The Kenya Medical Training College (KMTC) Preservice Training Manual for Cost Sharing

August 2000

Ministry of Health, Kenya

Kenya: APHIA Financing and Sustainability Project
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Designed by Christopher Frost

And with the best leaders
When the work is done
The task accomplished
The people will say:
We have done this ourselves.

Lao-tzu, China, 4000 BC

Acknowledgment

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Contents

Introduction

The **Kenya Medical Training College (KMTC) Preservice Training Manual for Cost Sharing** was produced by the **Division of Health Care Financing** in the Ministry of Health. The Manual compiles a set of simple but important and useful health care financing approaches and activities that seek to strengthen the role and performance of health service delivery and outcomes in Kenya.

In many developing countries, there is a general consensus that some kind of cost sharing is needed in view of escalating health costs and the limited capacity of public health networks to finance or deliver subsidized health care to all citizens.

In Kenya the government's ability to finance and expand health services has been undermined by poor economic performance, unprecedented rates of population growth, and the immense cost that the AIDS pandemic is beginning to impose on public health budget. And due to the critical need to improve health care financing and delivery in Kenya, it is time to introduce a pre service training module dedicated to the subject of Cost Sharing.

There are several options for financing better health care, but user fees and social health insurance (NHIF) are emphasized in this manual because they represent the largest percent of total health expenditures in Kenya.

Purpose

The purpose of the Manual is to develop and refine skills and expertise in broad health care financing issues at preservice level so that all KMTC graduates come out with the requisite skills and competencies in Cost Sharing to be immediately operational in the field.

Training in the **Cost Sharing Program** has acquired an important role in the Ministry of Health's policy to decentralize training, disseminate skills and consequently increase financial resources for health. The program has a set of policy, procedures and reporting requirements that must be understood and

followed throughout the health sector. And it is important that all the staff, both pre service and in service, with responsibility for Cost Sharing have the skills and knowledge to carry out Cost Sharing activities.

Finally, it is envisioned that this Manual will not only prepare future health workers to gain experience in setting, administering and collecting fees but also in allocating resources more efficiently to promote better health in the communities that they will serve.

Ummuro Adano
AFS Project Training Advisor
Management Sciences for Health

Module one 1

ORIENTATION

Module one contents

SESSION ONE

Policy reform: the need for cost sharing

Aim

The aim of this Session is to introduce participants to the broad strategic framework of the Cost Sharing Programme in terms of its policy, goals and principles, and the management structure.

Learning Outcomes

At the end of the Session participants will be able to

1. Explain the policy governing the Ministry of Health's Cost Sharing Programme
2. Demonstrate a clear understanding of the rationale, goals and objectives of the Programme
3. Demonstrate a clear and accurate understanding of the organization and management infrastructure of the Programme

Session Summary

a. Policy Reform
b. Objectives and Principles of Cost Sharing
c. Organization and Management
d. Lessons Learned
e. Future Challenges

Time

3 hours

Materials

Resources	Handouts/reference material
Flipchart/Chalk board Marker pens OHP	Orientation Manual

A: POLICY REFORM

Key Information

Since independence, health care in Kenya has been generally free, and in the first two decades great strides were made in improving services, with a positive impact on child and adult health.

However in the 80's, the Kenya Government felt it was no longer able to provide unlimited free health care, owing to insufficient budgetary allocations that continue to decline in the face of rising costs, populations, the advent of AIDS, and the resurgence of other diseases. At the same time, the Government recognizes the need for every Kenyan to gain access to good quality, affordable health care.

It was imperative that some radical health care financing policy measures had to be instituted to address the problem. USAID, the World Bank and other major donors worked with the government to design the health reforms. Health financing reform was introduced in late 1989, although support was by no means universal, since there remained a strong belief in the philosophy of free care. All the same, the Ministry of Health felt it had become necessary to supplement government financing through the introduction of user charges.

Fees for services policy was introduced in Government Hospitals and Health Centres on 1st December 1989. The existing policy on health care financing was again modified in 1992 to convert user charges from a consultation fee to a treatment fee.

Task 1.1.1 In pairs

1. List some examples of services in other sectors for which Kenyans are sharing costs.
2. How are funds that are generated being used?
3. Are there any useful lessons that could be learnt and adopted by the Cost Sharing Program of the Ministry of Health?

REMEMBER

This is not just a user fee programme. The National Hospital Insurance Fund (NHIF) is a big and important contributor to the programme. Over the years contributions by NHIF beneficiaries have grown from Kshs 20/= to 2% of gross monthly wage in 1990. The revenues generated from user fees and NHIF reimbursements are retained locally and are additional to budget allocations provided by Treasury.

