
# FACILITY IMPROVEMENT FUND
# OPERATION MANUAL

# HEALTH CENTRES

**December 2002**

Division of Health Care Finance
Ministry of Health
Nairobi, Kenya

## ACKNOWLEDGEMENTS

This manual was prepared by the members of the Division of Health Care Financing of the Ministry of Health. Technical assistance was provided by Dr. Wasunna Owino, long-term advisor from the POLICY project funded by the U.S Agency for International Development (USAID).

The contents of the manual are based on procedures originally established by the Ministry with modifications developed and tested through visits to facilities and provincial and district administrations, and workshops with staff from facilities and District Treasuries. Advice and comments from the Provincial Medical Officers and representatives of various departments at Ministry headquarters were also incorporated.

This version of the manual is intended especially for health centres. More detailed information on areas such as claiming from NHIF can be found in the main *Facility Improvement Fund Operations Manual*.

# Ministry of Health

Telegrams: "MINHEALTH",
Nairobi
Telephone : Nairobi 717077
When replying please quote

OFFICE OF THE
PERMANENT SECRETARY
AFYA HOUSE
CATHEDRAL ROAD
P.O. BOX 30016
NAIROBI

Ref. No. **CIRCULAR NO. DHCF/VOL. 1 (138)**

23rd December 2002

All Provincial Medical Officers
All Medical Officers of Health
All Officers in Charge of Health Centers
All District Accountants

**RE: FACILITY IMPROVEMENT FUND - HEALTH CENTRE OPERATIONS MANUAL**

In order to improve the collection, management and use of FIF revenues, the ministry has put together the attached operations manual. This manual provides a complete set of guidelines for operating the Facility Improvement Fund at health center level and should be read thoroughly and put into practice immediately. This manual complements the overall Operations Manual issued in 1997.

The procedure set out in the manual should be regarded as superceding those set out in any previous Ministry of Health circulars. It should be noted that specific instructions which vary over time, such as fee levels or exemption categories, are not included in the manual and will instead continue to be communicated to you through periodic circulars.

(Prof. Julius S. Meme, EBS, MBS, FAAP)
**Permanent Secretary**
c.c.

The Controller and Auditor General,
Exchequer and Audit Department,
P.O. Box 30084, NAIROBI

Accountant General
Accountancy Services,
The Treasury,
P.O.Box 3007, NAIROBI

## LIST OF ACRONYMS

| | |
|---|---|
| AIE | Authority to Incur Expenditure |
| ALOS | Average Length of Stay |
| CS | Cost Sharing |
| DA | District Accountant |
| DCO | District Clinical Officer |
| DDC | District Development Committee |
| DEC | District Executive Committee |
| DH | District Hospital |
| DHMB | District Health Management Board |
| DHMT | District Health Management Team |
| DMOH | District Medical Officer of Health |
| DMS | Director of Medical Services |
| DPHN | District Public Health Nurse |
| DT | District Treasury |
| DTC | District Tender |
| DTC | Drugs & Therapeutics Committee |
| DEEC | District Executive Expenditure Committee |
| FIF | Facility Improvement Fund |
| GOK | Government of Kenya |
| HQ | Headquarters |
| HCF | Health Care Financing |
| HCC | Health Centre Committee |
| HCMT | Health Centre Management Team |
| HMT | Hospital Management Team |
| HAO | Health Administrative Officer |
| HAO-FIF | Health Administrative Officer of FIF |
| LPO | Local Purchase Order |
| MCH | Maternal and Child Health |
| MOF | Ministry of Finance |
| MOH | Ministry of Health |
| MRO | Medical Records Officer |
| NGO | Non-Governmental Organization |
| NHIF | National Hospital Insurance Fund |
| OPD | Outpatient Department |
| P/PHC | Preventive/Primary Health Care |
| PGH | Provincial General Hospital |
| PMOH | Provincial Medical Officer of Health |
| PMT | Provincial Management Team |
| PS | Permanent Secretary |
| RHDC | Rural Health Demonstration Centre |
| RHTC | Rural Health Training Centre |
| RTA | Road Traffic Accident |
| SDH | Sub-District Hospital |

## SECTIONS AND CONTENTS PAGE

## ACTION POINTS

This manual is designed to help you to manage the Facility Improvement Fund successfully in your health centre. Experience in the health centres has shown that implementation of the policies and procedures described in the manual will improve the collection and use of funds, and enhance patient and staff satisfaction with services.

This list shows the **key actions** that the officer in charge must take to achieve success. They are described under the sections in which they appear.

**Section 1: Policy**

*Staff support:* Make sure that all health, administrative and support staff are aware of policies through meetings and circulars.

**Section 2: Managing for Success**

*Performance targets:* Use your service statistics and fee levels to set targets so that you know how much you should be collecting and waiving.

