context into account. The impact of each option on the MHO's viability must be carefully analysed. Abuses are diminished by the social control exercised by the members. However, control declines as the MHO grows.

GROUP ASSIGNMENT

ROLE PLAY : DETERMINING DEPENDANT ELIGIBILITY

The purpose of the role-play is to show the arbitrary parameters in the selection of dependants who are eligible for the MHO's services.

Scenario:

A group wants to set up an MHO and is talking about procedures for covering dependants: families with many children, diversity of illnesses and economic situations, polygamy, etc.

Assignment of roles:

Set up the following groups and explain to each one separately the role it is to play.

- ◆ One group of three persons that wants a maximum number of people in their family to be MHO members.
- ◆ A group of three persons arguing for the smallest possible number of beneficiaries, raising issues of polygyny, the concept of extended parenthood, adult unmarried children or women with income.
- ◆ A resource person with MHO experience, drawing everyone's attention to the risks of their options (social logic, financial viability);
- ◆ A health care worker, to provide technical information
- ◆ Three observers, who will note the arguments of each player to suggest a solution to the dependent problem and hand them in at the end of the role-play.

Have the players and other participants add to the observers' list.

2.2.2 REGISTRATION PROCEDURES

2.2.2.1 REGISTRATION FEE

Next, use the flipchart to introduce the registration fee and the different dues systems that an MHO may have.

The constitution may stipulate the payment of a registration fee when a member registers. General meetings may change these amounts periodically.

The registration fee is used to cover registration costs; it may be replaced by the sale of the membership card or booklet, which is easier for accounting and which members often find easier to accept.

2.2.2.2 DUES/CONTRIBUTION RATES

Four systems of family or individual dues are possible:

- ◆ The member and dependants pay the same dues
- ◆ The dependants pay lower dues than members do
- ◆ Two dues rates are used: one for persons with dependants, the other without
- ◆ Dues are exactly the same regardless of the number of dependants

The last three cases display solidarity between those who are alone and those with families, which is in line with the MHO spirit.

The IGM decides on the system to be used for dues and includes it in the constitution. Only the general meeting may change the system.

Because of the principle of solidarity and risk-sharing, dues should never be based on a member's age or health status. However, as indicated above, exceptions may be made when an elderly person joins for the first time.

Special dues may be stipulated in the constitution or introduced by a general meeting for well-defined purposes, such as an AIDS fund. Special assessments may also be levied for major projects which, of course, should be in line with the MHO's general goals.

Ask a few participants to indicate who the dependants are in their MHO and the corresponding dues.

Based on the following technical discussion, present the procedures for joining an MHO and the problems related to admitting certain categories of people (members or dependants).

Summarise everything by stating the following:

The decision as to how often dues are paid is based on the availability of members' income and is indicated in the MHO's rules and regulations. For example:

- ◆ Salaried employees pay dues monthly
- ◆ Farmers pay dues at harvest time, or once or twice a year depending on the region.

COSTLY MEMBERSHIP CATEGORIES

Theoretically, any person who has reached the minimum age as determined by the customs and conditions in the country or region may join an MHO without any discrimination on the grounds of their health status, gender, race, ethnic group, religion, philosophical or political beliefs, provided that s/he promises to abide by the rules and to pay the dues. However, membership of certain persons may cause financial problems for the MHO. These high-cost cases can deplete MHO funds to the point where it becomes impossible to pay for services for other members. There are three major high-cost categories:

- ◆ Elderly
- ◆ Chronically ill, such as persons with diabetes, hypertension, heart disease, etc.
- ◆ People with AIDS

The Elderly

A difficult question is setting an age limit for someone joining the MHO for the first time. In theory, the MHO requires everyone (or at least those in similar income position) to pay the same amount of dues, regardless of age. However, in one case, an MHO asked new members over a certain age to pay higher dues. This is justified if the person did not demonstrate solidarity by joining earlier, when his health was probably better, and hence he had less need for the MHO. (This assumes that the elderly person had the choice of joining when young.)

The Chronically Ill

The chronically ill require several months and sometimes years of treatment, such as for leprosy or tuberculosis, or illnesses that require repeated, long and costly treatments, such as sickle cell anaemia, diabetes or AIDS. These people are a major financial risk for an MHO's members and their dependants

In Ghana, care for diseases such as tuberculosis, leprosy or AIDS is paid for by special government programs or international donor agencies, and does not cause serious problems for the MHO.

Where there is no coverage for these diseases, the MHO can play a role to the extent of its means. Given the very high costs for treating these diseases, the MHO should balance its concern for these needy members and its obligation to sustain its financial viability and thus its survival.

The conditions for admitting the chronically ill are a serious problem that the MHO will have to resolve before it begins operating. Several restrictions on assistance to the chronically ill may be considered:

- ◆ Payment for drugs only
- ◆ Limit on assistance per beneficiary (monthly or yearly)
- ◆ Payment of hospitalisation costs for acute phases only
- ◆ Annual fixed payment according to type of disease
- ◆ Establishment of an assistance fund separate from the main account, such as an AIDS solidarity fund, in which assistance is limited to the amount available in the separate fund

Ask a few participants to briefly present their MHO's position on these categories of patients.

GROUP ASSIGNMENT

Organise a discussion of the following questions:

- ◆ What basis is used for deciding how often dues are paid?
- ◆ Why is a probation period necessary?
- ◆ How is this period determined?

2.2.2.3 PROBATION PERIOD

The probation period is when the member pays his dues yet does not have the right to obtain the MHO's services. This is also called the waiting period or qualifying period. It is usually six months, but may be only three months in some cases. A probation or waiting period of one year is usual for covering deliveries.

The main purpose of the probation period is to prevent people from joining just because they are ill or in need of the service. In fact, since there is no physical examination required at registration time, some people may wait until they need an MHO's services to join and, once cured, resign. This behaviour conflicts with one of the MHO's basic principles: solidarity among well and ill members, which makes this insurance system legitimate.

Dues paid during the probation period contribute to MHO funds for future use. They are particularly useful during the start-up period to build up sufficient funds to meet members' service utilisation at a time there is little or no other money yet available. The waiting period may be reduced in length if the MHO (as happens at Nkoranza) collects dues and accepts members only within a very limited period of the year, after which no one can join till the following year.

Ask a few participants to tell how long the probation period(s) is/are in their MHO.

2.2.3 ADVANTAGES AND DISADVANTAGES OF INDIVIDUAL, FAMILY AND GROUP MEMBERSHIP

Ask participants to discuss the relative advantages and disadvantages of individual and family/group membership of an MHO. Write the answers on a flipchart and, if necessary, use a role play to illustrate the advantages and disadvantages to everyone's understanding.

INDIVIDUAL MEMBERSHIP

Advantages

1. Management is easier to both provider and member.

Disadvantages

1. Does not give incentives to register more people, especially family members.
2. Does not take advantage of a community's solidarity mechanisms based on family and other groups, and promotes individualism.
3. Makes adverse selection easier as people register only the most vulnerable family members and join and leave the MHO as they wish, without regard to wider social considerations, e.g. on other family members.

FAMILY/GROUP MEMBERSHIP

Advantages:

1. Better social control through groups leaders, possibly limiting fraud.
2. Administrative costs may also be lower if group leaders could be entrusted with some responsibilities for social control and administration work.
3. Family membership involves family cards and allows a family's medical history to be kept and monitored.
4. Promotes family, community and group solidarity.
5. Minimises incidence of adverse selection since all members of a family are registered

Disadvantages

1. Could lead to abuses and fraud where social control and dependant identification mechanisms are weak.

EXAMPLE OF JOINING AN MHO THROUGH EXISTING COMMUNITY-BASED GROUPS OR ASSOCIATIONS

THE CASE OF THE LAWANSON COMMUNITY PARTNERS FOR HEALTH

The Lawanson Community Partners for Health (LCPH) in Lagos, Nigeria, is a partnership of 21 community-based organisations (CBO) covering a wide diversity of interests, and four health facilities, (Pine Hospital, Ijsha; Rock of Ages Hospital, Suru-Iere; Anthnie Clinic, Mbonu-Ojike St.; and Royal Health Care Hospital, Lawanson). A network of the four medical practices in Lawanson together constitute the provider side of the partnership. They meet within the framework of a managed care committee to agree on uniform care standards and pricing for their services, so that CPH members are assured of the same standard of care wherever they go within the network.

An interesting feature of the CPHs is that they are organised through existing community organisations of all kinds, from local trade unions, traders and professional associations, church groups including spiritual or charismatic church groups to Muslim groups, traditional birth attendants, etc. *CPH membership is not accessed directly as an individual, but through the local association, which offers a lot of advantages in terms of social control and prevention of abuse, fraud, etc. in addition to chasing up of defaulters.*

Through collective efforts, the CPH has been able to mobilise resources from different sources: from revolving drug funds, membership dues, interest on savings and from income generating activities which are supported by external partners. The members also offer voluntary labour to run the CPH and the health care activities.

2.2.4 PROCEDURES FOR ACCESSING AN MHO'S SERVICES

PRESENTATION

Make a presentation on the procedures for accessing an MHO's services and refer to the Participants' Guide.

Ask a few of the participants to describe their experience accessing an MHO's services.

Lead a discussion on their experiences.

WRAP-UP IN PLENARY SESSION

To conclude the module, ask the following questions. Each time ask a participant to answer:

- ◆ Who is eligible to be an MHO member?
- ◆ Who are the potential members who can cause problems?
- ◆ What is the difference between a member and a dependant?
- ◆ What are the problems in evaluating the eligibility of a dependant as such?
- ◆ What is the difference between the registration fee and dues?
- ◆ What is the probation period and what purpose does it serve?

2.2.5 MHO OPERATIONS MANAGEMENT

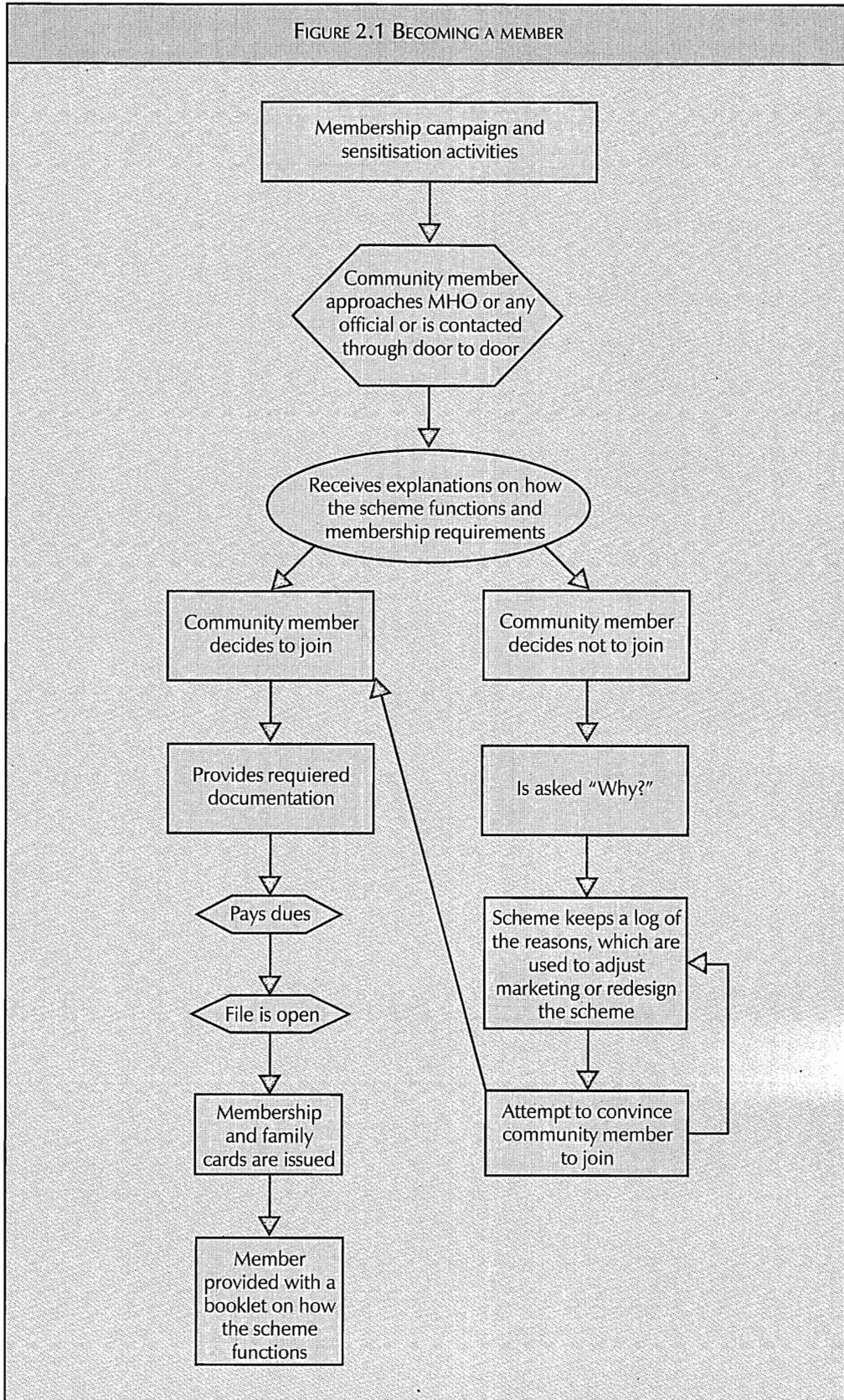
MHOs should have operational procedures to guide and standardise key operations like:

- ◆ Enrolling members
- ◆ Paying or contracting providers
- ◆ Collecting and managing financial and service data
- ◆ Maintaining member records

These should be compiled in a written document that is periodically reviewed and updated.

Staff members, scheme members, providers and all other stakeholders should understand the flow of activities, and the persons responsible for procedures should receive suitable training. Figure 2.1 depicts the procedures related to becoming a Member (if not joining by group)

FIGURE 2.1 BECOMING A MEMBER



ENROLMENT

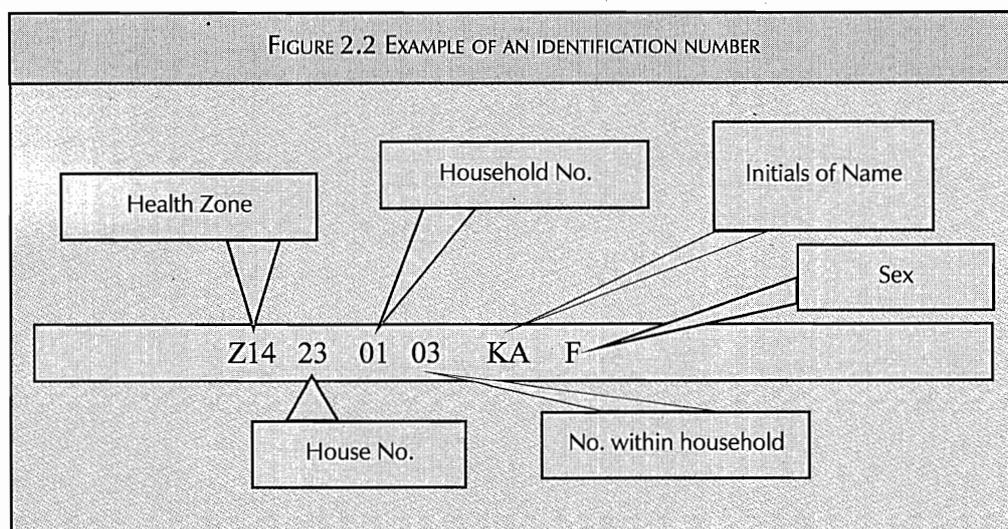
The scheme should decide on the documentation that will be required from members, such as birth certificates, other forms of identification, proof of income, pictures, etc. The scheme should also ask members for basic information regarding other members of their household. The information items are:

- ◆ Name
- ◆ Age
- ◆ Sex
- ◆ Address
- ◆ Relationship with household head
- ◆ Occupation.

IDENTIFICATION CARDS AND FAMILY CARDS

Most schemes will provide their members with an identification card that will be used to seek services from a provider. Identification cards are essential to facilitate identification of members by health providers.

Once a member is accepted, he/she should be assigned a unique identification number that will be used to identify him/her and the household. This identification number can be based on addresses (such as house number and zones), by following a numerical system, etc. This number is used by the scheme to keep track of membership activity (usage of services, costs, payment of dues, etc.). Figure 2.2 shows a sample identification number.



MHO management should be able to identify certain factors by looking at the number (such as village of origin); the identification number should also facilitate production of statistics from the database.

Utilising the initials and sex of the beneficiaries on the card is a quick and easy way of checking impersonation and misuse of others' cards. This is particularly useful where a photo is not attached to the card or is mutilated, or some additional indication of identity is required.

In addition to identification cards, most MHOs will hold family cards/files at the office (in addition to a computerised database where possible).

The scheme should also decide on the standard orientation, explanations or other information that will be given to new members for a clear understanding of the scheme and the way it functions, as well as to create and/or reinforce a sense of belonging and community ownership of the scheme (refer to Marketing section in Unit 8). Brochures explaining membership rules can be designed in areas where the literacy rate is high.

ENTERING AND MANAGING DATA

MHO schemes should maintain membership databases to help them manage their operations. Figure 2.3 presents sample tables for a database. Due to a high volume of data, even for the smaller schemes, it is highly recommended that the data be maintained in a computerised system. The system should provide the scheme with statistics on its members and services.

FIGURE 2.3 EXAMPLE OF A DATABASE

| MEMBERSHIP TABLE | | | | | | | | | | |
|------------------|------|------------|-----------|-------|--------------------------|-----|-----|------------|---------|---------|
| Ins. # | ID # | First name | Last name | Title | Relationship with member | DOB | Sex | Occupation | Address | Remarks |
| | | | | | | | | | | |
| | | | | | | | | | | |

| DIAGNOSIS TABLE | |
|-----------------|-------------------|
| Diagnosis # | Type of diagnosis |
| | |

| DUES OR PREMIUM TABLE | | | | | | | |
|-----------------------|------|-------------------------------|---------------|--------------------|-----------------|-------------|-------------------|
| Insurance # | ID # | Dues /Premium amount received | Date received | End waiting period | Expiration date | Enrolled by | Membership status |
| | | | | | | | |
| | | | | | | | |

| BILLING TABLE | | | | | | | | | | | | | | |
|---------------|------|----------------|----------------|---------------|-----------|-------|-----|--------------|--------|---------|-----------|-----------|------------------|---------------------|
| Ins. # | ID # | Admission date | Discharge date | Accommodation | Diagnosis | Drugs | Lab | Consultation | X-Rays | Surgery | Follow-up | Bill date | Cheque receipt # | Cheque receipt date |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |

Following is a sample of the information that can be retrieved if the information is entered into a database:

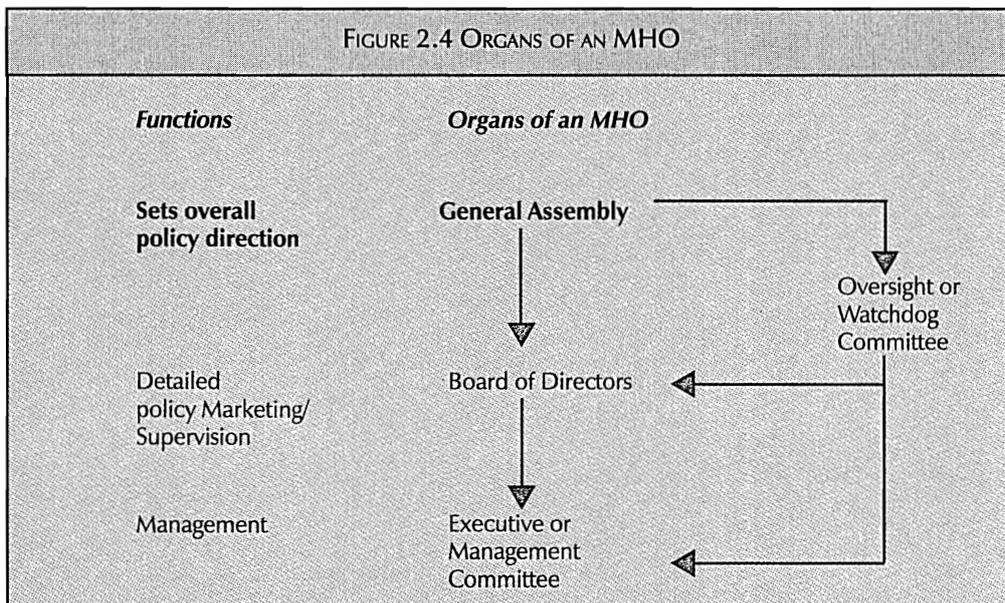
- ◆ How many new members joined last month?
- ◆ What is the rate of occurrence of a type of diagnosis?
- ◆ What is the cost per service per age/sex group per time period?
- ◆ What is the number of hospital days per admission?
- ◆ What are the morbidity and mortality rates?
- ◆ What is the drop-out rate?
- ◆ What is the membership composition (sex, age), occupation, etc.?
- ◆ Extract mailing lists
- ◆ What are the expenses per household per month?
- ◆ What is the number of members enrolled per field worker?

With the data, the scheme can identify trends for its planning projections, compare the health status of its members with that of other population groups, manage membership status, analyse cost evolution, design more efficient marketing tools by knowing its members, and perform a variety of other important management functions.

2.2.6 ORGANISATIONAL STRUCTURE OF AN MHO

The organs of an MHO are the following figure 2.4:

- ◆ The General Assembly
- ◆ The Board of Directors
- ◆ The Oversight or Watchdog Committee (sometimes called Control or Supervisory Committee)
- ◆ The Executive Committee



The General Assembly

The General Assembly comprises all the members unless the MHO is too large to make this feasible, in which case, the General Assembly is made up of delegates chosen by the members.

The primary responsibilities of the General Assembly are as follows:

- ◆ Identifies the MHO's mission and develops its general policy
- ◆ Approves and modifies the constitution
- ◆ Reviews and approves the activity reports of the different units, including the Control/Watchdog/Oversight Committee
- ◆ Reviews and approves the annual financial statements and the budget
- ◆ Sets the amount of dues and all special contributions on the basis of recommendations from the Board of Directors
- ◆ Elects the members of the Board of Directors
- ◆ Elects the members of the Control/Watchdog/Oversight Committee
- ◆ Determines new activities for the MHO on the Board's recommendations
- ◆ Can take the decision to merge with other MHOs and to dissolve the MHO when applicable
- ◆ Decides on all other matters addressed in the constitution
- ◆ Decides on the terms of admission to and expulsion of members from the MHO
- ◆ Appoints auditors
- ◆ Meets at least once a year

Board of Directors

The Board of Directors is elected by (and accounts to) the General Assembly and may include persons from outside the MHO but who have a particular technical expertise required for the successful running of the organisation. It meets more regularly than the General Assembly (e.g. every quarter) and is responsible for policy matters arising between meetings of the Assembly and also:

- ◆ Ensures compliance with the constitution in order to achieve the MHO's goals
- ◆ Recommends admission and expulsion of members and has the power to apply the stipulated disciplinary sanctions
- ◆ Appoints the management
- ◆ Approves the annual financial statements and budget for the following fiscal year
- ◆ Ensures the preparation of annual activity reports
- ◆ Represents the MHO in its relations with others and establishes relations with other associations, more particularly, with other social movements that are also based on solidarity
- ◆ Signs agreements and conventions, especially with health care providers
- ◆ Establishes the staff positions required and sets the conditions of service
- ◆ Sets compensation for employees
- ◆ Hires the director or manager (if salaried and not elected)
- ◆ Carries out all the other tasks assigned to it by the constitution or the General Assembly

Oversight (also called Control/Watchdog) Committee

The independent Oversight or Control/Watchdog Committee performs the following duties:

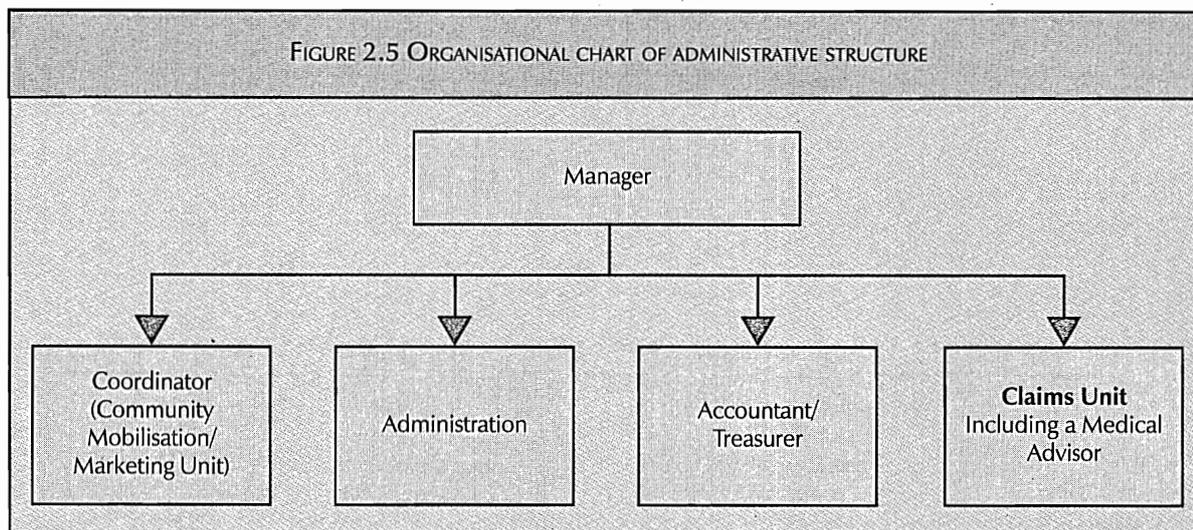
- ◆ Ensures that the MHO's official documents are in compliance with the constitution and rules and regulations and that they do not conflict with the laws and regulations in effect in the country;
- ◆ Audits the accuracy and reliability of the bookkeeping and the accuracy of financial transactions;
 - ❖ Oversees the implementation of the General Assembly's decisions;
 - ❖ Draws the attention of the organs or offices in charge to errors that may be or have been committed;
 - ❖ Oversees compliance with the MHO's rules and regulations;
- ◆ Studies annual reports and budgets before they are presented at the annual general meeting
- ◆ Receives member complaints about services and refers them to the appropriate unit or person for action;
- ◆ On receipt of complaints, contacts the appropriate person or organ meant to perform a task that was not carried out or poorly carried out to seek explanation or redress for the complainant;
- ◆ Reviews and determines the eligibility of members attending the General Assembly in accordance with the constitution of the MHO;
- ◆ Performs duties assigned to it by the constitution and the rules and regulations;
- ◆ Reports directly to the General Assembly and is not under the control of any of the other executive or management organs. Members may also not belong at the same time to any of the other organs, or be related to any of the members of those organs, except for the General Assembly.

Executive or Management Committee

The Executive Committee is composed of the manager, secretary, coordinator (or sometimes president) and accountant or treasurer and performs the following duties:

- ◆ Administers the MHO on a daily basis
 - ❖ Prepares the budget for the Board of Directors and, once approved, sees that it is properly implemented;
 - ❖ Presents the annual financial statements and budget implementation plans to the Board of Directors;
 - ❖ Negotiates agreements and conventions after submitting them to the Board of Directors;
- ◆ Keeps a record of the MHO's assets and funds;
- ◆ Hires and supervises the employees [except the director or manager who is hired by the Board];
- ◆ Acts as liaison between the MHO members and the Board;
- ◆ Co-ordinates the work of the various committees;
- ◆ Negotiates with health care providers and defends the members' health-related interests with other parties;
- ◆ Carries out all the duties required by the constitution or duties assigned to it by the Board of Directors and the General Assembly.

The following persons form the management team who hold monthly meetings to discuss reports from their departments (Figure 2.5).



Manager

- ❖ Knows or has vision of the roles and functions of MHOs
- ❖ Has knowledge of appropriate reforms in Health delivery
- ❖ Possesses leadership and supervisory skills
- ❖ Responsible, inter alia, for monitoring and periodic evaluation of MHO activities and performance
- ❖ The manager's functions include:
 - ❖ Is the overall Director of the MHO
 - ❖ Provides technical leadership
 - ❖ Represents the MHO
 - ❖ Ensures, through regular contact with the providers, that good quality of care is provided to the members of the scheme
 - ❖ Prepares budget for the Board of Directors and sees to its implementation after it has been approved
 - ❖ Presents annual reports/financial statements and budget implementation plans
 - ❖ Makes useful proposals to Board of Directors to better achieve the goals of the MHO
 - ❖ Negotiates agreements after approval by Board of Directors
 - ❖ Hires and supervises staff

Coordinator/Marketing Officer

- ❖ Enrolls new members
- ❖ Acts as liaison between MHO members and management and general public
- ❖ Develops strategies to promote the MHO and its image

- ◆ Carries out sensitisation/mobilisation activities and ensures community participation in MHO activities including decision-making
- ◆ Receives complaints and takes appropriate actions
- ◆ Monitors the quality of care provided to the members of the scheme

Administrator/Assistant Manager/Administrative Officer/Administrative Assistant

- ◆ Organises and executes training programmes
- ◆ Administers the MHO on a daily basis
- ◆ Supervises data management
- ◆ Handles correspondence
- ◆ Acts in the absence of the manager

Accountant/Treasurer

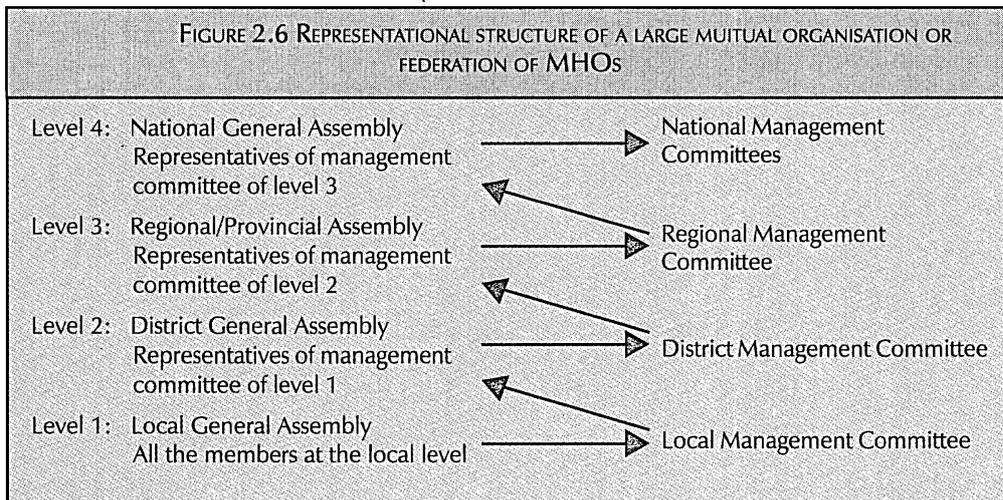
- ◆ Manages the MHO's assets and funds
- ◆ Prepares periodic financial statements/reports (quarterly, half-yearly, yearly, etc..)
- ◆ Develops financial controls
- ◆ Carries out other duty assigned to him/her

Claims Officer

- ◆ Links up with service providers
- ◆ Vets claims and advises on refunds
- ◆ Carries out other duty assigned to him/her
- ◆ Negotiates provider fees /contracts for approval by the Board and management

2.2.7 MEMBER REPRESENTATION IN A LARGE, GEOGRAPHICALLY BROAD MHO OR FEDERATION OF MHOs

Most often, the creation of a federation of mutual health organisations is to widen the base of solidarity so as to share risks among the widest number of persons possible. The powers and responsibilities of the different levels in the federation's structure depend on the purpose which led to the forming of a higher level (i.e. district, regional or national) association (Figure 2.6).



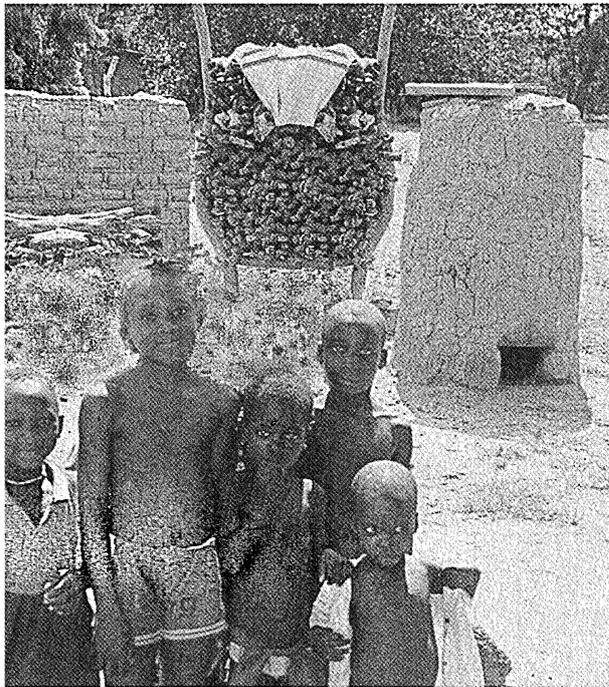
It is probable that the powers of the local general assembly will not allow it to directly set the dues and fee levels for its members, nor to determine the conditions under which the benefits and services of the association are offered or even to conclude agreements with the providers of health care. But the representatives of the local assemblies must be able to make their influence felt at the next higher level of the structure.

On the other hand, it is possible that there can be a de facto division of work between two levels in the structure in terms of the services offered. Thus, for instance, primary health care services could be handled by the local association (around the village health centre), while hospital care is organised by the district association. Numerous variants of this are also possible.

The structure by itself is not sufficient to ensure democratic functioning of the MHO, but it must serve the needs of the general membership of the association who can review and change it periodically.

UNIT 3

COSTING, SETTING DUES/ CONTRIBUTION RATES AND DETERMINING BENEFITS PACKAGES



| | |
|---|----|
| Module 3.1 Costing, setting dues/contribution rates and determining benefits packages | 74 |
| 3.1.1 Choosing the services to be covered | 75 |
| 3.1.2 Different types of contribution and their impact | 76 |
| 3.1.3 How to calculate dues or contribution rates | 77 |
| 3.1.4 The role of an MHO in the implementation of the government's exemptions policy | 85 |

MODULE 3.1

COSTING, SETTING DUES/ CONTRIBUTION RATES AND DETERMINING BENEFITS PACKAGES

LEARNING OBJECTIVES

At the end of the unit participants will be able to:

- ◆ List factors to be taken into consideration when deciding on services to be offered by an MHO, types of benefits packages and entitlements.
- ◆ Cost the services/benefits and determine dues or contribution rates.

TARGET GROUP

- ◆ Management team
- ◆ Initiators
- ◆ Supervisory/Oversight committee
- ◆ Elected officers

PREREQUISITES

All previous modules

CONTENT

- ◆ Choosing the services
- ◆ Knowing how to cost health services
- ◆ Methods of calculating dues
- ◆ How to implement exemption policies

TRAINING METHODS

- ◆ Group assignment
- ◆ Presentation
- ◆ Practical exercises

TEACHING MATERIALS

- ◆ Flipchart
- ◆ Participants' Guide and Workbook
- ◆ Slide or video projector

3.1.1 CHOOSING THE SERVICES TO BE COVERED

The choice of services to be offered by the MHO will be influenced by the following factors:

- ◆ The health care services currently available or that can be made available with the additional resources from the MHO
- ◆ The unmet health needs of members
- ◆ The ability of members to pay the dues required to provide the services

Two approaches are possible for choosing services the MHO will offer

3.1.1.1 APPROACHES TO SELECTING SERVICES

Approach one: Where the majority of the members are poor, hence where the major constraint is financial, the MHO must decide first what the members can afford to pay, then choose the priority health services to be covered within the limit fixed by the amount. The cost of services here includes *all* costs, including overhead and other costs, that the MHO will pay.

Approach two: Where the ability to pay is not a major limitation, the MHO can choose the priority health needs of its members first, then calculate the dues necessary to cover those services.

A mixture of the two is possible, i.e. the MHO can first choose the services it wants to cover, calculate the corresponding amount of dues required, and, if this is beyond members' ability to pay, review the list of services or extent of the coverage (reduce the percentage of cover or reimbursement) then recalculate and so on.

In either case, it is useful to know how to calculate the cost of the services chosen as a guide to fixing the dues or contribution rates.

3.1.1.2 SERVICES TO CONSIDER FOR THE BENEFITS PACKAGES

In general, health care benefits are classified as follows:

- ◆ Primary care services in the community
- ◆ Specialist physician services in individual practices, polyclinics or outpatient department
- ◆ Hospital inpatient care
- ◆ Drugs
- ◆ Ancillary services (e.g., x-rays, laboratory tests)
- ◆ Sight tests and spectacles
- ◆ Basic dental maintenance
- ◆ Restorative dentistry and dental prostheses
- ◆ Prostheses and appliances
- ◆ Transport to and from hospital

In Ghana some of these services are offered by the government or NGOs. These include:

- ◆ Immunisation is free, but illegal fees are sometimes collected.
- ◆ Family planning and maternity care - subsidised by the Government
- ◆ Care for the elderly (70+) and children under five
- ◆ Treatment for leprosy and tuberculosis

However, as explained later in this unit, even for such exempted categories, the MHO may be able to play a useful role in actually ensuring that those entitled to the exemptions get it.

3.1.2 DIFFERENT TYPES OF CONTRIBUTION AND THEIR IMPACT

Community-based MHOs generally apply a flat rate contribution where each person or equal-sized family pays the same amount of dues. Variations include having different fees based on family size, where the dues are not per individual but per family. In this case, larger families pay more, although this may not necessarily be proportional to the number of persons in the family. In other words, an MHO may decide as part of a policy to minimise adverse selection that the fee per head will decline as a member registers more of the family members.

With MHOs based on trade unions, occupation or profession, and work places, however, a wage-related contribution (where a percentage of the salary is demanded as dues) is frequently practised. In this case, the contribution is often independent of family size, but those who earn more contribute more. This is an expression of the strong solidarity that tends to exist within such groupings.

The main difference between varying types of contribution is the effect on the distribution of health costs among the members, as shown in table 3.1.