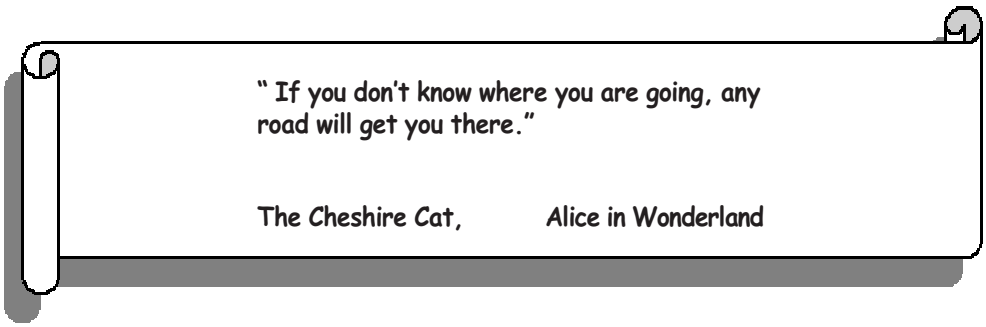
These funds are to be used to improve the quality of health services in facilities and to support district-level Promotive and Preventive Health Care (P/PHC).

Although there is considerable pressure to do so, cost sharing funds are not to be used to pay for wages, basic operating expenses or development activities. These funds should be collected and properly accounted for.

B: OBJECTIVES AND PRINCIPLES OF COST SHARING

Key Information

A Goal could be described as a shared vision. It is the collective sense of what is important for the future. It also provides a holistic sense of what's important and links the past with the present and future.



The Goal of the Cost Sharing Programme could be summarized as follows:

Increased financial resources from user fees and NHIF reimbursements for the improvement of facilities and the provision of high quality health and patient care on an equitable basis.

Objectives

- improved quality of health services in facilities
- enhanced facility level revenue collection capacity and planning for use of funds
- support to and improved district-level Promotive and Preventive Health Care (P/PHC) activities

Task 1.1.2 What I want for my hospital

Allow yourself to think freely about your facility, and identify two ways in which you want it to be better. Describe the hospital as you want it to be in these two respects:

1. _____

_____

2. _____

_____

_____

Our imagination is very powerful. It can create compelling ideas of future reality which are the key to constructive motivation to behave so as to bring the imagined state into being.

REMEMBER

If your desired goal or vision either for yourself or your facility involves other people being different than at present, remember that they will not share your goal. Reaching your goal might then involve finding ways of enlisting their support: if they do not share your goal, they have no reason to help you reach it!

C: ORGANIZATION AND MANAGEMENT

Key Information

The Ministry of Health (MoH) has four broad management levels:

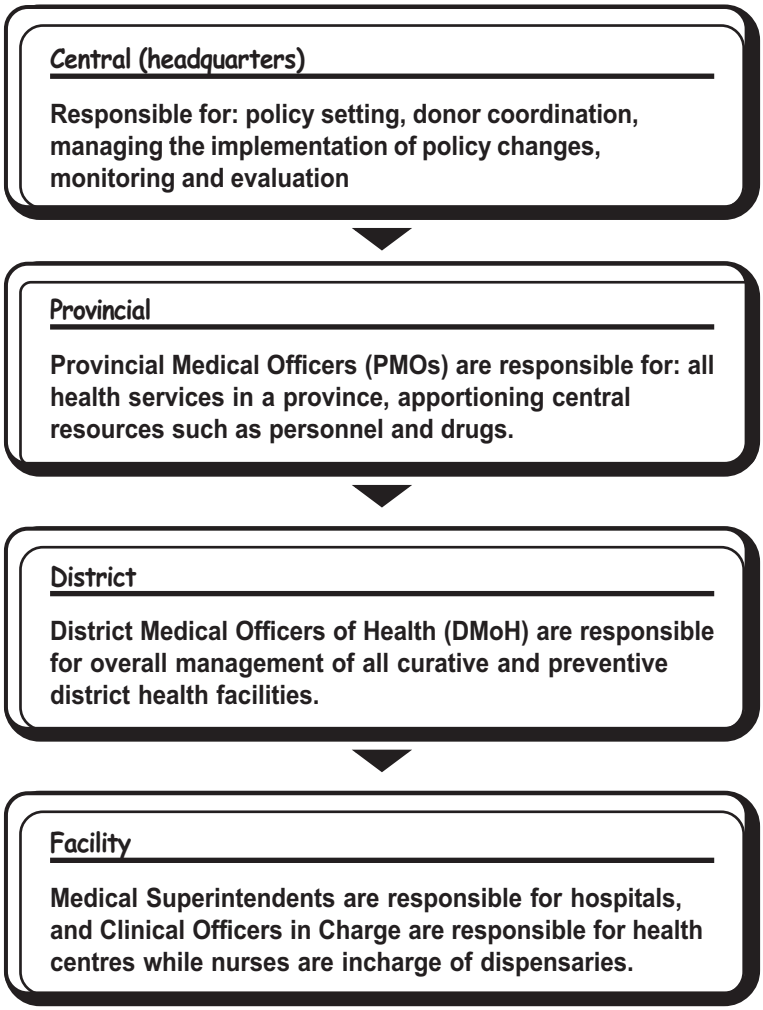


Figure 1.1.1 Organizational Structure of the Ministry of Health

Cost-Sharing Management

The cost-sharing management was designed to be part of the Ministry's general management structure.