*Set priorities:* See which departments have the greatest revenue potential and focus on improving performance in such departments.

*Spend money to make money:* Motivate staff to improve performance by spending a percentage of the department's revenue on improving services in that department.

*Monitor collection performance:* Compare actual collections with targets each month to detect good and bad performance.

**Section 3: Organization and Management**

*District supervision:* Let your DHMT members know what is happening, and help them to use supervisory visits to encourage staff support for cost sharing revenue.

*District support:* Work closely with your DMOH and District Accountant to ensure that you always have adequate supplies of essential receipts, medical stationery and record books.

*Staff responsibilities:* Make sure that all staff members know what they are supposed to do with regard to cost sharing revenue.

**Section 4: Fee Structure, Exemptions and Waivers**

*Fees and exemptions:* Make sure that fee-level and exemption posters are prominently displayed and that all staff are familiar with them.

*Access to the poor:* Make sure that staff are familiar with waiver procedures so that patients who cannot afford to pay are not turned away. Open a waiver register and record all waivers granted.

**Section 5: Fees Collection**

*Fees collection*: Minimize queuing and movement between departments to ensure that patients are not inconvenienced.

*Cash boxes:* Make sure that the Revenue Clerk uses a proper cash box for security and demonstration of accountability to patients.

*Departmental registers:* Make sure that each department enters information on fees in their service registers and prepares monthly summaries.

*Inpatient Summary Form:* Use the new Inpatient Summary Form to ensure that all inpatient fees are correctly charged.

**Section 6: Expenditure Planning and Management**

*Expenditure Planning:* Submit annual expenditure plans and quarterly AIE requests on time to make sure that there are no delays in spending funds.

*Expenditure monitoring:* Keep track of goods and services provided from your 75% funds through the DMOH's office.

**Section 7: Quality of Care and Local Public Information**

*Quality of care:* Make sure that funds are used to visibly improve patient services and that other aspects of patient care such as courtesy and cleanliness are observed.

*Patient and public information:* Tell patients how cost sharing revenue is being used and keep the community informed.

**Section 8: Accounting**

*Cash Analysis Book:* Make sure that the collections section of the Cash Analysis Book is properly maintained and that the original page is submitted to the DMOH by the 10th of the following month.

**Section 9: Performance Review**

*Monitor performance:* Prepare and use the monthly Revenue Summary Report and Collections Tracking Sheet to see where there is poor performance and take corrective action.
Reporting: Submit the monthly collection report to the DMOH by the 10th of the following month and the monthly Workload Report to the DMOH by the 15th of the following month.

## 1. POLICY

The Government of Kenya acknowledges that Kenyans are entitled to quality, accessible and affordable health care. As the need for health care services continues to increase, it has become necessary to supplement Government financing from other sources. One of such sources is cost sharing revenue.

The principle of cost sharing is not new and has been used for many years around the world. Kenyans are sharing costs through school fees, airport tax and are accustomed to paying mission and private hospitals for health services. Taking this into account, user charges were introduced in Government hospitals and health centers on December1, 1989.

Cost sharing revenues are deposited into a Facility Improvement Fund (FIF) account. Such revenues are additional to budget allocations from the Treasury. 75% of the revenue is retained for use by the generating facility and the balance is used for primary and preventive health care activities in the district where the money were collected to cover operating expenses, resulting in improved services.

The public has indicated willingness to pay for good quality services and it is agreed that emphasis must be placed on value for money, e.g., by maintaining adequate supplies of drugs. It is also recognized that all Kenyans should have access to health care. Fees are therefore waived for those patients who cannot afford to pay, and services which benefit society in general are provided free of charge.

## 2. MANAGING FOR SUCCESS

During 1999-2001 period, some Government facilities tripled their cost sharing revenue whereas others barely improved. The reason some Health Centres were more successful than others was good management.

Success in cost sharing revenue management means three things: maximizing collections, making good use of money and protecting hardship cases.

This section sets out some management practices, which, if used, will greatly improve the success of the cost sharing programme in your facility. It also describes procedures for setting targets—one of the most important management tools.

### 2.1 Good Management Practices

Lessons learned from successful facilities are as follows:

- There is no progress without people: All medical and administrative staff as well as the community must be closely involved in cost sharing activities. Of particular importance is the active personal participation of officers in charge. The support of the nurses, clerks and the Health Centre Committees (HCCs) is also critical.

- Set performance targets: It is vital to set targets so that you know how much you should be collecting. Without targets you and your staff would not know whether you are doing well or badly.

- Monitor performance: Officers in charge should maintain a wall chart that shows actual collections and targets. Monthly reports should be prepared and discrepancies investigated. Officers in charge should walk around the health centre from time to time, observe how systems are being implemented, and talk to staff and patients about problems and solutions.