TABLE 3.1 DIFFERENT TYPES OF CONTRIBUTION

| TYPE OF CONTRIBUTION | DESCRIPTION | SOLIDARITY BASIS | EASE OF HANDLING |
|--|---|---|--|
| Flat-rate dues | Same amount per head for all members and dependants | From healthy to sick; from young to elderly | Easy to handle and to calculate; may be more acceptable to members than income-related dues |
| Flat-rate dues for household heads and graduated fees for dependants | Same amount per titular member or household head but fee per dependant depends on size of family (less for larger families) | From healthy to sick; from young to elderly; from small families and single persons to large families | Less easy than flat rate but encourages people with large families to register |
| Wage-related dues | Percentage of income | From healthy to sick; from young to elderly; from high-income to low-income persons | Not as easy to handle and calculate as flat rate, but more progressive. However, difficult to apply especially in rural areas and informal sectors |

3.1.3 HOW TO CALCULATE DUES OR CONTRIBUTION RATES

3.1.3.1 BASIC CALCULATIONS USING SIMPLE ASSUMPTIONS

In the simplest possible case, suppose that an MHO with 1000 members covers only hospital admission, which costs them 20,000 cedis per day for every member admitted, and that the rate of illness requiring admission has been found to be 100 cases per year. Assuming further that this MHO run by volunteers has no other costs (for simplicity's sake): the cost of hospital admissions for the MHO is 20,000 cedis X 100 cases = 2,000,000 cedis per year. The dues required for the MHO to be able to pay all its bills is then $2,000,000 / 1000 = 2,000$ cedis per year per member.

In real life, however, calculation of the MHO dues is not so simple, because several other factors enter into the picture. First, most MHOs cover a package of services, so it is necessary to have reasonably reliable data about utilisation of all the services that the MHO will cover. It is also necessary to know the other costs that it will bear (administration, transport, training, etc.).

The feasibility study presented in Unit 2 would have afforded the MHO the opportunity to collect all the required data for this exercise. The estimated utilisation figures for the various services are multiplied by the prices that the MHO agrees on with the providers, then divided by the number of MHO members to get the cost per member.

Frequently you will find utilisation data given as the annual number of hospital admissions, deliveries, or outpatient visits per 100 members. You then need to divide the total number of dues paying members by 100 and multiply by the annual number of admissions, etc. per 100 members in order to get the estimated utilisation of services by the members.

Besides the MHO's operations costs, the dues should also take into account the need for a safety margin to protect the MHO against over-optimistic assumptions in regard to utilisation rates (in fact, utilisation rates based on existing general population trends may underestimate MHO costs insofar as adverse selection and moral hazard as well as better access play a role in the MHO' members' utilisation rates). Additionally, it is normal good practice to provide for a reserve fund, usually calculated as a sum sufficient to cover up to six months health care bills, in case of an abnormal increase in illness in the population or similar unforeseen situation that the MHO has to face. Though a reserve fund of six months' expenses is required for good practice, this fund is to be built up over a reasonable period of time and not to be seen as absolutely essential in the very first year of existence. A percentage (e.g. 20 percent) is added onto the dues every year to enable the constitution of the reserve fund over a reasonable period.

The exercises below also illustrate how monitoring utilisation rates can help MHO management keep track of the MHO's financial status and any need for contribution rate adjustments.

Exercise: Calculation of dues for community-based MHO covering only hospital admission

Parameters:

A group of MHO initiators in a small village decide to sensitise the villagers towards setting up an MHO in their village. The MHO will cover only hospital admission. A study of the hospital's records show that for every 100 inhabitants of the village, there are 41 hospital days per year. The initiators project that they will be able to attain 500 members in the first year, and that the dues will be paid annually. They have negotiated with the local hospital a charge of ₵40,000 cedis for each day of hospitalization for a member.

Additionally, through market research, they have estimated the MHO's operations costs will be ₵150,000 cedis for annual administration, transport, and miscellaneous costs and ₵200,000 cedis for annual training costs.

What dues should the MHO charge its members?

Solution:

Assuming for a moment that the MHO's membership reflects the health profile of the entire village, there will be 41 hospital days for every 100 members. Therefore, for 500 members, there will be $500/100 \times 41 = 205$ hospital days per year.

Each hospital day costs 40,000 cedis so 205 days will cost $40,000 \times 205 = 8,200,000$ cedis. That is, the MHO will face an annual hospital bill of 8.2 million cedis.

Adding in administration, transport and training costs, the total operating cost becomes 8.55 million cedis ($8,200,000 + 150,000 + 200,000 = 8,550,000$ cedis).

If the above assumptions are correct, the MHO should charge each member $8,550,000 / 500 = 17,100$ cedis per year to break even.

Questions:

Do you think it is reasonable to assume that the health profile of MHO members will mirror that of the whole village? If not, why not, and what will be the implications for the above calculation? Assuming that MHO members are 10 percent more likely to be admitted into hospital than non-MHO members, recalculate the MHO dues to anticipate the added cost.

What other factor(s) have not been taken into account in the above calculations?

Exercise: Calculation of MHO dues for a more complicated example

Parameters:

Services covered by the MHO: Hospital admission, normal delivery, outpatient visits

Data from market survey:

Annual hospital days/100 members: 41

Annual deliveries/100 members: 4.3

Annual outpatient's visits/100 members: 158

MHO's Costs:

| | |
|--|------------|
| Monthly administration, transport, and miscellaneous cost: | ¢405,200 |
| Annual training costs: | ¢2,186,600 |
| Prices negotiated with hospital: | |
| Hospital day: | ¢25,000 |
| Delivery: | ¢15,000 |
| Outpatient visit: | ¢5,000 |

Membership: 23,470

Contribution schedule: Every four months

Calculations

Expected annual costs for 23,470 people

| | | |
|--|-----------------------------|--------------|
| Training: | | ¢2,186,600 |
| Administration, transportation, and miscellaneous: | | ¢4,826,400 |
| Hospitalisations: | 41 X 25,000 X 23,470/100 = | ¢240,567,500 |
| Deliveries: | 4.3 X 15,000 X 23,470/100 = | ¢15,138,150 |
| Outpatient visits: | 158 X 5,000 X 23,470/100 = | ¢185,413,000 |

Total:

$$2,186,600 + 4,826,400 + 240,567,500 + 15,138,150 + 185,413,000 = \text{¢}448,131,650$$

Contribution required per member every four months:

$$448,131,650 / 23,470 / 3 = \text{¢}6,364.60$$

Question:

What will be the effect on dues if MHO members are 15 percent more likely to be admitted into hospital and the MHO decides that it would be prudent to add 20 percent to the dues as contribution towards the MHO's reserve fund provision?

3.1.3.2 MORE DETAILED CALCULATIONS

This section leads participants through calculations of MHO costs and dues that involve more detailed parameters than did preceding examples. The calculations incorporate factors such as age (or age group) and sex. Practice exercises are based on the Yefre MHO. Two case studies at the end of this unit deal with work place-based MHOs.

COST OF PHARMACEUTICALS

| FIGURE 3.1 COST OF PHARMACEUTICALS | | | | |
|------------------------------------|---|--|--------------------------------------|-----------------------------|
| Age | Number of members (by sex if possible) | Number of members having had at least one prescription for drugs | Total number of prescriptions filled | Total cost of prescriptions |
| Less than a year | | | | |
| 1-5 | | | | |
| 6-17 | | | | |
| 18 - 49 | | | | |
| 50 - 65 | | | | |
| 66 and above | | | | |

Figure 3.1 presents a table that can be used to calculate the average cost of pharmaceuticals per member by age, age group or sex (if statistics are available), using the following formulas:

Average cost per member = (Total cost / Number of prescriptions) X (Number of prescriptions) / (Number of users) X (Number of users / Number of members)

Exercise

In 1999, Yefre MHO had 3,000 members of which 300 used 600 prescriptions for pharmaceuticals for a total cost of ₵3,000,000. Calculate the average cost in pharmaceuticals per member.

$$\begin{aligned}
 \text{Average cost} &= (3,000,000 / 600) \times (600 / 300) \times (300 / 3,000) \\
 &= 5,000 \times 2 \times 0.1 \\
 &= ₵1,000
 \end{aligned}$$

CONSULTATIONS WITH GENERAL PRACTITIONER/SPECIALIST

| FIGURE 3.2 CONSULTATIONS (GENERAL PRACTITIONER/SPECIALIST) | | | | |
|--|-------------------|--|-------------------------|------------|
| Age | Number of members | Number of members having had at least one consultation | Number of consultations | Total cost |
| Less than a year | | | | |
| 1-5 | | | | |
| 6-17 | | | | |
| 18 - 49 | | | | |
| 50 - 65 | | | | |
| 66 and above | | | | |

Average cost per member = (Total cost / Number of consultations) X (Number of consultations / Number of users) X (Number of users / Number of members)

Exercise

Yefre MHO has 3,000 members of which 300 used 600 vouchers for consultations with general practitioners for a total cost of ₺4,800,000

Calculate the average cost per member of a consultation with a general practitioner.

$$\begin{aligned} \text{Average cost per member} &= (4,800,000/600) \times (600/300) \times (300/3,000) \\ &= (8,000 \times 2 \times 0.1) \\ &= ₺1,600 \end{aligned}$$

HOSPITALISATION COSTS

| FIGURE 3.3 HOSPITALISATION COSTS | | | | |
|----------------------------------|-------------------|--------------------------------|-------------------------|------------|
| Age | Number of members | Number of hospitalised members | Number of hospital days | Total cost |
| Less than a year | | | | |
| 1-5 | | | | |
| 6-17 | | | | |
| 18 – 49 | | | | |
| 50 – 65 | | | | |
| 66 and above | | | | |

Average cost per member =

(Total cost / Number of hospital days) X (Number of hospital days / Number of hospitalised members) X (Number of hospitalised members / Number of members)

Exercise

Yefre MHO has a total of 3,000 members of which 100 were hospitalised for a total 400 hospital days and a total cost of ₺6,000,000 Calculate the average cost of a hospital day per member.

$$\begin{aligned} \text{Average cost per member} &= (6,000,000/400) \times (400/100) \times (100/3,000) \\ &= 15,000 \times 4 \times 0.033 \\ &= ₺2,000 \end{aligned}$$

COST OF BENEFITS

The cost of benefits is obtained by multiplying the different average costs by the number of members.

Yefre MHO has 3,000 members and covers:

- ◆ Pharmaceuticals (average cost = ₺1,000)
- ◆ Consultations (average cost = ₺1,600)
- ◆ Hospital fees (average cost = ₺2,000)

Total costs per service are:

- ◆ Pharmaceuticals: ¢3,000,000
- ◆ Consultations: ¢4,800,000
- ◆ Hospital fees: ¢6,000,000

Total cost of benefits is ¢13,800,000

For caution, the Yefre MHO decided to constitute a safety margin equal to 10 percent of total costs of benefits.

$$\begin{aligned}\text{Safety margin} &= 13,800,000 \times 0.1 \\ &= \text{¢}1,380,000\end{aligned}$$

These costs are estimated using the cost estimate procedures described in the module on financial management. Operating costs for the Yefre MHO are estimated at ¢2,000,000.

DETERMINATION OF DUES

1. Total dues should cover the following:

- ◆ Total cost of benefits
- ◆ Safety margin
- ◆ Operating costs
- ◆ 0.20 percent of total dues; required contribution to the reserve fund

$$\text{Total dues} = 13,800,000 + 1,380,000 + 2,000,000 + (0.002 \times \text{Total dues})$$

$$\text{Total dues} = 17,180,000 + (0.002 \times \text{Total dues})$$

$$\text{Total dues} = 17,180,000 / (1 - 0.002)$$

$$= \text{¢}17,214,428$$

2. Determining the dues rate (dues per member)

A. Workplace-based MHOs (dues as percentage of salary)

Yefre MHO has 400 participants. The total wage bill amounts to ¢300,000,000

The contribution rate is calculated the following way:

$$\text{Contribution rate} \times 300,000,000 = \text{Total dues}$$

$$\text{Contribution rate} = 17,214,428 / 300,000,000$$

$$= 5.73 \text{ percent}$$

B. Community MHOs

Dues will be obtained by:

$$\text{Annual dues} = \text{Total dues} / \text{number of members}$$

$$= 17,214,428 / 400$$

$$= \text{¢}43,037$$

$$\text{Monthly dues} = \text{Annual dues} / 12$$

CASE STUDY 1: TRADE UNION- OR WORK-PLACE BASED MHO (KUMASI DISTILLERS)

1. Kumasi Distillers MHO, founded in 1978
2. Membership (1998) 621 members and 3,255 beneficiaries
3. Benefits expenses (1998) ₵53,333,333
4. Operating costs (1998) ₵28,224,000

All members received, for simplicity's sake, a monthly salary of ₵60,000

Determine the subscription rate the MHO needs to apply to each member's salary to ensure financial stability.

Solutions

The benefits and operating costs are given. We can therefore calculate:

1. Total dues (D)

$$D = ₵53,000,000 + 28,224,000 + (0.002 \times D)$$

$$D = 81,224,000 + (0.002 \times D)$$

$$(1 - 0.002) \times D = 81,224,000$$

$$D = 81,224,000 / 0.998$$

$$D = ₵81,386,773$$

2. Total wage bill

$$621 \text{ participants} \times ₵60,000 \text{ per month} \times 12 \text{ months} = ₵447,120,000$$

3. Subscription rate (R)

$$R \times 447,120,000 = ₵81,386,773$$

$R = (₵81,386,773 / ₵447,120,000) \times 100 = 18.2$ percent. This rate will then be divided between the company and its employees e.g. 10 percent of salary of each worker by the company and 8.2 percent by the employee.

CASE STUDY 2: WORK PLACE-BASED MHO (NYAMEKYE & Co.)

Nyamekye & Co. wants to establish an MHO for its employees.

Number of employees: 120

Number of beneficiaries: 600

Following a preliminary survey, the employees expressed priority needs for the following services: pharmaceuticals, consultations and hospitalisations.

Total wage bill: all employees receive a monthly salary of 60,000 cedis, for a total wage bill of ₵86,400,000 per/year (₵60,000 per month x 120 employees x 12 months).

The results of the study provided the following statistical information:

Pharmaceuticals

- ◆ Usage rate = 60%
- ◆ Average cost of a voucher = 3,250
- ◆ Number of vouchers = 2,400
- ◆ Average number of vouchers per user = 6.6

Consultations

- ◆ Usage rate = 30%
- ◆ Average cost of a consultation = 6,500
- ◆ Number of consultations = 1,800
- ◆ Average number of consultations per user = 6

Hospitalisations

- ◆ Usage rate = 5%
- ◆ Average cost of a hospital day = 8,500
- ◆ Number of hospital days = 210
- ◆ Average number of hospital days per user = 7
- ◆ Coverage rate: 60%

Solutions

Calculate the different costs of coverage/services.

Pharmaceuticals

- ◆ Average cost per member: $₵3,250 \times 6.6 \times 0.6 = 12,870$
- ◆ Coverage: $60 \text{ percent} \times 12,870 = 7,722$
- ◆ Total cost of pharmaceuticals: $7,722 \times 600 = ₵4,633,200$

Consultations

- ◆ Average cost per member: $₵6,500 \times 6 \times 0.3 = 11,700$
- ◆ Coverage: $60 \text{ percent} \times 11,700 = 7,020$
- ◆ Total cost of consultations: $7,020 \times 600 = ₵4,212,000$

Hospitalisations

- ◆ Average cost per member: $₵8,500 \times 7 \times 0.05 = 2,975$
- ◆ Coverage: $60 \text{ percent} \times 2,975 = 1,785$
- ◆ Total cost of hospitalisations: $1,785 \times 600 = ₵1,071,000$

Total cost of benefits

$$₵4,633,200 + 4,212,000 + 1,071,000 = ₵9,916,200$$

Safety margin (10 percent) = 991,620

Operating costs:

Salaries = ₵3,000,000

Others = ₵2,600,000

Calculate total dues (D)

$$D = ₵9,916,200 + 991,620 + 5,600,000 \times (0.002 \times D)$$

$$D = 16,507,820 + (0.002 \times D)$$

$$D = 16,540,901 / (1 - 0.002)$$

$$D = 16,507,820 / 0.998 = ₵16,540,901$$

Subscription rate (R)

$R \times \text{Total wage bill} = \text{Total dues}$

$$R = ₵16,540,901 / 86,400,000 = 19.5 \text{ percent}$$

Nyamekye and Co. decide to pay two-thirds of the rate (i.e. 13.05 percent of each employee's salary) and the employee is left with a third (i.e. 6.43 percent of salary) to pay.

NB: No reserve fund provision has been made in these calculations.

3.1.4 THE ROLE OF AN MHO IN THE IMPLEMENTATION OF THE GOVERNMENT'S EXEMPTIONS POLICY

To reduce the financial burden on vulnerable sub-population groups in the country, in 1997 the government stated its intention to introduce exemptions and hospital fees subsidies to certain categories of patients as well as persons suffering certain illnesses.

Specifically, the exemption clauses cover the following conditions:

1. Antenatal care: Limited to free consultation, free basic laboratory services (haemoglobin estimation), sickling status, blood film for parasites and routine urine testing and basic haematinics. It is proposed that this should cover an average of four visits per pregnant woman.
2. Care for the aged (above 70 years): Services limited to free consultation, basic laboratory and basic drugs for acute illnesses.
3. Care for children under five: Free immunisation and services provided at child welfare clinics. These will be supported by a subsidised fee schedule for children.
4. Leprosy: Free treatment.
5. Tuberculosis: Free treatment
6. Family planning: Drugs and supplies are subsidised in government-appointed centres.
7. Snake and Dog Bites: Free treatment.

Health care financing for AIDS and mental care are formally the responsibility of families. However, relatives usually abandon the patients at the designated treatment centres; thus, in practice the responsibility is being borne by the government.

ROLE OF THE MHO

In principle, this exemption policy should help MHOs by assuming the burden of covering the care of those most at risk from them so that MHOs' members would tend to use services less. But this could also remove the incentive for many people to join such schemes. In practice, however, not all people entitled to exemptions are getting it. Application of the policy so far appears patchy and non-uniform from one region to another. In this situation, the MHO has a role to defend the rights of members of the community who are entitled to the exemptions, to sensitise and educate them about these rights and to assist those in need to get access to the services.

Discussion is also ongoing as to whether MHOs may negotiate with regional health administrations to claim the exemptions funds so as to cover the exempted people directly. This requires government policy and the modalities of access to be further clarified.

UNIT 4

RELATIONS WITH SERVICE PROVIDERS, PAYMENT MECHANISMS AND RISK MANAGEMENT



| | |
|---|-----|
| Module 4.1 Relations with providers | 88 |
| Introduction | 89 |
| 4.1.1 ASSOCIATING THE SERVICE PROVIDERS WITH THE MHO PROJECT FROM THE START | 89 |
| 4.1.2 RELATIONS WITH DIFFERENT KINDS OF SERVICE PROVIDERS | 90 |
| 4.1.3 AGREEMENTS BETWEEN MHOs AND HEALTH CARE PROVIDERS | 92 |
| 4.1.4 NEGOTIATIONS AND CONFLICT RESOLUTION | 94 |
| Module 4.2 Provider payment methods | 95 |
| Introduction | 95 |
| 4.2.1 PROVIDERS INCENTIVES AND INTERESTS | 95 |
| 4.2.2 PAYMENT SYSTEMS | 96 |
| 4.2.3 BILLING METHODS | 102 |
| Module 4.3 Risk management | 104 |
| Introduction | 104 |
| 4.3.1 Types of risk | 104 |
| 4.3.2 Avoiding risk | 104 |

MODULE 4.1

RELATIONS WITH PROVIDERS

LEARNING OBJECTIVES

At the end of this unit, participants will:

- ◆ Know the different health service providers and how to relate to each
- ◆ Know about different provider payment mechanisms and the relative advantages and disadvantages of each mechanism,
- ◆ Understand the different techniques for managing the risks discussed in Unit 1.

CONTENT

- ◆ Relations with health providers
- ◆ Methods of paying for services and advantages and disadvantages of each
- ◆ Risk management techniques

TARGET GROUP

- ◆ Manager
- ◆ All elected officers
- ◆ Initiators
- ◆ Supervisory committee
- ◆ Accountant
- ◆ Public relations officer
- ◆ Field co-ordinator
- ◆ All members of Board of Directors and management

PREREQUISITES

- ◆ All previous units

CONTENT

- ◆ Relations with health providers
- ◆ Methods of paying for services and advantages and disadvantages of each
- ◆ Risk management

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TRAINING METHODS

- ◆ Plenary session
- ◆ Group assignment
- ◆ Presentation

TEACHING MATERIALS

- ◆ Flipchart
- ◆ Handouts
- ◆ Overhead projector

INTRODUCTION

The success and long-term viability of an MHO depends on its ability to ensure quality and to control the cost of health care provided to its members. Thus MHO initiators need assurance from the health care providers on the availability, quality and cost of health care. Interaction between the two parties in the design stage will enable MHO initiators to understand the attitude of providers toward the MHO and whether they will be willing to make any adjustments to accommodate the MHO. In addition, a positive relationship between the two will help make the MHO proposal more attractive to potential members.

This module examines the importance of associating health care providers with the MHO from the start, relations with the different kinds of service providers, the nature of agreements between MHOs and the health care providers and also includes a discussion on negotiations and conflict resolution. Finally, it examines risk management techniques, continuing from the introductory discussion on risks in Unit 1.

4.1.1 ASSOCIATING THE SERVICE PROVIDERS WITH THE MHO PROJECT FROM THE START

There are several possible advantages to associating the health care providers with the MHO project from the beginning. They include:

- ◆ Joint expectations and priorities can be set. This avoids or reduces future misunderstandings.
- ◆ Joint definition of problems and exploring ways to overcome such difficulties builds community solidarity.
- ◆ Staff of both the MHO and service providers jointly know the cost of what is at stake before the agreements are signed.
- ◆ Time to define expectations, including monitoring and evaluation standards.
- ◆ Possibility of associating providers with MHO's objectives and enlisting them as active partners, which enhances the legitimacy of the MHO and the chances of success.

- ◆ Arrangements can be made to organise specific training for provider staff on relations with the MHO, the expectations (especially in terms of quality) of the MHO members, quality improvement, payment mechanisms, etc.

It is also important, however, that the MHO should not bend to every demand of the providers, or else the MHO risks not serving the best interests of members. In the extreme case, they risk becoming a provider-run MHO, not one belonging to its members.

4.1.2 RELATIONS WITH DIFFERENT KINDS OF SERVICE PROVIDERS

There are two basic forms of relations: the direct method and the indirect method. In the first case, the MHO owns or is owned by the providing facility, and in the second the MHO and the providers are separate legal entities which enter into contracts.

Experience in some European and Third World countries shows that where the MHO owns the provider facility, quality problems could arise, whereas where the two parties enter into contracts, cost control may be the problem. To reduce the latter problem, cost control strategies could be instituted from the start.

With the development of sophisticated cost and quality control strategies (using 'managed care' – see module 5 'Risk Management') the model in which provider and MHO are separate legal entities is becoming more popular. There is indeed a worldwide trend (outside the health maintenance organization experience of the United States) towards separating 'purchasers' (such as MHOs) from 'providers'.

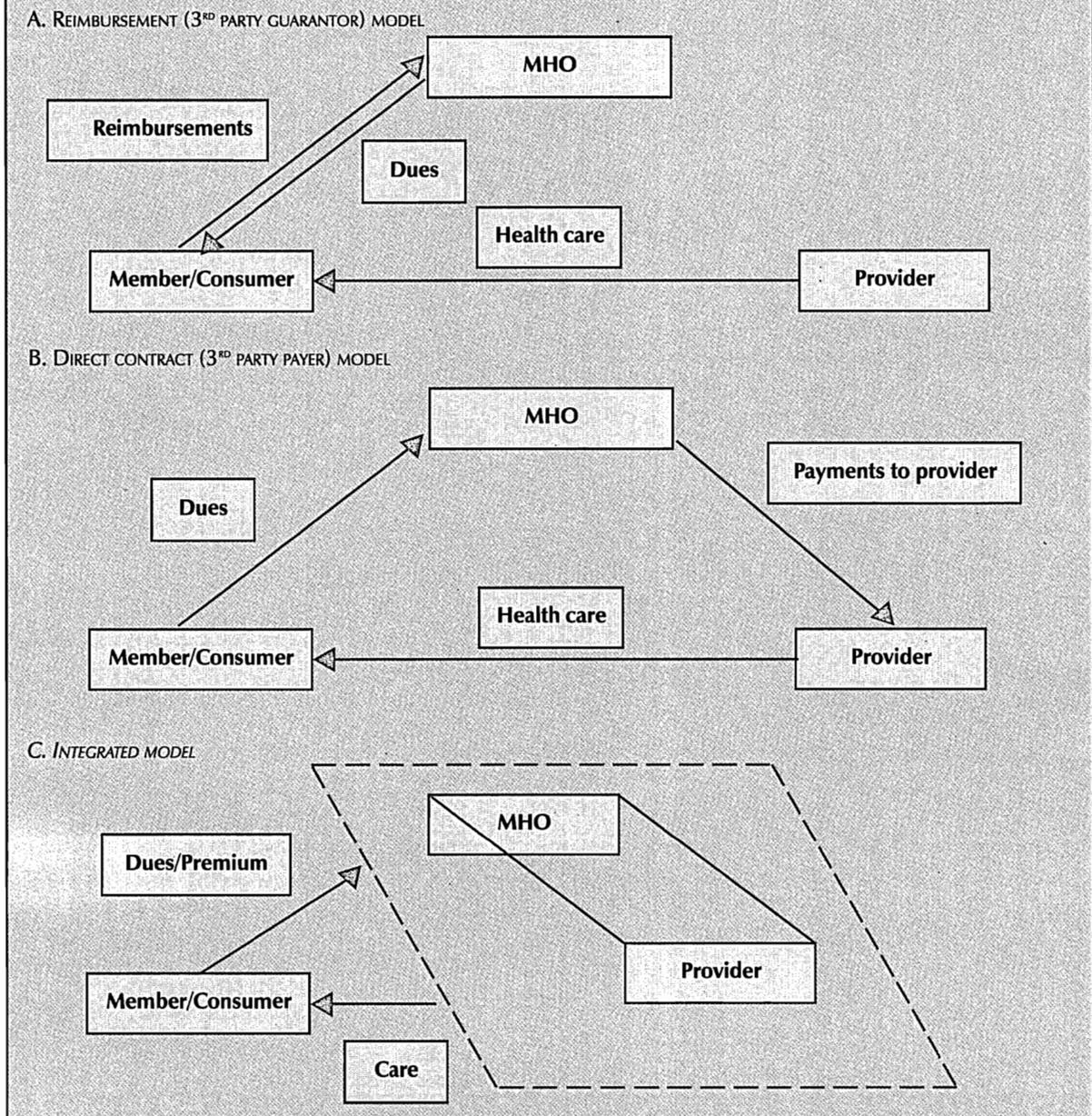
There are some special issues concerning MHO relations with traditional medical practitioners and traditional birth attendants. Where MHOs desire to cover the services provided by these professionals, the problems that may arise have to do, inter alia, with quality control and accreditation. With small MHOs in communities where everyone knows each other and confidence in each other is the basis of the mutual relations, these do not present much difficulty as it is fairly easy to know which traditional practitioners have followed the proper procedures to be qualified to practice and who may be just setting up a practice to profit from the MHO's cover.

With bigger MHOs, and especially those in which the promoters are not from the community, there may be problems of recognising which provider is genuinely qualified to practice, even of what the correct procedures are for getting qualified. If an association of traditional practitioners exists in the district or region, this may be the logical starting point for discussing issues to do with coverage of their services and the quality control/accreditation issues involved.

Whichever kind of provider the MHO decides to relate with, some training, periodically reinforced, for the provider staff will help a great deal to make the relations smoother and enhance the achievement of the goals of the MHO.

Figure 4.1 presents models of contracting with providers or, more broadly, articulating finance and delivery of health services involving insurance. The first is the reimbursement or third party guarantor ('tiers garant') model. In the model, consumers (patients) pay an insurance premium to the insurance company. When they use services, they pay the provider directly for their portion of the costs of services rendered. They

FIGURE 4.1 ALTERNATIVE CONTRACTING MODELS BETWEEN MHOs AND PROVIDERS



are then reimbursed directly by the company when they present it a receipt for medical expenditures. (Reimbursements may be subject to deductions specified in the insurance contract.) The reimbursement model is not an efficient way for an MHO to organise its insurance coverage for members because it means that the MHO itself has no direct relationship with the providers and so cannot influence provider behaviour with regards to quality or the costs of care.

The direct contract or third party payer ('tiers payant') model is one in which the MHO pays the providers directly for health care dispensed to the members. This affords the advantages that are not available with the reimbursement model. It permits direct negotiations with the provider to achieve efficiency and quality gains. (See Technical Note 4.1 for additional discussion.)

The integrated model reflects the health maintenance organisation experience of the United States where the insurance organisation and the provider are the same entity. This represents the opposite of current worldwide trends towards separating the purchaser from the provider of health care.

TECHNICAL NOTE 4.1 ADVANTAGES OF THE CONTRACT MODEL

At the international level, there is growing consensus about the advantages of the contract model. This consensus holds that, combined with universal, mandatory insurance and active regulation and supervision, the contract model can contribute to the resolution of various problems of the health sector. Its advantages lie in its potential to achieve efficiency gains at the micro- and macroeconomic levels. At the microeconomic level, it is expected that the competition among health care providers and among insurance companies will stimulate productivity gains that result in lower costs. At the macroeconomic level, the idea is that insurance companies will exercise their role as purchasers of health services for the insured ("prudent buyer on behalf of consumers") and establish payment mechanisms that stimulate efficiency. Thus, implementation of this model would help to contain the percentage of GDP spent for health. The efficiency gains depend on the capacity of various actors to negotiate with each other, as well as the capacity of insurers to be efficient purchasers of health services on behalf of the users; the capacity of providers to deliver services and negotiate rates with insurers; and the capacity of consumers to negotiate with insurers.

In order to achieve increases in productivity, it is advisable to introduce mechanisms of price competition among providers— but without sacrificing quality. However, the advantage of price competition among insurance agencies is a topic that still generates intense controversy. In fact, experience has shown a strong tendency towards risk selection (cream skimming) by the insurance companies. Independent of the degree of competition at the financial or provider level, the market imperfections that characterise the health sector make it necessary to strengthen regulation in order to prevent cream skimming practices on the part of insurers and oligopolistic behaviour by providers.

From Daniel Titelman and Andras Uthoff. 1999. 'The Health Care Market and Reform of Health-System Financing', paper presented at IHEA Conference, May 1999, Rotterdam.

4.1.3 AGREEMENTS BETWEEN MHOs AND HEALTH CARE PROVIDERS

Agreements with health care providers are extremely important and should be in the form of written contracts that cover the quality of medical or health services supplied by the provider, and the prices and modes of payment for those services covered by the MHO. (Figure 4.2 presents a sample contract.) In this way, MHO members are assured that, in return for their contributions, they will be well-treated at costs known beforehand.

The management of the health facility and the district director of health services should be co-signatories to the agreement signed with the MHO.

FIGURE 4.2 EXAMPLE OF AN AGREEMENT BETWEEN AN MHO AND A PROVIDER

Between: The _____ MHO, whose headquarters are located at _____, represented by the Chairman of its Board of Directors _____;

And: The _____ hospital/health centre represented by _____

An agreement is reached under the following clauses and conditions:

ARTICLE 1

The hospital/health centre undertakes to provide health care to patients referred by the _____ MHO and who have in their possession, letters of guarantee signed by the _____ of the MHO, whose specimen signature is to be deposited at _____.

ARTICLE 2

The hospital/health centre shall submit to the _____ MHO at the end of each month, the invoices for the various services provided.

ARTICLE 3

The Board of Directors of the _____ MHO undertakes to honour the invoices within thirty (30) days from the date of reception.

ARTICLE 4

The accumulation of unpaid invoices for three (3) months shall result in the suspension of the present agreement.

ARTICLE 5

Failure to settle arrears within six (6) months shall result in the termination of the present agreement.

ARTICLE 6

The present agreement is valid for two (2) years with effect from the date of signature and may be renewed by tacit agreement.

ARTICLE 7

The agreement may be terminated by either party provided that the other party is informed at least three (3) months beforehand through registered mail.

ARTICLE 8

Disputes arising between the two parties shall be submitted to an arbitration body consisting of _____ for settlement.

Done in _____

Date _____

For the MHO

The Manager or Chairman of Board

For the District Health Administration

For the Hospital/Health Centre

The Administrator/In-Charge

The District Director

4.1.4 NEGOTIATIONS AND CONFLICT RESOLUTION

Conflicts are inevitable in any human institution, because the different backgrounds and expectations of each party tend to create conflicts. What is crucial is how these conflicts are resolved.

Potential areas of conflict include:

- ◆ Fraud and abuse by members;
- ◆ Member complaints about the quality of care by service providers e.g. staff rudeness or bad reception;
- ◆ Provider complaints about patient behaviour (e.g. violent or aggressive patients);
- ◆ Provider billing practices (over-billing, charges for non-existent services or services not performed, etc).

The best way to resolve such conflicts is through direct negotiations between parties. If direct negotiations do not work, arbitration by an outside, mutually acceptable and impartial arbitrator should be used. A mechanism for such conflict resolution methods should be provided for in the agreement between the MHO and provider.

As already mentioned, initial and periodic training for provider staff is also a tool for preventing conflicts which may arise from differing expectations, misunderstanding and inability to factor in the interests of the other party.

MODULE 4.2

PROVIDER PAYMENT METHODS

INTRODUCTION

The precise method by which an MHO pays its provider(s) is important because the payment method has an impact on:

- ◆ Quality of health care services,
- ◆ Costs and efficiency,
- ◆ Equity,
- ◆ Complexity of administrative and management information systems,
- ◆ Risk management.

For example, the amount an MHO spends on health care benefits – an element critical to its sustainability – is determined by the volume of services and products that are prescribed or consumed and their price. Both these factors are influenced by the provider payment system.

This module attempts to answer the following questions:

- ◆ What are the interests of providers and what incentives are associated with each payment system?
- ◆ What forms of provider payment systems are available to an MHO and what are the relative advantages and disadvantages of each?
- ◆ What is the potential impact of each payment system on quality, costs/efficiency, risk management, equity and administrative complexity?
- ◆ How can an MHO set up an appropriate provider payment system for its situation?

4.2.1 PROVIDERS INCENTIVES AND INTERESTS⁷

To a large extent the providers, especially physicians and hospitals, can determine the demand for their own services and products, once the patient has taken the first step of contacting them. It is the physician, not the patient, who specifies the kind and quantity of treatment and medication required.

⁷From Normand Charles and Axel Weber. Undated. Geneva: ILO/WHO. "Social Health Insurance: a Guidebook for Planning".

It is important to consider the motivation of providers, especially physicians. Like most other people, providers want to maximise their incomes. Depending on the payment system, they can do this by:

- ◆ Providing as many treatments as possible
- ◆ Attracting as many patients as possible (e.g. by prescribing many drugs, even placebos, since this often reassures patients that they are receiving proper treatment)
- ◆ Sending patients with financially unattractive or hazardous conditions to other providers, such as hospitals,
- ◆ Asking patients to come back several times even when it is not necessary
- ◆ Unnecessarily using expensive equipment they have purchased (e.g. X-ray equipment) in order to amortise its cost.

Provider payment systems must allow the providers to achieve a reasonable income, in order to motivate them to produce services of good quality and to dissuade them from moving to better-paid jobs abroad. In addition, the potential to earn an attractive income can help to ensure a steady supply of qualified staff to provide services for members of the MHO.

A well-designed provider payment system must also prevent the kinds of waste and unnecessary service provision described above. Devising the provider payment system is therefore a very important task - these systems are a major instrument of cost containment. There are many different provider payment systems, and various combinations of different mechanisms are possible.

4.2.2 PAYMENT SYSTEMS

Provider payment systems that will be discussed here include:

- ◆ Fee for service (FFS)
- ◆ Case payment and payment by diagnosis-related groups (DRGs)
- ◆ Daily rate
- ◆ Budget payment
- ◆ Bonus payment
- ◆ Capitation payment

Table 4.1 describes each payment system, impact – advantages and disadvantages – of each, and the applicability to an MHO.