Responsibilities for the organization and management of health care financing in the Ministry of Health are also carried out at four levels:

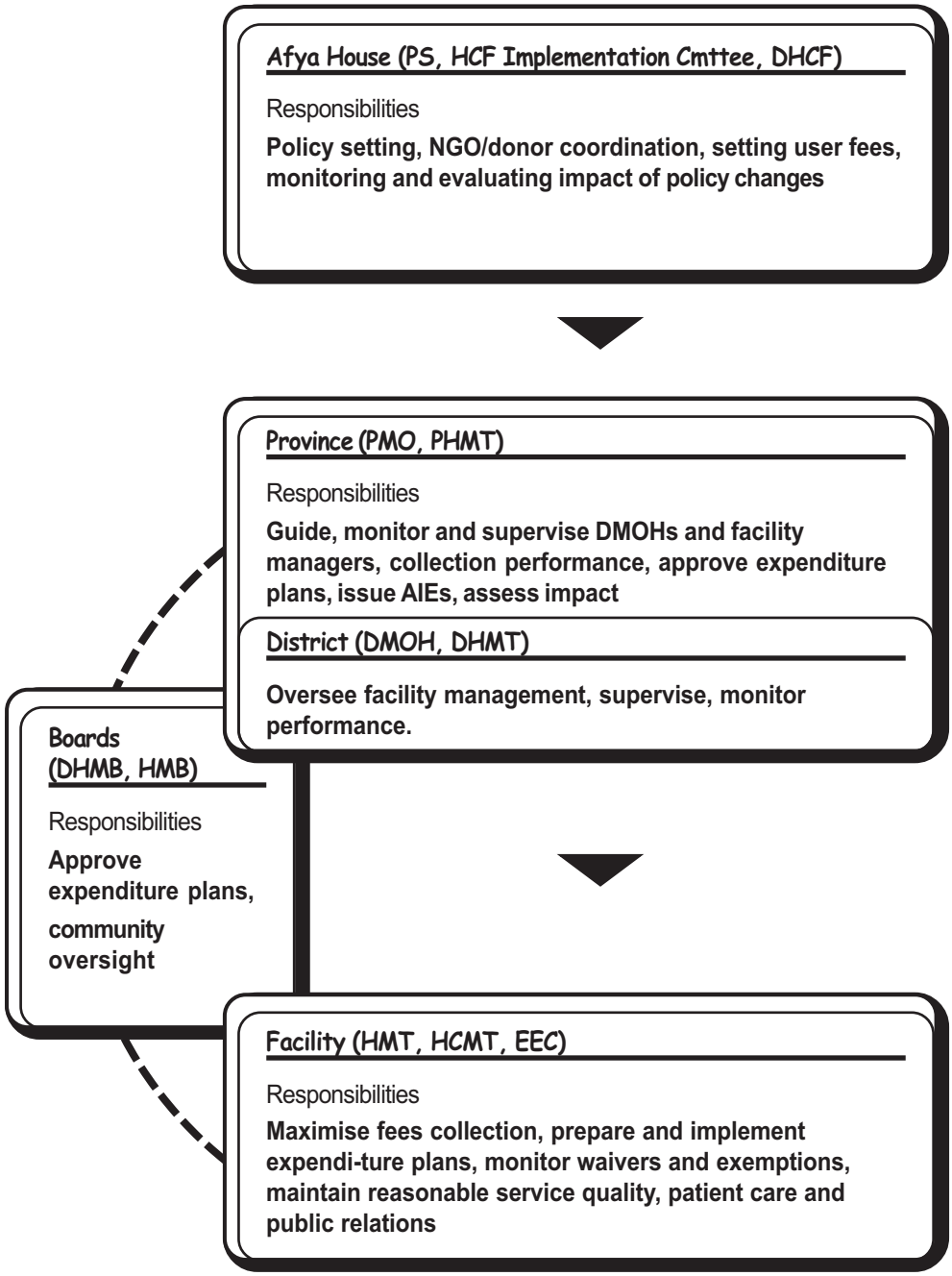


Figure 1.1.2 Cost-sharing management responsibilities of the Ministry of Health

D: LESSONS LEARNED

Key Information

Cost sharing brings a business approach to health care, and for it to be successfully managed and integrated into the MoH system, business attitudes, practices and systems must be adopted. Additionally, the introduction of cost sharing can be a catalyst that creates changes that can in turn have beneficial effect beyond cost sharing, such as in efficiency and quality of care.

Task 1.1.3: In groups of six

Using the headings below, discuss in your group and list some of the main lessons or constraints that you have encountered that relate to the implementation and management of the cost sharing programme.

1. **Policy issues**
2. **Social Insurance – NHIF**
3. **Management Structure – Boards and Teams**
4. **District Treasuries**
5. **Fee levels, Fee types**
6. **Quality of care**
7. **Continuing education and training**
8. **Monitoring and Evaluation**

Please appoint a Secretary who will make a poster presentation and report back group findings to the plenary.

REMEMBER

Full and proper implementation of cost sharing in all districts and facilities will take several years. Management skills and motivation vary considerably amongst staff, and bringing about system and attitude change takes time. Some facilities and individuals will proceed more slowly than others and inservice training and constant supervision will be needed for a long time.