- Use the 80/20 rule for setting priorities. Experience shows that 80% of collections comes from 20% of the departments. At health centre level, most of the collections should come from the outpatient treatment fees and drug items issued. If officers in charge focus their efforts on these collections, the bulk of the revenue will be collected.

- Spend money to make more money. To encourage departmental staff to participate fully, a percentage of the revenue collected by a department should be spent in that department. Funds should be used on selected, visible improvements (e.g., fixing the waiting area), and to ensure that registers, receipt books and other critical stationery are in supply. However, non-contributing departments should not be ignored.

## 3.0 ORGANIZATION AND MANAGEMENT

The organization and management of health care financing in the Ministry of Health is carried out at four levels, namely, at headquarters, provincial, district, and facility levels.

## 3.1 Headquarters

At headquarters, the implementation, support and supervision of cost sharing activities is the responsibility of the Division of Health Care Financing (DHCF).

## 3.2 District Management

The management of cost sharing revenue at the district level is the responsibility of the District Medical Officers of Health (DMOHs), District Health Management Teams (DHMTs), District Health Management Boards (DHMBs) and District Treasuries. Cost sharing revenues are held in special FIF bank accounts under the control of respective account holders and the District Treasury.

### 3.2.1 District Medical Officer of Health (DMOH)

The role of the DMOH and DHMT with regard to cost sharing funds is to supervise and monitor collections, and to recommend Health Centre expenditure plans for approval. These responsibilities fall under the District Executive Expenditure Committee (DEEC) comprised of the District Medical Officer, District Health Administrative Officer, District Public Health Nurse and District Public Health Officer. Specific responsibilities with regard to health centres include:

- Receiving details of banking and following up on late bankings;
- Receiving details of expenditures;
- Determining monthly facility balances and reconciling them with District Treasury balances.
- Supervising collection performance, expenditures and quality aspects of cost sharing as part of routine health center supervision. The DMOH also monitors service quality.

### 3.2.2 District Health Management Team (DHMT)

The role of the DHMT is to plan and coordinate health activities in a district. The DHMT reviews revenue targets and expenditure plans and monitors collection performance, service improvement and impact on utilization. Its members include the DMOH, District Health Administrative Officer, District Public Health Nurse, District Nutritionist, District Clinical Officer, District Pharmacist, District Public Health Officer, and Health Information and records officer (HIRO).

### 3.2.3 District Health Management Boards (DHMB)

The role of the DHMB is to oversee the provision of health care in the district, ensure client representation, and prudent use of funds. The DMOH acts as Secretary to the DHMB, which has three committees: (1) financial and general purposes, (2) quality of curative services, and (3) preventive and promotive health care. The responsibilities of the DHMB with regard to user fees are as follows:

- Review of district reports on collections and expenditures;
- Review of plans for spending cost sharing revenues and approve or suggest changes;
- Recommending areas to levy user charges; and
- Handling consumer complaints.

The Board is supposed to meet quarterly.

### 3.2.4 District Treasury

The role of the District Accountant and his staff is to help operate the FIF bank accounts, supervise and monitor collections, approve expenditures, and enter transactions in the Treasury accounting systems. Specific responsibilities include:

- Issuing and controlling official receipt books;
- Monitoring and supervising cash registers;
- Receiving and checking details of banking and recording them in a FIF cash book;
- Following up with facilities that do not report as often as required;
- Verifying that expenditures follow AIEs and recording details in vote books;
- Entering transactions into the Treasury accounting systems;
- Signing cheques and operating the bank account together with the officer in charge of the health center;
- Determining monthly facility balances and reconciling them with health centre records; and
- Arranging for audits of facilities where necessary.

## 3.3 Health Centre Management Team (HCMT)

The management of user charges at the health centre level is the responsibility of the Health Centre Management Team (HCMT) whose members include the officer in charge, one nursing officer and the Public Health Officer. The HCMT has the following responsibilities with regard to the cost sharing revenue.

- Preparing targets for annual cost sharing revenues;
- Preparing and submitting expenditure plans and AIE requests based on revenue targets;
- Implementing approved expenditure plans; and
- Monitoring collections, waivers, exemptions, expenditures and use of funds.

Table 3.1 shows the responsibilities that various staff have with respect to cost sharing management in health centres:

***Table 3.1:*** *Individual Responsibilities for FIF Activities in Health Centres*

| TITLE | GENERAL RESPONSIBILITIES | SUPERVISOR |
|---|---|---|
| Officer in charge | • Supervise and support all aspects of fee collection<br>• Review registers and Cash Analysis Book<br>• Prepare FIF Reports and submit to DMOH<br>• Prepare expenditure plans and AIE requests | DMOH |
| Revenue Clerk | • Receive, check and bank all collections<br>• Account for collections to District Treasury<br>• Maintain cash analysis book | Officer in charge |
| Heads of Departments | Ensure that registers are kept and monthly summaries prepared. | Officer in charge |
| Register Clerks | Record collection details in patient service registers | Officer in charge |

If a health centre has an administrative officer, the officer in charge may delegate some of the functions to that officer.