TABLE 4.1 PAYMENT SYSTEMS

| PAYMENT METHOD | DESCRIPTION | BASIS OR UNIT OF PAYMENT | IMPACT ON | | | | APPLICABILITY TO AN MHO |
|---|---|----------------------------------|---|--|---|--|--|
| | | | QUALITY | COSTS & EFFICIENCY | ADMINISTRATIVE & MANAGEMENT SYSTEMS | RISK SHARING & RISK MANAGEMENT | |
| Fee for service | Separate fees are charged for each service or treatment, e.g. consultation, tests, drugs (retrospective payment system) | Per unit of service or treatment | Quality impact usually presumed to be good; payment directly related to complexity of case/service | Incentive to produce too many unnecessary services; expensive and maybe wasteful | Requires providers to bill for and record every service or treatment performed; also for MHO this can entail complicated and costly claims processing and monitoring procedures to avoid fraudulent claims. | MHO bears all the risk involved and the provider has no incentive to cooperate with MHO, e.g. to check fraud; risk management demands on MHO very high | The most widely used method of payment but requires level of skill and competence by MHO for efficient results that are usually absent. This is the default method in most cases if MHO is not well-informed of alternatives |
| Simple case payment or fee per episode of illness | Fixed payment for all services or treatments involving a single illness episode or case, e.g. malaria, no matter how many times the patient is seen or attended to (prospective payment system) | Per episode or case of illness | Incentives to reduce cost per case (e.g. discouraging repeat visits) thus potentially impairing quality | Easier and less costly to operate than fee for service; but incentives to lower quality may have negative impact on efficiency | Easier claims processing than fee for service; strict control and monitoring required to ensure cases recorded in right illness categories | Provider bears some risk that illness may cost more than predetermined case fee; the MHO risks that cost of illness may be less than case fee. Risk management demands on MHO fair | Simple case payments often justified as a way to encourage patient to complete treatment course with no extra cost; however this advantage is not relevant in an MHO situation |

TABLE 4.1 PAYMENT SYSTEMS (CONT.)

| PAYMENT METHOD | DESCRIPTION | BASIS OR UNIT OF PAYMENT | IMPACT ON | | | | APPLICABILITY TO AN MHO |
|-------------------------------|---|--------------------------|--|--|--|---|---|
| | | | QUALITY | COSTS | ADMINISTRATIVE & MANAGEMENT BURDEN | RISK SHARING & RISK MANAGEMENT | |
| DRGs or modified case payment | A case payment system based on a schedule of diagnostic groups; the DRGs developed in the US identify around 470 groups and used mainly for hospital payments. DRG into which the patient's diagnosis falls, assigned after discharge of the patient, determines fee (prospective system) | Per diagnosis group | Incentives similar to simple case payment; also provider incentive to choose only illnesses having best cost-benefit ratio for provider and refer others | DRGs are complex to set up and operate | Not much cheaper to administer than fee for service; necessity to ensure control means MHO must have good validation and claims management system; providers must collect large amount of information on patient characteristics, diagnoses and procedures | If operated honestly, provider bears same risks as above; main risks for MHO however are ensuring cases are assigned to right groups; making sure patients not needlessly transferred; desired level of quality is maintained | Probably too complex for the average MHO; experience also shows that providers constantly try to maximise their income by recording more complex diagnoses than presented by patients |
| Daily rate or per diem | Used in hospital settings only, the fee covers all services and costs per patient per day (i.e. treatment, drugs, tests, accommodation and feeding, etc.) but some variations exclude care such as surgery (prospective system) | Per patient day | With fixed daily fee, there is incentive to reduce costs which could be at the expense of quality | Could have positive impact on costs but provider may also seek to maximise income by prolonging hospital stays | Very easy to administer; management requirements low; no fee schedules or detailed lists of prices involved; but need to track inpatient days to ensure patients not kept unnecessarily long in hospital | Risk is shared between provider and MHO; main risk management issues are ensuring quality is maintained within the fixed fee, ensuring patient stays are not unnecessarily long | Good for an MHO covering hospital admission costs; system used by mutuelles in Thiès, Senegal, with the Catholic district hospital (excludes surgery costs) |

TABLE 4.1 PAYMENT SYSTEMS (CONT.)

| PAYMENT METHOD | DESCRIPTION | BASIS OR UNIT OF PAYMENT | IMPACT ON | | | | APPLICABILITY TO AN MHO |
|----------------|--|--|---|---|--|--|---|
| | | | QUALITY | COSTS & EFFICIENCY | ADMINISTRATIVE & MANAGEMENT SYSTEMS | RISK SHARING & RISK MANAGEMENT | |
| Bonus payment | Payment to a provider who has achieved certain pre-defined objectives, e.g. lowering drugs budget or immunising children / pregnant women (retrospective system) | Lump sum for specified objective, e.g. percentage of target group children immunised | Unless the objective is quality related, or unless adequate quality control measures are put in place, attainment of the objective could be at the expense of quality (e.g. needed prescriptions not being given) | Effective for containing costs if the objective desired by the bonus payment is lowering of defined costs | Administration costs depend on existence of registration system for monitoring prescriptions, immunisations, etc. If none exists, it could be too expensive. | Main risk management issue is ensuring there is no fraud or manipulation in reporting the progress on attaining the objective; but also that quality is not sacrificed. Therefore payment should be for achieving objective but not proportional to the savings involved | MHO may combine this with another payment method, e.g. budget system to encourage certain provider practices (e.g. immunisation, promotion of family planning, health education, etc.) and to discourage others (e.g. excessive drug consumption) |
| Budget | Advance payment to a provider for total costs of services to MHO members in a specified time period; in a variable budget, certain end of period adjustments are allowed, e.g. to take account of higher than normal morbidity or epidemics (Prospective system) | All services for members in defined period; per prescription or item | Effect on quality is fair; quality may be compromised if provider's need to contain costs lead to substituting cheaper and lower quality treatments | Very good for containing costs; budget may be combined with bonus element where provider shares a portion of savings achieved, or is penalised for exceeding cost targets | Easy to set up and operate; no claims processing involved but may require utilization management to ensure quality service | With fixed budget, provider takes all risk of higher than budgeted costs, and MHO takes risks of reverse; with variable budget, risks shared. Main risk management issues are ensuring that efforts to contain costs by provider do not lead to deterioration of quality | Good financial and risk management tool for MHOs; easy to operate but need to decide on formula to use: historical budgets, per capita with variation for parameters such as sex, age distribution of members, or utilisation rates for previous year |

TABLE 4.1 PAYMENT SYSTEMS (CONT.)

| PAYMENT METHOD | DESCRIPTION | BASIS OR UNIT OF PAYMENT | IMPACT ON | | | | APPLICABILITY TO AN MHO |
|----------------|--|--|--|---|---|---|--|
| | | | QUALITY | COSTS & EFFICIENCY | ADMINISTRATIVE & MANAGEMENT SYSTEMS | RISK SHARING & RISK MANAGEMENT | |
| Capitation | The MHO pays the provider a fixed, agreed amount per member for all members of the MHO per month or other period such as quarterly or yearly; provider contracts to provide all the defined care for any member who needs it during the period without extra cost (Prospective system) | Per member per year or other agreed period of time | This works best where MHOs or their members have a choice of providers or an effective quality control system in place to ensure that economy of resource use is not at the expense of quality of care, as the MHOs or members can switch or sanction providers if they are not satisfied with the quality of care | Very positive effects on cost control; ensures that providers do not stand to gain by providing unnecessary services so keeping costs down. May also promote allocative efficiency by encouraging providers to engage in prevention and promotion activities to maximise their revenue; therefore suitable for primary care providers | Administrative costs could be low; only problems arise when members change providers. But overall management could be complex where quality control mechanisms are to be enforced and skills of providers and MHOs not high | Provider assumes all financial risks; MHO faces little risk. Main risk is that of ensuring quality is up to standard. Where no competition exists, requires adequate quality control mechanisms; utilization management required to prevent under-servicing of members. | Potentially good for MHO as it relieves it most of its risk management problems; but provider resistance to adoption of system may be difficult to overcome; also skills for ensuring quality care and utilization management not always present |

4.2.2.1 COMBINATIONS OF PAYMENT SYSTEMS

Multiple payment systems can be used, which greatly increases the number of options. Combinations can also produce a unique set of incentives, encourage certain behaviour or penalise inappropriate health service provision patterns. As an example, it is possible to combine:

- ◆ A capitation fee as the basic payment
- ◆ Fees for certain services (e.g. immunisation, preventive medicine)
- ◆ A bonus for achieving certain targets (e.g. certain number or percentage of immunised children)
- ◆ A budget for drugs and ancillary services

A combined payment system similar to the one described above is in fact used in the United Kingdom. Under the system, general practitioners (GPs) are paid capitation fees for every individual registered with the provider, up to a maximum number of patients. Capitation fees may vary depending on where the practice is located (urban or rural). Fees for specific services, including night calls, maternity services and adult vaccinations, are also paid. There are bonus payments for reaching certain performance targets (e.g., immunisations of children). In addition GPs are reimbursed for overhead costs and are provided allowances for other expenses, such as equipment.

4.2.2.2 PAYMENT SYSTEMS IN WEST AND CENTRAL AFRICA

The following payment methods were found to be practised in a survey of West and Central African MHOs.

Cash Indemnity

This refers to an arrangement where MHO members must first make pay providers out-of-pocket for their health care and then seek reimbursement by presenting the receipts or proof of payment to the MHO.

Advantages: Obliging members to first pay out-of-pocket, may discourage them from frivolously using the services, thus saving money for the MHO.

Disadvantages: The beneficiary may lack the money to make the payment, thus impeding access to care. The system could also be abused where beneficiaries and providers could also abuse the system by co-operating to over-charge for services or even issuing fictitious invoices.

Fixed Cash Subsidy or Grant:

This refers to the situation where the MHO gives sick members a fixed sum of money irrespective of the actual health care charges incurred, as a contribution to help them pay for their health care.

Advantages: The method is good for social risks covered in the MHO's package other than health, such as births, funeral grants and marriages which are easier for members to plan and save for. The methods foster a social bond among members.

Disadvantages: Not suitable for health care cover as sickness is unpredictable and difficult to save for. It could be extremely costly, exceeding the grant negotiating power of MHOs vis-à-vis providers.

Third Party Payer

In this method of payment, the MHO pays health providers directly for expenses incurred by members. However, if a co-payment, or deductible is involved, then members must still pay that portion, usually out-of-pocket and directly to the provider. Some MHOs have an agreement with the provider whereby the MHO pays the entire bill for a member's hospitalisation, and then the MHO claims the co-payment portion of the bill from the member.

Advantages: The system reduces the financial burden on members.

Disadvantage: This system may encourage frivolous use of services, thus raising the MHO's costs, as it appears to the member that 'someone else is paying' for their care. A possible improvement is to ensure that the MHO member receives a bill, fully itemised, for every case of illness.

Loan Advances to Members

MHOs use soft loans, that is, loans at either no interest or at interest rates well below commercial rates, to assist members facing health care expenses that they cannot afford. Most usually, such loans are an additional, optional benefit that members can draw upon after they have exhausted their main non-optional benefits under the scheme. (For example, the Bunkpurugu Scheme is based entirely on loans)

Advantage: Not a system to be recommended but certainly this ensures that the MHO's viability is considerably enhanced (if the scheme is well managed). But this does nothing much for the members who must pay back any loans contracted, although this is usually credit on soft terms.

Disadvantages: Solidarity and equity are reduced because loan amounts are usually related to what a member contributed and must be refunded. The ability to repay a loan could deter people from applying and hence this is not very effective for reducing financial barriers to seeking care, i.e. access is jeopardized.

The above mechanisms reflect the stage of development of MHOs in the sub-region, including the lack of knowledge and skills relating to the various alternative provider payment methods as discussed earlier, and the low negotiating power of MHOs vis-à-vis providers.

4.2.3 BILLING METHODS

4.2.3.1 BILLING METHODS FOR SERVICES AT DIFFERENT TYPES OF HEALTH FACILITIES

Health Centres

At the health centre level, billing may be done in different ways:

- ◆ A fixed fee per person registered with the centre: A member may register in the health centre of his/her choice, provided the centre has signed an agreement with the MHO. The health centre promises to provide care for the member and his/her

dependents for a given period, usually one year, for a standard fee, regardless of the care required. Once this fee is paid, it belongs to the health centre, even if the MHO member does not use its services. This fee system helps limit over-use, because once the amount of the fee is set, it is not in the health centre's interest to have the member return unless it is necessary, nor is it in its interest to prescribe unnecessary drugs for the member. The main problem is the determination of the fee.

- ◆ An amount per illness episode: The centre collects an amount that covers office visits, drugs and laboratory analyses per illness event. The advantage of such a system is that the patients do not discontinue treatment that is in progress for lack of money.
- ◆ An amount per consultation: This amount includes the cost of drugs and laboratory analyses. Often, the first visit costs more than the following ones.
- ◆ An amount per medical visit: in this case, drugs and laboratory analyses are counted as extras.

Hospitals

At hospitals, billing is according to the following procedures:

- ◆ A fixed fee per **day of hospitalisation**: This amount includes the hospital stay, medical and surgical care, nurses, technical services, drugs, etc.
- ◆ A fixed fee that covers **the entire hospital stay**: In this case, the MHO reimburses a single amount calculated on the basis of an estimate of the average length of hospital stay.
- ◆ Payment per service or **per procedure** performed: All medical services, the hospital stay and drugs are billed individually.

For hospitalisation, an MHO may limit the maximum number of reimbursable hospitalisation days or set maximum coverage per member. Then the patient pays all additional expenses.

MODULE 4.3

RISK MANAGEMENT

INTRODUCTION

If MHOs are to succeed financially, one of the most important skills that their management or leadership should master is how to assess the risks to which MHOs are exposed and how to minimise the threat of risks.

4.3.1 TYPES OF RISK

The major risks, introduced in Unit 1, are:

- ◆ Adverse selection
- ◆ Moral hazard
- ◆ Cost escalation
- ◆ Underestimating dues
- ◆ Fraud and abuse

4.3.2 AVOIDING RISK

4.3.2.1 ADVERSE SELECTION

As discussed in Unit 1, adverse selection occurs when persons with a high risk of disease join an MHO in large numbers, and persons in good health tend not to join.

The risk of adverse selection can be reduced by:

- ◆ Family membership: Making registration of entire families obligatory or automatic. This could be reinforced with incentives for registration of the entire family.
- ◆ Waiting periods: Enforcing waiting periods before a new member can start receiving benefits.
- ◆ Mandatory participation: Obliging all members of the target group to join the MHO. This is frequently the case with trade union- and other work place-based MHOs where social solidarity is very strong and mechanisms for enforcing compulsory participation exist.

- ◆ Group registration: Registering entire groups of people, e.g. associations, clubs, trade unions, etc.
- ◆ Graduated fees for family registration, so that the fee per head reduces the greater the number of family members registered.
- ◆ Incentives to those renewing their registration and have not used the facility.

4.3.2.2. MORAL HAZARD

Moral hazard is the tendency for insured persons to over-consume services, since they no longer pay the full cost of the services.

To lower this risk, the following steps may be taken:

- ◆ Establish a cost-sharing arrangement, either as co-payments paid by members at point of service, or a deductible (an amount over which expenses are reimbursed, while the members are responsible for anything under that amount);
- ◆ Establish a compulsory referral system before granting access to care at a higher level, which is often more expensive. For example, members may not use hospital services without being referred from medical staff in a health centre. Hospital care is more expensive, so this helps contain costs too;
- ◆ Use social control, in which members check each other's behaviour. This is a reflection of the social energies which can be unleashed by a social movement founded on the principles of solidarity and democratic participation, leading to a sense of ownership by members and in the MHO's performance and destiny.

TECHNICAL NOTES 4.2 CO-PAYMENTS AND DEDUCTIBLES

Co-payments were introduced when MHOs that paid for 100 percent of members' expenses found that members were abusing the system through over-utilisation. They began to require patients to pay something in order to reduce the use of health care.

Today, most MHOs reimburse only a portion of expenses, and the member must pay for the rest. The member's personal contribution is called a co-payment or deductible, where members are asked to pay up to a fixed amount of their health care bill and the MHO pays the balance.

Two arguments are used to support a personal contribution of patients in covering health costs. On the one hand, co-payments make patients responsible in using health care services by limiting their tendency to over-use health care. They also confirm the value of care provided. It is logical that a member who has paid his dues would wish to take maximum advantage of the benefits that are provided, but this may cause the MHO to incur excessive expenses.

The dilemma facing MHOs is determining the amount of the co-payment so that it prevents over-utilisation without impeding access to health care, as that would be contrary to the purpose of the MHO.

4.3.2.3 COST ESCALATION

Cost escalation refers to unexpected rapidly rising costs once the scheme starts. Both providers and members can be responsible for this. For example, providers and patients may collude to use costly treatment techniques or to provide excess services in the knowledge that the scheme will pick up the bill.

TECHNICAL NOTE 4.3 UTILISATION REVIEW
METHODS

Utilisation review (UR) is the process of evaluating the provider decisions before the scheme will pay the bill. Listed below are the UR methods that can be used to contain costs and improve/maintain quality.⁸ Though not all methods are applicable or practicable in the typical small MHO, they could be used by groups of small MHOs to apply for their mutual benefit:

Second opinion: A second doctor may be asked to review the decision of the first one before expensive care –e.g. surgery– is dispensed.

Pre-certification: The provider must obtain MHO approval before elective surgery is performed.

Concurrent review: Regular evaluations are carried out by a case control nurse to determine whether continued hospital stay or additional care is required.

Pre-admission testing: As many tests as possible are required to be performed on an outpatient basis before the patient is admitted, reducing hospital stay.

Database profiling: Maintaining comparative records of the services used by providers in the area to identify abnormal patterns of utilisation. (Could also be used to identify providers not conforming to "usual, customary and reasonable" fees as well as standard of care over time.)

Intensive case management: An MHO nurse follows and manages any case expected to cost more than a certain amount.

Generic substitution: a prescription for a brand-name drug is replaced with a cheaper generic version if the two are chemically and/or biologically equivalent.

Retrospective review: After a patient is discharged from hospital case is evaluated to identify medically unnecessary services for which payment will not be made.

Audits: Ensures that all services billed were actually performed.

⁸ From Getzen, Thomas E. 1997. *Health Economics: Fundamentals and Flow of Funds*. New York: John Wiley & Sons.

The following steps may contribute to minimising cost escalation:

- ◇ Standardising treatment plans and ensuring compliance by the MHO consulting physician.
- ◇ Requiring service providers to prescribe generic drugs or limiting reimbursement of certain drugs on the MHO drug list. Drugs are generally very expensive. For that reason, many MHOs limit drug coverage, while maximising cover for services less subject to moral hazard such as hospitalisation or surgery. Even without such limits, savings can be realized through use of generic drugs when available.
- ◇ Placing maximums on health care coverage. For example, the MHO may cover only a limited number of hospital days, and the member would be responsible for additional days.
- ◇ Establishing qualifying periods or a deductible for hospitalisation (such as the first day of hospitalisation to be paid by the patient to avoid non-essential hospitalisation).
- ◇ Requiring the members and their dependants to comply with available vaccination plans and other preventive/promotional care programmes in order to limit the risk of illness.
- ◇ Changing the provider payment or budget system to a capitation system, thus removing the provider's incentive to increase costs.
- ◇ Adopting some of the more advanced managed care techniques (see boxed text below).

4.3.2.4 UNDERESTIMATING DUES

In addition to following a rigorous dues calculation exercise, solutions include:

- ◇ Cost containment methods discussed under 'moral hazard' and cost escalation to help ensure that dues levels are adequate.
- ◇ Mandatory referrals: Beneficiaries are required to be properly referred by an approved lower-level medical officer, before they can see a higher-level medical officer, whose services are more expensive.
- ◇ Co-payments: MHO members pay a small portion of their health care charge out-of-pocket.
- ◇ Deductibles: MHO members pay up to a fixed amount of their health care bill, while the MHO pays the rest.

4.3.2.5. FRAUD AND ABUSE

To reduce fraud and abuse:

- ◇ Insist on family registration. This could be further encouraged with incentives to increase entire family registration.
- ◇ Issue photo identity cards for each beneficiary.
- ◇ Rigorously check patient identity at the health facility.
- ◇ Use social control. Making the community responsible for limiting fraud. This may require sensitising people on the consequences for everyone when some are permitted to cheat the system. In small communities and small MHOs, everyone knows everyone else, making cheating more difficult. In a big MHO, this option is often not available, and other more rigorous and objective ones must be relied on.

TECHNICAL NOTE 4.4

Contract models and methods of payment for services by an MHO

Two cases should be considered for payment for services the MHO offers. The one that is selected depends on whether the service providers that have agreements with the MHO are to be paid or whether it is the structures set up by the MHO itself that are to be paid.

Payment of service providers that have an agreement with the MHO

As discussed above, the patient and the MHO generally share the cost of health care services. In other words, a three-party relationship is established among the member, the MHO and the health care provider.

Health care is paid for as follows:

- △ The patient pays the full amount of the services and is reimbursed by the MHO; or
- △ The MHO pays the service provider directly (third party payer system); or
- △ One or the other form of payment is used depending on the type of care: reimbursement for small expenses (consultations) and direct payment by the MHO for large expenses (hospitalisation).

(See sub-section 4.1.2 above for general discussion of various contracting models)

PAYMENT OF CARE BY THE MEMBER

The MHO may ask its members to pay the cost of services rendered and then reimburse them later. In this case, the member pays, according to the procedures the service provider has adopted (payment for a service, per illness episode or consultation), and in accordance with the rates agreed upon with the MHO.

The member then has the service provider give proof of payment, such as a receipt or invoice that must show as a minimum:

- △ Identification of the care provider
- △ Positive identification of the beneficiary
- △ Type of services provided
- △ Price and date of services

The member then goes to the MHO office to be reimbursed, taking health booklet membership card and proof of payment.

For the member, the drawbacks of this type of payment are: on the one hand, the requirement to have the full amount necessary to pay for the care and, on the other hand, the requirement to go through long procedures to be reimbursed.

For the MHO, the advantage of this system is that it limits overuse, and the tendency to abuse the system though vigilance is required to check attempts by members to present fraudulent invoices even if it limits such abuse by the providers. The disadvantages are a heavier management load and hence, higher administrative costs.

(cont)

TECHNICAL NOTE 4.4 (CONT.)

DIRECT PAYMENT BY THE MHO

In some cases, a member pays the service provider only the co-payment. The MHO pays the provider the balance directly upon presentation of an invoice. This is called the third party payer system. The MHO pays instead, as the MHO is considered a third party, the service provider and the beneficiary being the other two parties. This system is frequently used for "major risks," involving higher costs that the member cannot pay, such as hospitalisation and surgery.

The third party payer system is obviously more advantageous for the member in that he does not have to worry about his cash availability, he has no procedures to carry out and he need not wait a long time to be reimbursed.

Administratively, this system may be less expensive because it consolidates payments by provider and not by patient. However, there are fewer opportunities to check that the care has actually been provided, and the risks of overuse and cost escalation are much greater.

PAYMENT OF SERVICES IN MEDICAL INSTITUTIONS ESTABLISHED BY THE MHO

Services provided by medical institutions set up by the MHO may be offered to members and non-members alike, with special reduced rates for members.

For the sake of good organisation and transparency, and in order to evaluate the performance of the different units individually, the bookkeeping of the MHO and the medical institutions must always be kept separate, even when non-members do not have access to the services.

HEALTH CENTRES AND HOSPITALS SET UP BY THE MHO

Several cases may be considered:

- ▲ either the beneficiary is covered 100 percent once his probation is over; then he receives care upon presenting his membership card;
- ▲ or the consultation is free as long as the care and drugs are paid based on the products that are used;
- ▲ or the member remits a fixed copayment (cost-sharing) for each consultation and service;
- ▲ or the MHO establishes a proportional copayment; then the patient is responsible for paying a certain percentage of the total cost of the consultations, care and various technical procedures.

MHO's medicine depots

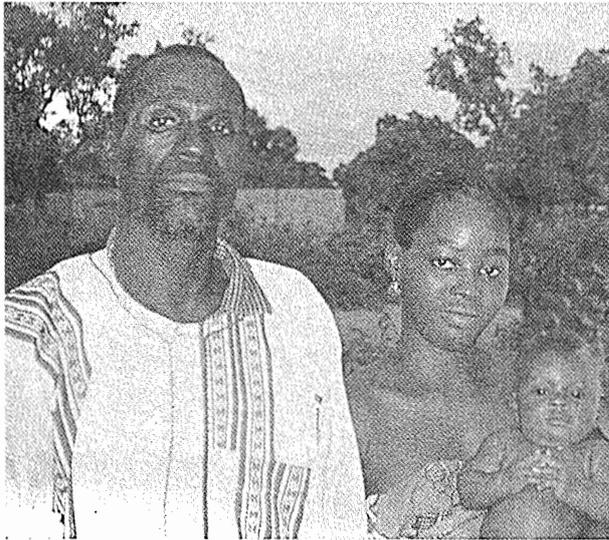
The MHO will encourage the sale of generic drugs and will only provide specialty drugs when absolutely necessary. Members will receive a reduced rate, while non-members may purchase drugs at market price.

To encourage the use of generic drugs, different discounts may be given, depending on whether the drugs are essential generic or specialty drugs.

An MHO may also help resolve a problem of drugs shortage (frequent stock-outs) by making funds available (through a special contribution for instance) for the setting up of a revolving drug fund with the provider.

UNIT 5

INTRODUCTION TO THE FINANCIAL MANAGEMENT OF MHOs



| | |
|---|-----|
| Introduction | iii |
| Module 5.1 ACCOUNTING BOOKS | iii |
| 5.1.1 ENTERING AND MANAGING TRANSACTIONS | iii |
| 5.1.2 THE CASH AND BANK BOOKS | 112 |
| 5.1.3 RECONCILIATION STATEMENTS | 116 |
| 5.1.4 REGISTER OF INVOICES | 119 |
| 5.1.5 THE ASSET BOOK AND DEPRECIATION TABLE | 120 |
| 5.1.6 THE LEDGER (OR SUMMARY) ACCOUNTS | 124 |
| 5.1.7 THE JOURNAL | 125 |
| Module 5.2 FINANCIAL STATEMENTS | 127 |
| 5.2.1 THE BUDGET | 127 |
| 5.2.2 PREPARING TO DO A BUDGET | 128 |
| 5.2.3 PREPARING AN MHO ANNUAL BUDGET | 132 |
| 5.2.4 THE CASH PLAN | 134 |
| 5.2.5 THE INCOME AND EXPENDITURE STATEMENT | 135 |
| 5.2.6 THE BALANCE SHEET | 136 |
| Module 5.3 COST ACCOUNTING | 139 |

LEARNING OBJECTIVES

At the end of this module the participants will be able to understand, explain and use the basic financial procedures and tools necessary to run a MHO.

CONTENT

MODULE 1: ACCOUNTING BOOKS

- ◆ Accounting books to be kept
- ◆ Source documents for accounting books
- ◆ Accounting periods
- ◆ Cash records and bank book
- ◆ Reconciliation
- ◆ Assets register, register of invoices
- ◆ Ledger or summary accounts
- ◆ Journal
- ◆ Depreciation

MODULE 2: FINANCIAL STATEMENTS

- ◆ Budget
- ◆ Cash inflows and outflows
- ◆ Income statements
- ◆ Balance sheet

TARGET GROUPS

- ◆ Senior officers of an MHO
- ◆ Manager
- ◆ Co-ordinator
- ◆ Accountant
- ◆ Cashier
- ◆ Public relations officer
- ◆ Executive committee
- ◆ Supervisory committee

PREREQUISITES

The participants should have gone through the previous modules of this manual.

TRAINING METHODS

- ◆ Handouts
- ◆ Audio-visual aids
- ◆ Flipchart
- ◆ Practical exercises

MODULE 5.1

ACCOUNTING BOOKS

INTRODUCTION

Money is the lifeblood of any business and finance is the study of how that lifeblood circulates – how money is raised, managed and spent. Finance sustains business by making it possible to innovate, market and manage new products and services, and to hire, train and manage people to carry out these new products and services.

However, like most resources, money is a limited resource and therefore needs to be managed carefully to ensure that organisations are compensated for their services and, in turn, can pay for the services they require. This involves recording all financial transactions so that an organisation has accurate data that allow it to analyse and present its financial position.

Financial management, however, does not stop at preparing such documentation. All the entries and statements presented in this unit should be analysed in detail and should be used to highlight actions that need to be taken to correct potential financial difficulties or reinforce positive trends.

5.1.1 ENTERING AND MANAGING TRANSACTIONS

An efficiently managed MHO scheme uses accepted accounting methods to enter daily transactions and to monitor finances of the organisation. The main accounting books a scheme should hold are:

- ◆ a cash book for cash transactions and a bank book for cheques
- ◆ a register of invoices
- ◆ an asset register and depreciation table
- ◆ a ledger
- ◆ a journal

Source documents for accounting books:

1. Recording payments
 - ◆ Pay vouchers
 - ◆ Receipts for cash payments

2. Recording receipts

- ❖ Duplicate receipts for cash and cheques received
- ❖ Asset register and depreciation table

5.1.2 THE CASH AND BANK BOOKS

The cash books and bank book are used to record *all* payments and receipts made in connection with the scheme. The entry sources are payment vouchers, cheques, receipts, etc. Since it is highly recommended that cheques be used for most transactions, the cash book should contain relatively very few transactions.

5.1.2.1. COLLECTING AND MANAGING CASH

The importance of cash to any organisation, including MHO schemes, cannot be overemphasised. It is therefore extremely important for scheme managers to record transactions and safeguard cash. The following guidelines should be used to account for cash:

- ❖ Ensure all transactions are authorised and entered on a timely basis,
- ❖ Prevent unauthorised access not only to cash, but also to non-asset items such as pre-numbered receipts,
- ❖ Ensure the recorded accountability of assets, such as cash on hand, are periodically compared and tested against actual amounts and that appropriate action is taken to correct any discrepancy.

The following specific measures may be taken to safeguard cash:

- ❖ Purchase and use a safe
- ❖ Use a cash register
- ❖ Deposit all money received into the bank promptly and intact; none should be used for “petty cash”
- ❖ Open and use a bank account; limit cash transactions to the minimum
- ❖ Set a maximum amount that may be kept in the cash box for small cash payments
- ❖ Set a maximum amount for cash transactions to be paid out of petty cash
- ❖ Use standing orders where possible
- ❖ Do not make a single person responsible for all the financial management of the scheme; clearly divide the responsibilities of the treasurer, bookkeeper and cashier
- ❖ Perform regular cash audits, preferably without notice
- ❖ Where possible, set up an automatic dues payment system through the members’ bank accounts or payroll
- ❖ Require supporting documents for all transactions, such as receipts or vouchers for withdrawals or payments of funds

5.1.2.2. THE CASH BOOK

Figure 5.1 presents sample pages of a cash book. The total of the “amount” column has to tally with the sum of the totals of the “analysis of receipts” columns for the receipts and the “analysis of payments” columns for the payments.

FIGURE 5.1 EXAMPLE OF FINANCIAL TRANSACTIONS

| Quarter 3 - 1999 – RECEIPTS | | | | | | Quarter 3 – 1999 - PAYMENTS | | | | | |
|-----------------------------|--------------------|--------|----------------------|-----------|-----|-----------------------------|------------------|--------|----------------------|----------|----------|
| Date | Transaction Ref. * | Amount | ANALYSIS OF RECEIPTS | | | Date | Transaction Ref. | Amount | ANALYSIS OF PAYMENTS | | |
| | | | Dues | Reg. Fees | Int | | | | Claims | Salaries | Supplies |
| 10/25 | Receipt #0245 | 150.00 | | 150.00 | | 10/29 | Transac. #0150 | 100.00 | | | 100.00 |
| | | | | | | 11/02 | Transac. #0151 | 250.00 | 250.00 | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | TOTALS | 150.00 | | 150.00 | | | TOTALS | 350.00 | 250.00 | | 100.00 |

*The transaction Ref. should be a voucher number, or any other method of labelling and identifying transaction documents.

PRACTICE EXERCISE

Yefre MHO is three years old. It has no outside funding and relies on locally generated funds to meet its expenses. During the third quarter of 1999, Yefre MHO collected ₦840,000 in dues and ₦40,000 as registration fees of new members. A dinner dance to raise funds to support the MHO’s activities yielded ₦50,000.

Expenses during the same period of the year were as follows: claims ₦500,000, supplies ₦50,000, salaries ₦120,000 and utilities (kerosene, water, etc) ₦80,000. Receipts and payments were all in cash.

Required: Show the cash book for Yefre MHO for the above quarter.

FIGURE 5.2 SOLUTION: CASHBOOK

| Quarter 3 - 1999 – RECEIPTS | | | | | | Quarter 3 – 1999 - PAYMENTS | | | | | | |
|-----------------------------|------------------|--------------|----------------------|-----------|--------------|-----------------------------|---------------------|--------------|----------------------|----------|----------|-----------|
| Date | Transaction ID * | Amount cedis | ANALYSIS OF RECEIPTS | | | Date | Transaction ID | Amount cedis | Analysis of payments | | | |
| | | | Dues | Reg. Fees | Fund-raising | | | | Claims | Salaries | Supplies | Utilities |
| 30 June | Receipt #0245 | 840,000 | 840,000 | | | 1 July | Invoice #0150 | 500,000 | 500,000 | | | |
| 1 July | Receipt #0250 | 40,000 | | 40,000 | | 12 July | Invoice #0151 | 50,000 | | | 50,000 | |
| 30 July | Receipt #0255 | 50,000 | | | 50,000 | 26 July | Voucher #0155 | 120,000 | | 120,000 | | |
| | | | | | | 30 July | Cust. Ref. 00055577 | 80,000 | | | | 80,000 |
| | | 930,000 | 840,000 | 40,000 | 50,000 | | | 750,000 | 500,000 | 120,000 | 50,000 | 80,000 |
| | | | | | | 30 July | Cash Balance | 180,000 | | | | |
| | | 930,000 | | | | | | 930,000 | | | | |
| 1 Aug | Cash Balance | 180,000 | | | | | | | | | | |
| | TOTAL | | | | | | TOTALS | | | | | |

5.1.2.3. THE BANK BOOK

The total of the “amount” column has to tally with the sum of the totals of the “analysis of receipts” columns for the receipts and the “analysis of payments” columns for the payments.

The same principles used to prepare the cash book are used in preparing the bank book., the only difference being that, payment is in cheques instead of cash.

FIGURE 5.3 BANK BOOK

| Quarter 3 - 1999 – RECEIPTS | | | | | | Quarter 3 – 1999 - PAYMENTS | | | | | | |
|-----------------------------|-----------------|--------------|----------------------|-----------|--------------|-----------------------------|----------------|--------------|----------------------|----------|----------|-----------|
| Date | Transaction ID* | Amount cedis | ANALYSIS OF RECEIPTS | | | Date | Transaction ID | Amount cedis | Analysis of payments | | | |
| | | | Dues | Reg. Fees | Fund-raising | | | | Claims | Salaries | Supplies | Utilities |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
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| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | TOTAL | | | | | | TOTALS | | | | | |

PETTY CASH AND THE IMPREST SYSTEM

In the Imprest System, a cashier gives a petty cashier (a spending official who needs small amounts of money for minor daily expenses) enough cash to meet needs for a given period, for example, a month. At the end of the period, the cashier finds out the amounts spent by the petty cashier, and gives him/her an amount exactly equal to the amount spent. The petty cash in hand at the start of the following period should then equal the original amount with which the previous period was started. /

The amount of the petty cash varies from one organisation to another, depending largely on size and the volume of business transacted.

ILLUSTRATION OF A PETTY CASH BOOK

The receipts column is the debit side of the petty cash book. On receipt of the imprest (also called float), the credit entry is made in the cash book while the debit entry is made in the petty cash book.

Payments of expenses are entered on the credit side of the total column and extended into the appropriate analysis column.

The analysis columns are totalled at the end of the period and the amount spent is refunded by the cashier to bring the total to the original amount started with.

Figure 5.4 illustrates a petty cash book (here, from Kroye Kuo an MHO of Akosombo). As seen in the figure, the Kroye Kuo management maintains five columns for petty cash purposes, namely, motor expenses, staff travelling, postage, clearing and ledger for personal debts.

PETTY CASH BOOK

FIGURE 5.5 KROYE KUO PETTY CASH BOOK

| Date 1999 | Receipts | Amount | Date 1999 | Payments | Amount (Total) | ANALYSIS OF PAYMENT | | | Clearing | Ledger |
|--------------|---------------|--------|--------------|------------------|-------------------|------------------------|-----------------|---------|----------|--------|
| | | | | | | Motor Exp. | Staff Travel | Postage | | |
| Sept. 1 | Cash | 50,000 | Sept. 2 | Petrol | 6,000 | 6,000 | | | | |
| Sept. 30 | Cash | 48,000 | Sept. 3 | Abu M. T. Exp. | 4,000 | | 4,000 | | | |
| | | | Sept. 3 | Postage | 2,000 | | | 2,000 | | |
| | | | Sept. 4 | J. Allan T. Exp. | 4,000 | | 4,000 | | | |
| | | | Sept. 7 | Clearing | 3,000 | | | | 3,000 | |
| | | | Sept. 10 | Petrol | 6,000 | 6,000 | | | | |
| | | | Sept. 14 | Postage | 7,000 | | | 7,000 | | |
| | | | Sept. 15 | Petrol | 6,000 | 6,000 | | | | |
| | | | Sept. 29 | J. Aikins | 10,000 | | | | | 10,000 |
| | | | | | 48,000 | 19,000 | 8,000 | 8,000 | 3,000 | 10,000 |
| | | | Sept. 30 | Cash Bal. C/d | 48,000 | | | | | |
| | | 98,000 | | | 98,000 | | | | | |
| Oct. 1 | Cash bal. B/d | 50,000 | | | | | | | | |

5.1.3 RECONCILIATION STATEMENTS

Reconciliation statements are prepared to reconcile or correct the difference between the balance in office's bank records and the balance in the bank's statements of accounts. Ideally, a value entered into the office's bank book should correspond to the bank's records, and vice versa. The procedures are:

- ◆ Enter items that are in the bank statement but not in the offices bank book into the bank book,
- ◆ Add cheques that were received and entered in the bank book to the bank statement (add to ending balance on bank statement),
- ◆ Add cheques that were paid out and entered in the bank book to the bank statement (subtract from ending balance on bank statement).

The balance on the bank book and on the bank statement should correspond. Figure 5.6 presents a sample reconciliation statement.

FIGURE 5.6 SAMPLE BANK RECONCILIATION STATEMENT

| | |
|------------------------------------|-------|
| Cash at bank as per cash book | _____ |
| Plus unrepresented checks | _____ |
| Plus credit transfers | _____ |
| Total | _____ |
| Less bank lodgements | _____ |
| Cash at bank as per bank statement | _____ |

Balances may still differ, due to:

- ◆ Bank charges
- ◆ Commission
- ◆ Standing orders
- ◆ Transfers into the MHO's account
- ◆ Cheques received, entered into the books of the MHO, but not yet paid into bank
- ◆ Cheques paid out but not yet cashed by the payee/receiver

GROUP ASSIGNMENT

On 31 December 1998, Yefre MHO received its bank statement from Yefre Rural Bank. The accountant saw that the balance on the bank statement, €875,000 differed from the office cash book balance, which stood at €678,000. On this date, cheques totalling €115,000 had been received and paid into the bank but not yet entered on the bank statement. The MHO had also paid out cheques totalling €256,000. These cheques had been entered in the bank records in the office, but not yet presented to the bank for payment.

A credit transfer of €56,000 was entered on the bank statement but not yet entered in the cash book.

Have participants prepare a suitable statement to reconcile the two balances. Figure 5.7 shows the solution.

FIGURE 5.7 SOLUTION TO EXERCISE: YEFRE MHO RECONCILIATION STATEMENT

| | | |
|-------------------------------|---------------|----------------|
| Cash at bank as per cash book | | €678,000 |
| Add unrepresented cheques | 256,000 | |
| Add credit transfers | <u>56,000</u> | |
| | | <u>312,000</u> |
| | | 990,000 |
| Less bank lodgements | | <u>115,000</u> |
| Cash at bank as per statement | | <u>875,000</u> |

Note: Both in theory and in practice, the statement could start with the bank statement balance and worked backwards.