E: FUTURE CHALLENGES

Key Information

The formal implementation of cost sharing may be complete, but much remains to be done for the programme to work properly in all facilities and at all levels. The challenge now is to continue strengthening and developing systems in a way that:

- generates increasing revenues (e.g. the introduction of cash registers at Coast General and the subsequent dramatic increase in revenue collection);
- maintains the principle that these revenues are additional to Treasury funding;
- makes a greater contribution to quality of care; and
- minimizes the negative impact of user fees on vulnerable groups.

Experience so far has shown that a well-managed programme of cost sharing can contribute significantly to the funding of government health services, without significantly reducing access to the public, especially the poor.

However, the resources required to carry out such a major, sustained, long-term effort are phenomenal, and without commitment at all levels, especially from the policy makers, the public and providers, as well as facility managers, even a well-designed cost sharing policy may flounder.

There is no longer any debate about the need for cost sharing in the funding of government health services in the future. However, cost sharing alone cannot solve the problems – it is not the *magic bullet*; the allocation and use of resources must be improved. Additionally, NHIF full potential is yet to be realized. The additional revenue generated including improved NHIF reimbursements, new business systems and practices being adopted, and the contribution of cost sharing to successful decentralization will make it easier to continue the reform process.

Task 1.1.4: In groups of six

The long-term impact, success and continued public acceptability of the cost sharing program depends on a number of integrated issues. Some of these factors are listed below. Discuss in your group and add to the list:

a) Improving NHIF claiming and cash collection efficiency
b) Expanding and increasing fees
c) Management improvements at facility level
d) Not relying on cost sharing only to stem the continuing decline in the public health sector

e) _____

f) _____

SESSION TWO

Boards and non-MoH bodies: Roles and functions

Aim

The aim of this Session is to provide participants with knowledge and information on the functions and operation of District Health Management Boards (DHMBs), Hospital Management Boards and District Treasuries regarding the management of health services and cost sharing at district level.

Learning Outcomes

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

1. Demonstrate a clear and accurate understanding of the role of District Treasuries as well as the DHMBs and their three standing committees
2. Provide support to the work of Hospital Boards to improve management efficiency and promote quality health care services in the district

Session Summary

a. Role of DHMBs
b. DHMB Standing Committees
c. District Treasuries

Time

2 hours

Materials

Resources	Handouts/reference materials
Flipchart/Chalk board Marker pens OHP	Legal Notice No.162 The Public Health Act (Cap. 242) Guidelines for District Health Management Boards (Green booklet), GoK – Ministry of Health

A: ROLE OF DISTRICT HEALTH MANAGEMENT BOARDS

Key Information

The District Health Management Boards were established by the government under Legal Notice No. 162 of 1992.

The Boards have representatives from consumers under other sectors to oversee the provision of health care in the district, to ensure client representation and the accountable use of funds.

The members of the Board are appointed by the Minister for Health and it operates under the broad direction of the District Development Committee (DDC)

Boards and their three standing committees need not get involved in the day-to-day management of health services and cost-sharing. The emphasis of their role is primarily one of fiscal supervision and policy monitoring, for example to ensure that voted funds are used on activities for which they were planned.

B: ROLE OF DHMB STANDING COMMITTEES

REMEMBER

There have been mixed results, from one district to another, regarding the role and functionality of DHMBs over the six years that they have been in place. In most cases, extensive ongoing training will be required to help clarify their roles and allow them to start supervising and supporting the cost-sharing programme.

Most Boards have begun with their expenditure approval role, but some have moved to a wider role of supervision and support, representing their communities and acting as a central link between the Ministry and the facilities. All Boards shall need to be trained, informed and encouraged to grow and develop in this direction so that they can make their presence felt.