## 3.4 Health Centre Management Committee

This manual establishes the Health Center Management Committee whose members shall comprise at least eight elected community leaders, three of whom shall be women from the catchment area of the health center. The committee shall elect its chairperson and the officer in charge of the health centre shall be its secretary, two members of the HCMT shall be ex-officials.

### 3.4.1 HCMC Allowances

The committee will be entitled to a sitting allowance whose rates will be determined by the accounting officer from time to time.

### 3.4.2 Roles of Health Center Management Committee

The HCMC shall:

a) Represent the community's interest in the health centre;
b) Identify health problems among the community;
c) Advocate for cost sharing and promote health awareness in the community; and
d) Receive, review and approve the utilization of cost sharing funds.

### 3.4.3 Conduct of Meetings

*Quorum:* The quorum for committee meetings shall be five members, one of whom must be the secretary and two members of the HCMT.

*Agenda:* For efficient conduct of business, there shall be an agenda drawn by the Secretary in consultation with the chairman.

*Minutes:* To Keep track of business conducted and follow up decisions, it is important that accurate and comprehensive minutes of all meetings are kept. The minutes should be in the form of an action plan, stating:

a) Decisions made at the meeting;
b) Actions to be taken;
c) Who will carry out these actions?
d) By when?
e) With what resources?

*Meetings:* There shall be four meetings in a year of the Health Centre Management Committee and one meeting per month of the Health Centre Management Team.

*Special Meetings:* It may be necessary occasionally to hold special meetings to discuss urgent matters such as crises.

## 4.0 FEE STRUCTURE, EXEMPTIONS AND WAIVERS

Fees are charged for selected services provided to patients. Sub-section 4.1 describes some of the fees that are generally charged. Certain types of service, illness and patients are exempted under Government policy, and these are discussed in sub-section 4.2. Patients who cannot afford to pay may be granted a waiver and these procedures are described in sub-section 4.3.

## 4.1 Fee Structure

The cost sharing fee schedule changes from time to time and is therefore not included in this manual. All departments involved in cost sharing revenue collection should have a copy of the current fee schedule. Fee posters should be prominently displayed for patients and staff. When fee changes are announced, staff should be comprehensively informed through meetings and circulars. At the same time, fee change notices should be displayed and fee posters amended accordingly.

The following are clarifications of specific fees:

### 4.1.1 **Daily inpatient fees** (including maternity)

The daily inpatient fee includes bed, food, delivery, drugs and consultation fees, Laboratory tests are charged separately.

The amount claimed from NHIF for NHIF beneficiaries is a fixed rate that covers all charges for the patient. NHIF and other insured patients are charged for the total number of days they stay in a Health Centre. Although NHIF does not currently cover Government health centre services, it may do so in future.

Inpatient services given to refugees should be charged to UNHCR. Consult the Division of Health Care Financing, Ministry of Health.

### 4.1.2 Outpatient treatment fees

The outpatient treatment fee is chargeable for each treatment provided. The definition of "treatment" and the fee level will change over time and the officer in charge of the facility is responsible for having the most recent list of fees and chargeable treatments. At health centres, outpatient treatment is generally provided in three departments: pharmacy, injection, laboratory and dressings. Generally, outpatient treatment includes the following:

- Each take-home medicine dispensed (every item on the prescription);

- Each course of injections given;
- Intravenous fluids regardless of number of bottles used;
- Suturing of wounds, incision and drainage (I&D) or other surgery;
- Dressing of wounds; and
- Application of POP (plaster of paris) casts.

The following special rules apply to charging outpatient treatment fees:

a) Follow-up treatment within fourteen (14) days for the same problem is done without charge, provided the patient presents the receipt or patient record from the initial visit. If, at any time, the patient returns with a different problem as determined by the clinician, the usual outpatient treatment fees should be charged.

b) Maximum dispensing quantities: Since patients will be paying for treatments received, certain minimum dispensing quantities will be applied. Unless specifically directed by the clinician, drugs should not be dispensed in less than the prescribed amounts.

c) No treatment, no fee. If treatment is not provided because the treatment (e.g., drug) is not available, there is no charge. If the patient purchases materials privately, there is no charge for applying the treatment. Emphasis: Consultation with a clinician is free. Where there are no official receipt books all patients shall be automatically exempted from paying fees.

#### 4.1.3 Laboratory charges

Laboratory services are charged separately from treatment fees. Special rules for laboratory services are as follows:

- A fee is charged for each test, not each patient;
- Inpatients should be charged for every test, including follow-up tests;
- Chronic disease patients (e.g., diabetes) should be charged for each test. If the patient cannot afford to pay the fees, relief should be sought through the waiver system;
- Fee for diagnostic investigations done as part of medical examination are excluded from medical examination fees and are charged separately;
- Patients referred from a non-GoK facility for diagnostic investigations should be charged according to a separate private fee schedule.