MORE DETAILED BANK RECONCILIATION STATEMENTS

When the bank balance and the office bank records differ, it is necessary to know what the items at the credit and debit side of both the bank statement and the cash book represent. Therefore, the MHO must prepare a statement to reconcile the two balances. Procedures to prepare such a statement are:

1. Compare the receipts side of the office cash book with the credit side of the bank statement, and tick items that appear on both the office cash book and the bank statement.
2. Update the cash book by entering items on the bank statement that are not on the cash book to the cash book: that is, record items on the credit side of the bank statement on the receipts of the office cash book, and items on the debit side of the bank statement on the payment side of the cash book.
3. Prepare the reconciliation statement.

Two terms should be understood in order to do a reconciliation:

- ◆ **Unpresented cheques:** These are cheques which have been issued by the payer, recorded in the payer's office records, but not yet sent to the bank by the payee for payment.
- ◆ **Uncredited cheques:** Cheques that have been received, paid into bank by the payee, but not yet added to the payee's account at the bank. Such cheques increase the bank balance in the office in the first instance until a credit is made in the bank.

GROUP ASSIGNMENT

Yefre MHO's office bank records show the following details (Figure 5.8):

| FIGURE 5.8 YEFRE MHO OFFICE BANK RECORDS | |
|--|------------------|
| 1999 | (Totals Only) |
| Dec. 1 Total b/fwd | ¢200,000.00 |
| Dec. 1 Ama Fofie | 6,000.00 |
| Dec. 22 Togar Aba (b) | <u>22,000.00</u> |
| | ¢222,000.00 |
| | ===== |
| Dec. 1 Total b/fw | ¢160,000.00 |
| Dec. 9 Kofi Sam | 10,500.00 |
| Dec. 15 Esi Bonso (a) | 1,500.00 |
| Dec. 30 Balance c/d | <u>56,000.00</u> |
| | ¢228,000.00 |

Yefre MHO's Bank Statement, from Yefre Rural Bank, is in Figure 5.9.

| FIGURE 5.9 YEFRE MHO BANK STATEMENT | | | |
|-------------------------------------|-----------|----------|-------------------------|
| 1999 | Dr. | Cr. | BALANCE |
| Dec. 1 balance b/fwd. | ¢ | ¢ | ¢40,000.00 Cr. |
| Dec. 2 Cheque | — | 6,000.00 | ¢46,000.00 Cr. |
| Dec. 10 Kofi Sam | 10,500.00 | | ¢35,500.00 Cr. |
| Dec. 20 Credit Transfers: | | | |
| Alhassan Seidu (c) | | 7,000.00 | ¢42,500.00 Cr. |
| Dec. 30 Bank Charges (d) | 2,000.00 | | |
| | | | ¢40,500.00 Cr. ===== |

Notes:

- (a) Items not ticked on the receipts side of the cash book are cheques not credited.
- (b) Items not ticked on the payments side of the cash book are unrepresented cheques.

Solution :

(a) Cash Book Update:

| | |
|----------------------------------|--------------|
| Cash Book Balance on 30 December | ¢56,000 |
| Add Credit Transfer | <u>7,000</u> |
| | 63,000 |
| Subtract Bank Charges | <u>2,000</u> |
| New Cash Book Balance | 61,000 |

(b) Reconciliation Statement:

| | |
|---------------------------------|---------------|
| Cash Book Balance (new balance) | ¢61,000 |
| Add Unpresented Cheques | <u>1,500</u> |
| | 62,500 |
| Less Uncredited Cheques | <u>22,000</u> |
| Bank Statement Balance | 40,500 |
| | ===== |

5.1.4 REGISTER OF INVOICES

It is extremely important for an MHO scheme to maintain good working relations with its providers and an efficient cash management system will facilitate this. In this pursuit, payments should be made in a timely manner, and funds collected in order to make the payments. The scheme should therefore keep a log of all incoming and outgoing invoices (Figure 5.10).

FIGURE 5.10 EXAMPLE OF REGISTRY OF INVOICES

| INCOMING | | | | | |
|--|-----------|--------------|----------|----------------|-----------------|
| Invoice No. | Issuer | Invoice date | Due date | Amount due (D) | Amount paid (P) |
| | | | | | |
| | | | | | |
| | | | | ↓ | ↓ |
| Total | | | | | |
| Balance (D-P) ⇒ (Accounts Payable) | | | | | |
| OUTGOING | | | | | |
| Invoice No. | Recipient | Invoice date | Due date | Amount due (D) | Amount paid (P) |
| | | | | | |
| | | | | | |
| | | | | ↓ | ↓ |
| Total | | | | | |
| Balance (D-P) ⇒ (Accounts Receivable) | | | | | |

More importantly, the MHO scheme must set up a system for filing the invoices. Once invoices are stamped with a receipt date, they could be filed under “paid” and “unpaid”. Once paid, the invoices should also be stamped “paid”, with an indication of the payment method, payment date, and a signature from the receiving party.

5.1.5 THE ASSET BOOK AND DEPRECIATION TABLE

5.1.5.1. THE ASSET BOOK

The asset book, or asset register provides information on all equipment bought, supplied and installed; on the planned preventive maintenance schedule; etc. It is also used to verify the existence of the equipment. Figure 5.11 contains a sample asset register.

FIGURE 5.11 EXAMPLE OF AN ASSET REGISTER

| Type of Asset | ID number | Date of purchase | Location | Manual available (Yes/No) | Value | Expected life span (years) | Supplier | Date of instal. | Deprec. Rate |
|---------------|-----------|------------------|-----------|---------------------------|---------|----------------------------|----------|-----------------|--------------|
| Computer | CO715 | 05/16/97 | Manager | Yes | \$1,200 | 5 | TecnoCo | 05/20/97 | 20% |
| Chair | CH742 | 12/12/96 | Reception | No | \$25 | 5 | WoodPlus | 12/12/96 | 0% |
| Desk | DE826 | 12/12/96 | Reception | No | \$50 | 5 | WoodPlus | 12/12/96 | 0% |

PRACTICE EXERCISE

On assuming office in 1999, the new management of Yefre MHO found that no records of MHO assets existed. After a thorough search, several receipts and other documents were found showing cost of various fixed assets over the two previous years.

A summary of the asset records is:

- ◆ Photocopier in the general office was bought for ₦1.5 millions on 10 April 1997.
- ◆ Manual typewriter in the co-ordinator's office was bought for ₦300,000 on 30 June 1997.
- ◆ A diesel generator, cost and installation, bought for ₦5 millions, the last payment for which made on 30 September 1997.
- ◆ Two Compact computers, with all accessories, bought for ₦3 millions cedis each, on 15 December 1997. One computer was in the general office, the other in the manager's office.

Figure 5.12 shows how this information was recorded in the MHO assets book.

| Date of Purchase 1997 | Type of asset | Location | manual available | Value | Expected life span | supplier | Date of Installation 1997 | Rate of depreciation |
|-----------------------|------------------|------------------|------------------|------------|--------------------|-------------------|---------------------------|----------------------|
| 10 April | Photocopier | General office | Yes | ₦1,500,000 | 4 years | Blue chip | April | 15% |
| 30 June | Type Writer | General Office | NO | ₦300,000 | 6 years | Business machines | 30 June | 10% |
| 30 Sept | Diesel Generator | Compound | Yes | ₦5,000,000 | 5 years | Business machines | 30 Sept | 10% |
| 15 Dec. | Computer 1 | General office | Yes | ₦3,000,000 | 4 years | Blue chip | 15 Dec | 15% |
| 15 Dec. | Computer 2 | Manager's office | Yes | ₦3,000,000 | 4 years | Blue chip | 15 Dec | 15% |

5.1.5.2. DEPRECIATION

The asset register serves as a basis for calculating depreciation. Depreciation is an annual reduction in the value of durable assets (building, office equipment, vehicles, etc.) as a result of deterioration, wear and tear from daily use and/or technology enhancement. Depreciation is also a means of calculating the cost of using a particular asset for a specific time-period. For example, if a computer is purchased for \$1,000 and is expected to last five years, then it costs roughly \$200 per year for five years to use that computer. Depreciation is considered an expense; it should therefore be deducted from revenue each financial year.

There are basically two methods for calculating depreciation. An MHO scheme should select one method and use it consistently:

Fixed Installment or Straight-line Method

The same amount is written off the book value of the asset each year. This is represented in the following formula.

$$\text{Depreciation value per year} = \text{Cost of asset} - \text{residual value} / \text{Useful life in years}$$

The cost of the asset is the purchase value of the equipment; the residual value is the estimated value the asset could sell for once it is fully depreciated; the useful life in years is the number of years the asset will be used, before being replaced. Once an asset is fully depreciated, it should no longer figure on the asset book or on the balance sheet. Figure 5.13 contains two examples of fixed installment depreciation.

FIGURE 5.13 FIXED INSTALLMENT DEPRECIATION

EXAMPLE #1:

△ Cost of a computer: ₵700,000 - Date of Purchase: December 1996

△ Useful life: 5 years

△ Residual value: ₵200,000

△ Depreciation: $(700,000 - 200,000) / 5 = ₵100,000$

Therefore, ₵100,000 should be expensed on the statement of income and expenditure and deducted from the assets on the balance sheet each year for 5 years.

| | Depreciation | Book value |
|-------|--------------|--------------------------|
| 12/96 | | 700,000 |
| 12/97 | 100,000 | 600,000 |
| 12/98 | 100,000 | 500,000 |
| 12/99 | 100,000 | 400,000 |
| 12/00 | 100,000 | 300,000 |
| 12/01 | 100,000 | 200,000 (residual value) |

EXAMPLE #2:

△ Cost of motor bike: ₵6,000,000 - Date of purchase: December 1996

△ Useful life: 4 years

△ Residual value: 0

△ Depreciation: $6,000,000 / 4 = ₵1,500,000$

Therefore, ₵1,500,000 should be expensed on the statement of income and expenditure and deducted from the assets on the balance sheet each year for 4 years.

| | Depreciation | Book value |
|-------|--------------|--------------------|
| 12/96 | | 6,000,000 |
| 12/97 | 1,500,000 | 4,500,000 |
| 12/98 | 1,500,000 | 3,000,000 |
| 12/99 | 1,500,000 | 1,500,000 |
| 12/00 | 1,500,000 | 0 (residual value) |

Figure 5.14 shows a depreciation table for Yefre MHO 1999, using fixed installation method of depreciation. Following the figure are calculations for each of the assets listed in the figure.

| Description | Date of purchase | Value | | Total depreciable value | Depreciation | | | |
|-------------|------------------|-------|----------------|-------------------------|----------------------|---------------------------|----------------------|-------------------|
| | | Cost | Residual value | | Life-span (in years) | Accumulated Dep./Previous | Depreciation/Current | Acc. Dep./Current |
| Computer | 01/01/98 | 1,200 | 50 | 1,150 | 5 | 230 | 230 | 460 |
| Copier | 01/01/97 | 2,000 | 50 | 1,950 | 4 | 976 | 488 | 1,464 |
| Fax | 12/31/96 | 500 | 25 | 475 | 4 | 238 | 119 | 357 |
| TOTAL | | 3,700 | | | | 1,444 | 837 | 2,281 |

Calculations for Computer:

Initial cost of \$1,200 – Residual value of \$50 = \$1,150

$\$1,150 / \text{Life span of 5 years} = \230 , which is the amount to be depreciated each year for 5 years

◇ \$230 depreciated for 1998

◇ \$230 depreciated for 1999

Accumulated depreciation: $230 + 230 = \$460$

Calculations for Copier:

Initial cost of \$2,000 – Residual value of \$50 = \$1,950

$\$1,950 / \text{Life span of 4 years} = \488

◇ \$488 depreciated for 1997

◇ \$488 depreciated for 1998

◇ \$488 depreciated for 1999

Accumulated depreciation: $488 \times 3 = \$1,464$

Calculations for Fax:

Initial cost of \$500 – Residual value of \$25 = \$475

$\$475 / \text{Life span of 4 years} = \119

◇ \$119 depreciated for 1997

◇ \$119 depreciated for 1998

◇ \$119 depreciated for 1999

Accumulated depreciation: $119 \times 3 = \$357$

Diminishing Balance Method

A fixed percentage is written off the book value cost of the asset less the depreciation amount since the asset was purchased. Figure 5.15 contains an example of the value of the asset each year. It is more suitable in cases where the value of the asset falls faster in the earlier years of use than in later years and therefore an organisation wants to charge a higher amount against earlier profits.

$$\text{Depreciation value} = \text{Book value} \times \text{rate of depreciation}^8$$

⁸ The most generally used depreciation rates are: land 0 percent; buildings 2–5 percent; furniture 20 percent; equipment 20–33 percent.

FIGURE 5.15 DIMINISHING BALANCE DEPRECIATION

- △ Cost of a computer: 70,000
- △ Rate of depreciation: 30 percent
- △ Useful life : 5 years

| | |
|---|---------------------------------------|
| Year 1: Depreciation = .3 x 70,000 = 21,000 | Book value = 70,000 – 21,000 = 49,000 |
| Year 2: Depreciation = .3 x 49,000 = 14,700 | Book value = 49,000 – 14,700 = 34,300 |
| Year 3: Depreciation = .3 x 34,300 = 10,290 | Book value = 34,300 – 10,290 = 24,010 |
| Year 4: Depreciation = .3 x 24,010 = 7,203 | Book value = 24,010 – 7,203 = 16,807 |
| Year 5: Depreciation = .3 x 16,807 = 5,042 | Book value = 16,807 – 5,042 = 11,765 |

5.1.6 THE LEDGER (OR SUMMARY) ACCOUNTS

A ledger or summary book shows the final relationship between parties to a business transaction. The ledger indicates who owes whom, how much and at what period (Figure 5.16).

FIGURE 5.16 SAMPLE LEDGER

| Date | Details | Receipts | Payments | Balance |
|------|---------|----------|----------|---------|
| | | | | |

GROUP ASSIGNMENT

Yefre MHO had cash of ₵870,000 in the office on 2 January 1999. In February, new members paid registration fees of ₵30,000. Total dues collected, from both old and new members, amounted to ₵400,000.

During the first quarter of the year, the MHO paid claims of ₵500,000. Salaries of ₵200,000 and operational costs came to ₵100,000.

Record the above in a ledger. Figure 5.17 shows the resulting ledger.

FIGURE 5.17 EXAMPLE OF AN IDENTIFICATION NUMBER

| Date | Details | Receipts | Payments | Balance |
|----------|-------------------|----------|----------|-----------|
| 1999 | | | | |
| 2 Jan | Cash balance | | | 870,000 |
| Feb. | Registration Fees | 30,000 | | 900,000 |
| | Dues | 400,000 | | 1,300,000 |
| March 31 | Claims | | 500,000 | 800,000 |
| | Salaries | | 200,000 | 600,000 |
| | Operations | | 100,000 | 500,000 |

5.1.7 THE JOURNAL

The journal is used to record daily non-cash or non-bank financial transactions (Figure 5.18). The journal is also used to record general financial data that are neither cash nor bank transactions. Examples of this type of items include returns of drugs either bought or sold, correction of errors, etc.

FIGURE 5.18 SAMPLE JOURNAL

| Date | Details | Debit | Credit |
|------|---------|-------|--------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

GROUP ASSIGNMENT

At the end of 1998 financial year the accountant of Yefre MHO found the following outstanding financial issues.

On May 1, the MHO bought a motor vehicle on credit from Japan Motors for ₪80,000,000.

On June 30, a debt of ₪34,000 owed by Koo Nimo, a member of the MHO, was written off.

On July 15, the manager took ₪45,000 worth of drugs from the pharmacy without paying for them.

On August 5, the accountant paid an insurance bill thinking it was entirely for the MHO. He now discovers that ₪76,000 of the amount went to insure the manager's private house.

Enter above items in a suitable financial record book.

Figure 5.19 shows the completed journal

| FIGURE 5.19 YEFRE MHO JOURNAL, 1998 | | | |
|-------------------------------------|---|--------|--------|
| Date | Details | Debit | CREDIT |
| 1998 | | | |
| May 1 | Motor Vehicles | 80,000 | |
| | Japan Motors | | 80,000 |
| | Motor Vehicles bought on Credit | | |
| June 30 | Bad debt | 34,000 | |
| | Koo Nimmo | | 34,000 |
| | Debt written off | | |
| July 15 | Manager | 45,000 | |
| | Stock of drugs | | 45,000 |
| | Drugs taken by manager for personal use. | | |
| Aug 5 | Manager | 76,000 | |
| | Insurance | | 76,000 |
| | Insurance paid for manager, Charged in error to MHO, now corrected. | | |

MODULE 5.2

FINANCIAL STATEMENTS

The transactions entered in the books described above serve as a basis for preparing the financial statements. The statements should be prepared on a monthly basis (especially during the first year of operations), quarterly (for internal use) or annually (for the general public: members, board of directors, providers and all other stakeholders) and clearly dated, so that the period they cover is easily recognizable. These statements highlight the financial status of the organisation. They are:

- ◆ The budget
- ◆ The cash plan
- ◆ The statement of income and expenditure or income statement
- ◆ The balance sheet

The cash plan, the income statement and the balance sheet tell the scheme where it is, whereas the budget tells where it is going.

5.2.1 THE BUDGET

BASIS

Statistics from internal database, past financial statements, estimated inflation, organisational needs, etc.

DEFINITION

The budget is an itemised summary of probable expenditures and income of an organisation for a given period⁹. A budget expresses the resource requirements for implementing the strategic plan of the organisation. It is the principal tool used to manage major decisions in the organisation's work about the benefits to be provided to members and the amount of the corresponding dues. The budget should be prepared not only at the inception of the scheme, but every year, and should be used by the promoters to evaluate different scenarios (for example, what are the financial consequences of setting the coverage rate at 90 percent instead of 100 percent). It also

⁹ Webster's II, New Riverside University Dictionary, The Riverside Publishing Company, Houghton Mifflin Company.

should be used to measure achievements against projections; however, to provide a fair basis for evaluating performance, budgeted amounts should be set at realistic and achievable levels. If budgeting costs are either too high or too low in relation to actual cost, they could give a distorted picture of the real situation and can adversely affect management decisions.

In short, a budget is a translation of pre-planned activities into monetary terms or value: it balances projected cost and projected revenue. It serves as a control tool to keep a programme on course.

BENEFITS OF GOOD BUDGETING

Careful planning and preparation of a budget benefits an organisation in many ways; inadequate or sloppy budgeting indicates a weak or inexperienced management.

First, good budgeting increases management's awareness of the organisation's internal and external financial environment. It helps management know how much to expect from both within and outside of the organisation.

Second, good budgeting gives advance warning of problems. If, for example, the budget shows the organisation will run short of cash during a certain period, management has advance warning of the need to maintain expenditure at given levels or to obtain additional financing.

Third, good budgeting provides management with an opportunity to co-ordinate the activities of the various departments. Where there are no departments, good budgeting helps management know how an activity fits into the rest.

Finally, a good budget is a tool for performance evaluation and control. It serves as a yardstick against which actual performance may be measured.

A budget should be conservative and use the least advantageous projections (some organisations create three budgets, with low, no and high increase predictions).

5.2.2 PREPARING TO DO A BUDGET

The period covered by the budget should be long enough to show the effect of managerial policies, but short enough so that estimates can be made with reasonable accuracy. In view of this, different types of budgets should be made for different time spans, the period depending on the purpose of the budget.

It must be stated that preparing a good budget can be a complex and lengthy process. This is because of the interaction between the different sections of the organisation. As a such, enough time should therefore be set aside well in advance, so as not to rush to meet dead lines.

THE PROCESS

The budgeting process involves estimating the amounts of the different budget line items. The major sources of income and expenditure and the key information required to set a budget were identified in Units 2 and 3. Once the scheme has been operating for at least a year, it will have its own data and should use the information in this budget.

ESTIMATING THE NUMBER OF POTENTIAL MEMBERS

Several factors should be taken into consideration when estimating the number of potential members for the following year. For example, if a new marketing plan will be implemented, it should estimate the new number of members it could bring in. In the case of a rural MHO, a decline in sales of agricultural products may decrease the number of members. In summary, all related factors should be analysed and aggregated into a single estimated increase or decrease in membership.

An estimation example: if the number of members was 500 in 1997, 550 in 1998 (10 percent increase from 1997) and 605 in 1999 (10 percent increase from 1998), and assuming that the environment is similar to previous years, the MHO can estimate that membership in 2000 will be 666. This is done, by taking the average rates of increase from previous years $((10 \text{ percent} + 10 \text{ percent})/2 = 10 \text{ percent})$ at 666 members $(605 \text{ members in } 1999 \times 10 \text{ percent increase} = 61 \text{ membership increase})$. It is also possible to suggest that since the rate of increase increased between 1997, 1998 and 1999, it should increase in 2000 as well, by approximately 11 percent.

ESTIMATING SERVICES COVERED AND THEIR COST

The services covered will be decided by the scheme's governing body (the General Assembly in most cases), based on past financial results, members' requests, and service availability. Factors affecting the cost of services include:

- ◆ The estimated number of potential members
- ◆ The choice of services offered
- ◆ The usage rate from the previous year
- ◆ The coverage rate
- ◆ The prices of services (estimates including inflation or provided by health providers)

ESTIMATING FREQUENCY OF USE OF SERVICES COVERED

This is calculated by dividing the number of users by the number of members. For accurate projections by age group and sex, this should be calculated by service use for each age group and sex. The scheme should use past data to identify trends. Especially in the case of a new scheme, one should take into account increases in usage rates resulting from reduced financial barriers to access which the scheme makes possible, as well as possible moral hazard or over-utilisation.

Using the above data the following formula is used to estimate costs for frequency of services used:

Average cost of a service per member = Average cost of a service X Average number of times the service was accessed by a single user X Usage rate

ESTIMATING OPERATING/ADMINISTRATIVE COSTS AND COSTS OF SERVICES

These costs are based on past years and projection of volumes (for example, if new staff will need to be hired) and should take inflation into account.

ESTIMATING DUES

The membership and cost estimates should be used to set dues or premiums (see Unit 3). It is difficult to increase the premium in the case of many MHOs which target poor populations. Any projected increase will therefore have to be accompanied by a social marketing plan to sensitise all stakeholders. Other alternatives, such as adjusting

(possibly reducing) the benefits package or increasing co-payments may also be considered if cost escalation is a problem.

SOURCES OF REVENUE/INCOME OF AN MHO

The sources of income can be classified into two categories:

1. Principal Sources
 - ❖ Registration fees/sale of ID or membership cards
 - ❖ Dues
 - ❖ Interest on treasury bills and fixed deposits (after a minimum period of time)
 - ❖ Sale of promotional materials (bags, pens, stickers, T-shirts)
2. Secondary Sources
 - ❖ Donations
 - ❖ Fund raising
 - ❖ Government and NGO assistance

TYPES OF EXPENDITURE OF AN MHO

The types to which an MHO's expenses are related, could be classified into five categories:

1. Services
 - ❖ Payment of health bills
 - ❖ Refund of drugs
2. Operational
 - ❖ Salaries and allowances
 - ❖ Travel and transport
 - ❖ Fuel
 - ❖ Film and printing
 - ❖ Office supplies
 - ❖ Rent
 - ❖ Utilities
 - ❖ Office equipment
 - ❖ Cost of promotional materials
3. Social marketing activities
 - ❖ Role-play and groups
 - ❖ Rental of equipment
 - ❖ Transport for community entry
 - ❖ Publicity
4. Training and outreach
 - ❖ Seminars and workshops
 - ❖ Teaching materials
 - ❖ Office supplies
 - ❖ Per diem
5. Incidental expenses

TABLE 5.1 EXAMPLE OF AN INITIAL MHO BUDGET

Scenario: Initial Budget for an MHO providing inpatient services

EXPENDITURE

a) Services

| | | |
|---------------------------|------------------|------------|
| △ Payment of Health Bills | 61,000,000 | |
| △ Refund of Drugs | <u>2,000,000</u> | |
| Sub-Total | | 63,000,000 |

b) Operational

| | | |
|---------------------------------|----------------|------------|
| △ Salaries & Allowances | 4,000,000 | |
| △ Travel & Transport | 200,000 | |
| △ Fuel | 360,000 | |
| △ Film & printing | 100,000 | |
| △ Office supplies | 190,000 | |
| △ Rent | 200,000 | |
| △ Utilities | 100,000 | |
| △ Office equipment | 2,000,000 | |
| △ 1 motorbike, 1 bicycle | 10,000,000 | |
| △ Cost of promotional materials | <u>500,000</u> | |
| Sub-total | | 17,650,000 |

c) Social marketing

| | | |
|---------------------------------|--|-----------|
| △ Role play & groups | | |
| △ Transport for community entry | | |
| △ Publicity | | |
| Sub-total | | 2,400,000 |

d) Training & outreach

| | | |
|------------------------|--|-----------|
| △ Seminars & workshops | | |
| △ Teaching materials | | |
| △ Per Diem | | |
| △ Office supplies | | |
| Sub-total | | 1,500,000 |

e) Incidental expenses(10 percent of sub-total)

1,000,000

Grand Total

85,550,000

INCOME

| | | |
|---------------------------------|------------|-------------------|
| △ Registration fees | 20,000,000 | |
| △ Dues | 60,000,000 | |
| △ Donations | 5,000,000 | |
| △ Sale of promotional materials | 550,000 | |
| Total | | 85,550,000 |

Notes to the MHO initial budget:

1. Projected members: 20,000 X Registration fees (¢ 1000) = ¢20,000,000

Average in-patient bill: ¢ 61,000 X expected number of patients among the members:

61,000 X (20,000 X 5 percent) =

61,000 X 1000 =

¢61,000,000

Dues = 85,000,000 - 20,000,000 - 5,000,000 - 550,000

(expenses) (reg. fees) (Donation) (Promotional material)

20,000 (members)

Dues = ¢3000 per member

2. The costs of social marketing and capital outlay are very high because it is the beginning of the scheme.
3. Setting up the initial budget of an MHO should be treated as a group assignment.
4. Quantification: After the parameters for preparing a budget have been identified, the next step is to quantify them.

Note also that MHO's are expected to operate a Reserved Fund in order to meet their liquidity requirements in case of unexpectedly high costs (e.g. during epidemics).

5.2.3 PREPARING AN MHO ANNUAL BUDGET

REQUIREMENTS

In order to prepare a budget, it is necessary to clearly define objectives and planned activities and to estimate the cost of each activity. It is also necessary to state all possible sources of income and amount of income expected from each source.

Specifically for an MHO, the following factors are important:

- a) Number of members to estimate amount of dues to be received
- b) Cost of medical services
- c) Prices of drugs
- d) Cost of operations
- e) Inflation
- f) Donations

It is necessary to ensure that income and expense totals balance or agree.

FIGURE 5.20 YEFRE MHO BUDGET, 1998

| Expenses | ¢ | Income | ¢ |
|------------------|----------|-------------------|----------|
| Medical services | 500,000 | Registration fees | 40,000 |
| Drugs (refunds) | 360,000 | Premium | 840,000 |
| Operating cost | 30,000 | Donations | 20,000 |
| Training | 20,000 | Miscellaneous | 10,000 |
| | 910,000 | | 910,000 |

BUDGET MONITORING

Used properly, the budget is a powerful management tool to help the organisation achieve its goals in the most efficient manner. For this to happen, the budget must be monitored usually as regularly and frequently as possible, on a monthly or quarterly basis (Figure 5.21).

FIGURE 5.21 EXAMPLE OF A BUDGET AS A FINANCIAL CONTROL OR MONITORING TOOL

| YEFRE MHO BUDGET FOR 2000 | | | | | | | | | |
|---------------------------|----------|--------|------------|----------|--------|------------|----------|--------|------------|
| | January | | | February | | | March | | |
| INFLOWS | Budgeted | Actual | Difference | Budgeted | Actual | Difference | Budgeted | Actual | Difference |
| Registration fees | | | | | | | | | |
| Co-payment | | | | | | | | | |
| Dues | | | | | | | | | |
| Donations | | | | | | | | | |
| Total Inflows | | | | | | | | | |
| OUTFLOWS | | | | | | | | | |
| Medical expenses | | | | | | | | | |
| Drugs | | | | | | | | | |
| Salaries & allow. | | | | | | | | | |
| Rent | | | | | | | | | |
| Office supplies | | | | | | | | | |
| Electricity | | | | | | | | | |
| Water | | | | | | | | | |
| Telephone | | | | | | | | | |
| Office maintenance | | | | | | | | | |
| Equipment | | | | | | | | | |
| Insurance | | | | | | | | | |
| Travel and transport | | | | | | | | | |
| Publications | | | | | | | | | |
| Publicity | | | | | | | | | |
| Bank fees | | | | | | | | | |
| Meetings | | | | | | | | | |
| Total outflows | | | | | | | | | |
| Balance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

To monitor a budget is to compare the estimates or projections with actual expenses. Expenses should not greatly exceed estimates. Any deviation or difference must be investigated and addressed quickly.

To stay within budget limits, the financial officer should approve all expenses. Before approvals are given, the officer should ascertain or find out whether the expense for which request is made was budgeted for and how much.

Ideally, monitoring should be done as regularly and frequently as possible, and major differences addressed quickly.

POSSIBLE CAUSES OF BUDGET DEVIATION

A deviation or difference between budgeted figures and actual expenditures may result from several factors, including the following:

1. The budget was unrealistic, for example because efforts to investigate all possible cost factors were not exhaustive.
2. There was a sudden, unexpectedly high price increase. This situation is common in a developing country like Ghana where sudden price increases are common.

3. The budget was not strictly followed due to lack of management control. Many development institutions in developing countries lack the capacity to effectively monitor the performance of budgets, partly because of lack of knowledge of basic accounting and financial principles.
4. An emergency called for high expenditure that was not budgeted for.
5. Income failed to materialise, possibly without warning. The budgets of many NGOs include promised income of donor agencies that fails to materialise.
6. Management is unable or unwilling to control expenditure that are classified as unavoidable.

5.2.4 THE CASH PLAN

BASIS

Cash and bank books

DEFINITION

The cash plan shows projected cash inflow and cash outflow to be covered each month during a given fiscal year (Figure 5.22). The use of a cash plan enables a scheme to ensure that it always has sufficient cash to meet its obligations vis-à-vis its members and providers.

FIGURE 5.22 EXAMPLE OF A CASH PLAN

| YEFRE MHO – CASH PLAN FOR THE FIRST QUARTER OF 1999 (IN CEDIS) | | | | | | | | | |
|--|------------------|------------------|-----------------|------------------|------------------|-----------------|------------------|------------------|-----------------|
| Items | January | | | February | | | March | | |
| | Budgeted | Actual | Difference | Budgeted | Actual | Difference | Budgeted | Actual | Difference |
| INFLOWS | | | | | | | | | |
| Registration fees | 500,000 | 450,000 | -50,000 | 500,000 | 500,000 | 0 | 500,000 | 525,000 | 25,000 |
| Dues | 2,500,000 | 2,000,000 | -500,000 | 2,500,000 | 2,100,000 | -400,000 | 2,500,000 | 2,250,000 | -250,000 |
| Total Inflows | 3,000,000 | 2,450,000 | -550,000 | 3,000,000 | 2,600,000 | -400,000 | 3,000,000 | 2,775,000 | -225,000 |
| OUTFLOWS | | | | | | | | | |
| Medical expenses | 1,250,000 | 1,200,000 | -50,000 | 1,250,000 | 1,250,000 | 0 | 1,250,000 | 1,300,000 | 50,000 |
| Drugs | 250,000 | 300,000 | 50,000 | 250,000 | 450,000 | 200,000 | 250,000 | 400,000 | 150,000 |
| Operating costs | 800,000 | 750,000 | -50,000 | 800,000 | 650,000 | -150,000 | 800,000 | 800,000 | 0 |
| Total outflows | 2,300,000 | 2,250,000 | -50,000 | 2,300,000 | 2,350,000 | 50,000 | 2,300,000 | 2,500,000 | 200,000 |
| Balance (Inf. -Outf.) | 700,000 | 200,000 | -500,000 | 700,000 | 250,000 | -450,000 | 700,000 | 275,000 | -425,000 |
| Investment (-) | -200,000 | -100,000 | -100,000 | -200,000 | -50,000 | -150,000 | -200,000 | -50,000 | -150,000 |
| Inv. Withdrawals (+) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Loans (+) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Loan repayment (-) | -50,000 | -50,000 | 0 | -50,000 | -50,000 | 0 | -50,000 | -50,000 | 0 |
| Balance | 450,000 | 50,000 | | 450,000 | 150,000 | | 450,000 | 175,000 | |
| Carryover prev. month | 100,000 | 100,000 | | 550,000 | 150,000 | | 1,000,000 | 300,000 | |
| Bal. Carried forward | 550,000 | 150,000 | | 1,000,000 | 300,000 | | 1,450,000 | 475,000 | |

PREPARATION

To prepare the cash plan, each item of the scheme's cash outflow and inflow are evaluated on a monthly basis throughout the year; previous cash and bank books should be used, adjusting for the number of members and cost of services for the current year.

MONITORING

The cash plan should be closely monitored on a monthly basis so that corrective action may be taken if necessary.

If cash outflow is low, the scheme should make good use of its money by placing it in a safe place and investing it with interest (preferably low risk investments).

If a negative cash position is projected, the cash plan is needed to negotiate loans or extensions in payment deadlines with creditors, take action to obtain some cash inflow earlier than planned or sell an asset to obtain new funds.

5.2.5 THE INCOME AND EXPENDITURE STATEMENT

BASIS

Cash book and bank book.

DEFINITION

The statement of income and expenditure (or income statement) is a summary of an organisation's revenue and expenses over a given period (Figure 5.23). The income statement illustrates how much the organisation earns or loses during the year by subtracting expenses from revenue to arrive at a net result, which is either a profit or a loss.

FIGURE 5.23 EXAMPLE OF AN INCOME AND EXPENDITURE STATEMENT

YEFRE MHO STATEMENT OF INCOME AND EXPENDITURE - 1998

| 1998 | (in cedis.) |
|----------------------------|-------------------|
| Income: | |
| Member dues | 10,000,000 |
| Registration | 2,000,000 |
| Fund raising | 5,000,000 |
| Interest & misc. income | 3,000,000 |
| Total | 20,000,000 |
| Expenditure: | |
| Health care bills (Claims) | 11,000,000 |
| Wages and salaries | 3,000,000 |
| Marketing costs | 1,500,000 |
| Training | 1,000,000 |
| Other Operating costs* | 1,500,000 |
| Total | 18,000,000 |
| Surplus (loss) | 2,000,000 |

* Other operating costs include 500,000 depreciation for 1998. A motorbike was purchased during 1998 but the entire cost is not included as an expenditure since it will be depreciated.

PREPARATION

Expenditure, whether paid immediately by the bank or out of petty cash, or whether payment is deferred in time by incurring a debt (money owed to suppliers) may have two purposes: either it serves to acquire durable goods (such as buildings or vehicles) that will become part of the scheme's assets and will be depreciated, or it is used to pay for certain goods and services the scheme needs to do its work; this may be reimbursement for health care, travel costs, rent, etc. However, only the second category is a recurrent expenditure and has a negative effect on the scheme's income.

Similarly, income may be earned immediately or over time and may come from two types of sources: sources external to the scheme, such as grants and loans, or internal sources based on its activities, such as membership dues, interest on investments, etc. Only this category of revenue has a positive effect on a scheme's income.

In summary, expenditures include all the expenses which are not depreciated, as well as the depreciation amount for the period only, loan repayments and taxes; revenue includes all the earnings from activities for the period.

The outcome is a profit if revenue is greater than recurrent expenditures and a loss if recurrent expenditures are greater than revenue.

5.2.6 THE BALANCE SHEET

BASIS

Register of invoices, asset register, depreciation table, cash and bank book, bank statements.

DEFINITION

The balance sheet is a summary table that shows the status of the organisation's worth at a given date (Figures 5.24 and 5.25). From the balance sheet, it is possible to

FIGURE 5.24 BALANCE SHEET EXAMPLE

| YEFRE MHO BALANCE SHEET AS AT 30 TH JUNE 1999 (IN '000 CEDIS) | | | |
|--|---------------|------------------------------------|---------------|
| Assets (Uses) | | Liabilities (Sources) | |
| Short-term assets: | | Short-term liabilities: | |
| Cash | 1,800 | Accounts payable | 3,000 |
| Accounts receivable | 8,000 | Short-term debt | 15,000 |
| Short-term investments | <u>6,000</u> | Total short-term liabilities | <u>18,000</u> |
| Total short-term assets | 15,800 | Long-term debt: | 20,000 |
| Long-term assets: | | Reserve fund | 30,000 |
| Equipment | 30,000 | Profit (loss) for the fiscal year: | <u>2,800</u> |
| Investments | 25,000 | | |
| Total long-term assets | <u>55,000</u> | | |
| TOTAL ASSETS | 70,800 | TOTAL LIABILITIES | 70,800 |

answer the question: where has the money come from and how has it been used? The balance sheet gives the value of assets (properties or how the money has been used) and liabilities (debts or where has the money come from?) and net worth.

PREPARATION

The balance sheet should contain the following line items:

- ◆ Total assets, comprised of current and long-term assets.
 - ❖ Current assets are assets that will be converted to cash or will be used by the scheme in a year or less, and comprise the following:
 - ▼ Cash: Cash available on the date of the balance sheet; this includes all cash in hand and cash in current and savings accounts (from cash and bank books, after bank reconciliation has been performed).
 - ▼ Accounts receivable: Total income that was earned prior to the date of the balance sheet and is yet to be received (from register of invoices).
 - ▼ Short-term investments: Investments that can be redeemed in less than one year, such as treasury bills (from bank statements and other proofs).
 - ◆ Long-term assets are assets that are durable and assets that will be converted to cash in more than one year, and comprise the following:
 - ▼ Equipment: Cost of all depreciable equipment less accumulated depreciation (from depreciation table).
 - ▼ Land and building: Cost (book value) of land and buildings, if owned by the scheme, less accumulated depreciation (from depreciation table).
 - ▼ Long-term investments: Investments that can't be converted into cash in less than one year (from bank statements).
- ◆ Total Liabilities, comprised of current liabilities and long-term liabilities.
- ◆ Current liabilities are the debts of a scheme that are due within one year, and are comprised of the following:
 - ❖ Accounts payable: Bills from providers and suppliers which are due but haven't been paid (from register of invoices).
 - ❖ Short-term debt: Any loan (debts) due within a year (from bank statements and other proofs).
- ◆ Long-term liabilities are loans (debts) that are due within a period over a year (from bank statements and other proofs).