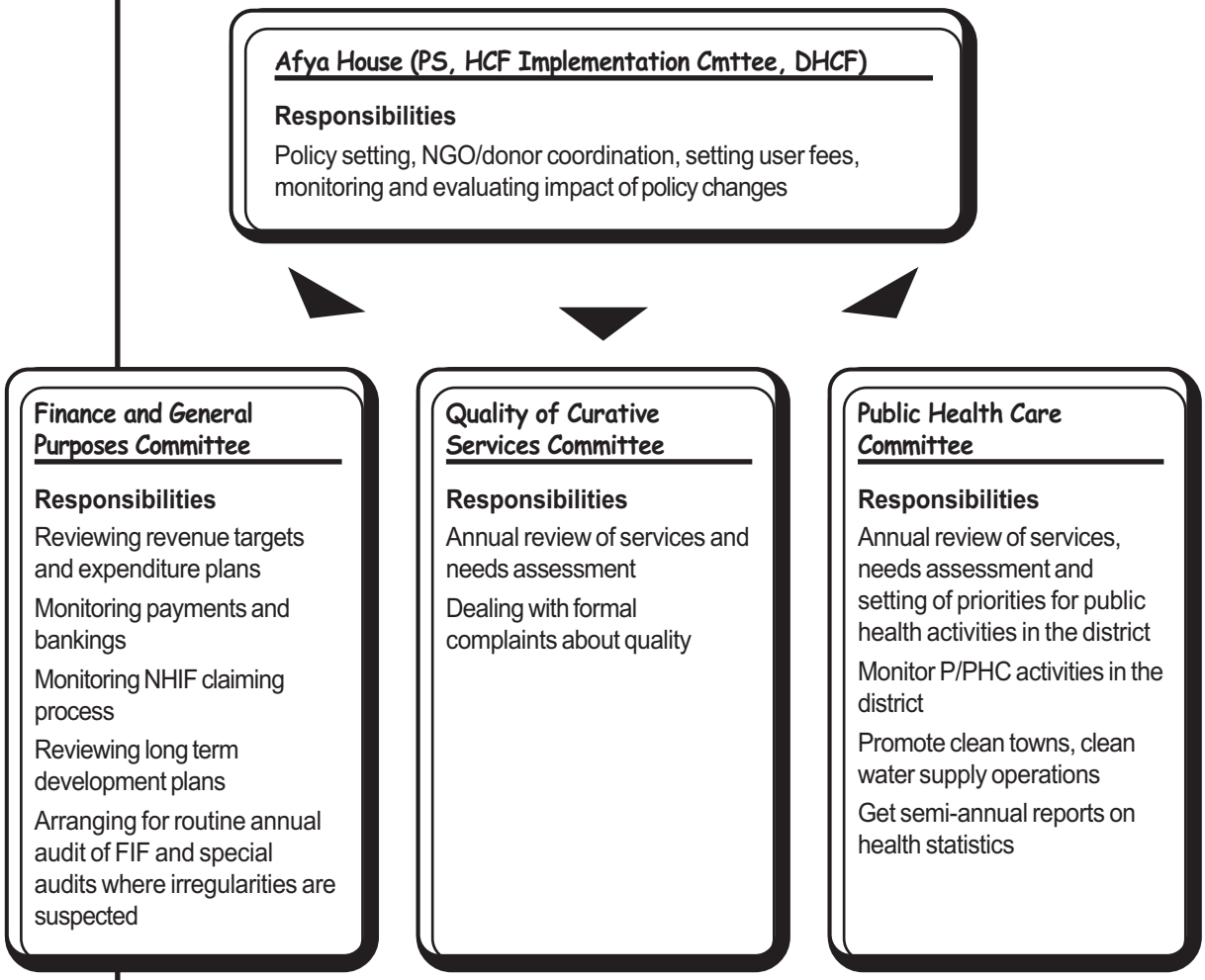


Figure 1.2.1 The role of DHMB standing committees

C: DISTRICT TREASURIES

Key Information

Task 1.2.1 In groups of six

The DHMB That We Want

Discuss and develop a list of factors that will add to the overall effectiveness of your Board. Some of these factors include:

a the dynamism of the Board Chair and the enthusiasm of the members
b the number and quality of training workshops and supervision visits

District Treasuries provide a degree of local financial accountability and management control of the cost sharing programme. All hospital, health centre, and P/PHC funds are kept in one bank account, with joint signatory power held by the District Accountant and the DMoH.

The District Treasuries are responsible for:

- ensuring that all revenue is collected (using official cash receipts) and banked
- overseeing expenditure trends
- auditing and providing financial advice and support

Task 1.2.2 In groups of six

Effective collaboration with District Treasuries

1. List some of the major difficulties you face in dealing with your District Treasury
2. How can some of these issues be resolved satisfactorily?

Handout

User Fees

The biggest challenge facing the Kenyan public health network is not whether or not to continue charging user fees but rather how to use cost sharing fees to promote better, visible, more equitable health care and to create a self-sustaining mechanism for financing health care.

The main goals of user fees are to mobilize local revenues, promote efficiency, foster equity, increase decentralization and sustainability, and encourage the growth and development of the private sector.

Key lessons learned so far:

- Kenyan households are paying for health care and private out-of-pocket expenditures are the largest single contributor to health care expenditures in Kenya.
- Negative fee effects on service utilization have been overstated. Many factors besides fees – including distance to health facilities, staff attitude, and the quality of care – play an important role in health seeking behaviour.
- People will pay for quality care, especially when the introduction of user fees is accompanied by simultaneous improvements in service quality and health outcomes.

If appropriately implemented and efficiently administered, user fees can make health care delivery more equitable and promote a self-sustaining financial base for better health care.

The pathway to the successful implementation of user fees include:

- Encouraging the use of fee-based health care through campaigns and local public information that clarify the rationale for user fees
- Retaining fees at the local level and establishing local control over quality improvements and staff involvement
- Establishing methods that improve cash collection and administration efficiency

In conclusion, time and experience are required to develop a well-functioning system of fees for health care services. The actual potential of user fees is seldom lost, for several reasons. Policies mandating these fees tend to be poorly administered, facilities are often inefficient in collecting fees and unpaid bills, patients are unwilling to pay for low-quality services, and abuses of exemption policies are widespread.