## 4.2 Exemptions

Certain categories of patients are exempt from payment because of their age or type of illness. Exemptions follow Government policy and any patient who fits any of the exemption criteria is automatically exempted from paying. Exemptions are different from waivers, which are granted if a patient is too poor to pay and are not automatic. Waivers are discussed in the next section.

The following are automatically exempt: prisoners, National Youth Service personnel, street children and children under five years of age..

## 4.3 Waivers

### 4.3.1 General

It is important to ensure that everyone has access to health services. It is Government policy that people who are too poor to pay can get a waiver. However, the waiver system must be implemented with care: if it is too easy to obtain a waiver, the system will be abused and revenue will be lost; on the other hand, if the existence of the waiver system is not known, or if it is too difficult to obtain a waiver, patients who need health care may be turned away.

### 4.3.2 Procedures

The procedures for processing a waiver are as follows:

a) Officers in charge of health centres decide if a waiver will be authorized.

b) A waiver book must be used to record waivers granted and each waiver must have a number.

c) The waiver number must be recorded in the cost sharing section of the department's service registers. The number and value of waivers granted is shown on the monthly departmental summary.

d) The monthly Revenue Summary Report sent to the DMOH shows the total value of waivers granted.

### 4.3.3 Deciding whether or not to grant a waiver

The decision to grant a waiver or not should be based on history taken and observation of the status of the patient and the patient's relatives. Information noted on the waiver form (occupation, number of children, means of transport, alcohol and cigarette consumption, and type of clothing) should be carefully considered. Patients who should be sympathetically considered for a waiver include (1) students away from home with no funds of their own, (2) patients with chronic illnesses that are not exempt, and (3) patients who have spent a lot of money to travel to the facility. A partial waiver may be granted where part payment has been made.

### 4.3.4 Implementation of the waiver system

The officer in charge must ensure that the waiver system is fully implemented at the health centre. Implementation includes the following actions:

a) *Informing all facility staff* about the operation of the waiver system through staff meetings. Support staff should be included since they are often the people that patients first turn to with their questions.

b) *Informing patients:* An acceptable mechanism should be used to let financially handicapped patients know of the existence of a waiver system.

### 4.3.5 Recording waivers

A book is used to record all waivers granted. The following information are recorded in the book for each waiver:

- Waiver number, running consecutively from 1;
- Patient's name, age, sex, marital status, occupation, address;
- Inpatient or outpatient number;

- Date of treatment or discharge;
- Services provided;
- The total amount charged;
- The amount of money waived; and
- Name and designation of the person granting the waiver.

#### 4.3.6 Monthly review of waivers granted

The value of waivers granted is checked by the HCMT when reviewing the monthly Revenue Summary Report. DHMT members review the level of waivers granted during supervision visits. When reviewing the level of waivers, it is important to remember that too many waivers may mean that the system is being abused; too few waivers may mean that hardship cases are not being identified and that patients who need care may not be receiving it.

Circumstances vary around the country, so it is not possible to state how many waivers should be given. By regularly reviewing the numbers of waivers, the HCMT and DHMT should be able to develop an idea of the approximate number of waivers for its patients.

## 5.0 FEE COLLECTION AND ACCOUNTING

## 5.1 Fee Collection and Accounting Procedures

For the user fee programme to be successful, fees must be collected in a way that causes minimum inconvenience to patients and staff, ensures maximum collections and can be easily accounted for. The following points apply to all departments that charge fees for services (such as pharmacy, laboratory, dressings, injections, medical examinations, circumcisions, and inpatient services).

#### 5.1.1 General collection guidelines

a) Consultation (OPD) flow:
   Step *One*: Patient seen by RCO;
   Patient prescribed medicine;
   Patient prescribed diagnostic investigation.
   Step *two*: Patient pays at case point (e.g., pharmacy) for drugs and lab tests.
   Step *three*: Patient proceeds to service points with the official receipts and obtains service.

b) Inpatient flow:
   Consultation (admission centre)
   Step one: Patient seen by RCO;
   Patient Admitted to appropriate ward.
   Step two: Treatment, laboratory tests are billed both at the departmental level and the ward and appropriate register is used.

#### 5.1.2 Departmental reports

Daily and monthly totals should be entered in the registers. The Inpatients Register totals should separate the total laboratory from ward fees to help in reconciling them with laboratory records. The officer in charge of the department should review the summary, sign and date it to show approval. A Daily Fee Summary sheet should be used to calculate the monthly totals. The officer in charge of the health centre will extract the totals from each register at the end of the month and include them in the Monthly Collection Report.