It is highly recommended that insurance schemes hold a reserve or endowment fund, in the event of unpredictable increases in expenditures, such as a malaria epidemic or a high rate of inflation; the recommended amount is the equivalent of six months' health care bills and is treated as a liability.

Total assets should ALWAYS equal total liabilities, and the difference between total assets and total liabilities will result in a deficit or surplus in the general (operating) fund (reserve).

The balance sheet can also be presented in the following alternative format:

FIGURE 5.25 BALANCE SHEET: EXAMPLE 2

YEFRE MHO BALANCE SHEET AS AT 30TH JUNE 1999

| Fixed assets (Uses) | Cost | Depreciation | Net |
|---|-----------------|---------------------|-----------------|
| Office equipment | ¢60,000 | ¢5,000 | ¢55,000 |
| Land and building | ¢100,000 | ¢10,000 | ¢90,000 |
| | ¢160,000 | ¢15,000 | ¢145,000 |
| Current assets | | | |
| Cash in hand | ¢20,000 | | |
| Cash at bank | ¢50,000 | | |
| Stock of drugs | ¢30,000 | ¢100,000 | |
| | | | ¢245,000 |
| Liabilities (Sources) | | | |
| Equipment grants | | | ¢80,000 |
| Short-term debts (Service providers) | | | ¢65,000 |
| Member contributions | | | ¢100,000 |
| | | | ¢245,000 |

MODULE 5.3

COST ACCOUNTING

Cost is defined as the sum of all payments or expenditures made in order to produce an article or deliver a service.

“Cost accounting is involved with the identification, measurement, collection, analysis and communication of financial information. It includes the procedures for processing and evaluating operating cost data and reporting such cost information to management or other interested parties. The reports often include comparisons against historical and predicted standards of performance. By understanding the amount and nature of how costs are incurred, scheme managers are better prepared to make improved decisions as to how resources are more efficiently and effectively employed.”

Unit 3 presented formulas to determine the costs of different services for the purpose of setting premiums and budgeting. The scheme should continuously collect and analyse such data. If, for example, the scheme realises a service has an unusually high cost per member and could jeopardise the MHO’s financial stability, it can suggest to the governing body and to members to maintain the service, yet introduce a co-payment for that particular service.

Unit 7, highlights the importance of using management information systems (MIS). The MIS system provides statistical data that should be used to monitor trends and compare category breakdowns from year to year, as well as compare them with breakdowns from other schemes or similar organisations.

Example 1: Breakdown of expenditures

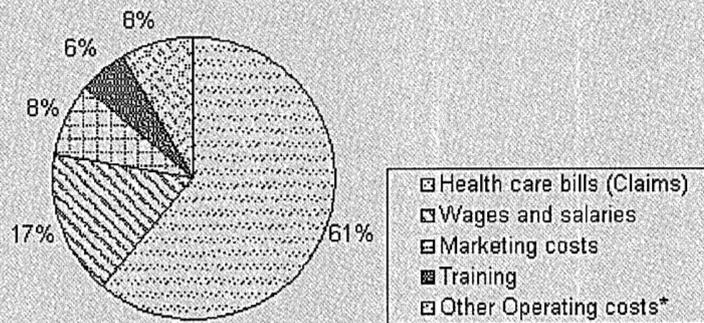
Using the following example, a pie chart can be designed that shows the breakdown of costs.

If the cost of health care increases from 61 percent to 75 percent for one year to another, management should order a careful analysis to show the exact cause of the increase and whether it is a problem or not.

FIGURE 5.26 EXAMPLE OF A BREAKDOWN OF COSTS

| Yefre MHO | Costs |
|----------------------------|------------|
| Health care bills (Claims) | 11,000,000 |
| Wages and salaries | 3,000,000 |
| Marketing costs | 1,500,000 |
| Training | 1,000,000 |
| Other Operating costs* | 1,500,000 |

BREAKDOWN OF COSTS - YEFRE MHO



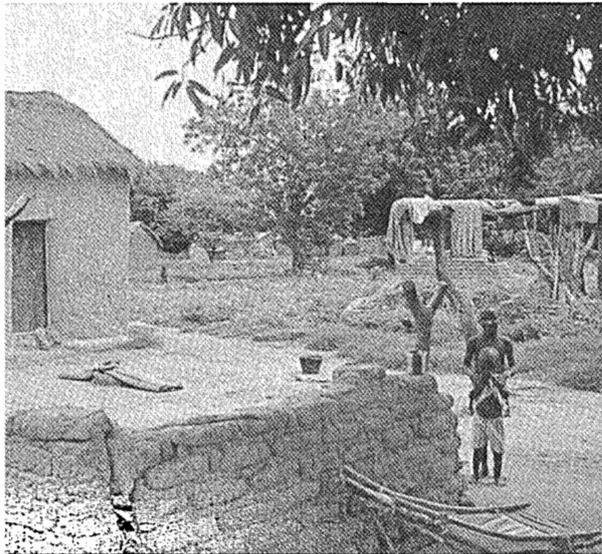
Example 2: Breakdown of health care bills

Even though MHO schemes have no control over the price of medical services, it is still extremely important that the costs from different services be recorded and monitored. Not only can seasonal trends be identified and preventive management put in place, but also, those services that are extremely costly and tend to put the scheme in financial jeopardy can be highlighted and action taken (e.g. no longer offer the service, require co-payment, etc.).

Other elements of cost accounting are discussed in Unit 7.

UNIT 6

HUMAN RESOURCES MANAGEMENT



| | |
|---|-----|
| INTRODUCTION | 143 |
| Module 6.1 RECRUITMENT AND HIRING | 144 |
| 6.1.1 DEFINING TASKS | 145 |
| 6.1.2 PREPARING JOB DESCRIPTIONS AND SPECIFICATIONS | 145 |
| 6.1.3 DETERMINING REMUNERATION/BENEFIT PACKAGE | 148 |
| 6.1.4 HEALTH AND SAFETY | 148 |
| 6.1.5 RECRUITMENT/SELECTION: | 149 |
| 6.1.6 APPOINTMENT AND PLACEMENT | 150 |
| 6.1.7 ORIENTATION | 150 |
| Module 6.2 STAFF DEVELOPMENT AND TRAINING | 151 |
| 6.2.1 TRAINING | 151 |
| 6.2.2 STAFF DEVELOPMENT | 151 |
| 6.2.3 STAFF PERFORMANCE APPRAISAL | 152 |
| 6.2.4 DISCIPLINE | 152 |
| 6.2.5 SUPPORT AND SUPERVISION | 152 |

LEARNING OUTCOMES

At the end of this unit, the participant should be able to:

- ◆ Determine staffing needs
- ◆ Develop job descriptions
- ◆ Recruit staff
- ◆ Manage staff

TARGET GROUP

- ◆ Manager
- ◆ Co-ordinator
- ◆ Accountant (if he manages other staff)
- ◆ Board of Directors

PREREQUISITES

Units 1 and 2

CONTENT

Basic principles of human resources management (HRM) of an MHO
Processes of HRM

TRAINING METHODS

Plenary session
Presentation
Group assignment

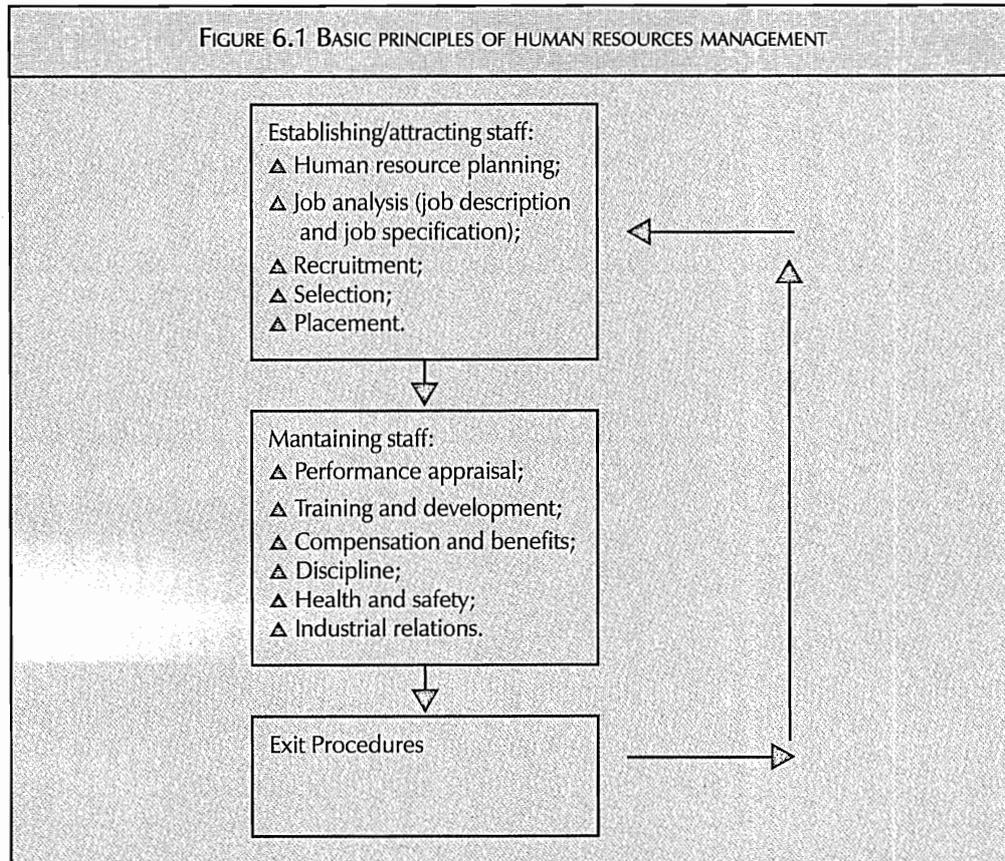
TEACHING MATERIALS

Slides
Supporting text
Flipcharts

INTRODUCTION

Human resources management is the process of determining staffing needs, recruitment and placement; training and development; and providing motivation, support and supervision of the human assets of an organisation. It deals with the strategic issues and takes a holistic view of the staff of an organisation.

Figure 6.1 is a flow chart that illustrates the basic principles of human resources management.



MODULE 6.1

RECRUITMENT AND HIRING

This module will explain the processes involved in establishing staff positions and recruiting and hiring staff. Briefly the steps are:

1. Define tasks
2. Prepare job descriptions
3. Set qualification requirements and candidate profile
4. Determine remuneration/benefit package
5. Implement recruitment process:
 - ❖ Advertisement
 - ❖ Selection
 - ❖ Interview
 - ❖ Appointment
 - ❖ Placement
6. Conduct orientation

Knowledge of the following terms will be useful to understanding this module:

Human resource planning: The process of determining human/manpower requirements and the means for meeting these requirements in order to carry out the tasks of the organisation. In practical terms, it involves ensuring that the right people are in the right job at the right time.

Job analysis: The process of defining all the tasks that are to be carried out and translating/classifying them into jobs in order to identify positions to be filled. It includes creating job descriptions and job specifications

Job description: Statement of the purpose, scope, organisational relationships, responsibilities and tasks which constitute a particular job.

Job specification: Description of the personal characteristics and qualifications and other personal requirements for the job. It normally outlines the type of employee required for a job in terms of skill, experience and special aptitudes. Qualifications spell out the skills, technical know-how and relevant experience of a prospective employee.

The following sections describe the steps for recruitment and hiring process.

6.1.1 DEFINING TASKS

- ◆ List all the tasks that need to be done by the MHO
- ◆ Classify the tasks into jobs
- ◆ Identify positions to be filled, for example: manager, co-ordinator, public relations manager, cashier, accountant, field worker, secretary, messenger, driver, cleaner

6.1.2 PREPARING JOB DESCRIPTIONS AND SPECIFICATIONS

Components of a job description are:

- ◆ Job title
- ◆ Appointed by
- ◆ Responsible to
- ◆ Overall purpose
- ◆ Key result areas (task descriptions)
- ◆ Performance standards

Standards need to be set as part of a job description.

For example, performance will be deemed to be up to standard when:

1. Realistic plans are made to assure financial viability of the MHO for the year to come.
2. Performance management is introduced by the end of the year 2000 and used annually.
3. Quarterly and annual financial and annual project reports are prepared and presented to the Board on schedule.
4. Relevant data on enrolments, usage and cash flows are documented, analysed and feedback is given to the Board, staff and MHO members.

GROUP ASSIGNMENT: JOB DESCRIPTIONS

Based on their familiarity with real MHOs and knowledge learned from earlier units of this manual, ask participants to define typical MHO tasks, classify those tasks into jobs and identify positions. Then have them write job descriptions for each position.

Be sure participants mention the following positions and duties:

MANAGER

- ◆ Ensures security of cash
- ◆ Supervision
- ◆ Authorises disbursements
- ◆ Makes investments
- ◆ Ensures preparation of reports (financial and activities) and analysis
- ◆ Oversees internal auditing
- ◆ Directs human resource management
- ◆ Oversees budget preparation
- ◆ Does planning and monitoring
- ◆ Liaises with Board of Directors and other groups
- ◆ Translates policy

- ◆ Ensures discipline
- ◆ Ensures regular auditing of accounts

CO-ORDINATOR(S)

- ◆ Co-ordinate(s) field work
- ◆ Identifies and recommends field workers
- ◆ performs in-service training
- ◆ Collects premiums and contributions from field workers
- ◆ Does recordkeeping of field activities

PUBLIC RELATIONS/SOCIAL MARKETING OFFICER

- ◆ Co-ordinates information and education activities
- ◆ Ensures customer service
- ◆ Organises community durbars/meetings
- ◆ Prepares advertising materials
- ◆ Makes media contacts
- ◆ Oversees design, printing, distribution of materials

CASHIER

- ◆ Oversees revenue collection
- ◆ Does banking
- ◆ Pays salaries and other allowances

NB: The work of the cashier and accountant depends on the size of the MHO.

ACCOUNTANT

- ◆ Ensures security of cash
- ◆ Records cash transactions
- ◆ Prepares information for disbursements
- ◆ Prepares financial reports
- ◆ Processes salaries and other allowances
- ◆ Verifies bills
- ◆ Prepares budget
- ◆ Supervises accounting staff
- ◆ Reconciles bank statement and other books of accounts
- ◆ Keeps assets register and other valuable books of accounts, and safeguards the assets of the MHO

FIELD WORKER(S)/CONTACT PERSON(S)

- ◆ Registers members
- ◆ Disseminates information/marketing of scheme
- ◆ Collects dues and registration fees
- ◆ Liaises with community leaders

SECRETARY

- ◆ Does correspondence
- ◆ Does typing
- ◆ Does filing

- ◆ Manages office
- ◆ Reports and keeps minutes
- ◆ Organises meetings
- ◆ Does recordkeeping
- ◆ Answers phone
- ◆ Serves as receptionist

OUTSOURCE

- ◆ Equipment maintenance

GROUP ASSIGNMENT: JOB SPECIFICATIONS

Qualifications for recruitment and hiring depend on the calibre of employees required. This includes their technical qualifications and aptitudinal and behavioural characteristics. For each position listed in the preceding exercise, have participants list minimum requirements which prospective employers could use when hiring. Be sure lists include the qualifications enumerated below.

MANAGER

- ◆ Higher National Diploma or higher degree, depending on size and scale of MHO
- ◆ Knowledge of simple accounting principles
- ◆ Credibility in the community
- ◆ Ability to work with and through people
- ◆ Five years working experience

CO-ORDINATOR

- ◆ Secondary education
- ◆ Training experience
- ◆ Availability for extensive travel
- ◆ Ability to work with and through people
- ◆ A valid motor/bike driving license
- ◆ Three years working experience

PUBLIC RELATIONS/SOCIAL MARKETING OFFICER

- ◆ "A" Level or certificate in social work
- ◆ Ability to speak appropriate local language
- ◆ Experience in social mobilisation activities
- ◆ Excellent negotiation skills
- ◆ Ability to work with minimal or no supervision
- ◆ Ability to work with and through people
- ◆ Three years working experience

CASHIER

- ◆ RSA II, SSS
- ◆ Provide two sureties
- ◆ Two years working experience

ACCOUNTANT

- ◆ RSA 111, GCE A Level
- ◆ Ability to supervise subordinates
- ◆ Three years working experience

FIELD WORKER/CONTACT PERSON

- ◆ Middle School leaving certificate/JSS
- ◆ Provide two sureties
- ◆ Ability to keep accurate records
- ◆ Ability to speak the appropriate local language
- ◆ Excellent public relations skills
- ◆ Two years working experience

SECRETARY

- ◆ SSS, NVTI for secretarial practices
- ◆ Ability to type 40 words per minute
- ◆ Good public relations skills
- ◆ Computer literacy an advantage
- ◆ Two years working experience

6.1.3 DETERMINING REMUNERATION/BENEFIT PACKAGE

The determination of remuneration package(s) for staff of an MHO is extremely difficult since an MHO is not a profit-making entity. In order to motivate them to perform their assigned tasks, consideration of a suitable salary and allowance packages relevant to the community concerned should be developed accordingly. The package should be designed with the size of the MHO in perspective. The existing salary structure of comparable non-governmental organisations would be a source of information.

Core benefits should include:

- ◆ Salaries, allowances and social security
- ◆ Medical treatment (as for an MHO member)

Fringe benefits may include:

- ◆ Rewards, both extrinsic and intrinsic
- ◆ Certificates of appreciation
- ◆ Verbal statements of appreciation
- ◆ The provision of welfare funds

6.1.4 HEALTH AND SAFETY

Organisations are required to provide a clean, healthy and safe working environment for their staff. This includes protective clothing (e.g. helmet, boots, etc); medical treatment for injuries during work; private insurance (workman's compensation).

In addition, the law requires that any establishment with more than five employees should register the staff with the Social Security and National Insurance Trust (SSNIT). However, to ensure the future of the employees, small MHOs with fewer than five employees at their secretariat are strongly encouraged to register with SSNIT.

6.1.5 RECRUITMENT/SELECTION:

Recruitment and selection is the process of attracting and hiring employees for an organisation. The major goal of recruitment is to create a large pool of persons who are able and willing to work for the organisation. It involves a search effort both inside and outside the organisation.

Selection is the process of hiring employees who will best fit the needs of the organisation. The selection decision is based on the analysis of relevant information on the would-be employees and the job itself to select the right employee.

The recruitment process:

- ◆ Determines actual need for staff
- ◆ Makes provision in the budget for a salary
- ◆ Ensures that money is available to pay the salary on an on-going basis
- ◆ Set work plan for hiring process
- ◆ Advertises within the community, using local FM radio, oral advertisement and other suitable methods that are available
- ◆ Specifies mode of application: required profile, drop-off point, date, time, references
- ◆ Reviews applications, short-lists applicants
- ◆ Prepares for interview: prepares checklist for interviewing (see Technical Note 6.1); constitutes an interview panel
- ◆ Prepares interview form, agree on criteria and rating (see Technical Note 6.1)
- ◆ Arranges on date and place of interview and documents the applicants should bring, e.g. original certificates, testimonials, etc

TECHNICAL NOTE 6.1 CHECKLIST FOR INTERVIEWING

DURING INTERVIEW

- ▲ Introduce panel members to interviewee
- ▲ Ask interviewee to introduce him/herself
- ▲ Explain responsibilities of the available position to the interviewee
- ▲ Identify skills, knowledge and experience required for employment
- ▲ Describe conditions of service, including working hours, salaries and incentives
- ▲ Ask the applicant to discuss his/her skills, knowledge and experience and why he/she wants the job
- ▲ Ask the applicant if he/she has any questions
- ▲ Inform interviewee when to expect result

AFTER INTERVIEW

- ▲ Panel decides regarding the suitability of the applicant
- ▲ Panel selects suitable candidate or re-starts process

6.1.6 APPOINTMENT AND PLACEMENT

The appointment letter should contain the following:

- ◆ Job title
- ◆ Salary range and starting point
- ◆ Job description (as attachment)
- ◆ Conditions of service (as attachment)
- ◆ Effective date of appointment
- ◆ Date for acceptance or rejection of offer of appointment
- ◆ Need for medical certificate
- ◆ Probation period

6.1.7 ORIENTATION

Orientation aims at enabling the new employee to familiarise him/herself with the work environment. The new employee has to be introduced to the work culture, and jargons of the organisation and the authority relationships that exist.

The process of orientation includes the following activities:

- ◆ Welcome
- ◆ Introduction to senior, junior and support staff
- ◆ Tour of working space (place) and organisation
- ◆ Briefing
 - ❖ Culture of organisation
 - ❖ Mission of organisation
 - ❖ Expectations (both sides)
 - ❖ Reporting relationships
 - ❖ Working hours
 - ❖ Grievance and discipline procedures
 - ❖ Provide reports, previous studies, etc.
- ◆ Attachment to various units and departments
- ◆ At the end of the orientation session, the new employee assumes full responsibility

MODULE 6.2

STAFF DEVELOPMENT AND TRAINING

6.2.1 TRAINING

Training is a process of sharpening the skills of an employee to enable him/her improve upon performance in the current job. The training process involves the following steps:

- ◆ Determine training needs through supervision, performance appraisal and in relation to job requirements/description
- ◆ Develop training tools
- ◆ Develop in-service training programme
- ◆ Prepare budget
- ◆ Organise the training
- ◆ Evaluate the training session (this is a continuous process through appraisal)

6.2.2 STAFF DEVELOPMENT

Staff development is a continuous process of evaluating the staff needs in an organisation in order to determine new knowledge, skills and attitudes (KSA), that are required by staff to enable them perform new task(s).

PROCESS

- ◆ Assess organisational objective
- ◆ Determine training needs
- ◆ Develop career plan for staff
- ◆ Search/look for training institutions
- ◆ Develop succession plan for staff
- ◆ Determine type of training and budget
 - ❖ Attachment
 - ❖ Apprenticeship
 - ❖ Short and long courses (within and outside the institution and/or the country)
 - ❖ Bond/agreement (ensure that the organisation utilises the staff on return before he/she decides to leave)

6.2.3 STAFF PERFORMANCE APPRAISAL

Performance appraisal is the process of evaluating performance in relation to previously agreed standards and specific targets. There are two types of appraisal systems:

- ◆ Staff appraisal system
- ◆ Management team appraisal system

Staff appraisal should be done on a regular basis by the supervising officer. The supervisor should base the appraisal on a checklist created from the agreed standards. The standards may differ for senior and junior staff. The parties involved are the supervisor, subordinate and countersigning officer.

The management team appraisal system is a process where all members of the management team appraise the performance of the whole organisation in relation to their own performance over a specified period.

People involved in appraisal

- ◆ Appraisee
- ◆ Supervisor

6.2.4 DISCIPLINE

Discipline is a process of instituting and using corrective and punitive measures to encourage changes of unacceptable behaviour.

Procedure:

- ◆ Counselling (discuss with offender possible causes of misbehaviour)
- ◆ Verbal warning (reprimand offender)
- ◆ Written query
- ◆ Hearing

6.2.5 SUPPORT AND SUPERVISION

Support and supervision facilitate working relations. Activities include:

- ◆ Regular meetings
- ◆ Regular visits to subordinate
- ◆ Field trips with checklist to have on-the-spot checks
- ◆ In-service training
- ◆ Open-door policy of managers
- ◆ Regular feedback from managers
- ◆ Clear definition the process of supervision and who does what (line of authority, unity of command, span of control)
- ◆ Staff appraisal

UNIT

7

MONITORING, EVALUATION AND CONTROL IN A MUTUAL HEALTH ORGANISATION



| | |
|--|-----|
| Module 7.1 MONITORING AND EVALUATION | 156 |
| 7.1.1 DEFINITIONS | 156 |
| 7.1.2 INDICATORS OF MONITORING AND EVALUATION | 158 |
| Module 7.2 MECHANISMS OF CONTROL | 169 |
| 7.2.1 CONTROL OF MHO ACCOUNTS | 169 |
| 7.2.2 CONTROL OF MHO MANAGEMENT | 170 |
| 7.2.3 CONTROL OF MHO BENEFITS/SERVICES | 170 |
| Module 7.3 FINANCIAL AUDIT | 172 |
| 7.3.1 BASICS OF A FINANCIAL AUDIT | 173 |
| 7.3.2 IMPLEMENTING A FINANCIAL AUDIT | 178 |
| Module 7.4 MANAGEMENT AUDIT | 186 |
| 7.4.1 DEFINITION AND OBJECTIVES OF MANAGEMENT AUDITING | 187 |
| 7.4.2 NORMS OF MANAGEMENT AUDITING | 189 |
| 7.4.3 IMPLEMENTING A MANAGEMENT AUDIT | 189 |
| 7.4.4 PROCEDURES, TECHNIQUES AND TOOLS | 190 |
| 7.4.5 EVALUATION OF THE EFFECTIVENESS OF THE MANAGEMENT COMMITTEE AND THE BOARD OF DIRECTORS | 191 |
| 7.4.6 AUDITING THE STRATEGY | 193 |
| 7.4.7 AUDITING CASH MANAGEMENT | 193 |
| 7.4.8 AUDITING THE RECORD-KEEPING AND ARCHIVING SYSTEMS | 193 |
| 7.4.9 SOCIAL AUDITING | 194 |
| 7.4.10 AUDITING OF MANAGEMENT TOOLS | 194 |
| 7.4.11 AUDIT REPORT | 194 |

LEARNING OBJECTIVES

At the end of this module the participants will be able to understand and explain the basic monitoring, evaluation and control processes involved in running an MHO, including audits of both the finances and the management.

CONTENT

Module 1: Monitoring and Evaluation

- ◆ Definitions
- ◆ Indicators

Module 2: Mechanisms of Control

- ◆ Control of the accounts
- ◆ Control of the management
- ◆ Control of the beneficiaries and non-beneficiaries
- ◆ Control over the utilisation of the services
- ◆ Medical control

Module 3: Financial Audit

Module 4: Management Audit

TARGET GROUPS

- ◆ Senior elected officers of an MHO
- ◆ Manager
- ◆ Co-ordinator
- ◆ Accountant
- ◆ Cashier
- ◆ Marketing officer or public relations officer
- ◆ Members of the Board of Directors
- ◆ Members of the executive committee
- ◆ Members of the supervisory or watchdog/oversight committee

PREREQUISITES

The participants should have gone through modules 1–6.

TRAINING METHODS

- ◆ Handouts
- ◆ Audio-visual aids
- ◆ Flipchart
- ◆ Practical exercises

INTRODUCTION

This unit will briefly consider three areas pertaining to the monitoring, evaluation and control processes in an MHO. It will examine the different types of indicators which are the chief instruments of any process of monitoring and evaluation as well as the verification and auditing of the accounts and services of the MHO.

As in every enterprise, it is the duty of the MHO's leaders to know the stage of execution of its programmes, and to evaluate periodically that both the spirit and letter of the MHO's mission are being followed. To do this, they must have the tools that require them to organise systematically all the information regarding the operation of the organisation.

In addition, periodic audits are necessary to ensure that various organs set up by the MHO, and especially its management, are fulfilling their responsibilities, that they have executed their duties faithfully and honestly, that if there are any abuses they can be checked in time, that procedures laid down by the MHO are being followed, etc. Properly done audits give confidence to both the members and external partners of the MHO that it is a going and worthwhile concern operating in accordance with objective standards required of such types of enterprise. In short, audits are an instrument of monitoring, verification and control.

Two forms of audits are discussed here: financial and management. Each deal with specific but interrelated areas of the organisation's life that need close and regular attention. Although it is standard practice to call in technical experts to carry out audits, the MHO has an interest in understanding the audit processes in order to:

- ◆ Set the appropriate terms of reference for the audit team;
- ◆ understand and appreciate the report that will be submitted by the auditors, often written in technical language;
- ◆ Judge the quality of the report and assess whether it fully meets the terms of reference and therefore represents the product they have paid for; and
- ◆ Make use of the report to improve the performance of their organisation.

In addition, the information in these modules on auditing serves a related but more basic purpose: for MHOs to recognize and correct problems for themselves, before an external audit. Experience has frequently shown that many organisations and individuals are found wanting by external auditors not because they have been dishonest or incompetent in their work, but simply because they lack knowledge of the kinds of verification and documentation revealed by an audit. In other words it is useful for them to know the procedures involved so that the organisation is run in accordance with the required norms in the first place rather than wait for an auditor to 'correct' problems later, an experience that can be very painful for both individuals and organisations involved.

The Supervisory or Oversight Committee of an MHO is usually empowered to carry out evaluations and audits on behalf of the General Assembly.

MODULE 7.1

MONITORING AND EVALUATION

7.1.1 DEFINITIONS

MONITORING

Monitoring is an activity which consists of making sure that the MHO's programme is running according to the provisions fixed beforehand or according to the norms commonly accepted by the MHO movement.

Monitoring can be compared to the use of a compass by a navigator in the middle of the ocean. It enables the navigator to keep to the chosen course, and, if need be, to take appropriate remedial actions.

EVALUATION

Evaluation is a periodic activity. It is an exhaustive stock-taking or assessment carried out either during the course of an activity or at the end of the activity. Evaluation assesses on the social and financial planes, if the objectives which the association has set itself have been achieved completely, partially or not at all. It looks for the reasons for disparities between the planned and actual levels of achievement.

In addition, evaluation sheds light on:

- ◆ The implementation of the programme of activities,
- ◆ The execution of the budget,
- ◆ The quality of the management.

Internal evaluation is carried out by the members (e.g. by the Supervisory or Watchdog/Oversight Committee on behalf of the AGM) and/or the officers of the association. External evaluation requires engaging outside consultants or experts.

Monitoring and evaluation of an MHO calls on different actors, depending on the particular case and the objectives sought. They can be:

- ◆ The members
- ◆ The elected officials
- ◆ Salaried staff, in particular the managers
- ◆ The (external) promoters of the MHO association
- ◆ Personnel from (external) support institutions,
- ◆ External consultants.

INTERNAL CONTROL

Internal control will be discussed extensively in Module 7.3. In summary, that module describes internal control as the organisational plan and all the procedures adopted by an organisation to safeguard its assets, control the preciseness and the accuracy of its accounting documents, to promote the efficiency of its operations, and to follow through the policies prescribed by management.

The accounting and other control measures defined, applied and monitored by management and under its responsibility should ensure:

- ◆ Safeguarding of the assets
- ◆ Regular and accurate accounting entries for accurate financial statements
- ◆ Orderly and efficient operations
- ◆ Decision making is in accordance with management policies

SELF-EVALUATION

CONTROL BY THE MEMBERS

An MHO is a democratic organisation in which all the members are equal in rights and duties. This implies that the results of its management can be evaluated by its members. Therefore, the balance sheet, the profit and loss account and the various analyses of the financial situation must be presented in a manner that is comprehensible to each member. These documents should also be explained in simple terms during the meetings so that everyone can pose all the questions they wish to. Financial transparency is an important requirement for maintaining the confidence of members.

Self-evaluation or participatory evaluation is the most widespread technique and the most appropriate for evaluating activities whose success depend closely on the participation of the beneficiaries. It enables the beneficiaries to take charge of the strategic leadership of the association by placing them at the centre of the processes of analysis and decision making. Apart from its utility as an instrument of evaluation, it is also a central tool in the processes of animation and training which are designed to lead to the ownership of the organisation being taken by its members, and permits the latter to run the organisation according to their real needs, and not those of the people charged with the daily running of the organisation or its promoters.

The implementation of this technique depends on a number of prerequisites:

- ◆ It is necessary to have in place a truly functioning information system which allows all information relating to the social and financial objectives of the association to be made available.
- ◆ It will be necessary, for this reason, to design some self-evaluation forms indicating the immediate objective, verifiable indicators, where the relevant information can be obtained, who is responsible for their production, how they will be interpreted, etc.
- ◆ It is often necessary to develop some tools of communication and animation specially adapted to the level of understanding of members (diagrams, images, etc.).
- ◆ It is essential that the responsible staff master the techniques of animation which will enable them to ensure genuine participation and free expression by members.

7.1.2 INDICATORS OF MONITORING AND EVALUATION

The techniques of evaluation are based on a series of indicators.

There are several types of indicators, which can be classified into four categories as follows:

- ◆ **Institutional indicators**, which show the development, progress and impact of the MHO as an institution and as a social movement;
- ◆ **Indicators of the effectiveness of the MHO's service delivery**, which assess the MHO's success in delivering the defined services package to its members;
- ◆ **Indicators of efficiency**, which take effectiveness of service delivery a stage further, by assessing whether the costs associated with delivering the services have been minimised and, in particular, whether certain risks associated with running the MHO have been held in check or not;
- ◆ **Financial performance indicators**, which give an idea of the MHO's financial health.

To get a complete picture of the overall performance and viability (both financial and management) of the organisation, it is necessary to make use of all four sets of indicators.

The dynamic interpretation of these indicators is facilitated by the extent to which it is possible to establish comparisons, either in time (evolution, tendencies) or with other mutual organisations (competing MHOs or ones operating in other regions, etc.).

7.1.2.1 INDICATORS OF INSTITUTIONAL DEVELOPMENT, PROGRESS OR IMPACT OF AN MHO

The following sections discuss each category of indicators in detail.

TABLE 7.1 INDICATORS OF MHO INSTITUTIONAL DEVELOPMENT, PROGRESS OR IMPACT

| INDICATOR | DEFINITION | HOW IT IS OBTAINED OR CALCULATED | WHY IT IS IMPORTANT FOR MONITORING/EVALUATING THE MHO | OTHER REMARKS |
|---|---|--|---|---|
| Number of members/beneficiaries | Number of members is number of individuals (usually family heads) who have enrolled and paid the dues (if applicable) as titular MHO members; beneficiaries include the titular members and their enrolled dependants | Easily obtained from enrollment/ registration records; total number of beneficiaries is number of titular members plus their enrolled dependants in the MHO | Useful for checking against rate of consumption of services and for calculating other ratios/indicators; rate of growth of members /dependants very important to track as explained below | |
| The rate of growth of membership /beneficiaries | The rate of new registrations in relation to the existing membership/beneficiaries in a given period, usually a year (normally given as a percentage) | Number of newly enrolled members divided by total number of existing members times 100; number of newly enrolled beneficiaries divided by total number of existing beneficiaries times 100 | This is one of the most important indicators of the vitality of the MHO and especially of the attractiveness or relevance of its services/benefits to the target population | The number of beneficiaries per member may also be calculated and its evolution tracked especially if membership is by family with unique family fees since the number of beneficiaries per member then significantly affects the likely costs of services in relation to revenue |
| The rate of participation in meetings | This is the relationship between the number of attendees and the total number of persons expected at meetings, or the rates of attendance. | Number of attendees divided by total membership times 100 | A rate approaching 100 percent indicates a high level of participation and a high degree of motivation; can be calculated for the general assemblies, the management committee, etc. | |

TABLE 7.1 INDICATORS OF MHO INSTITUTIONAL DEVELOPMENT, PROGRESS OR IMPACT (CONT.)

| INDICATOR | DEFINITION | HOW IT IS OBTAINED OR CALCULATED | WHY IT IS IMPORTANT FOR MONITORING/EVALUATING THE MHO | OTHER REMARKS |
|--|---|--|--|---|
| The rate of participation in elections | Relation between the number of members voting in an election and the total number eligible to vote | Number of valid votes cast in the election divided by total number of members entitled to vote times 100 | This rate gives an idea of the democratic and participative operation of the MHO. It indicates the degree of involvement of the members in its running. | |
| The rate of payment of dues | Ratio between the amount of the dues actually collected to the total amount expected during a given period | Amount of dues actually collected divided by total dues expected in the period times 100 | <p>A rate nearer to 100 percent indicates active participation and enhances the MHO's ability to pay for the services it offers. It may also signify the attainment of the objectives of a campaign of sensitisation and promotion.</p> <p>On the other hand, an unimpressive (especially declining) rate of dues payment can also signify that the members are losing interest in their association or they are experiencing important financial difficulties, or it may be that the dues' level is too high.</p> | The true reasons behind low dues' payment rates should be researched and not assumed as due to 'poverty' as is so often the case; the level of dues could be unrealistic in the context, or the services offered are not truly a priority; both should possibly be revised. |
| The percentage of members who are not in arrears with their dues | This indicator is close to the previous one, but this one is not expressed in terms of the volume of funds, but rather in accordance with the relationship between the number of members who have paid their dues and the total number of members | Number of members who have paid their dues divided by total number of members times 100 (or number of beneficiaries not in arrears divided by total number of beneficiaries times 100) | Similar to the above. | It is also interesting to see a breakdown of this ratio giving the proportion of members in arrears in terms of the number of months (or other period) of arrears. |

7.1.2.2 INDICATORS OF EFFECTIVENESS OF MHO IN ITS TARGET POPULATION

TABLE 7.2 INDICATORS OF MHO EFFECTIVENESS IN ITS TARGET POPULATION

| INDICATOR | DEFINITION | HOW IT IS OBTAINED OR CALCULATED | WHY IT IS IMPORTANT FOR MONITORING/EVALUATING THE MHO | OTHER REMARKS |
|--|--|---|---|---|
| The rate of penetration or coverage of the target population | Ratio of the number of MHO beneficiaries of the to the total target population. This target group could be a geographic zone, a village, a professional branch, an enterprise, a trade union, etc. | Total number of beneficiaries divided by total population of target group times 100 | The rate of penetration gives an indication of the representativeness of the MHO and its impact on the community in which it is working. Like the rate of growth of membership, it indicates the attractiveness or relevance of the MHO's services. Lastly, it measures the extent to which the MHO has enabled access to quality health care for the target group, a common objective of an MHO. | This indicator can be further decomposed into the rate of participation by sex or age, in order to discover more precisely which sections of the population are adhering in higher numbers to the MHO and which are adhering less. This information could be useful for designing promotional campaigns |
| The rate of attendance at medical facilities or utilisation of the services by beneficiaries | Ratio of the number of consultations by the beneficiaries at the health facilities to the total number of beneficiaries of the MHO during a given period | Number of consultations or visits by beneficiaries divided by total number of beneficiaries times 100 | A rising rate of attendance could signify an improvement in accessibility to health care (the MHO's objective), but it could also be the result of over-consumption, the appearance of an epidemic, bad quality health care, etc. | The evolution of the rate of attendance at health facilities by the beneficiaries compared to other users is an interesting indicator of MHO performance but requires close study to determine if a rise is caused by over-consumption or better access. |
| The rate of cover (insurance) provided by the MHO | The proportion of the health care costs paid by the MHO in relation to the total costs, i.e. what the MHO pays for the beneficiary's health care costs excluding co-payments, deductibles and ceilings | If an MHO covers 80 percent of the costs, then the rate of cover is 80 percent. If the MHO covers a fixed number of days of hospital admission days, then the rate of cover is that fixed number of days allowed divided by the average hospital duration, times 100. | E.g. An MHO which imposes a co-payment of 50 percent is, a priori, less attractive than one where the charge is 20 percent. However, the co-payment must be considered along with the relationship of dues to services offered. | |

TABLE 7.2 INDICATORS OF MHO EFFECTIVENESS IN ITS TARGET POPULATION (CONT.)

| INDICATOR | DEFINITION | HOW IT IS OBTAINED OR CALCULATED | WHY IT IS IMPORTANT FOR MONITORING/EVALUATING THE MHO | OTHER REMARKS |
|---|---|---|--|--|
| The rate of morbidity among the members | Ratio of the number of cases of a given illness in a given population and the total size of that population | <p>Number of cases of beneficiaries falling ill divided by total beneficiary population times 100.</p> <p>Repeat visits for the same episode of illness are not counted; but the same beneficiary falling ill at different times will be counted as separate cases.</p> | <p>This is an important indicator of the health of the members, on the whole. A decline in the morbidity rate within the MHO population can signify an improvement of the health care cover, so long as all cases of illnesses are actually registered, i.e. all the sick people seek treatment. However, care must be taken not to misinterpret the findings: if an MHO increases access to health care, then it is possible that more people will <i>report</i> ill to the health facilities covered, which will not necessarily mean that more people are <i>falling</i> ill.</p> | <p>The ratio can be calculated for the MHO population itself and compared with the data available for the whole population of a region or country, when such statistics are available.</p> <p>The comparison of this ratio for the beneficiaries of the MHO and the general morbidity rate will permit an appreciation of the health cover provided by the MHO</p> |
| The rate of mortality among members | Ratio of the number of deaths among members to the total number of members in a course of a given period. | Number of deaths among beneficiaries in given period (say 1 year) divided by total number of beneficiaries times 100 | It is interesting to compare the rate of death among members to the average mortality of the population concerned (of a region, a country, etc.), in order to measure the impact of membership of the association on health in general. | |

TABLE 7.2 INDICATORS OF MHO EFFECTIVENESS IN ITS TARGET POPULATION (CONT.)

| INDICATOR | DEFINITION | HOW IT IS OBTAINED OR CALCULATED | WHY IT IS IMPORTANT FOR MONITORING/EVALUATING THE MHO | OTHER REMARKS |
|------------------------|---|--|---|--|
| Quality of health care | A noticeable improvement in the quality of health care delivered to members as perceived by the members and (in this case) in terms of the usual indicators that are important to those members (see usual criteria in next column) | These are not easy to measure normally, but in general, MHO members in Ghana and other African countries tend to perceive quality of health care in terms of: i) Staff attitudes to patients (best measured through a consumer satisfaction survey) ii) Average waiting time to see a doctor or other health personnel (direct observation at relevant waiting areas is best, but consumer survey can also be done) iii) Over-crowding: direct observation against an accepted norm is required iv) Drugs availability: calculate average stock-out duration for all required drugs over a period v) Cleanliness: direct observation required | MHOs tend to be successful only when they are organised around a provider or providers who give quality health care; otherwise, the MHO will make it one of its objectives to achieve improvements in the areas indicated in the previous column. This means that quality indicators are among the most useful that the MHO should use to evaluate the effectiveness of its services. | Other more sophisticated measures of quality of care exist, including the quality of the doctors' prescriptions and other interventions, but their measurement is beyond the means of most MHOs. However, MHOs or groups of MHOs who have a medical advisor and pharmacist employed to assist them can undertake such evaluations as well. |

An analysis of effectiveness may usually also include the number and kinds of illnesses/conditions covered by the dues and the number and range of other social risks covered.