Module two 2

OPERATIONS

Module two contents

SESSION ONE

Revenue generation: Fees, Exemptions and Waivers

Aim

The aim of this session is to provide participants with the knowledge and skills to carry out key revenue setting, billing and collection procedures of the cost-sharing programme by following set guidelines and other procedural requirements.

Learning Outcomes

At the end of the session, participants will able to

1. List all the different services being offered at the facility level and the amount of fee charged in each case
2. Explain the application of fee collection guidelines
3. Demonstrate a clear understanding of the importance and usefulness of different types of fee collection registers
4. Demonstrate a practical understanding and application of the procedure of granting waivers and exemption criteria

Session Summary

a. Fee Structure and Collection Guidelines
b. Fee Collection Registers
c. Exemptions
d. Waivers

Time

2 hours

Materials

Resources	Handouts/reference material
Flipchart/Chalk board Marker pens OHP	Categories of exemption

A: FEE STRUCTURE AND COLLECTION GUIDELINES

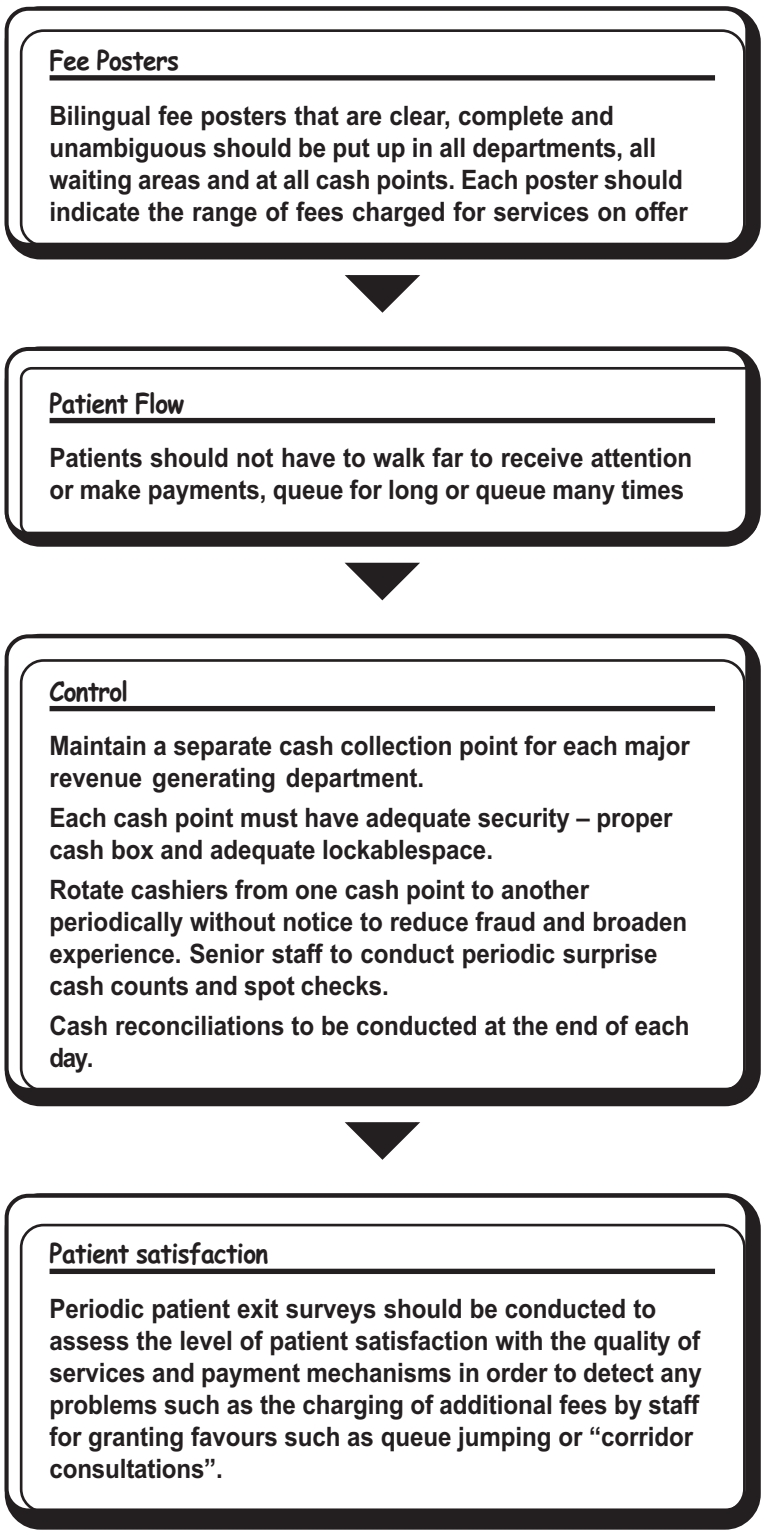


Figure 2.1.1 Four Key Steps

Key Information

Efficient collection of revenues is an important aspect of user fees. Fees need to be collected in a way that causes minimum inconvenience to patients and staff, ensures maximum collections and can be easily accounted for.