The monthly total of each type of drugs issued should be included in the Pharmacy Register. This provides useful information for ordering drugs and stock control.

#### 5.1.3 Fee posters

Fee posters should be put up next to each departmental reception desk, in all waiting areas, and at all cash points. Each poster should show the fees and exemptions and should advise patients to obtain and keep a cancelled stamp or receipts for all payments.

#### 5.1.4 After hours

The staff member who delivers a service after hours is responsible for collecting the fees. A receipt book may be given to the person on duty, who will account for the cash the next working day.

## 5.2. Inpatient Billing

#### 5.2.1 Charging

An Inpatient Summary Form must be opened for every patient on admission. This form is maintained in the ward with the patient records. All charges are recorded in the form when services are carried out. When the patient is discharged, the ward nurse should make sure that all charges are reflected in the form and should submit it along with supporting documents (e.g., laboratory slips) to the nursing Officer in charge for approval.

The nursing officer in charge checks entries and calculations on the Inpatient Summary Form and records payment details as follows:

- If a waiver, write "Waived" and the waiver number;
- If an exemption, write "Exempt" and the reason for exemption (e.g., age);
- If NHIF, write "NHIF" and the invoice number; and
- If cash, write "pay cash".

If cash is to be paid, the patient takes the form to the cash point, pays the total due and the revenue clerk issues a receipt. The patient returns to the ward and shows the receipt or evidence of waiver or exemption to the nurse and details of payment are entered in the Inpatient Register. Discharge papers are then issued by the nurse.

#### 5.2.2 Absconders

In order to reduce absconding, the ward nurse should retain the discharge prescription until proof of payment, waiver, or exemption is produced. In addition, the revenue clerk should visit the wards every day before discharge time to identify patients who are about to be discharged and collect the fees or to establish how and when they are to be paid.

## 5.3 NHIF Claiming

NHIF may be claimed for inpatient services provided to a member. At present, claiming is not easy and small health centres that perform few deliveries for NHIF members may not find it worthwhile to claim. However, if the NHIF rate is significantly higher than the daily cash rate, it may be worth the effort for larger health centres to claim.

If you decide to claim, you should note that it will be necessary to:

- Identify NHIF beneficiaries at or soon after admission;
- Get the member to provide documentation supporting the claim (NHIF card, Identity Card, etc.);
- Use cost sharing revenue to cover costs of claiming; and
- Keep proper records of all claims and follow up frequently with NHIF.

A detailed set of guidelines for NHIF claiming, including examples of necessary forms can be obtained from the DHCF. In addition, the District Health Administrative Officer should be familiar with claiming procedures.

## 5.4 Accounting

Accounting is done through Health Care Services Fund in accordance with the requirement of the Exchequer and Audit Act Cap. 412.

## 5.5 Health Centre Accounting Procedures

The following procedures are for use in accounting for cost sharing revenues in health centres. Using them helps to ensure that revenues are maximized, funds are looked after, and expenditures are properly made.

### 5.5.1 Collection control

(a) Receipt Books: Only official receipt books and automated cash registers (where in use) may be used for collecting money from facility users. Miscellaneous receipt books and Health Care Financing (HCF) receipt books are issued to health centers by the District Accountant and must be recorded in a counterfoil Receipt Books Register (F.O.13).

(b) Departmental Registers: Each department that provides chargeable services must record fees earned and services provided. Health centres must record daily collections for each department in a cash collection register. In every case, one page is used for one month and must be written in duplicate using a carbon paper. The original collections page is detached and sent to the DMOH every month within 10 working days after the end of the month. The copy remains in the book.

(c) Custody of Funds: Safe custody of funds in Health Centres must be ensured through the use of cash boxes obtainable from the District Treasury. In case of there being none, then the District Treasury can authorize purchase using cost sharing funds.

(d) Banking: All money collected must be banked intact at least once every two weeks and receipt vouchers surrendered monthly to the District Treasury. Where collections are high, the money should be banked more frequently to minimize the risk of robbery. Spending revenue at source is illegal.

(e)Facility Filing (Health Centre): Health centres shall maintain a cost sharing file containing notes of receipt books and cash register reports (where in use).

(f) Standing Imprest: A standing imprest will be maintained by the officer In charge to meet petty expenses. It shall be applied for from the District Accountant using F.O. 24 (Imprest Warrant Form) and shall be recorded in the FIF imprest register. All expenses arising from the use of imprest shall be processed at the District Treasury using F.O. 21 for reimbursement and shall be surrendered on or before 30th June of every financial year and balances banked.

(g) Administration of AIE: The Officer in charge of the health centre shall be the AIE holder. The officer in charge and his deputy shall operate the health centre's bank account. Two alternating signatories

from the health centre and District Treasury shall sign the centre's cheques.