7.1.2.3 INDICATORS OF EFFICIENCY

It is not easy to evaluate overall efficiency of MHO service delivery by means of measurable indicators. It is relatively easy to determine the number and financial volume of the services rendered, but more difficult to appreciate their quality. Indicators are not sufficient and must often be supplemented by satisfaction surveys or interviews among the members themselves.

The state of good health is difficult to estimate, except with the aid of indirect indicators such as the rate of vaccination, infant and maternal mortality rates or life expectancy. Since state of health is not truly quantifiable, the attempt to capture it is often through the use of negative indicators (health expenditure, incidence of illness or of malnutrition, etc.).

TABLE 7.3 INDICATORS OF EFFICIENCY OF THE MHO'S SERVICE DELIVERY AND RISK MANAGEMENT

| INDICATOR | DEFINITION | HOW IT IS OBTAINED OR CALCULATED | WHY IT IS IMPORTANT FOR MONITORING/EVALUATING THE MHO | OTHER REMARKS |
|---|--|---|---|--|
| The evolution of health care expenses per beneficiary | The level of health care expenses per beneficiary is measured by the relationship between the total volume of expenses and the number of beneficiaries | Divide the total expenses of the MHO on health care (refunds or payments to the providers) by the total number of beneficiaries | The calculation for any one year by itself is not as important as the trend over a number of years. Its evolution indicates the rate of consumption of health care. | By breaking down the expenses according to their category (drugs, consultation, admissions, etc.) it is possible to analyse the causes of fluctuations in the level of consumption, and if need be, to take the necessary corrective measures (for example to limit over-consumption or raise access to health care) |
| The evolution of expenses by health care category | The relationship between the health care expenditure in a particular category (generalist or specialist consultations, admissions, drugs, lab tests, dental care, etc.) to the total number of beneficiaries | The total expenses in the category concerned divided by the total number of beneficiaries | Measuring the evolution of expenses according to each category of health care enables the association to find out which expenditure areas are increasing most rapidly. It is very useful for making the budget, and possibly too, to take steps to control expenses related to particular categories. | As above |
| Risk management indicators | The measures or management tools used by the MHO to combat or minimise the negative effects of the main risks facing it, as described in Units 1 and 4 | Examine the MHO's rules and regulations, its policies as well as the mechanisms laid down for beneficiaries to access to health care and/or to be reimbursed; the provider payment mechanism and the means of checking the identity of beneficiaries and of ensuring that fraud is minimised (see Unit 4 for specific risks involved and suggested ways of minimising them) | The main risks involved are: adverse selection, moral hazard, fraud, and cost escalation. It is no exaggeration to say that the MHO's success or failure lies to a large degree on its risk management techniques. Yet it is an area where many MHO's are frequently found wanting, usually because they have failed to see that their activity is in essence a health insurance activity | Because of the importance of this subject, this manual devotes two modules on MHO risks (in Unit 1) and possible solutions to them (Unit 4). The reader is urged to consult those units for more detailed discussion of the subject. |

In addition, to the indicators in the table, the financial performance indicators discussed below also enable the efficiency of the MHO's activities to be assessed. A complete appreciation of the MHO's efficiency will therefore encompass more than just the factors discussed above. It should also be noted that an assessment of effectiveness is one stage in measuring efficiency, the latter relating the effectiveness achievements to their costs in order to see whether the members of the MHO are getting value for their money.

7.1.2.4 INDICATORS OF FINANCIAL PERFORMANCE

The financial monitoring indicators are all in the form of ratios (relationships between two numbers). These financial ratios are especially important because they constitute the indicators that enable a good assessment of the financial health of the MHO, i.e. its capacity to meet its obligations to members and third parties at any given moment.

The principal financial ratios in the context of a mutual health organisation are:

- ◆ The current ratio
- ◆ The liquidity ratio
- ◆ The long-term solvency ratio
- ◆ The ratio of dues to expenses or charges
- ◆ The ratio of coverage of expenditure
- ◆ The ratio of operating costs to income

CALCULATION OF RATIOS

As an example to show how the ratios are calculated from an MHO financial statement, the Yefre MHO balance sheet of 30 June 1999 is presented in Figure 7.1 and used to show the calculations of the first three ratios.

| FIGURE 7.1 YEFRE MHO BALANCE SHEET OF 30 JUNE 1999 | | | |
|--|-----------------|----------------|------------------|
| Fixed assets (Uses) | Cost | Depreciation | Net |
| Office equipment | ¢60,000 | ¢5,000 | ¢55,000 |
| Land and building | ¢100,000 | ¢10,000 | ¢90,000 |
| | <u>¢160,000</u> | <u>¢15,000</u> | <u>¢145,000</u> |
| Current assets | | | |
| Cash in hand | ¢20,000 | | |
| Cash at bank | ¢50,000 | | |
| Stock of drugs | ¢30,000 | | ¢100,000 |
| | | | <u>¢245,000</u> |
| Liabilities (Sources) | | | |
| Equipment grants | | | ¢80,000 |
| Short-term debts (Service providers) | | | ¢65,000 |
| Member contributions | | | <u>¢100,000</u> |
| | | | <u>¢ 245,000</u> |

1. Current Ratio

The current ratio is the relationship between the current assets and current liabilities:

$$\text{Current Ratio} = \frac{\text{Current Assets}}{\text{Current Liabilities}}$$

A current ratio of around 2 is considered satisfactory. This means that short-term obligations can be met approximately twice over by existing short-term sources of funds, without selling all current assets. From the Yefre balance sheet, the current ratio will be calculated:

$$\frac{\text{Current Assets}}{\text{Current Liabilities}} = \frac{100,000}{65,000} = 1.6$$

2. Liquidity Ratio

Ratio of cash and bank balances to current liabilities or debts. This ratio tells whether the MHO can meet its immediate financial commitments. This ratio should not be less than 1.

In the above example, the ratio is given by:

$$\frac{\text{Liquidity Ratio} = \text{Liquid Assets (Cash, Bank and Debtors)}}{\text{Current Liabilities}} = \frac{20,000 + 50,000}{65,000} = 1.1$$

This result is satisfactory.

Too low a liquidity ratio (below 1) could result in:

- a) Payment of creditors being delayed and as a result, discounts might be lost;
- b) A constant problem of how to find enough cash to pay wages;
- c) Creditors withholding supplies because of late payment;
- d) Postponement of essential maintenance and replacement of fixed assets;
- e) Investment plans delayed or shelved.

Too high a liquidity ratio is (more than 3), dispenses with anxiety over cash flow, but equally undesirable results may follow:

- a) Capital will be tied up unproductively so that the overall rate of return is reduced;
- b) Unnecessarily large stocks may be maintained for example, (where the MHO scheme holds drugs in stock) resulting in high storage costs.

3. Long-term Solvency

Current and liquidity ratios measure an organisation's short-term solvency, or ability to pay its bills as they fall due within a period of, at most, 12 months.

Long-term solvency measures the organisation's ability to pay its debts for periods longer than 12 months. This ratio indicates the MHO's ability to honour its debts without relying on loans. The ratio is satisfactory if it is more than 1.

The formula for calculating long-term solvency is:

$$\frac{\text{Total External Liabilities}}{\text{Members Contribution}} = \frac{80,000 + 65,000}{100,000} = \frac{145,000}{100,000} = 1.5$$

4. Dues/Annual Expenses Ratio

This ratio answers the question: are dues sufficient to cover cash outflows, as dues are a principal source of cash inflow. The formula is:

$$\frac{\text{Dues}}{\text{Annual Expenses}}$$

This ratio is favourable if it is at least 1.

Assuming dues are ₡200,000 and annual expenses are ₡250,000, the ratio will be:

$$\frac{200,000}{250,000} = 0.8$$

An increase in the dues will be indispensable in this case of less than 100 percent cover in order to re-establish equilibrium. Assuming that the principal cost elements remain unchanged (i.e. no rise in costs of benefits and no rise in consumption of same by the beneficiaries), the increase in dues required for the next year will be:

$$\frac{(250,000 - 200,000)}{200,000} = 25 \text{ percent}$$

Calculation of the final two ratios, will make use of the Yefre MHO's income and expenditure statement in Figure 7.2.

FIGURE 7.2 YEFRE MHO STATEMENT OF INCOME AND EXPENDITURE, 1998

| 1998 | (in cedis.) |
|----------------------------|-------------------|
| Income: | |
| Member dues | 10,000,000 |
| Registration | 2,000,000 |
| Fund raising | 5,000,000 |
| Interest & misc. income | 3,000,000 |
| Total | 20,000,000 |
| Expenditure: | |
| Health care bills (Claims) | 11,000,000 |
| Wages and salaries | 3,000,000 |
| Marketing costs | 1,500,000 |
| Training | 1,000,000 |
| Other Operating costs* | 1,500,000 |
| Total | 18,000,000 |
| Surplus (loss) | 2,000,000 |

* Other operating costs include 500,000 depreciation for 1998. A motorbike was purchased during 1998 but the entire cost is not included as an expenditure since it will be depreciated.

5. Reserves/Monthly Expenses Ratio

Another index of the financial stability is the relationship between the MHO's reserve fund (discussed earlier) and the average expenses on benefits/services which it has to face.

Usually, the accumulated reserves must correspond to the average expenses for up to six months. The desired objective is to ensure sufficient stability to meet exceptional expenditures arising from, say, an epidemic.

Let us assume that the total surplus of 2,000,000 cedis from 1998 is set aside by the MHO as a reserve fund, and that there were previously no funds in reserve. The monthly expenditure on health care services in 1998 is:

$$\frac{11,000,000}{12} = \text{¢}916,667$$

The reserves to monthly expenses ratio is therefore:

$$\frac{2,000,000}{916,667} = 2.18$$

The reserves will therefore cover just two months of bills in 1999 and this is not sufficient.

6. The Ratio of Operating Costs to Income

This is the ratio of operating costs to the total receipts for the year. Operating costs include all the costs related to the administration and management of the organisation, such as salaries or allowances, rent, supplies, etc.

As a general rule, this ratio should not exceed 5 percent, but for large MHOs with considerable administrative costs, the recommended figure is not to exceed 10 percent. It is possible to exceed these recommendations during the start-up phase if extensive sensitisation and marketing campaigns (transport, fuel, allowances, printing, etc.) are needed. However, once the MHO has stabilised, and as soon as possible, efforts should be made to keep within the recommended percentages. This allows the MHO to provide more services, more efficiently.

For the Yefre MHO, total income in 1998 was 20,000,000 cedis. Operating expenditure was 5,500,000 cedis (18,000,000 minus 11,000,000 [health care] minus 1,000,000 [training] minus 500,000 [depreciation fund]). Therefore the ratio of costs to income is:

$$\frac{5,500,000}{20,000,000} = 0.275 \times 100 = 27.5 \text{ percent.}$$

This is well beyond the recommended limit of 10 percent for large MHOs. Inspection of the figures shows that it is not marketing expenses, but rather salaries and wages that caused the unfavourable results. Therefore the MHO needs to examine whether it is not overstaffed in relation to its revenue and membership.

MODULE 7.2

MECHANISMS OF CONTROL

The mechanisms of control may be considered part of the monitoring system of the organisation¹⁰. Control is exercised by members of the MHO elected for that purpose (the supervisory/watchdog committee), possibly by a technical body appointed by the management committee (internal control) or by an external structure (control exercised by the responsible public authorities, e.g. a ministry or other agency which registers social organisations, or a private accounting or audit firm).

As we saw in Unit 2, the General Assembly must put in place a control organ (supervisory or watchdog/oversight committee) which must report regularly to it. To this must be added the democratic control exercised by the members themselves.

Internal control works (to *prevent* errors and fraud), achieved in part due to the division of work and sharing of responsibilities. For example, the same person should not be in charge of cash and bookkeeping. In addition, internal control establishes and updates a series of administrative procedures and circulation channels for the different documents of the MHO, including the receipts and other pieces of documentary proofs.

External control works to *correct* errors. It is done by persons who are independent of the MHO (consultants, audit firms or sometimes the responsible public authority). Either the organisation's constitution/rules or public legislation might oblige the organisation to call on external auditors.

7.2.1 CONTROL OF MHO ACCOUNTS

Like any enterprise, the mutual health organisation must submit its accounts to some form of control or audit. The object of such control is, first, to maintain the confidence of the members; second, to protect members against abuses, fraud and bad management; and third, to give outsiders or third parties an objective basis for assessing the credibility of the MHO.

The accounting controls consist of:

- ◆ Verifying the correctness of the registrations by examining these against the documents of proof;

¹⁰ See also "Mutuelles de santé en Afrique: Guide pratique à l'usage des promoteurs, administrateurs, et gérants." (ANMC/BIT - ACOPAM/WSM, 1996. Dakar)

- ◆ Noting and signalling cases of fraud, correcting errors and verifying if the accounts correctly reflect the actual situation of the enterprise;
- ◆ Interpreting and commenting on the balance sheet and profit and loss accounts.

Regular financial audits of the accounts (internal and/or external) are the best way to ensure this form of control. The next module, 7.3, details this subject.

7.2.2 CONTROL OF MHO MANAGEMENT

Financial audits are one form of control of management's performance. However, management's responsibilities for the running of the organisation go far beyond ensuring the financial health of the organisation, and encompass its effectiveness in the pursuit of all the goals of the organisation, the upholding of norms and procedures, etc. A specific management audit shows the organisation how effective the management has been in the period under review. Module 7.4 deals with that subject.

7.2.3 CONTROL OF MHO BENEFITS/SERVICES

The control of MHO benefits and services is important, not only to avoid abuses by the providers of care and the members, but also to ensure control over the expenditure and the quality of health care. This control consists of two parts: administrative control and medical control.

Administrative control aims to limit certain important risks which can imperil the MHO: usurpation of rights and benefits by non-beneficiaries, over-consumption by beneficiaries, over-prescription of medical care and drugs, and over-invoicing by the providers.

7.2.3.1 USURPATION BY NON-BENEFICIARIES

To achieve proper control over expenditure, it is very important to establish a system to verify that a patient has indeed the right to MHO benefits. In a small MHO, where all the members know each other, social control may be sufficient, but in large MHOs, fraud is more common and control is more complex. There are three aspects to verify:

- ◆ That the person in question is indeed an MHO member or beneficiary;
- ◆ That any probationary period has been respected;
- ◆ That the member has paid dues.

To do this, it is important to have a membership card or booklet, with the complete identity (if possible with photos) of the beneficiaries, the date of joining and proof of payment of dues (stamps stuck onto booklet, receipts, etc.).

7.2.3.2 DEMAND FOR SERVICES OUTSIDE BENEFITS PACKAGE

A second point to verify is that the care or benefits demanded by the member conforms to what is provided for in the rules of the MHO and in the conventions signed with care providers.

For example, it may happen that the MHO agrees to reimburse only dental care which is the result of certain tests, and only up to a certain age. The MHO must have some objective criteria which would enable it to determine administratively (i.e. without the necessity of medical opinion) if the demand is founded or not, and in the case where upper limits are placed on how much cover the MHO will accord a beneficiary, whether the intervention or demand is within those fixed limits.

7.2.3.3 MEDICAL CONTROL

Some MHO services may need medical review in addition to administrative control. An approved medical opinion is required before the association can pay for those services. For example, this can be applied to cases of costly care, for special medical aids or for the prolongation of hospital admission beyond a given duration. In these cases, a medical opinion based on the medical history or files of the patient is necessary.

This task is assigned to the association's medical advisor. This person assists the association in its relations with the health care providers and advises members concerning their health problems.

The medical advisor also verifies the pertinence and quality of the care which is provided or the drugs prescribed. In order to do so, the advisor may agree upon standard treatment schemes for certain illnesses with the health care institutions, and then monitor the application of these agreements.

In addition, the medical advisor plays an important role in the area of prevention and health education, and assists the MHO to organise its information campaigns for members.

7.2.3.4 OVER-INVOICING

Invoices presented for reimbursement by members or care providers, can be verified in three ways:

- ◆ Does the invoice correspond to the care actually received (genuineness of the invoice)?
- ◆ Are the charges applied correct?
- ◆ Is the quantity or duration of the care provided in order?

In the case of consultation at a health centre or ambulatory care facility, it is necessary to verify that the charges correspond to the services cited in the form describing the care delivered and to the fees agreed in the accords with the care providers.

For the refund of drug purchases, a strict check is necessary to avoid fraud and over-consumption, sometimes organised in collusion between the providers and members. If such drugs have been bought outside a health care institution, there should be no refund unless they were prescribed by an approved medical officer. It would then be necessary to compare the prescription and the invoice or receipt issued by the pharmacist.

In general, in order to limit cost escalation, it is wise to reimburse only the cost of drugs on the essential drugs list, and the cost of the generic drugs.

In the case of hospitalisation, besides checking the details of prescriptions and the tariffs, the duration of hospital stay must be verified. Some hospitals try to keep sick persons for financial reasons more than medical ones, or invoice for more days than they were actually admitted. To avoid this, it may be advantageous to negotiate fixed fees for each admission or for each disease condition rather than a price for each day of admission.

MODULE 7.3

FINANCIAL AUDIT

This module presents an introduction to financial and accounting auditing. It explains the basic notions of financial auditing, as well as the different components of internal control and the standards of auditing.

LEARNING OBJECTIVES

At the conclusion of the module, the participants should be able to:

- ◆ Understand the purpose of financial and accounting auditing;
- ◆ Understand the process and norms for conducting such an audit.
- ◆ Determine and apply appropriate auditing procedures.

CONTENTS

BASICS OF AUDITING

Financial information and its users
Definitions, objectives and standards of financial and accounting auditing
Internal control
Supporting elements

THE PROCESS OF FINANCIAL AND ACCOUNTING AUDITING

Planning
Gaining general knowledge of the MHO
Examination and evaluation of internal control
Auditing accounts
Managing the audit

7.3.1 BASICS OF A FINANCIAL AUDIT

7.3.1.1. FINANCIAL INFORMATION AND ITS USERS

Although financial statements are prepared by accountants or other financial staff, managing the MHO is ultimately the responsibility of its leadership, that is, the persons or entities that have the power and responsibility to plan and run the MHO. The leadership also must publish the financial results and make them available to all interested parties. The potential users of the financial information published by the MHO are:

- ◆ The Board of Directors
- ◆ Management
- ◆ Members
- ◆ State institutions in charge of MHOs (Ministry of Health)
- ◆ Banks and other potential sponsors
- ◆ Providers (hospitals, pharmacies, etc.)
- ◆ Other organisations (consumer protection agencies, etc.)

They should therefore take ownership of the financial statements, and verify that the information meets the following criteria:

- ◆ Reliable
- ◆ Relevant
- ◆ Complete
- ◆ Rapidly available

How can the potential users listed above be assured of the reliability and completeness of the information contained in the financial statements produced by the MHO? This question shows the necessity to have the published financial information verified by a person or entity who is not affiliated to the MHO executive committee or its Board of Directors. This implies using external control. One of the most complete external controls is accounting and financial auditing by external auditors.

7.3.1.2. DEFINITION, OBJECTIVES AND STANDARDS OF FINANCIAL AND ACCOUNTING AUDITING

a. Definition of Financial Auditing

Financial auditing is conducted by professionals. It provides a well-founded opinion on the reliability and honesty of financial statements.

b. Objectives of Accounting and Financial Auditing

The purpose of financial auditing is for the auditor to express his/her opinion on the accuracy of the financial situation and the operating results presented by the MHO in its financial statements, according to generally accepted accounting principles and rules called standards, or norms.

c. Standards of Financial and Accounting Auditing

The standards can be divided into three categories:

- ◆ General standards
 - ◆ Competence

- ❖ Professional conscientiousness
- ❖ Independence
- ❖ Professional confidentiality
- ❖ Technical training
- ◆ Work standards
 - ❖ Organised and well executed planning
 - ❖ Adequately supervised auditing personnel
 - ❖ Study and evaluation of internal controls
 - ❖ Sufficient data to support the audit report
- ◆ Reporting standards
 - ❖ Scope
 - ❖ Name of MHO
 - ❖ Period covered
 - ❖ Standards used
 - ❖ Opinion
 - Favourable
 - Unfavourable
 - With reservations
 - Unable to state an opinion

7.3.1.3 INTERNAL CONTROL

a. Definition of Internal Control

Internal control includes the organisational plan and all the procedures adopted by an organisation to safeguard its assets, control the preciseness and the accuracy of its accounting documents, promote the efficiency of its operations, and follow through the policies prescribed by management.

The accounting and other control measures defined, applied and monitored by management and under its responsibility should ensure:

- ◆ Safeguarding of the assets
- ◆ Regular and accurate accounting entries for accurate financial statements
- ◆ Orderly and efficient operations of the organisation
- ◆ Decisions in accordance with management policies

Key elements of the definitions:

- ◆ Organisational plan
- ◆ Accounting information
- ◆ Safeguarding of the MHO's resources against numerous potential losses
- ◆ Control to ensure that the policies and overall instructions set by management are applied appropriately

b. Achieving Quality Internal Control

Organisational plan:

- ◆ Clear and detailed organisational chart
- ◆ Job descriptions
- ◆ Appropriate distribution of responsibilities between key staff members

In principle, no single person should have the responsibility of managing all phases of internal control. If possible, managing operations, records and accounting activities should be separated. In addition, the following steps should be taken:

- ◆ Authorise and record transactions: during the elaboration of procedures, provide for a system for authorising transactions. Also select an accounting system and a system to control the accuracy of amounts recorded in the accounts.
- ◆ Set appropriate procedures that are recorded in a manual.
- ◆ Hire competent and honest staff members who can apply the procedures.
- ◆ Limit access to assets to a select number of people.
- ◆ Establish a process to supervise employee performance.
- ◆ Produce and save satisfactory information in terms of quantity and quality.

c. Internal Control in Small Entities such as MHOs

The internal control system described above is difficult to carry out in small entities such as MHOs, for the following reasons:

- ◆ Generally, the number of employees of an MHO is too small for a separation of functions to be feasible. For example, there are MHOs where the manager is also the accountant;
- ◆ Division of labour is often more apparent than real;
- ◆ Employees are not always qualified for their function, which increases the risk of errors;
- ◆ MHOs generally cannot afford to employ highly qualified staff on a full-time basis;
- ◆ Certain leaders do not attach much importance to control. Even though this attitude can also be found in large companies, the problem is more crucial in small entities since management is usually composed of few people, sometimes a single person.

Nevertheless, even small MHOs can observe certain minimal rules of internal control:

- ◆ Multiply controls;
- ◆ Make maximum use of personnel that is not part of the accounting unit (secretary, receptionist, etc.);
- ◆ Encourage the use of computers;
- ◆ Utilise external services for certain aspects of accounting such as the production of financial statements;
- ◆ Increase the responsibilities of the external auditor;
- ◆ Ensure quality managerial supervision:
 - ❖ Participate directly in certain key tasks,
 - ❖ Analyse all the reports,
 - ❖ Prepare budgets and monitor and analyse spending,
 - ❖ Observe the way operations are conducted and the behaviour of employees.

Managerial supervision should compensate for a lack of control. However, the managers themselves have to be honest and respect the control systems they put in place.

7.3.1.4. SUPPORTING ELEMENTS OF A FINANCIAL AUDIT

One of the standards of auditing stipulates that the auditor should assemble enough elements to support his report.

a. Verifying Assertions

The auditor should verify assertions in the financial statements:

- ◆ Existence: Do the assets (or the liabilities) exist?
- ◆ Fact: Did the transactions really occur?
- ◆ Comprehensive: Are there additional assets (or liabilities) that were not counted?
- ◆ Ownership: Do the assets really belong to the MHO? Is the MHO, and not another entity, responsible for the assets?
- ◆ Value: Are the assets correctly and adequately valued?
- ◆ Appraisal: Are the different components of the results correctly measured?
- ◆ Presentation: Are the assets, liabilities and different components of the results well-described and presented?

The auditor should search for convincing though not necessarily irrefutable supporting elements.

- ◆ Physical inspection (tangible goods, records, documents, supporting documents)
- ◆ Observation (application of procedures)
- ◆ Inquire and seek confirmation (MHO personnel, banks, providers, suppliers, participants, members, etc.)
- ◆ Calculations (recalculate recorded transactions)
- ◆ Analysis (identify the elements of different accounts, and analytical procedures – comparisons, analysis of ratios)

b. Risks in Auditing

The auditor attempts to reach a reasonable rather than absolute level of certainty when searching for errors in the financial statements. As a result, he/she takes into account “risks in auditing” throughout the process, particularly in the planning and evaluation of internal control stages.

Risks of fraud and errors:

- ◆ Paying out benefits for non-members
- ◆ False prescriptions
- ◆ Billing errors by MHO
- ◆ Billing errors by providers (dues for example)
- ◆ Errors in filing invoices
- ◆ Recording errors
- ◆ Overcharging
- ◆ Substitution of non-covered pharmaceuticals for covered ones
- ◆ Substituting generic drugs or cheap drugs for patented or expensive ones, overcharging for the latter
- ◆ Forgery of vouchers
- ◆ Forgery and use of forgery

Risks linked to auditing:

There are three types of risks:

- ◆ **Inherent risk:** Risk that an important error occurs. The assessment of this type of risk aims at helping the auditor establish the nature, extent and timetable for applying the procedures that will assist him in identifying the account balances and the transactions likely to contain errors.
- ◆ **Risk from lack of control:** Risk that the MHO's internal control systems don't prevent or detect important errors. Its assessment aims at determining the extent to which the auditor can rely on the capacity of the MHO's internal control to prevent or detect errors.
- ◆ **Risk of not detecting errors:** Risk that an important error undetected by the MHO's control system isn't detected by the auditor.

Inherent risk and risk from lack of control are distinguished from the risk of not detecting errors by the fact that they are independent of the audit. They are a function of the organisation, of its economic environment and the nature of its control systems, whether an audit is conducted or not.

TECHNICAL NOTES 7.1 INDICATORS OF BREAKDOWN IN INTERNAL CONTROL

Indicators that can bring an auditor to suspect errors:

- a. Unreasonable audit completion deadlines imposed by the MHO manager
- b. Reluctance from the manager to establish honest and open communication with third parties such as banks and legal authority
- c. Limitation of the scope of the audit by the manager
- d. Discovery of important elements unrevealed by the manager or the treasurer
- e. Contradictory and insufficient supporting elements provided by the manager and/or the personnel of the MHO
- f. Unusual supporting documents; for example, documents containing hand-written changes or hand-written documents that are usually electronically produced
- g. Reluctance and delays in communicating information
- h. Incomplete and/or deficient accounting books
- i. Operations without supporting documentation
- j. Operations unusual by their nature, volume or complexity, especially if conducted at the end of an accounting period
- k. Considerable differences between journal and ledger, or between the physical count of a stock and the balance on the inventory books; differences that were not satisfactorily researched and quickly corrected
- l. Inadequate control of electronic entries; for example, high volume of errors or delays in producing results and statements
- m. Considerable differences between results from analysis and expected results;
- n. Rate of response to requests for confirmation lower than expected or considerable differences between information provided by the MHO and the results from the audit.

The importance of these indicators varies with the size of the entity, its complexity and its structure (for example, a multi-enterprise MHO).

▲ **Environment of the MHO**

- Ineffective board of directors
- Bad reputation of management in business circles
- Same administrative decisions for all the operating and financial issues
- Weaknesses in applying the official ethical code of conduct or absence of such a code

(cont.)

△ Financial pressures

- Decline of the organisation or the sector
- Low or inconsistent profits compared to other entities in the industry
- Financial difficulties
- Low debt collection rate
- Bonuses or motivation programs for managers based on short-term financial results
- Restrictive clauses in loan agreements
- Management too focused on achieving financial goals
- Unrealistic budgetary constraints
- Rapid evolution of conditions specific to the sector
- Financial performance vulnerable to factors such as inflation, interest rate and unemployment

△ Management systems

- Constant situation of crisis
- High turnover rate of key staff, more particularly at the treasury level
- Decentralised organisation lacking an adequate system of co-ordination and supervision
- Low internal control
- Inefficient internal auditing
- Lack of action by management to correct weaknesses
- Insufficient control of accounting estimates (personnel does not have the required knowledge due to negligence or lack of experience)
- Inadequate policies and procedures for asset safeguarding (access of non-authorised persons, lack of research on employees prior to hiring, etc.)
- Difficulties in justifying amounts or operations
- Unusual operations

On the other hand, the risk of not detecting errors is linked to the nature, extent and application timetable of procedures established by the auditor. The auditor assesses inherent risk and risk from lack of control, and, based on this assessment, conceives corroboration procedures that will enable him/her to lower the risk of not detecting errors.

7.3.2 IMPLEMENTING A FINANCIAL AUDIT

7.3.2.1 PLANNING

The planning stage elaborates a global strategy and a detailed application schedule that will take into account the nature, extent and calendar of the audit. Planning should take into consideration:

- ◆ Conditions of the assignment and the expected date of issue of the report
- ◆ Nature of the MHO operations
- ◆ Experience gained from previous audit assignments
- ◆ Accounting principles and level of complexity of accounting system
- ◆ The risk components of the audit
- ◆ The purpose of other forms of control

- ◆ The number of people involved and their level of experience
- ◆ The deadlines to accomplish the different steps, taking into account availability of key information to be collected, and the effectiveness of the procedure if applied at a particular date

7.3.2.2. GAINING GENERAL KNOWLEDGE OF THE MHO

An auditor should understand the external and internal environment of the MHO.

External aspects include:

- ◆ Evolution of the general and industry environment
- ◆ Agreements and accounting practices proper to MHOs
- ◆ Regulatory environment

Internal aspects include:

- ◆ Legal status (single or multi-enterprise MHO)
- ◆ Structure
- ◆ Day-to-day operations and types of services offered to members
- ◆ Financial practices
- ◆ Contractual and legal stipulations
- ◆ Key components of assets and liabilities, income and expenditures, and sources of income
- ◆ Key beneficiaries and suppliers
- ◆ Accounting system
- ◆ How are transactions recorded, classified and grouped
- ◆ Accounting books and registers (journal? ledger? other books?)
- ◆ Financial statements from the previous period
- ◆ Stated problems from previous controls and audits
- ◆ Potential risks

Methodology:

- ◆ Analysis of external documents (statistics, legal framework, etc.)
- ◆ Analysis of internal documents (organisational chart, annual reports, etc.)
- ◆ Visit to location
- ◆ Interviews with manager and MHO personnel
- ◆ Etc.

7.3.2.3. EXAMINATION AND EVALUATION OF INTERNAL CONTROL

The objective of auditing internal control is to:

- ◆ Decide on the degree of confidence to give to the internal organisation of the MHO for its capacity to produce reliable data that in turn allows reliable financial statements;
- ◆ Determine the scope of the controls that need to be carried out, depending on how reliable the MHO's internal control is;
- ◆ Highlight the strengths and weaknesses of the control system that could affect the reliability of the financial statements and the safeguarding of the MHO's assets;
- ◆ Formulate suggestions to safeguard assets and increase the efficiency of the organisation.

The examination and evaluation of internal control is conducted in five phases:

1. Understanding procedures
 - ❖ Use charts, memos and the MHO's manual of procedures (See Figure 7.3 for examples of procedures)
2. Testing conformity and existence
 - ❖ Assess a few transactions to verify the existence of procedures.
 - ❖ Which procedures that favour efficient internal control are used?
 - ❖ Are these procedures followed?
 - ❖ How satisfactory are these procedures in ensuring quality internal control?
3. Preliminary evaluation
 - ❖ Conduct a diagnosis to highlight the activity cycles of the MHO, analyse the procedures that are in place and identify the strengths of the internal control system and the weaknesses in the conception of the system
4. Testing
 - ❖ Carry out tests to ensure that the strong aspects are in effect applied
5. Final evaluation
 - ❖ Highlight the strengths and weaknesses (in the conception and application) of the internal control system and the possible solutions.

FIGURE 7.3 EXAMPLES OF INTERNAL CONTROL PROCEDURES

Example 1: Joining a Multi-enterprise MHO (workplace MHO)

- a. The member sends a letter requesting membership to the MHO; the letter should include the number of employees, family size and salaries
- b. The MHO answers the potential member after consideration by the Board of Directors of the MHO, and an informational meeting is organised with the applicant
- c. Prior to accepting the application, the MHO verifies the solvency of the potential member, who is asked to pay a registration fee and dues.
- d. The MHO creates a file for the member and beneficiaries: identification, pictures, supporting documents for family status.
- e. The member is issued a registration and health card.

Example 2: Coverage

- a. The member or beneficiary brings his health card to the MHO
- b. The receptionist verifies his identity and that the information contained in the member's file matches the information on the health card
- c. The receptionist inquires about the member's needs
- d. The member is issued a voucher that allows him to see a provider
- e. The member has a consultation at the doctor's office
- f. Subsequently, the member brings to the MHO:
 - A prescription: he is then provided with a pharmacy voucher
 - A treatment or a referral: he is then provided with a voucher for consultation or treatment
- g. Receipt and verification of the invoice and supporting documents
- h. The receptionist sends invoice and supporting documents to the accounting department for recording, after calculating amounts
- i. Accounting determines the member's share
- j. The MHO produces and sends invoice or reimbursement status to the employer of the member.

7.3.2.4. AUDITING ACCOUNTS

There are three phases to auditing an organisation's accounts:

1. Determination of the consequences of the evaluation of internal control
 - ❖ Adapt the program of the audit (simplify or reinforce through additional testing)
2. Validation and coherence tests
 - ❖ Coherence tests (review information, compare using calculations)
 - ❖ Validation tests using internal documents (supporting documents, accounting books, etc.)
 - ❖ Validation tests through external confirmation (banks, providers, beneficiaries)
 - ❖ Validation tests through physical inspection
3. Concluding the audit
 - ❖ Review accounting principles
 - ❖ Review post-closing date events
 - ❖ Review presentation and complementary information (annexes)
 - ❖ Review files
 - ❖ State opinion

Verification Procedures

For each of the balance sheet and income statement accounts, verify the key assertions listed above; for example, respond to the following questions:

1. Are the amounts in the statements supported by accounting documents and do they correspond to the amounts entered in the books?
2. Do the assets and liabilities truly exist?
3. Is the account adequately valued?
4. Does the presentation in the financial statements respect generally accepted accounting principles?

BANK

Are the amounts on the statements supported by accounting documents and do they correspond to the amounts entered in the books?

Verify that the accounting information entered in the ledger accounts corresponds to the information in the journal.

Verify the dates of the different entries into the bank receipts account to ensure that the account was closed after the end-date of the statements. One way to proceed is to be present the day the books are closed and to list all the cheques and money orders issued and received but not yet cashed; another way of proceeding is to examine all the pending deposits to ensure that the total amount is not higher than usual and that those immediately following the closing date are not less than their usual amount.