B: FEE COLLECTION REGISTERS

Key Information

Inpatients and Outpatients are potentially the largest sources of revenue to a hospital but in practice often little of that revenue is actually collected. In order to achieve full potential it is vital that proper laid down procedures are followed and the appropriate financial registers are kept and completed at all times by the various revenue generating departments.

In practice, these involve the following MUST DOs:

- You must claim for all patients covered by NHIF
- You must charge all in-patient x-ray and lab services to their accounts
- You must ensure that all in-patient bills are either collected or charged to NHIF
- You must ensure that waivers or exemptions are correctly granted

Task 2.1.1: Match Making

In each case, draw a line to match the procedure/role with the appropriate activity/responsibilities.

Procedure/Role	Purpose
Inpatient Admissions	All the inpatient payment details are completely and correctly entered here
Inpatient Accounts Office	It is used to record every issue of drugs, amount charged,receipt number, waiver number or reason for exemption
Inpatient Billing Book	They have authority to grant credit, waive or exempt
Pharmacy Revenue Register	Papers for all patients (discharged, dead or absconded) leaving the hospital must pass through here where services received are accounted for.
Medical Superintendent/ Health Administrator	A charge sheet is opened here for every patient admitted (incl. exempt, waived and NHIF patients)

C: EXEMPTIONS

Key Information

The term *exemption* is used to mean an automatic excuse from payment based on defined status such as being under five years, being a prisoner, having specific communicable disease such as tuberculosis, STI and AIDS or using a special service such as prenatal care. A complete list of exemptions is at Handout 2.1A.

The main purpose of this feature of the programme is to promote equity and to protect the poor and medically vulnerable so that they do not feel discouraged from seeking care when they genuinely need to do so.

D: WAIVERS

Key Information

The term *waiver* refers to a system that involves a discretionary full or partial release from payment based on inability to pay. This is another protection mechanism that is available to the disadvantaged or low-income earners.

However, the waiver system must be managed and implemented with care. If it is too lax, too informal, and too easy to maintain a waiver, then the system will be abused, revenue will decrease ad the benefit of user fees will be reduced.

On the other hand, if the system is too rigid, patients are not well informed about the existence of a waiver system, or if it is too difficult to obtain a waiver, then needy health care seekers will be turned away.

How do you Grant a Waiver?

Granting a waiver is a two-step process:

- The clinician or nurse seeing the patient recommends a waiver, preferably with the help of a social worker

- The Medical Superintendent or Health Administrator makes the decision to authorize the waiver.

And for all waiver cases, a Waiver Application Form must be completed and approved by an authorized official.

Criteria for Granting Waivers

It is important that the information provided on the waiver form should be carefully considered and if possible verified. The history as well as the socio-economic status of the patient should help you decide whether to grant or not to grant a waiver.

In addition, there are other categories of patients who are more likely to be granted waivers. These include:

- Students away from home with no funds of their own;
- Patients with chronic illnesses which are not automatically exempt;
- Patients who have spent their money to travel a long distance to the hospital

REMEMBER

It is the responsibility of the **Health Administrator** to ensure that the waiver system is fully implemented at the hospital.

Key Actions of Implementation

- Task designated staff with responsibility for granting waivers
- Ensure that Waiver Forms are available at all times
- Inform all staff and the public about how the waiver system works

Task 2.1.2 In groups of six

Exempt, Waive or Pay Game

The trainer will give each group a pack of six cards which will be placed on the table facing downwards. Each member of the group shall pick one card at random. Each card carries a simple message describing a specific patient category seeking health care at a public facility. The members will take turns to read the message on their cards and the group will discuss and decide whether the "patient member" should be exempted, waived or asked to pay fully for the service provided.

Trainer's Note

Examples of some of the card messages might include statements such as:

- I am a Medical Training Centre student from a well to do family.
- I am a nurse from the female ward
- I am a wealthy entertainer suffering from chronic tuberculosis. I smoke but I don't drink.
- I am a very poorly dressed pastoralist with 100 goats and sheep and family of ten
- I am an exchange student from the Democratic Republic of Congo
- I am an illegal immigrant in police custody

SESSION TWO

National hospital insurance fund

Aim

The aim of this session is to provide participants with information on the role of NHIF in revenue generation and help them develop skills to make claims and receive reimbursements from NHIF in a regular and timely fashion.

Learning Outcomes

At the end of the session participants will be able to

1. Explain the role of NHIF in revenue generation under the Cost Sharing Programme
2. Demonstrate a clear understanding of how to organize for NHIF claiming
3. Follow and apply the guidelines for claiming from NHIF
4. Conduct effective NHIF ward census
5. Complete all the necessary NHIF reporting forms

Session Summary

A. Role of NHIF
B. Organizing for NHIF Claiming
C. NHIF Ward Census and Reporting

Materials

Resources	Handouts/reference material
Flipchart/Chalk board	Operations Manual Part 2
Marker pens	
OHP	

A: ROLE OF NHIF

Key Information

The NHIF was established by an Act of Parliament in 1966 with the primary purpose of providing health insurance cover to members and their listed beneficiaries. The model in operation is that of a health insurance fund. Participation in this scheme is mandatory for all salaried employees earning taxable income.