The cheque book shall be under the custody of the District Accountant as well as:

- ¤ Clearance receipts issued for collections by the District Accountant;
- ¤ Copies of receipt and payment vouchers;
- ¤ Required cost sharing reports; and
- ¤ Copies of banking slips.

(h)Bank Reconciliation Statement: The officer in charge of the health center must reconcile the cost sharing bank account on a monthly basis with the cash book with the assistance of the District Accountant. A copy of the reconciliation statement, bank statement and bank certificate of balance should reach the DHCF not later than the 10th of the following concluding month. Other copies should go to the PMO and District Treasury and one copy should be retained at the facility.

(i) Vote Book: Health centres must maintain a Vote Book control in which payments and commitments are recorded in line with types of expenditure approval on AIEs. A similar Vote Book control should be maintained at the District Treasury.

(j) Bank Interest and Charges: When interest is credited to the bank account, an F.O. 17 voucher should be raised so that the amount may be credited to the health centre's cash book . On the other hand, when bank charges are incurred, payment vouchers (F.O. 21) should be raised to debit the charges into the health centre cash book.

- The District Accountant issues both miscellaneous and Health Care Financing receipt books directly to the health centers on written request and ensures that issues are recorded on continuity control sheets (CCs).

- When a collector reports to the District Accountant, the collector will be issued with an official receipt for the money deposited at the local bank.

- The District Accountant verifies the following documents which must be produced by the facility in support of the money collected and deposited:

  - ¤ F.O. 17 receipt vouchers in triplicate, signed by the officer in charge and showing the account codes and amounts for the 75% and 25% portions;
  - ¤ Collection control sheet (CCs);
  - ¤ Banking slips;
  - ¤ Duplicate of used miscellaneous and HCF receipt books;
  - ¤ Daily Till Status Report (in case of Automated Cash Register).
  - ¤ A properly posted cash book;

- All receipts and payment vouchers are processed by the District Accountant and must follow Government accounting procedures and financial regulations.

- All cost sharing payment vouchers and receipt vouchers are sorted out, balanced and entered into the computer by the District Data Centre.

- The District Accountant completes form RGAS/03 "A" in respect of cost sharing services and forwards it weekly in duplicate to the Paymaster General.

- The amount shown on form RGAS/03 "A" is not reimbursable but the information shown on it is required to enable the Ministry of Health headquarters to pass journal entries through the District Suspense Account and the District Fund Control Account (Cash Control Account).

- The District Accountant maintains a Manual Ledger with a separate folio for each health centre in which the 75% portion of the collections for the facility and all payments made for that facility are entered. There is also a folio for P/PHC funds in which the 25% portion of all collections for the facility and all payments made for that facility are entered. The transactions recorded in the Manual Ledger are reconciled monthly with ledger statements from Ministry of Health headquarters.

## 6.0 EXPENDITURE PLANNING & MANAGEMENT

The primary objective of the FIF is to generate funds to improve the quality of patient care and strengthen preventive and primary health care. Planning and managing expenditure of FIF funds is therefore very important. From the funds generated by each health centre, 75 % is used by the health centre itself and 25 % remains with the district for District P/PHC activities.

### 6.1 Planning Responsibilities

The officer in charge at each health centre has the following responsibilities for the use of cost sharing revenue:

a) Submitting to the DMOH an Annual FIF Plan for the health centre;
b) Submitting to the DMOH quarterly AIE requests for expenditures to be made;
c) Making recommendations to the District PHC Coordinator and DMOH for use of the 25 % funds allocated for district P/PHC activities.
d) Each month when depositing cash collections for the month, checking with the District Accountant to verify the current balance of unspent, uncommitted 75 % funds available for the health centre. This means checking the banking and payments sections of the District Cash Analysis Book.
e) Keeping track of the value of supplies, drugs, renovations, and other goods and services provided to the health centre from its 75 % funds.

The expenditure planning process should ensure that revenue from user fees is spent in a timely and accountable manner according to the guidelines.

### 6.2 Guidelines for Use of Cost Sharing Revenue

In general, the 75% of the cost sharing revenue retained by facilities are intended to supplement the recurrent budget for the purpose of improving the quality of patient care. To encourage collection of cost sharing revenue, a health centre may earmark a certain percentage of the revenue generated by each department for use by that department. For example, the laboratory could be allocated a certain percentage of its cost sharing revenue for purchase of supplies.

Guidelines and regulations for expenditure of cost sharing revenue change from time to time and are contained in Ministry of Health circulars. Such guidelines are the basis for determining whether the DHMB and the DHCF can approve annual plans and AIE requests. The officer in charge of each facility should have a copy of the most recent circular and ensure that all staff involved in planning the use of cost sharing revenue are kept up to date.

Health centres may operate a standing imprest of up to 15% of their 75% revenue, or Ksh.20,000, whichever is less. The 25 % funds for district P/PHC activities can be used for most elements of primary care, depending

on the district's needs. Health centre staff are encouraged to help the District PHC Coordinator and DHMT to plan the use of such funds.