Verify the end-date of entries into the bank receipts account; for this, ensure that the checks recorded in this account have not cleared at the date of closing (which is uncontrollable by the organisation). This verification can be conducted either by checking the number of the last check prior to closing the accounts or by verifying the payment date by the bank.

Are the funds available?

Perform reconciliation or verify the one that was completed (if done by another person). A reconciliation is a mathematical procedure and verifies the validity and accuracy of the accounts in question.

Send a form signed by the manager of the MHO to the bank, requesting confirmation of the balances of each account on the last day of the accounting period and the loans the MHO has taken out from the bank.

Does the presentation in the financial statements respect generally accepted accounting principles?

The following are not counted as short-term assets:

- ◆ Amounts that by restriction cannot be allocated to operations (reserve fund),
- ◆ Amounts allocated for exceptional transactions, unless there are collateral to short-term debt.

Questions to ask concerning funds:

- ◆ Cash flows: are they adequate?
- ◆ Level of petty cash satisfactory?
- ◆ Existence and level of an allowance for bad debt account.
- ◆ Optimisation of financial resources.
- ◆ Are there any pending memberships accounts?
- ◆ Does the MHO benefit from any advantageous terms from its suppliers and health providers?
- ◆ Does the MHO possess sufficient necessary information to control its financial situation?
- ◆ Does the MHO possess a satisfactory accounting system?
- ◆ Can the accounting system issue monthly statements?
- ◆ Is the MHO capable of reducing its expenditures, if required?
- ◆ Is the financial structure solid?
- ◆ Are the surplus levels, if any, satisfactory?

Investments

- ◆ Carry out an inventory of the bonds that are usually kept in a bank safe.
- ◆ Ensure that the bonds are recorded under the name of the entity.
- ◆ Are the amounts recorded in the financial statements supported by accounting documents and do they match the amounts entered in the books?
- ◆ Ensure that the information gathered from the bonds corresponds to the information entered in the accounting books.
- ◆ Ensure that dividends and interest received were accounted for in the accounting period in question.
- ◆ Are the investments adequately valued?
- ◆ Inquire about the market value of the investment or use personal judgement.
- ◆ Presentation
- ◆ Only investments with short-term returns should be accounted for as short-term assets.
- ◆ Take into account the decrease in value of investments.

- ◆ Registration and membership dues: collection and accounting
- ◆ Does the MHO collect dues and membership fees?
- ◆ Ensure that dues and membership fees are collected by confirming with the members.
- ◆ Are there accounting documents that support the amounts entered on the balance sheet and do they match the amounts entered in the accounting books?
- ◆ Ensure that the dues amounts entered in the ledger account are the same as those entered in the journal.
- ◆ Ensure that the membership fee amounts entered in the ledger account are the same as those entered in the journal.
- ◆ Verify the end-date of entries on dues collected by selecting entries made prior to the closing date and verify, using supporting documents, that the amounts were entered when collected.
- ◆ Are the dues adequately valued?
- ◆ Pay attention to the number of insured persons and to late payments of dues.
- ◆ Analyse the overdue accounts.
- ◆ Analyse the overdue accounts that are increasing.
- ◆ Ensure that late payment fees are correctly tabulated.
- ◆ Ensure that the allocation of the bad debt account was done the same way as the previous year, that it is conservative in order to account for all possible losses and that it is realistically based on past experience.
- ◆ Presentation of financial statements
- ◆ The provision for bad debt should be based on the assessment of dues that are overdue at the end of the statement, and take into account all known circumstances.

Stocks

- ◆ Are there accounting documents that support the amounts entered on the balance sheet and do they match the amounts entered in the accounting books?
- ◆ Assure that the stocks do exist, that they are well valued and belong to the organisation.
- ◆ Verify the date of recorded purchases by determining whom the goods belong to at the closing date. Select transactions from the Supplies account before and after the closing date and trace them using delivery forms.
- ◆ Examine the documents that support the accounting entries in the control account to ensure their authenticity and the accuracy of the balances at the closing date.
- ◆ Check operations: prices, order forms, extensions, additions, etc.
- ◆ Use ratios and compare them with ratios from previous years: percentage of purchases relative to the number of members, for example.
- ◆ Are there stocks?
- ◆ Verify the procedures used to conduct inventories (independent counts, differences certified by a manager).
- ◆ Be present during the physical count.
- ◆ Use sampling to verify that the quantities entered on the stock lists are identical to the ones entered in the inventory book.

- ◆ Ensure that during the inventory process, delivery of goods stopped, avoiding the transfer of goods from one area to another.
- ◆ Are the stocks adequately valued?
- ◆ The basis for evaluation should be in conformity with generally accepted accounting principles (First-in-First-Out (FIFO) (Last-in-First Out) (LIFO) or Average Cost method (AVCO) and constant throughout the years.
- ◆ Ensure that the inventory book is updated based on a physical count.
- ◆ The basis for evaluation should be clearly indicated on the financial statements.
- ◆ Take depreciation into account (obsolete forms, for example).

Fixed Assets

- ◆ Are there accounting documents that support the amounts on the financial statements and do they match the amounts entered in the accounting book?
- ◆ Analyse the different accounts and transactions of the accounting period in question.
- ◆ Verify that the authorisation from the board of directors or the manager of the organisation is authentic, depending on the nature and the amount of the transaction, to ensure that the investment policies of the entity are respected.
- ◆ Verify that the amount entered in the ledger account corresponds to the one entered in the journal.
- ◆ Ensure that the assets that changed ownership during the accounting period, by sale or other, are authorised and accurately recorded.
- ◆ Verify capitalisation of certain costs of fixed-assets (maintenance costs, for example).
- ◆ Do the assets really exist?
- ◆ Conduct a physical check.
- ◆ Analyse the documents relative to the assets: for example, mortgage documents, registration of cars, insurance.
- ◆ Are the assets adequately valued?
- ◆ Examine the depreciation method used by the organisation and if it is the same as the one used in previous years.
- ◆ Verify that the life-span and residual value are adequately valued?
- ◆ Verify that the beginning balance of the current statement is equal to the ending balance of the previous period, and that the rates used are the same.
- ◆ Verify the depreciation calculations for the period.
- ◆ Presentation in financial statements
- ◆ Accumulated depreciation should be indicated as a deduction from fixed-assets.
- ◆ Separate long-term assets.
- ◆ The income statement should include depreciation of the current period and the notes to the statement should mention the rates and methods used.
- ◆ Purchases (services, drugs, supplies and other services) – disbursements and supplier accounts
- ◆ Are there accounting documents to support the amounts on the statements and do they match the amounts entered in the accounting books? Do the accounts really exist?

- ◆ Obtain a list of supplier accounts and compare the total with the total in the journal.
- ◆ Compare the amount owed to each supplier with the account of each supplier, or analyse the main invoices.
- ◆ Are the supplier accounts adequately valued?

7.3.2.5. MANAGING THE AUDIT

PLANNING AND PREPARATION

Planning and preparing an audit at the MHO's level should reduce the risk that the audit may have consequences unfavourable to the MHO.

- ◆ The auditor may not be able to express an opinion on the financial statements,
- ◆ The auditor's opinion is delayed and therefore does not allow the MHO to respect the law and fill other needs.

SELECTING AN AUDITOR

In establishing an audit agreement, the MHO should take into account quantitative as well as qualitative issues.

Qualitative issues are:

- ◆ The reputation of the auditor and his/her competence,
- ◆ The experience of the auditor and the team in the sector of the MHO,
- ◆ The independence of the auditor vis-à-vis any other assignment that could put him/her in a situation of conflict of interest with the MHO.

Quantitative issues are:

- ◆ Estimating the fees of the auditor,
- ◆ Cost of internal support to the auditing process.

CONTRACTING AN AUDITOR

The terms of reference (or assignment letter) is an agreement between the MHO and the auditor on the services to be rendered. The assignment letter should include the following:

- ◆ The objective and extent of the audit, as well as the main areas that will be audited;
- ◆ The members of the audit team, including the name of the associate and the mission chief, the number of auditors, as well as their competencies and experience;
- ◆ A list of precise activities that require the involvement of MHO personnel, as well as a calendar of the activities they will perform;
- ◆ The timetable and deadlines for the periodical controls and completion of the audit;
- ◆ The time spent on the audit, the hourly rate and other scales used in calculating the rates, as well as an estimate of the total cost of the audit;
- ◆ The agreed upon billing process and payment procedures;
- ◆ The co-ordinators from both sides (MHO and audit team)

MODULE 7.4

MANAGEMENT AUDIT

In addition to familiarising the participants with certain aspects of internal auditing, particularly the interaction between internal auditing and management control, this module introduces the concepts, objectives and techniques of management auditing. The application phase is conducted by verifying whether resources (financial, human and material resources for example) are used to their optimal level or not, and by evaluating the strategy of the MHO and its operations (auditing of the strategy, auditing of legal aspects, etc.). In sum, the purpose is to bring the participants to conduct an evaluation of the way the MHO is managed, the improvements that are required and how it can meet its obligation to report.

LEARNING OBJECTIVES

At the conclusion of the module, the participants should be able to:

- ◆ Define and explain the concepts and characteristics of management auditing
- ◆ Describe the process of management auditing
- ◆ Master the procedures, techniques and verification tools used in a management audit
- ◆ Apply the concepts, procedures and techniques of management auditing to a function or a particular aspect of MHOs

TARGET GROUP

- ◆ MHO administrators
- ◆ MHO managers
- ◆ MHO accountants
- ◆ Inspectors/auditors from supervising agencies
- ◆ Members of supervisory/watchdog/oversight committee

PREREQUISITES

- ◆ Basic knowledge of accounting and management, or
- ◆ An introductory course in accounting and management

TRAINING METHODS

The module includes case studies and lectures. Case discussions favour the understanding of fundamental concepts in management auditing by applying them to situations or cases. Lectures aim at reinforcing the understanding of the concepts and illustrating them with real-life examples.

The success of this approach is highly dependent on adequate preparation by the participants prior to each session. Consequently, it is extremely important for the participants, when necessary, to complete readings and prepare case studies before each session.

TEACHING MATERIALS

- ◆ Slides
- ◆ Supporting texts
- ◆ Case studies
- ◆ Overhead projector
- ◆ Flipchart

CONTENTS

1. Definition and objectives of management auditing
2. Norms of management auditing
3. Different steps of management auditing
4. Procedures, techniques and tools
5. Evaluation of the effectiveness of the board of directors and the executive committee
6. Auditing the strategy
7. Auditing cash management
8. Auditing the record-keeping and archiving systems
9. Social auditing
10. Auditing the management tools
11. The audit report

7.4.1 DEFINITION AND OBJECTIVES OF MANAGEMENT AUDITING

7.4.1.1 DEFINITION

Ask the participants to define management auditing.

Give the participants time to answer before providing the following definition:

Management auditing is the examination of each element of an organisation's operating procedures and methods, aimed at assessing their cost-effectiveness, efficiency and efficacy.

The cost-effectiveness, efficiency and efficacy of operations are far more difficult to evaluate objectively, than are accounting principles. A broader definition of management auditing includes evaluating internal control systems and testing their effectiveness. In practice, management auditors are more interested in making recommendations aimed at improving performance.

7.4.1.2 OBJECTIVES

Cost-effectiveness

What is understood by cost-effectiveness?

Give the participants time to answer before providing the following definition:

Cost-effectiveness is any acquisition of resources that corresponds to the following criteria:

- ◆ Minimal cost
- ◆ Quantity and quality in accordance with established norms
- ◆ Opportune timing and location

Efficiency

What is understood by efficiency?

Give the participants time to answer before providing the following definition:

- ◆ It is maximum output from minimum input.
- ◆ It is therefore expressed as the output-input ratio: the higher the ratio, the higher the efficiency and vice versa.
- ◆ A servicing system is efficient if it offers a service of a given quality to a number of members, at the least cost. If the services are produced at a low cost, but of poor quality, they are economical, but not necessarily efficient.

Efficacy

What is understood by efficacy?

Give the participants time to answer before providing the following definition:

- ◆ It is defined in relation to a given objective.
- ◆ It indicates how well the objective was attained.
- ◆ It is independent of cost.

7.4.1.3 SCOPE OF MANAGEMENT AUDITING

Which aspects of an MHO can be subject to a management audit?

Give the participants time to respond before providing the following answer:

In management auditing, the examination is not limited to accounting. It can include the evaluation of:

- ◆ Organisational structure
- ◆ Information technology
- ◆ Marketing
- ◆ Strategy
- ◆ Administrative policies
- ◆ Conformity with the law/regulations, etc.

What is the difference between management audit, audit of operations and performance audit?

Give the participants time to respond before providing the following answer:

All three terms refer to the examination of organisational cost effectiveness, efficiency and efficacy. Different users prefer one term or the other.

7.4.1.4 DIFFERENCES BETWEEN MANAGEMENT AND FINANCIAL AUDITING

What are the differences between management and financial auditing?

Give the participants time to respond before providing the following answer:

The differences are situated at three different levels, at least:

- ◆ The objective: financial auditing aims at determining if financial information was correctly recorded. Management auditing evaluates cost-effectiveness, efficiency and efficacy.
- ◆ Recipients of the audit report: A financial audit has many potential users while a management audit is for management and the General Assembly of members.
- ◆ Non-financial issues are taken into account in management auditing.

7.4.2 NORMS OF MANAGEMENT AUDITING

As with all forms of auditing, management auditing scrupulously respects accepted norms: quality of supporting documents, rigor of the evaluation procedures, faithful presentation of facts.

However, management auditing stresses the existence of responsibility flows, and how well the different actors understand them.

It also differs by the elements the auditor selects. He/she determines beforehand the areas to control, the stages, activities and systems, and methodically selects those aspects that are essential to the judicious use of resources and key to reaching goals.

7.4.3 IMPLEMENTING A MANAGEMENT AUDIT

7.4.3.1 PLANNING A MANAGEMENT AUDIT

- ◆ Divide the area to be audited in “auditable” items
- ◆ Elaborate a suitable work plan, including the types of supporting documents and information sought
- ◆ Develop a budget (time and costs)
- ◆ Establish a work plan for the preliminary research phase

GROUP ASSIGNMENT

You have been asked to conduct an audit of the human resources management aspect of your MHO by the manager. Elaborate an action plan.

7.4.3.2 GAINING KNOWLEDGE OF THE AREA TO BE AUDITED

Collect information useful to accurately determining the major areas of concern the auditing exercise should concentrate on, notably:

- ◆ Define, understand and analyse the activity that will be audited

- ◆ Consult the sources of information of the activity in question (accounting, budgeting, performance indicators, policies, rules and procedures, etc.)
- ◆ Identify relevant management methods and information systems to be audited
- ◆ Consult past reports and studies
- ◆ Become familiar with the organisational structure of the MHO: organisation charts, job descriptions
- ◆ Collect documentation on key success factors in the field being audited

GROUP ASSIGNMENT

You have been asked by the manager to conduct an audit of the human resources management aspect of MHO solidarity. With which aspects of human resources management of the MHO should you familiarise yourself?

7.4.3.3 BREAKDOWN OF AUDIT IN "AUDITABLE" ASPECTS

- ◆ Divide each process into activities and each activity into tasks
- ◆ Define the objectives of each task and potential risks to avoid
- ◆ Determine the means to achieve objectives and manage risks

GROUP ASSIGNMENT

You have been asked to conduct an audit of the human resources management aspect of an MHO by its board of directors. Separate the human resources management process into "auditable" components: appointment and/or hiring of personnel, allocation of resources, remuneration, training, evaluation, leave, termination of a contract or function, etc.

7.4.3.4 SUPPORTING EVIDENCE AND EVALUATION

Collect information for the audit via the following methods:

- ◆ Documentation
- ◆ Interviews
- ◆ Observation
- ◆ Physical evidence
- ◆ Confirmation
- ◆ Analytical tests
- ◆ Etc.

7.4.4 PROCEDURES, TECHNIQUES AND TOOLS

Which investigative approaches can be used in a management audit?

Give the participants time to respond before providing the following answer:

7.4.4.1 GENERAL APPROACH

- ◆ Economic and financial analysis
- ◆ Volumes and types of transactions
- ◆ Flowcharts
- ◆ Analysis of available documents

7.4.4.2 INTERROGATION APPROACH

- ◆ Interviews
- ◆ Questionnaires
- ◆ Internal control questionnaires

7.4.4.3 VERIFICATION APPROACH

- ◆ Physical observations
- ◆ Compare and reconstitute
- ◆ Consult computer files
- ◆ Statistical surveys
- ◆ Calculations

N.B.: The audit team is usually made up of persons with different skills and occupations including economists, statisticians, computer experts, and management consultants. It is therefore possible for these different approaches to be combined.

7.4.5 EVALUATION OF THE EFFECTIVENESS OF THE MANAGEMENT COMMITTEE AND THE BOARD OF DIRECTORS

The focus in this case is very different from financial and accounting control since it is extended to the management, which is charged with responsibility for conducting a self-evaluation and reporting to the Board of Directors on its general management of the MHO. The administrators also have the duty to conduct self-evaluations and report the results of their management to members.

7.4.5.1 EVALUATION OF THE EFFECTIVENESS OF THE MANAGEMENT COMMITTEE

Which aspects are taken into account in evaluating the quality of management of the management committee?

Give the participants time to respond before providing the following answer:

- a. Management outlook: to what extent are the objectives of the MHO, its programmes or activities and the functions of the employees clearly stated, well integrated, understood, and reflected in an appropriate manner in the plans, structure, and delegation of authority and decision-making processes of the organisation?
- b. Relevance: to what extent is a service, programme or activity necessary, relative to the difficulties and conditions it was created in response to?
- c. Logic: how logical is the design of and effort put into a service, program or its main components, relative to the specific goals that are to be reached?
- d. Achievement of expected results: how closely have the goals and objectives been reached?
- e. Satisfaction level: how satisfied are the beneficiaries with a service, programme or activity?
- f. Side effects: how extensive are the side-effects, whether intentional or not, positive or negative?

- g. Costs and productivity: links between costs, input and results.
- h. Capacity to adapt: the ability of the MHO to adapt to changes in its environment (competition, available financing, technology, etc.)
- i. Financial results: to what extent have financial results improved? Were the improvements achieved by sacrificing quality of services?
- j. Work environment: does the organisation provide an adequate working environment to its employees? Does it offer appropriate opportunities for development and achievement, and does it encourage commitment, initiative and security?
- k. Safeguarding of assets: how well are the important assets – such as supplies, precious goods, key personnel, agreements, important information and files – maintained, for the organisation to be protected from potential losses that could threaten its success, credibility, continuity and even existence?
- l. Control and communication of conclusions/results: how well are the key performance areas and areas of organisational strength detected, communicated and closely monitored?

7.4.5.2 EVALUATION OF THE EFFECTIVENESS OF THE BOARD OF DIRECTORS

Which aspects are taken into account in evaluating the effectiveness of the Board of Directors?

Give the participants time to respond before providing the following answer:

- a. Has the Board of Directors defined strategic orientations for the MHO?
- b. Are the strategic choices in tune with the mission of the MHO, its external environment (more specifically, its legal environment) and the available or potential resources?
- c. Have the major risks been identified?
- d. Did the board verify that appropriate systems to control potential risks are in place?
- e. Is the board of directors sufficiently independent vis-à-vis the management committee, enabling it to freely inquire about all aspects of the MHO, including the most sensitive issues?
- f. Does the Board of Directors hold regular meetings with the manager and the treasurer?
- g. Does the Board of Directors receive sufficient information, in a timely manner, enabling it to follow up on the level of achievement of objectives and strategies, to control the financial situation and the operating results, and to keep itself informed of the conditions and terms of important contracts?
- h. Does the Board of Directors receive sensitive information in a timely fashion and is it informed of sensitive situations, investigations and inappropriate behaviour (for example, information on the transportation expenses of management, disputes, investigations conducted by supervisory entities, embezzlements or improper use of assets, etc.)

7.4.6 AUDITING THE STRATEGY

Which aspects should be investigated when auditing the strategy of an MHO?

Give the participants time to respond before providing the following answers:

1. Identification of the mission of the MHO: is the mission clearly defined?
2. Identification of the objectives; are they in line with the mission of the MHO?
3. Adopting a process for strategic planning: is there a strategic plan?
4. Strategic choices: do they take into account the internal and external environment of the MHO and its mission? Are they realistic?
5. Is there an action-plan for the implementation of the strategy?
6. Have the major risks been identified? Have appropriate systems for controlling these risks been put in place?
7. Does the MHO have a long-term business plan?
8. Are the leaders aware of the performance indicators used in the industry?
9. Is performance evaluated periodically and the action plan readjusted as a consequence?
10. Marketing and communication strategy of the MHO.
11. Are the coverage rates competitive?

7.4.7 AUDITING CASH MANAGEMENT

Which aspects should be verified when auditing the cash of an MHO?

Give the participants time to respond before providing the following answers:

1. Procedures for debt recovery such as dues and late fees
2. Are the leaders aware of the financial situation of the MHO?
3. Do they know the amount of debt of the MHO?
4. Is the MHO able to respect its due dates?
5. Are the leaders capable of analysing financial statements on their own?
6. Are the expenditures in conformity with the budget?

7.4.8 AUDITING THE RECORD-KEEPING AND ARCHIVING SYSTEMS

Which aspects should be verified when auditing the records of an MHO?

Give the participants time to respond before providing the following answers:

1. Are the member files well maintained?
2. Are the invoices and supporting documents well documented and archived?
3. Are the provider files well maintained?
4. Are the personnel files well maintained?
5. Are the files relative to the management of the MHO properly kept and maintained?
6. Are these files and documents properly filed? Well kept?

7.4.9 SOCIAL AUDITING

Which aspects should be verified when conducting a social audit of an MHO?

Give the participants time to respond before providing the following answers:

1. Are job descriptions, including background and competency requirements, available?
2. Are the new employees aware of what is expected of them?
3. Are the salaries of the employees comparable to salaries in other MHOs?
4. Is staffing adequate?
5. Is the staff turnover rate comparable to the rate in the industry?
6. Is there a reward system in place?
7. Is the system of delegation of responsibilities, if it exists, complemented by mechanisms of co-ordination and supervision?
8. Is the coverage rate competitive?
9. In case of a financial surplus, does the MHO decrease the dues rate or increase the coverage rate?
10. In general, are the members satisfied with the MHO?
11. Are the social objectives always achieved?
12. In general, are human resources optimised?
13. Is health care coverage adequate?

7.4.10 AUDITING OF MANAGEMENT TOOLS

Which aspects should be verified when conducting an audit of the management tools of an MHO?

Give the participants time to respond before providing the following answers:

1. Are the information technology resources well managed?
2. Are they sufficient and do they correspond to the needs of the MHO?
3. Is the accounting up-to-date?
4. Are the accounting and financial reports produced on time?
5. Have evaluation indicators been developed?
6. Is the budgetary process efficient and effective?
7. In general, are the management tools optimised?

7.4.11 AUDIT REPORT

7.4.11.1 CONTENTS

- ◆ Objectives
- ◆ Methodology
- ◆ Results
- ◆ Recommendations
- ◆ Application

7.4.11.2 RECIPIENTS OF REPORT (AT LEAST THE REQUESTOR OF THE AUDIT AND THE PERSONS IN CHARGE OF EXECUTING RECOMMENDATIONS)

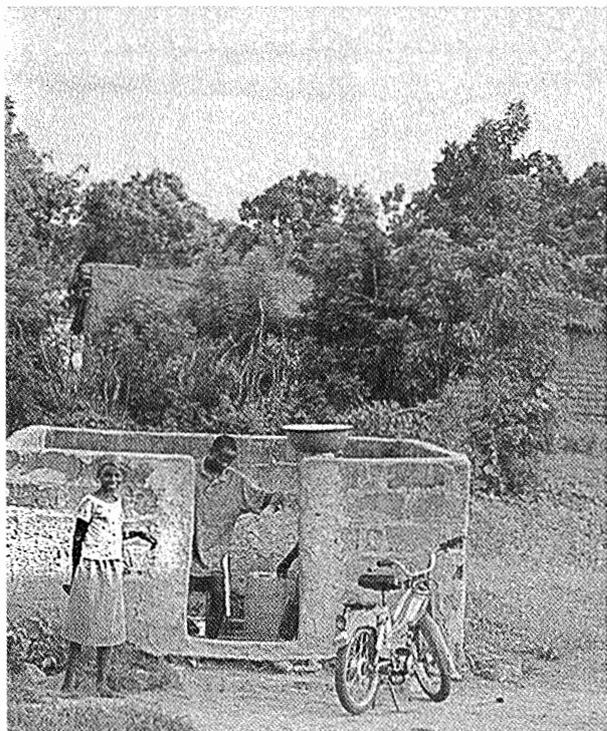
- ◆ Board of Directors
- ◆ Manager
- ◆ Personnel
- ◆ Archives
- ◆ The General Assembly

GROUP ASSIGNMENT

Constitute groups of 2 - 3 participants; chose a particular aspect of MHOs to audit and an application site for the auditing process. Schedule a debriefing session for presentation of the work of the different groups in a plenary session.

UNIT 8

MARKETING/COMMUNICATION, COMMUNITY MOBILISATION AND PARTICIPATION



| | |
|--|-----|
| Module 8.1 MARKETING AND COMMUNICATION | 199 |
| 8.1.1 INTRODUCTION | 199 |
| 8.1.2 BASIC DEFINITIONS | 199 |
| 8.1.3 ELEMENTS OF A MARKETING PLAN | 200 |
| Module 8.2 COMMUNITY MOBILISATION | 204 |
| 8.2.1 INTRODUCTION | 204 |
| 8.2.2 BASIC DEFINITIONS | 204 |
| 8.2.3 THE COMMUNITY MOBILISER: REQUIRED COMPETENCIES | 205 |
| 8.2.4 THE MOBILIZATION CYCLE | 205 |
| Module 8.3 METHODS FOR COMMUNITY PARTICIPATION | 208 |
| 8.3.1 INTRODUCTION | 208 |
| 8.3.2 DEFINITIONS | 208 |
| 8.3.3 INTERPRETATIONS AND CRITICAL ISSUES | 209 |
| 8.3.4 APPROACHES TO PARTICIPATION | 210 |
| 8.3.5 PARTICIPATORY METHODS AND TOOLS | 210 |
| 8.3.6 PARTICIPATORY RURAL APPRAISAL | 211 |
| 8.3.7 ENSURING PARTICIPATION OF DIFFERENT GROUPS | 211 |
| 8.3.8 RECAP AND SUMMARY | 212 |

LEARNING OBJECTIVES

At the end of the unit, participants should be able to:

- a. Identify marketing needs of their organisations and implement a marketing plan
- b. Measure effectiveness of marketing and communication strategies
- c. Understand and apply sound practices of community entry and mobilization (acquire and be able to use sound community entry and mobilization skills)
- d. Be able to do community diagnosis
- e. Understand the concept of participation and have a critical appreciation of the various views and approaches to participation in development work
- f. Apply the various participatory methods in the work of their organisations

TARGET GROUP

Promoters and initiators
Management
Coordinators
Marketing /public relations officers

PREREQUISITES

Completion of the Unit 1 'Introduction to MHOs'

CONTENT

Marketing: definition; elaborating a strategy; monitoring and evaluation
Community mobilization: definitions; the mobiliser; mobilization cycle; community diagnosis
Participation: definition, types, perspectives, interpretations and critical issues; approaches to participation; PRA: key features, methods and tools.

TRAINING METHODS

Plenary session
Presentation
Individual and group assignments
Teaching materials
Flipchart
Overhead projector
Slides
Case studies

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MODULE 8.1

MARKETING AND COMMUNICATION

8.1.1 INTRODUCTION

This module deals with the concept of marketing/communication in the context of MHOs.

Marketing is an essential tool for the MHO manager because an MHO can succeed only if it attracts a large number of members and spreads the risks among many. To accomplish this, it must be able to market itself and what it offers. Communication, like marketing, is a tool that facilitates the work of MHOs and it is necessary that MHO managers and staff are equipped with the techniques of selecting and using the most appropriate channels of communicating with their target groups. In this manual, no distinction is made between marketing and communication.

8.1.2 BASIC DEFINITIONS

8.1.2.1 MARKETING

Marketing is MHO activities aimed at presenting the services to potential or existing members to incite them to join or remain active members. It includes pricing services, consumer satisfaction surveys, studies on demand for new services, analysis of the MHO's environment, including competitors, etc.

The MHO marketer should employ the tools of community diagnosis and mobilization to understand and define the target groups.

8.1.2.2 MARKETING MANAGEMENT

The process of planning, organizing, implementing and controlling marketing activities should facilitate the marketing process effectively and efficiently.

8.1.3 ELEMENTS OF A MARKETING PLAN

The critical step in the marketing process is for the MHO to develop a plan to guide relationships. A marketing plan describes chosen markets, the timing and quantity of financial and human resources allocated to each market segment, and the expected results. The marketing plan entails the collection and analysis of data necessary for the planning.

The marketing planning process is made up of the following steps:

- ◆ Analyse organization (mission, objectives, goals, strengths and weaknesses, etc.)
- ◆ Analyse external environment (including communities to be served, competition, social, political and economic environments).
- ◆ Set marketing objectives and goals.
- ◆ Set marketing strategy in relation to target market, competitive position, communication and marketing mix.
- ◆ Implement strategy.
- ◆ Assess performance.

8.1.3.1 ANALYSE ORGANISATION

Before setting objectives, a thorough analysis of the organisation should be performed. This knowledge will facilitate understanding of the need for a strategy and for targeting specific issues, and whether these require corrective or consolidating actions.

8.1.3.2 ANALYSE EXTERNAL ENVIRONMENT

This includes communities to be targeted, and their political, social, economic and cultural characteristics.

Social marketers need to be aware of the competing messages pulling on their target audiences. It may be another service/package or it may be non-performance of the behaviour they are promoting. To be accepted, a service/package must be more attractive than the alternatives. Also affecting people's reaction to a programme, environmental factors, e.g. political changes, news events that change the context in which people hear a message, or work done by other organizations that affect an MHO's message. A marketer must be able to monitor these changes in the environment and adjust the programme accordingly.

8.1.3.3 SETTING MARKETING OBJECTIVES AND GOALS

Example of an objective: Increase MHO membership by 10 percent by December 2000.

8.1.3.4 SET MARKETING STRATEGY

The strategy involves decisions about the target group, service/package, price, providers, channels of communication, etc.

Target Group

- ◆ MHO members (can be divided by age, sex, occupation, education level, etc.)
- ◆ Former MHO members
- ◆ Community members
- ◆ Community leaders

- ◆ Community groups
- ◆ Trade unions
- ◆ Other specialised groups
- ◆ Health care providers
- ◆ National authorities (such as Ministry of Health)
- ◆ Development partners (such as NGOs)

Segment your target group either by sex, age, ethnicity, etc. This is because people respond differently to particular approaches. The audience segments targeted may not always be the same people your campaign addresses. For example, if your research shows that the people you want to reach are more likely to listen to their family members or doctors, you may have more success with a message to those secondary groups urging them to talk about the issue with the person whose behavior you ultimately want to change.

Service/Package

In the case of an MHO, this refers to services being provided or offered to members and potential members. Position your service/package, especially services like behaviors and attitudes which require long-term commitments. Positioning determines how the people in your target group think about your service/package as compared to the competition, i.e. your product needs to be positioned in relation to the alternatives. Service positioning is usually based on either the benefits of the service (what will it do for me?) or removal of barriers (how difficult is it for me to do?). By talking about the service with your target group, you can learn the benefits they value most and the barriers they foresee. Based on this, a program could either promote and reinforce the positive aspects of the service/package or provide ways to get around the barriers.

Price

The MHO manager is concerned with establishing pricing policies and determining product prices. The consumers or members are interested in prices because they are concerned about the value obtained in the exchange.

Distribution

These are the channels for obtaining the service or package. For MHOs, this usually refers to places where the services can be obtained.

Communication

Effective channels of communication need to be selected. These could include traditional chiefs, town criers, community leaders and other recognised opinion leaders, elders, local government structures, health providers, age groups, religious leaders, relatives, health staff and traditional healers, teachers and school children, students, local improvement unions, professional and community associations, discussions in markets, village squares, public gathering places, mass-media, door-to-door, etc.

When selecting communication channels, adhere to the following points:

- ◆ Go to where your audience is. People will not go out of their way to find your message. You will need to put your message in places your target audience will encounter.
- ◆ Utilise a variety of approaches. Mass media, community, small group and individual activities. When a simple, clear message is repeated in many places and formats throughout the community, it is more likely to be seen and remembered.

- ◆ Design a logo and a slogan for the MHO. They will be used for identification purposes, and should convey good health, security and solidarity within a community.
- ◆ Example of a logo: Sun-tree- with four people holding hands
- ◆ Example of a slogan: *Yen Nkwa a Yenso mu yie*

Implementation

This stage would elaborate on: objectives, targets, persons responsible for the activity within the MHO, costs, timetable, etc.

The following case study illustrates this:

Background: in December 1998, Akwaaba MHO located in Offinso District found that only 50 percent of the households in the Kojo krom village, were members of the scheme, whereas the district average was 75 percent.

Objective: increase membership by 25 percent in the village by December 1999.

Target group: Households that are not members of the Akwaaba MHO.

Data collection:

- ◆ Village household head breakdown by sex is 90 percent male and 10 percent female (when the average for all villages is 50 percent male and 50 percent female); however, most male household heads work in the city and only visit their families during harvest.
- ◆ Average age of household heads is 40 years
- ◆ Occupation: 90 percent of the women (spouses and household heads) are market women.
- ◆ 99 percent of the women belong to some type of susu group (30 susu groups in total in the village)
- ◆ Source of information on health and most trusted source of information: susu group.
- ◆ Health seeking behaviour: 75 percent of consultations are initiated by female members.
- ◆ Cultural aspect: even with a lack of continuous presence of the male household head, he is the authority figure and makes the final decisions concerning his family members.

Marketing strategy

- ◆ The male generally is responsible for the financial commitments of a household and would therefore be the one to decide whether or not to join the MHO.
- ◆ The females are the most sensitive to the health needs of the household.
- ◆ Marketing should focus on both groups by pointing out to the men the financial benefits of joining the MHO; and to the women how the MHO facilitates access to quality health care. The purpose is for the female group to better understand the MHO and “pressure” the male household heads to join the MHO.

Implementation

The information campaign that implements the marketing strategy is laid out in Table 8.1. Table 8.2 budgets the campaign by activity

Assess Performance

TABLE 8.1 INFORMATION CAMPAIGN TO INCREASE MHO MEMBERSHIP

| ACTIVITIES | PERSONS RESPONSIBLE FOR THE ACTIVITY WITHIN THE MHO | TIMETABLE |
|--|---|--|
| Activity 1: Meet with susu group leaders to introduce MHO and possibly attend meetings to present MHO to whole group | Field worker | Meet with 30 susu group leaders by end-January 1999 Conduct 5 general meetings with susu group members by end-July 1999 |
| Activity 2: Hire two field workers for 3 days to introduce scheme to women during market days | Public relations officer | By end-January 1999, hire two field workers By end-February, field workers should have completed work |
| Activity 3: Send correspondence and brochures about MHO to absent male household heads, stressing the financial benefits | Public relations officer | By end-February, complete brochure design By end-March, complete brochure reproduction By end-April, mail brochures |

TABLE 8.2 BUDGET FOR INFORMATION CAMPAIGN

| ACTIVITIES | PERSONS RESPONSIBLE FOR THE ACTIVITY WITHIN THE MHO | TIME-TABLE |
|------------|--|------------|
| Activity 1 | Transportation to meet with susu group leaders (2.000 cedis per visit X 30 visits) Transportation to meet with susu group members (2.000 cedis X 30 visits) | 60.000 |
| Activity 2 | 2 field workers X 3 days X 20.000 cedis per day | 60.000 |
| Activity 3 | Reproduction of 75 brochures X 5.000 cedis per brochure | 120.000 |
| | Mailing of 75 brochures X 1.000 cedis | 375.000 |

MODULE 8.2

COMMUNITY MOBILISATION

8.2.1 INTRODUCTION

This module deals with community mobilization in the context of MHOs. Community mobilization is essential for MHO initiators, managers and promoters if they are to establish good working relationships with target communities and ensure participation of all sectors of the community.

8.2.2 BASIC DEFINITIONS

Community has been defined as any group of people sharing attributes such as:

- ◆ Culture
- ◆ Geographical area
- ◆ Leadership (administration)
- ◆ Institutions
- ◆ Interests
- ◆ Facilities (markets, schools, infrastructure, health facilities, etc.)

A second definition is: a group of mutually dependent people, living in a geographical area, having a sense of belonging and sharing common values, norms, and some common interests and acting collectively in an organized manner to satisfy their major needs through a common set of organizations and institutions.

A community is not a collection of individuals but rather a system that transcends individuals. As a system, it has various dimensions: technological, economic, political and perceptual. People come and go out of the community through birth, death, marriage, etc., yet the system persists and is always changing.

Community mobilisation can be defined by the following characteristics:

- ◆ Bringing together all the members of a community, discussing and securing their co-operation
- ◆ Collaborative involvement and commitment of a community for a common purpose

- ◆ Bringing both material and human resources of a community together to achieve a goal within a specific period
- ◆ Assisting or helping a people learn how to meet their own and each other's needs more effectively

8.2.3 THE COMMUNITY MOBILISER: REQUIRED COMPETENCIES

Clarity and knowledge about goals: These may vary from community to community but common elements include poverty eradication, good governance, community capacity building, etc. It is important to understand the goals so as not to be tackling the symptoms. Make the goals your own instead of someone's or a community's.

Knowledge of target community/group: Its social organisation, economy, languages, problems, politics, etc. This could be done through mapping, survey, diagnosis, etc. Viewing a community as a system would ensure that change can be in desirable directions.

Develop necessary skills: In communication, planning, managing, organising, analysing, monitoring, etc. There is also the need to develop personal character (honesty, enthusiasm, tolerance, etc.). Your reputation is your greatest asset.

Understand fundamental concepts: Development, community development, community participation, participatory methods, sustainability, transparency, etc. Relate these concepts to your goals. If the goal is poverty reduction, you need to know more than the symptoms and results of poverty. By understanding these concepts, you would understand the causes in order to support and promote changes that will counteract the causes.

8.2.4 THE MOBILIZATION CYCLE

- ◆ Getting the necessary authorizations/permissions, especially for a new process or new facilitator.
- ◆ Awareness creation, targeted at both authorities and community. With the authorities, explain goals and methods, and convince them of mutual benefits, etc. Necessary to overcome resistance from those with vested interests. The goal is to work towards sustainability by moving towards an enabling context or environment around and above the community thus turning the authorities into facilitators. With the target community: Explaining goals, methods, adjusting expectations, etc. The goal is to strengthen the community by promoting self-help actions.
- ◆ Community assessment (diagnosis) and agreeing on priorities. Together with the people, consider:
 - ❖ Needs
 - ❖ Social factors: beliefs, customs, etc. that affect a particular problem, family and social structures, traditional forms of problem solving, ways people in the community relate to each other, who controls whom and what (distribution of land, power and resources)
 - ❖ Resources: People with special skills (leaders, story tellers, teachers, etc.), land, crops, water, availability of work, earnings in relation to cost of living.

Technical note 8.1 contains further suggestions on carrying out a community diagnosis.

TECHNICAL NOTE 8.1 - DOING COMMUNITY ASSESSMENT

People in a village or community already know most of the essential facts from their own experience. This analysis or diagnosis should not be **of** the community, but a self-analysis **by** the community. What they need to do is ask themselves:

- ▲ How do the combined facts of our situation – needs, social factors and resources – affect our health and well-being?
- ▲ How can we work with these facts – using some, changing or reorganizing others – to improve our health and well-being?

Suggestions for carrying out a survey:

Starting off with a detailed community survey may sometimes be a mistake. A survey is often seen as ‘what outsiders need to find out about what insiders of a community already know.’

However surveys may be used to get specific information: how many people attend the clinic per week, or how many children are malnourished. Or it may be used to find out whether a particular activity produces results.

Because surveys often show results that would not otherwise be noticed, they can help to renew people’s enthusiasm for continuing an activity or to stop or change an activity that is not working.

In carrying out a survey or gathering information:

- ▲ Go to people’s homes and get to know them. Information learnt through friendly, casual visits is often truer and more useful.
- ▲ Try to find out what problems people feel are most important or want to solve first. Learn what ideas they have for solving them.
- ▲ Involve local people in gathering information.
- ▲ Try to avoid taking along long written questionnaires. Avoid writing notes while someone is talking to you. Listen carefully and write your notes later.
- ▲ Look for ways of making the survey a learning and exploring experience for those being questioned. Try to ask questions that not only seek information, but that also get people thinking and looking at things in new ways.
- ▲ Go slowly when giving people advice, especially when it concerns their attitudes and habits. It is often better to tell a story about how others solved a similar problem by trying a new way.

- ◆ Facilitate unity of community: Community mobilisation should recognize and identify conflicts of interest both inside and outside the community. Different persons and social groups have different economic and political positions. Too much emphasis on common interests may prevent people from recognizing and working to resolve the conflicting interests underlying the social causes of poor health. Being inclusive and giving voice to the marginalised are part of the process of facilitating unity of the community.
- ◆ Facilitate community choice of action.
- ◆ Setting up structures or revitalizing existing ones: Other factors being equal, the level of effectiveness of organisation determines the strength of a group or community. Better organisation makes better capacity. MHO executives must be part of the community and be responsible to the community. In forming executives, break down assumptions (for example, that only women or literates can be treasurers) The process must be culturally appropriate and acceptable to community members; hence the need to know your target community.
- ◆ Design project and action plan.

- ◆ Encourage and motivate process of implementation helping to ensure transparency, monitoring and reporting.
- ◆ Evaluation.

The second assessment starts the process all over. The second time, they are stronger, more self-reliant and local capacity built.

GROUP ASSIGNMENT: ROLE PLAY

ROLE PLAY EXERCISE - COMMUNITY MOBILISATION

Kwesi has heard of the concept of community health financing from a colleague. He was very impressed with the concept and saw it as a solution to the problems of the Georgia community.

He brushes aside his colleague's advice to learn more about the concept before attempting to sell it to others.

Armed with just his enthusiasm and the little he had learnt from his colleague, Kwesi went to Georgia village.

At the village, Kwesi used his contacts with the assemblyman to call a community meeting without informing the chief or any of his elders.

At the meeting, Kwesi is not able to answer most of the questions posed to him by the community and the community health officer.

The chief, who is at loggerheads with the assemblyman, appears at the meeting to accuse Kwesi of taking sides in the conflict and seeking to undermine him.

In the midst of the confusion, Opanyin Yaw Boadu, a widely respected elder of the village, steps in to make the following suggestions/comments:

1. Kwesi's error in by-passing the chief and traditional system of the community. He points out the right way of entering the community.
2. The setting up of a committee comprising representatives of both sides of the conflict (but excluding the principal adversaries) to seek more information on the concept and to report to a subsequent meeting.
3. An appeal to use the process of tackling the health care problems to reconcile the community as problems do not discriminate and development only takes place in an atmosphere of unity

PRINCIPAL CHARACTERS

1. Chief
2. Kwesi
3. Assemblyman
4. Opanyin Yaw Boadu
5. Community health officer
6. Community (about six persons)

MODULE 8.3

METHODS FOR COMMUNITY PARTICIPATION

8.3.1 INTRODUCTION

This module deals with community participation in MHOs. Ensuring effective participation by members or communities in the work of MHOs is essential if MHOs are to realize the principles of democratic accountability and participation which should be a defining characteristic of such movements. Beyond that, participation is often necessary for the MHO to achieve its other goals of sustainability and good risk management: for example, involving members helps to control fraud and abuse of services. It is therefore necessary that MHO managers and staff as well as promoters and initiators are equipped with the techniques of selecting and using the most appropriate methods of ensuring participation.

8.3.2 DEFINITIONS

Introduce concept by giving examples of everyday usages of the word. Ask participants to explain their understanding of the word without necessarily attempting a definition. List these on the flipchart and discuss with participants.

From the ideas, associations, etc. above, attempt some working definitions with participants.

Compare these definitions with the following:

Community participation means substantively involving local people in the selection, design, planning and implementation of programmes and projects that will affect them, thus ensuring that local perceptions, attitudes, values and knowledge are taken into account as fully and as soon as possible.

It also makes continuous and comprehensive feedback an integral part of all development activities.

Discuss above definitions and those formulated by participants. Ask participants about their relative strengths and weaknesses as development facilitators.

8.3.3 INTERPRETATIONS AND CRITICAL ISSUES

Discuss with participants, the following interpretations of participation. Encourage them to relate these interpretations to the way their organisations have approached participation and rationale for each approach;

- ◆ A voluntary contribution by people in projects without their taking part in decision making.
- ◆ Sensitisation of people to increase their receptivity and ability to respond to development projects.
- ◆ The fostering of dialogue between the local people and the project preparation, implementation, monitoring and evaluation staff in order to obtain information on the local context and on social impacts.
- ◆ Voluntary involvement of people in self-determined change.

The discussion of the above should lead to the introduction of the two concepts of participation:

- ◆ **Transformational participation:** Participation seen as an end in itself. This entails empowerment, i.e. everyone's right to have a say in decisions concerning their own lives. Thus participation becomes a tool in the promotion of goals such as social justice, democracy, etc.
- ◆ **Instrumental participation:** Participation seen as a means to development, achieving objectives, etc. Thus participation becomes a means to efficiency in project management or as a tool to implement projects. Because this leads to achievement of measurable targets, is usually preferred by development workers.

Ask participants to relate their experiences or practice of participation to above concepts and discuss merits and demerits of their approaches in relation to the two concepts.

Based on foregoing discussions, bring out the following critical issues for discussion, relating them to examples of MHOs:

- ◆ Who participates? i.e. what factors are involved in such a decision?
 - ❖ What do we need to know?
 - ❖ Who takes decisions about the issue? Who will be expected to act on the decisions? Who could benefit from the experience of analyzing problems together and working out appropriate solutions? Whose active support is essential for the success of the programme? Who is likely to feel threatened by the possibility of changes to the programme?
- ◆ Who has the final say?
- ◆ Conflicts with principles of organisation: when the outcome of a participatory exercise conflicts with organisation principles, what happens? For example, where a community decides that girl-child education is irrelevant, how would this be reconciled with organisational principles promoting girl-child education?
- ◆ How can local people have an interest in something new and different if they have no prior knowledge of what that could be? What are benefits to promoting participation?
 - ❖ Promotion of ownership: People are more willing to change the way they work or behave if they are involved in designing these changes, if they understand them and support them.

- ❖ **Relevance of work:** By drawing on the experience and views of different people, the true nature of problems and the viability of alternative solutions becomes clearer.
- ❖ **Access to work:** Participation means talking to different groups and considering systematically their different points of view. It helps to ensure that different groups are aware of the work, that activities are not biased according to gender, age, disability, etc. and that all groups in the target population have access to the programmes and its outputs.
- ❖ **Sustainability:** Any mechanism for self-financing or cost recovery, for example, will depend on proper participation by those concerned.

8.3.4 APPROACHES TO PARTICIPATION

Brainstorm on participant's knowledge of, or their organisations' approaches to participation. Write down responses on flipchart. These approaches should include:

- ❖ **Passive participation training and information:** Also known as the 'we know better than you what is good for you' approach. Characterised by one-way communication between project staff and local people at village visits. Different packages are advertised for the people to adopt.
- ❖ **Active participation sessions:** Also known as 'training and visit' approach. Characterised by dialogue and two-way communication. Gives local people an opportunity to interact with extension officers and educators.
- ❖ **Participation on local request:** Also known as 'demand-driven approach' or participatory rural appraisal approach.

8.3.5 PARTICIPATORY METHODS AND TOOLS

Ask participants the various areas of project activity in which one can use participatory tools and methods. List and discuss them. These should include:

- ❖ **Assessment:** This is the process of identifying and understanding a problem and planning a series of actions to deal with it.
- ❖ **Monitoring:** This is the systematic and continuous collecting and analyzing of information about the progress of a piece of work over time. It is a tool for identifying strengths and weaknesses in a piece of work and for providing the people responsible for the work with sufficient information to make the right decisions at the right time to improve its quality.
- ❖ **Review:** Review is the assessment at one point in time of the progress of a piece of work. The basic purpose of a review is to take a closer look than is possible through the process of monitoring. Reviews can be carried out to look at different aspects of a piece of work and can use a range of criteria to measure progress.
- ❖ **Evaluation:** This is usually more formal than a review. It is an assessment at one point in time that concentrates specifically on whether the objectives of the piece of work have been achieved and what impact has been made.

Introduce participatory methods such as:

PRA: Participatory Rural Appraisal

PALM: Participatory Appraisal and Learning Methods

PAME: Participatory Appraisal Monitoring and Evaluation

RRA: Rapid Rural Appraisal

8.3.6 PARTICIPATORY RURAL APPRAISAL

Introduce and focus on PRA as a method for participatory project activities. Explain the concept of PRA as a method that enables rural people to analyse their own situations in ways they normally do not do and to plan and act on their own premises.

Emphasise that PRA need not be rural or appraisal. The A could be 'assessment', 'activity', etc.

Discuss with participants main features of PRA, such as:

- ◆ Reversal of learning: To learn from the people directly, on site and face to face, gaining from local physical, technical and social knowledge.
- ◆ Off-setting biases: Especially of rural development tourism, by being relaxed and not rushing, listening and not lecturing, probing instead of passing on to the next topic and seeking out the poorer people and women and learning their concerns and priorities.
- ◆ Triangulating: Using a range of methods, types of information, investigators, etc. to crosscheck.
- ◆ Facilitating: They hold the stick. Facilitating investigation, analysis, presentation and learning by rural people themselves so that they present and own the outcomes and they also learn. This often entails an outsider starting a process and then sitting back and not interrupting or interviewing.

Discuss with participants various PRA methods such as:

- ◆ Direct observation.
- ◆ Semi-structured interviews: with key individuals, focus groups, homogenous or mixed groups, etc.
- ◆ Ranking: Scoring and ranking of options or situations such as well-being, wealth, etc. Uses matrix scoring and ranking, etc.
- ◆ Mapping: Construction and analysis of maps, models, diagrams, etc. such as social and resource maps, census maps and models, transects, etc.
- ◆ Diagrams: Time lines, trend analysis, seasonal diagrams, activity profiles, Venn diagrams, etc.
- ◆ Triangulation: Data triangulation, investigator triangulation.

8.3.7 ENSURING PARTICIPATION OF DIFFERENT GROUPS

Ask participants to identify the different groups of people in the community in which their organisation operates. List them on the flipchart. These would include: children, women, people with disabilities, minority ethnic groups, etc.

For each group identified, ask participants to indicate barriers to participation and how these could be overcome. For example:

- ◆ **Children:** Barriers include adults not believing that children can add much to a programme; adults think they are too young, too inexperienced or too passive; etc. Children can be involved in the following ways: asking them their views directly; observation of children's needs and behaviour. Communicating with adults. Certain skills and techniques can be employed to make children feel at ease and talk about their lives. Different techniques will be needed to communicate with children of different age groups.
- ◆ **Women:** Barriers include inequalities between genders in many cultures and societies; lack of time due to heavy workloads and family responsibility; lack of experience and confidence; lack of education, training and access to information; fear of retribution (e.g. physical violence); etc. Participation of women needs to be facilitated, for example, by ensuring settings in which women feel comfortable and by helping them to define and express their own needs. Other ways of overcoming these barriers include: careful choice of staff; careful choice of time and place of meetings; taking time to explain concepts; training in confidence-building with women; working with men to increase their understanding of the need for women's involvement.
- ◆ **People with disabilities:** Barriers are based on exclusion of people with impairments because of physical, social and institutional barriers and because of the beliefs and attitudes of others. Such barriers also include: being forgotten in activities that do not specifically focus on disability; isolation due to cultural beliefs, etc. Overcoming these barriers involves, among other actions, providing disability awareness sessions for agency staff and partners and awareness-raising sessions with the community.
- ◆ **Minority ethnic groups:** Barriers include personal prejudice about the abilities of individuals from these groups; language used; etc. Overcoming these barriers includes finding out about ethnic languages, community leaders, communication channels and levels of literacy to make it possible to communicate effectively with different groups; taking into account the different traditional practices and values in all activities; providing awareness training for programme staff to foster mutual respect and understanding between different groups and ensuring that members of different ethnic groups are included on any team carrying out the exercise.

GROUP ASSIGNMENT

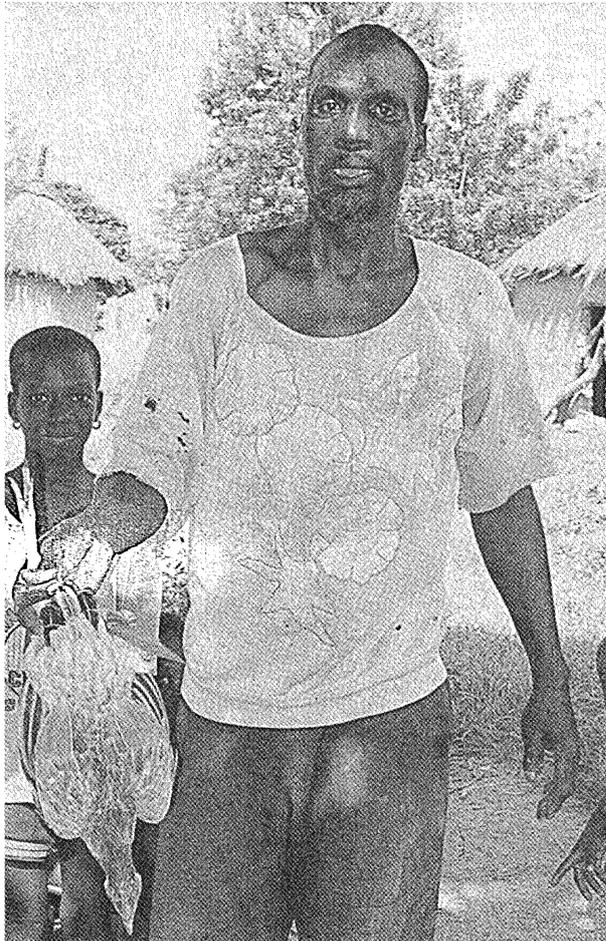
- ◆ Break participants into groups and assign each group a practical exercise on one of the PRA methods.
- ◆ Ask each group to present its findings.
- ◆ Discuss with participants, the strengths and weaknesses of each of the methods used based on the group presentations.

8.3.8 RECAP AND SUMMARY

Recap main sessions.

UNIT 9

MANAGING THE MHOs EQUIPMENT AND ASSETS



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|--|-----|
| Module 9.1 MANAGING THE MHOs EQUIPMENT AND ASSETS | 215 |
| 9.1.1 INTRODUCTION | 215 |
| 9.1.2 OVERVIEW OF FACILITY AND EQUIPMENT MAINTENANCE | 215 |
| 9.1.3 ESTABLISH QUALITY STANDARDS | 216 |
| 9.1.4 DEVELOP A PLAN TO REGULARLY MAINTAIN THE HEALTH UNIT FACILITY AND GROUNDS | 217 |
| 9.1.5 IDENTIFY REPAIRS AND IMPROVEMENTS | 219 |
| 9.1.6 EQUIPMENT INVENTORY | 222 |
| 9.1.7 EQUIPMENT INSPECTION AND MAINTENANCE | 224 |
| 9.1.8 THE EFFECT OF DEPRECIATION | 225 |

OBJECTIVE

To enable participants appreciate the fact that the condition of the MHO facility/ equipment and furniture affects the quality of the MHO service and determines whether the community accepts and uses the MHO. This will be achieved by learning how to maintain the MHO facility and grounds and equipment.

TARGET GROUP

- ◆ Manager
- ◆ Co-ordinator
- ◆ Accountant
- ◆ Field worker
- ◆ Secretary
- ◆ Driver
- ◆ Maintenance officer (if any)

PREREQUISITE

- ◆ None

CONTENTS

- ◆ Maintaining MHO facilities
- ◆ Maintaining MHO equipment

TRAINING METHODS

- ◆ Plenary sessions, group work, field trip

TRAINING MATERIALS

- ◆ Files (one per participant)
- ◆ Pens and pencils
- ◆ Two flipchart stands with pads and coloured markers or one flipchart stand with pad and coloured markers and one chalkboard with coloured chalk
- ◆ Masking tape (one roll)

PREPARATIONS FOR TRAINING BY FACILITATOR

1. Prepare appropriate flipcharts that are used at the MHO's

These will include:

- a) Inspection checklist form
- b) Procedures for regular maintenance form
- c) Work plan activities form
- d) Equipment inventory list form
- e) Take an equipment common to most MHO's to demonstrate proper inspection and maintenance. (forms attached)

MODULE 9.1

MANAGING THE MHOs EQUIPMENT AND ASSETS

9.1.1 INTRODUCTION

To deliver health services, MHO staff use the health unit facility, equipment and furniture. The condition of the facility, equipment and furniture is one factor which determines whether the community accepts and uses the health unit. To provide the community with proper health care, the health unit facility and equipment must be in proper working condition.

Because money is limited, the MHO staff must learn how to maintain the health unit facility and its equipment to prevent frequent and costly repairs. The MHO staff can save money by regularly inspecting and maintaining the health unit facility and equipment.

In brief, three points should be kept in mind:

- ◆ Inspection and maintenance of the health unit is only effective if it is done regularly.
- ◆ The MHO management team and staff must work together to ensure the proper upkeep and maintenance.
- ◆ Maintenance is not expensive, repair is!

9.1.2 OVERVIEW OF FACILITY AND EQUIPMENT MAINTENANCE

How does the condition of the MHO facility, equipment and furniture affect the quality care your MHO provides?

Solicit responses. Ask participants to describe the quality of health care the MHO provides when equipment is broken or not working properly.

What is maintenance?

Solicit responses. Answers should include the following points:

- ◆ Maintenance is taking action to keep something in proper working condition.
- ◆ Equipment, furniture and facilities which are regularly being taken care of will last longer.
- ◆ It is more efficient to inspect and maintain the MHO facility and equipment periodically than to wait for a malfunction or major problem.

How can regular maintenance benefit your MHO?

Solicit responses and write accurate answers on the flipchart or board.

9.1.3 ESTABLISH QUALITY STANDARDS

W *hat is a standard?*

Solicit responses. Answer:

- ◆ A standard is an indicator or a gauge which can be used to measure performance or assess conditions.
- ◆ Quality standards should be set for the physical condition and appearance of your health unit facility and grounds.
- ◆ Standards should be realistic, observable and measurable.

Ask participants for examples of quality standards for the physical condition of their health unit that are realistic, observable and measurable.

Write accurate responses on the flipchart or board. Possible answers:

- ◆ The MHO facility provides protection from heat, wind, and rain.
- ◆ The MHO roof is strong and does not leak.
- ◆ The MHO floors are clean and free of trash.
- ◆ The MHO walls are clean and free of dust, webs and nests.
- ◆ The MHO doors and windows open and close properly. The window panes are not broken.
- ◆ The entrance to the MHO is free of obstacles.
- ◆ The MHO grounds are free from trash and tall grass.
- ◆ The MHO has a refuse disposal and placenta pit.
- ◆ The MHO latrines are clean.

Explain to participants that all health units should have a refuse disposal and a placenta pit in which they discard hazardous waste material.

Why is it important to establish quality standards for your MHO?

Solicit responses. Possible answers:

- ◆ By setting standards, you define the level of quality and performance that the MHO should maintain at all times.
- ◆ By setting standards, everyone knows the level of quality and performance that is expected and required.

Ask participants who should set quality standards for their MHO.

Emphasise that the management team staff work together to establish quality standards.

9.1.4 DEVELOP A PLAN TO REGULARLY MAINTAIN THE HEALTH UNIT FACILITY AND GROUNDS

Ask participants to describe procedures or schedules for facility and grounds maintenance at their MHO.

Why is it important to develop a plan for regular maintenance for your MHO?

Solicit responses. Possible answers:

- ◆ If a MHO does not develop a plan, it is unlikely that regular maintenance activities will take place.
- ◆ Regular maintenance identifies potential problems, reduces breakdowns and results in more efficient use of MHO staff time.
- ◆ MHO can be alerted to poorly functioning equipment and any misuse can be corrected.
- ◆ Facilities which are regularly being taken care of will last longer.

There are three parts to develop a plan of regular maintenance:

1. Identify Priority Areas to Inspect as Part of Regular Maintenance

Before you establish procedures for regular maintenance of the MHO facility and grounds, conduct an inventory to identify priority areas that you will inspect as part of regular maintenance.

Ask participants how they decide which areas are priority for inspection.

Emphasise that participants should consider the following when identifying priority areas for inspection:

- ◆ What area or part of the MHO facility and grounds will endanger the life of patients or MHO staff if it is not in good condition? For example, the floor, the roof, the drain pipes, the latrines.
- ◆ What areas are critical to providing good quality service delivery? For example, the waiting area, the pharmacy (secure door and locks), the treatment room.
- ◆ What are the priority areas of the MHO facility and grounds that you will inspect as part of regular maintenance? For example, you might include on your list: the consultation area; the stock room; delivery room; the refuse disposal; the placenta pit and the latrines.
- ◆ What will you inspect in each priority area? For example, you might check the ceiling, windows and door in the stock room to make sure they are secure.

2. Develop a Checklist to Use Each Time You Inspect Your MHO Facility and Grounds

Why should you develop a checklist?

Solicit responses. Possible answers:

- ◆ To make sure everything is inspected
- ◆ To identify repairs and improvements
- ◆ To keep record of regular inspections
- ◆ To present a record of the inspection and identified repairs or improvements to the health committee for consideration.

- ❖ To make sure that items were repaired or improved.
- ❖ To check any repairs or improvements made since the last inspection

3. Develop Procedure for Regular Maintenance

After you determine priority areas for inspection, develop procedures for maintaining the facility and grounds.

1. Identify what needs to be done and how well in order for you to make sure the MHO meets quality standards.
2. Identify who should perform each task. The appropriate person will vary according to what is to be inspected. Some parts of the MHO facility should be inspected by specialised staff. For example, the roof should be inspected every six months by a carpenter (from the community, if possible).
3. Identify when and how often the task should be performed. Plan a general inspection of the building on a regular basis (e.g. every six months). The general inspection should be done before the participatory planning meeting in order to include possible major repairs on the workplan.

Table 9.1 presents a worksheet to use to develop a maintenance schedule for your MHO.

Refer to the blank work sheet you created on the flipchart or board before training.

TABLE 9.1 PROCEDURES FOR REGULAR MAINTENANCE OF THE MHO

| WHAT NEEDS TO BE DONE | QUALITY STANDARD | WHO PERFORMS THE TASK | WHEN THE TASK SHOULD BE DONE |
|---|---|---|---|
| Inspect the MHO facility and grounds for repairs and improvements | | MHO nurse, vice chairperson | The first day of every month |
| Sweep and mop the health unit floors | The floors are clean and free of trash. | Cleaning staff | Every day |
| Cut the grasses around the health unit facility | The MHO grounds are free of tall grass. | Cleaning staff | The first and third Friday of every month |
| Inspect and maintain MHO equipment | All MHO equipment works properly. | In-charge | First day of every month |
| Do general building inspection | MHO facility provides protection from heat, wind and rain. The entrance is free of obstacles. | Person(s) experienced in carpentry, plumbing etc. | Every six months |
| Inspect roof | The roof is strong and does not leak. | Carpenter | Every six months |
| Inspect the refuse disposal and placenta pit | All hazardous waste and garbage are thrown into the pits. The pits are not overflowing. | In-charge | Every month |

9.1.5 IDENTIFY REPAIRS AND IMPROVEMENTS

- ◆ During regular maintenance, always inspect the MHO facility and grounds to identify repairs and improvements.
- ◆ Who should inspect the MHO during maintenance?

Solicit responses. Explain to participants that both the health committee and MHO staff can inspect and identify repairs and improvements.

- ◆ During the inspection, check whether the actual condition and appearance of the facility and grounds meets your MHO's quality standards.
- ◆ Use your inspection checklist to identify and record:
 - ❖ Minor and major repairs
 - ❖ Cleaning needed
 - ❖ Service needed
 - ❖ Supplies needed
 - ❖ Improvements

Work through an example of identifying repairs and improvements using the inspection checklist. Refer to the sample checklist on the following page, as needed.

Determine Which Repairs and Improvements to Make

During the inspection, you may identify several minor and major repairs and improvements.

- ◆ Decide which ones you will act on.
- ◆ The MHO staff and health committee should work together to decide which improvements and repairs should be made.

Minor Repairs and Improvements

- ◆ Some repairs and improvements may be minor and do not require approval or funds.

Ask participants to identify examples of repairs and improvements that do not require approval.

Ask participants to explain how they know which type of repairs and improvements require approval.

- ◆ Record on work done for minor repairs and improvements in the cash and bank book and on the appropriate budget item expenditure form (e.g. The building maintenance budget item expenditure form).
- ◆ You will use information on the budget item expenditure form to determine:
 - ❖ How much money was spent on minor repairs, and
 - ❖ How much should be budgeted for the next budgeting period
- ◆ Also consider recording information on work done for minor repairs and improvements in a notebook. Include information on:
 - ❖ The problem with the facility or grounds
 - ❖ The cause of the problem
 - ❖ How the problem was resolved
 - ❖ Parts repaired or replaced
 - ❖ Total cost.

Major Repairs and Improvements

- ◆ Major repairs and improvements may need to be discussed and approved by the health committee and community.

Ask participants to identify examples of major repairs and improvements that require approval.

Ask participants to describe how major repairs and improvements are approved in their community.

- ◆ Prioritise the major repairs and improvements because money, resources and manpower may be limited.
- ◆ Use the consensus method to prioritise major repairs and improvements.
- ◆ For each major repair and improvement that you decide is high priority:
 1. Estimate the cost.
 2. Identify the resources required and the amount of time needed.
 3. Check the budget and the appropriate budget item expenditure form to make sure that money is available to make the repairs or improvements.
 4. If money has not been budgeted or is not available for repairs or improvements, identify how you will obtain resources.
- ◆ Decide how many top priority repairs or improvements the MHO can feasibly try to make.
- ◆ The decision will depend on how much money the MHO has to invest in making repairs and/or improvements.

Develop a Work plan

Explain to participants that the following is a review of what they should consider when developing a work plan for repairs and improvements during participatory planning.

- ◆ Major repairs and improvements should be included in the work plan developed during participatory planning.
- ◆ After the community decides which major repairs and improvements to make, they will work with the MHO staff and health committee to develop a work plan.
- ◆ The work plan from participatory planning should include:
 1. What needs to be done
 2. The resources needed
 3. The date by which the task will be completed
 4. Who is responsible for making sure each task is completed

Refer to sample summary work plan you prepared on the flipchart or board before training.

Use your own sample work plan or the one presented in Figure 9.1.

What Needs to Be Done?

- ◆ List all the tasks to be done to make each repair or improvement.
- ◆ For each repair or improvement, rewrite the list of tasks on the work plan in the order in which they should be completed.

FIGURE 9.1 EXAMPLE OF WORK PLAN ACTIVITIES

| WORK PLAN ACTIVITIES | | | | |
|----------------------|------------------------|------------------|--------------------|--------------------|
| Total Cost | what Needs to be done? | Resources Needed | Date of Completion | Person Responsible |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

With What Resources?

- ◆ Identify the main resources you need to complete each task, such as materials, equipment, and the person(s) who will do the repair.
- ◆ If you need to purchase some resources, estimate the cost. For example, the cost of paying someone, such as carpenter, to do the repair. You will refer to these costs when you develop the health unit budget.

By Which Date Should it Be Completed?

- ◆ Estimate when each task should be completed.
- ◆ All tasks should be done on time.

Who is Responsible for Making Sure it is Completed?

- ◆ If you do not specify who is responsible for making sure each task is done, the tasks may not be completed.
- ◆ Decide who in the MHO, health committee or community will be responsible for making sure each task is completed. This person will not be the one who does the task.

In conclusion, use the work plan to:

- ◆ Make sure work is on schedule.
- ◆ Make sure work is within budget.
- ◆ Make sure work was completed.

GROUP ASSIGNMENT

The condition for the MHO equipment affects the quality of health services. To obtain information about the condition of MHO equipment, regularly inspect and maintain MHO equipment.

Why is it important to regularly inspect and maintain MHO equipment?

Solicit responses. Possible answers:

- ◆ Regular inspection ensures that equipment is functioning properly and safely.
- ◆ Regularly inspecting and maintaining equipment reduces breakdowns and results in more efficient use of MHO staff time.
- ◆ When problems do occur, the amount of time that the equipment is not functioning decreases because MHO staff are familiar with the equipment and will therefore be able to restore it to working order quicker.
- ◆ MHO staff can be alerted to poor functioning of equipment and any misuse can be corrected.

- ◆ Improves awareness and knowledge of good use and care of equipment.
- ◆ Saves money for the MHO.
- ◆ Extends equipment life.

Explain to participants that maintaining MHO equipment should be part of their plan to regularly maintain the MHO.

Who should be responsible for maintaining MHO equipment?

Solicit responses. Answer:

- ◆ In-charge
- ◆ MHO staff

To successfully and effectively maintain the condition of your MHO equipment:

1. Develop an inventory list of equipment.
2. Inspect and maintain equipment

9.1.6 EQUIPMENT INVENTORY

An equipment inventory provides consistent, accurate and up-to-date information on:

- ◆ Equipment description
- ◆ Date of purchase
- ◆ Manufacturer
- ◆ Model number
- ◆ Serial number
- ◆ Functioning status
- ◆ Price

Figure 9.2 presents a sample inventory list.

FIGURE 9.2 EQUIPMENT INVENTORY LIST

| Description of equipment | (1) Manufacturer (2) Model Number (3) Serial Number | Date of Purchase | Functioning Status | Price/other information |
|--------------------------------------|---|------------------|------------------------|-------------------------|
| refrigerator kerosene 220 volt, 2401 | (1) Electrolux (2) Model RCW 23 (3) 11405 | 28 Jan 1990 | working satisfactorily | USD \$140.26 |
| vaccine cold boxes, 221 capacity | (1) (2) (3) | 28 Jan 1990 | working satisfactorily | USD \$ 70.75 |
| drum sterilising | (1) (2) (3) | 28 Jan 1990 | working satisfactorily | USD \$ 130.75 |
| table for pelvic examination | (1) (2) (3) | 28 Jan 1990 | working satisfactorily | USD \$ 390.00 |
| Thermometer | (1) (2) (3) | 10 April 1995 | working satisfactorily | USD \$ 5.50 |
| Stethoscope | (1) (2) (3) | 3 Feb 1993 | working satisfactorily | USD \$ 15.00 |

| Description of equipment | (4) Manufacturer (5) Model Number (6) Serial Number | Date of Purchase | Functioning Status | Price/other information |
|---------------------------|---|------------------|---------------------------------------|-------------------------|
| Otoscope | (1) (2) (3) | 27 Aug 1994 | working satisfactorily | USD \$45.55 |
| speculum vaginal bi-valve | (1) (2) (3) | 3 Feb 1993 | working satisfactorily | USD \$40.75 |
| stethoscope foetal | (1) (2) (3) | 3 Feb 1993 | working satisfactorily | USD \$20.75 |
| infant scale | (1) (2) (3) | 28 Jan 1990 | working satisfactorily | USD \$63.20 |
| flash light | (1) (2) (3) | 10 April 1995 | not working - batteries not available | USD \$5.75 |
| scissors for dissection | (1) (2) (3) | 1 March 1993 | need to be sharpened | USD \$17.50 |

Ask participants to explain why they need to make an inventory that includes specific equipment information.

Possible answers:

- ◆ To make sure all equipment is accounted for
- ◆ To be able to identify if it is missing or stolen
- ◆ To be able to identify parts or supplies needed

9.1.7 EQUIPMENT INSPECTION AND MAINTENANCE

Using the equipment inventory list, inspect and maintain equipment according to the regular maintenance plan you developed for your MHO facility and grounds. Obtain a complete set of manuals, including operator and service manuals, and inspect and maintain equipment according to the manuals.

Ask participants how often they should inspect and maintain MHO equipment.

Ask participants who should conduct the inventory and inspection of MHO equipment.

Ask participants what they would do to inspect and maintain equipment and furniture if manuals are unavailable.

To maintain MHO equipment in proper working condition:

1. Visually check the equipment for damages, necessary parts, etc.
2. Clean the equipment according to proper procedures.
3. Operate or use the equipment to make sure it is working properly.
4. Check that the equipment is stored properly when not in use (avoid exposure to sunlight, seal in plastic bag, etc.).
5. Perform regular maintenance on the equipment as needed. For example, exchange parts subject to wear, repair defective parts or adjust equipment.
6. Record inspection and maintenance results in a notebook for future reference.

Work through the steps of inspecting and maintaining equipment using a piece of equipment found in all MHO's, for example, an infant scale.

Also consider recording information on equipment repairs in a notebook. Include information on:

- ◆ The problem with the equipment
- ◆ The cause of the problem or malfunction
- ◆ How the problem was resolved
- ◆ Parts repaired or replaced
- ◆ Total cost

Ask participants why they should keep records of equipment repairs.

Possible answers:

- ◆ To determine how much money, time and resources were spent on repairing and maintaining equipment.

- ◆ To determine how much money should be budgeted for regular maintenance and repairs.
- ◆ To determine whether to repair or replace an item. For example, if an item breaks frequently, it may be more efficient to replace it.

Maintenance of Office Equipment (Computers, photo-copiers and typewriters)

The purpose of maintenance is to keep the equipment in perfect working condition. Maintenance also prolongs the life span of the equipment. In maintaining computers, copiers and typewriters, dust and temperature are two factors that will have to be borne in mind.

Maintenance of Computers

Summary of maintenance requirements:

1. Computers must be covered to prevent dust from entering the component parts and mother board. As this requirement is almost unavoidable, the computer must periodically be blown with air pressure machines to get rid of any accumulated dust.
2. As much as possible, computers should be in air-conditioned rooms. In the absence of such, fans could be provided to prevent the equipment from over heating.

Without these artificial cooling systems, the computer should be sited in airy rooms. It is also best to use it in the early part of the day or at night, as those periods are usually cooler. It is also advisable to use the equipment over short periods of time, one or two hours at a stretch.

3. Ensure the computer is virus-free by installing anti-virus mechanisms. It is also good to avoid using diskettes used on others computers unless it is certain those computers are virus-free.
4. Use Uninterrupted Power Supply (UPS) to avoid a crash of the hard disk due to irregular power supply and sudden surges in the power supply.
5. Free hard disk of old data by storing them on diskettes. Too much data slows down the hard disk. The hard disk needs to be ungraded periodically.

Maintenance of Photo-copiers

Periodically, and depending on volume of work, blow copier of dust. Check and service the toner, drum as well as the lens.

The copier should be covered to reduce contact with dust.

Maintenance of Typewriters

The typewriters should be covered to reduce contact with dust. The component parts should be oiled periodically.

9.1.8 THE EFFECT OF DEPRECIATION

Technical Note to Trainers: Refer to Unit 5 for a detailed discussion on depreciation.

Depreciation reduces the useful life of fixed assets. Provision for depreciation must be applied on a consistent basis on all fixed assets whose value is material on the final date of the financial year. The method of depreciation adopted must be used over the years unless very good reasons necessitates a change.

To keep track of all fixed assets an inventory register or list should be maintained, to show cost of each assets the date of acquisition, and actual depreciation.

To provide for replacement of fixed assets, it is recommended to invest the estimated amount for depreciation outside the MHO, after charging such an amount as an expense.

SUPPORTIVE TEXT 1: BENEFITS OF REGULAR MAINTENANCE

Adhering to a regular maintenance schedule yields numerous advantages to the MHO:

- ◆ Ensures that the facility and equipment are functioning properly and safely
- ◆ Reduces frequency and severity of failures or equipment
- ◆ Extends the useful life of the facility or equipment
- ◆ When problems do occur, it decreases the amount of time that the health unit is not functioning because health unit staff are familiar with the facility or equipment and will therefore be able to restore it to working order quicker
- ◆ Decreases operating costs
- ◆ Improves awareness and knowledge of good use and care of facility and equipment.

To successfully and effectively maintain the appearance and condition of the MHO:

- ◆ Establish quality standards for the upkeep and maintenance of the MHO facility and grounds.
- ◆ Develop a plan to regularly maintain the MHO facility and grounds.
- ◆ Identify major repairs and improvements.



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