## 6.3 Planning Cycle

Planning for expenditure of FIF revenue should follow a routine schedule in line with the GoK budget cycle. Two types of plans are required:

a) An Annual FIF Expenditure Plan which sets out the health centre's financial needs over the coming fiscal year taking into account areas where there are generally deficiencies in recurrent budget allocations. It is based on the uncommitted balance of funds available at the beginning of the year and the revenue targets for the coming year.

c) Quarterly AIE Requests that state specific expenditures to be made during the next quarter. The AIE request should follow the priorities shown in the annual plan but is based on the uncommitted balance of funds available to the health centre at the time the request is submitted. Quarterly requests should reduce emergency requests for AIEs and allow more timely expenditure of funds.

The HCMT is responsible for preparing the 75% plan and AIE requests. These are submitted to the DMOH who combines all health centre plans for the district into a single Annual FIF Plan or Quarterly AIE Request. The schedule for submission of these plans and requests is:

| DOCUMENT | SUBMISSION DATE | EXPENDITURE PERIOD COVERED |
|---|---|---|
| Annual FIF Expenditure Plan | 15th June | 1st July – 30th June |
| 1st Quarter AIE Request | 15th July | 1st July – 30th September |
| 2nd Quarter AIE Request | 15th October | 1st Oct. – 31st December |
| 3rd Quarter AIE Request | 15th January | 1st January – 31st March |
| 4th Quarter AIE Request | 15th March | 1st April – 30th June |

Since local procurement procedures can be time consuming and FIF funds are no-year funds, it is expected that facilities may be expending money on two or three FIF AIEs at the same time. However, all pending AIEs expire at the end of the fiscal year and the unspent amounts are re-programmed in the annual plan and first AIE request for the following year.

Funds may be reallocated within an AIE with the approval of the DMOH. The request should identify the AIE and state from which item(s) funds will be taken and for what new expenditures they will be used in accordance to the approved MOH clusters.

## 6.4 Format and Contents of Plans

Annual and four-monthly plans must be approved in the minutes of the HCMT, which should be submitted with the plans.

**The Annual Cost Sharing Plan** can be as short as one page but must include:

1. Name of district, name and location of health centre, and date of submission;
2. Estimated workload for the following year based on the four-monthly Workload Report;
3. Collection targets calculated from the estimated workload; and
4. All proposed expenditures for the year, divided by four months, if possible.

The Four **Monthly AIE Request** should include:

1. Name of district, name and location of health centre, and date of submission;
2. Unspent balance of 75 % funds for the health centre at the date of submission; and
3. A list of requested expenditures with estimated costs and justification for expenditures that are unusual.

## 7.0 QUALITY OF CARE AND LOCAL PUBLIC INFORMATION

### 7.1 Quality of Care

The basic goal of the FIF is to generate money for improving the quality of care at facilities. "Quality of care" means different things to different people. For patients, it may mean courteous staff and clean toilets. For doctors and nurses quality of care may mean repairing needed equipment or having medical supplies.

When patients are asked to pay for services, they expect better services, higher quality of care.

> At first, the facility should make quality of care improvements that are easily visible to patients. This could be done by improving physical facilities (by painting the building, providing functional equipment, making available adequate supplies and maintaining a friendly attitude toward patients). To achieve this, some little but necessary expenditure will be incurred from FIF to promote patient satisfaction.

While some of these problems can only be solved by spending money, others simply require time, commitment, awareness, and follow-up action.

### 7.2 Some Steps to Improving Care

As part of their role in implementing the FIF, officers in charge of health centres should prepare a plan of action for improving quality of care. Specific steps could include:

- Holding frequent meetings with all staff (including support and subordinate staff) to increase awareness of patient care issues. This is especially important around the time changes in the fees schedule are introduced.

- Queues and patient flow: Look at the flow of patients and the length of queues in each department. Where are the longest queues? How can patient flow be improved? How can queues be shortened?

- Courtesy: Meet with staff to encourage them to be more courteous.

- Clean toilets and washrooms: Walk around your facility as a patient would. Are the washrooms and toilets reasonably clean? What can be done?

- Improve confidentiality and privacy: Particularly for outpatients by ensuring that only one patient at a time is in the examination room.

- Reduce back door and corridor consultation: By requiring health staff and dependents to seek treatment at slack times and to produce a Sick Sheet.

- Inform patients as soon as possible when drugs or investigations are unavailable so that they are not kept waiting needlessly.

## 7.3 Patient and Public Information at the Local Level

Patient and public acceptance of the Facility Improvement Fund is vital for its continued development. Health centres work to inform patients and the public about the benefits of the Facility Improvement Fund. Health centres have an important role to play in communicating with patients and local leaders about the benefits that cost-sharing funds are bringing.