Membership contributions are remitted to NHIF which in turn reimburses accredited health care providers for services provided to NHIF members and beneficiaries. Accredited providers include GoK hospitals, Mission Hospitals, private hospitals and nursing homes. A contributor or beneficiary can only derive benefits from NHIF if contributions are up to date. At the moment, NHIF reimbursements cover only inpatient care using a daily inpatient care fee rate reimbursement method.

NHIF is perhaps the single most important and steady source of revenue for hospitals. Reimbursements from NHIF are deposited in the cost sharing account along with fee revenues and are planned for and spent on improving facility and district services.

REMEMBER

Your facility stands to lose hundreds of thousands of shillings each month just through under-reimbursement for NHIF patients

And the reasons are simple:

- Staff failure to identify NHIF beneficiaries in the hospital;
- Staff failure to complete and submit claims;
- NHIF failure to process and pay claims promptly and in full or
- Fraudulent encashment of NHIF cheques

B: ORGANISING FOR NHIF CLAIMING

Key Information

NHIF produces a comprehensive set of guidelines for NHIF claiming, including examples of necessary forms, which can be obtained either from NHIF offices or the Division of Health Care Financing of the Ministry of Health.

The guidelines provide details on procedures and structures that will help you to organize for NHIF claiming, a summary of which is provided below.

Actions essential *for NHIF Claiming*

Claiming from NHIF involves several steps:

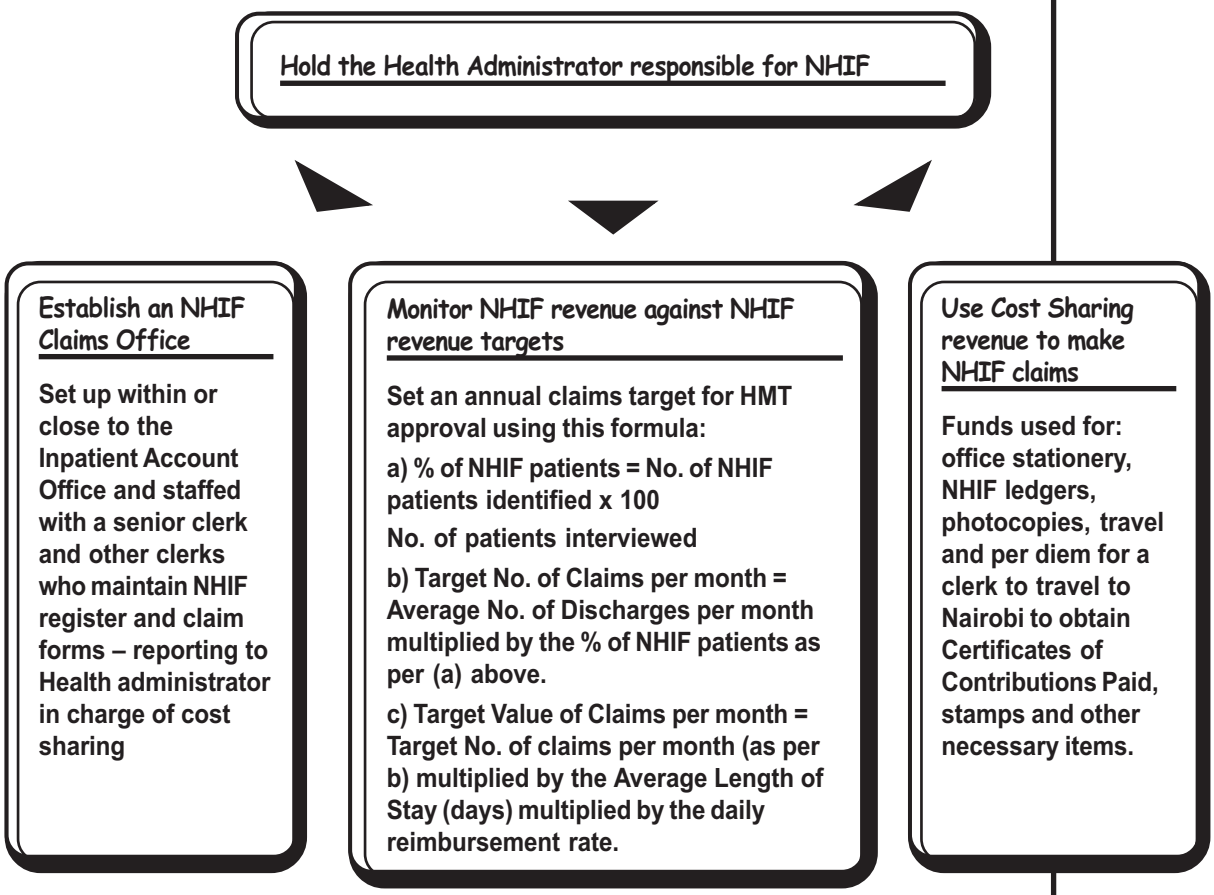


Figure 2.2.1 Structures for NHIF claiming

Steps for Claiming from NHIF

Claiming from NHIF involves several steps:

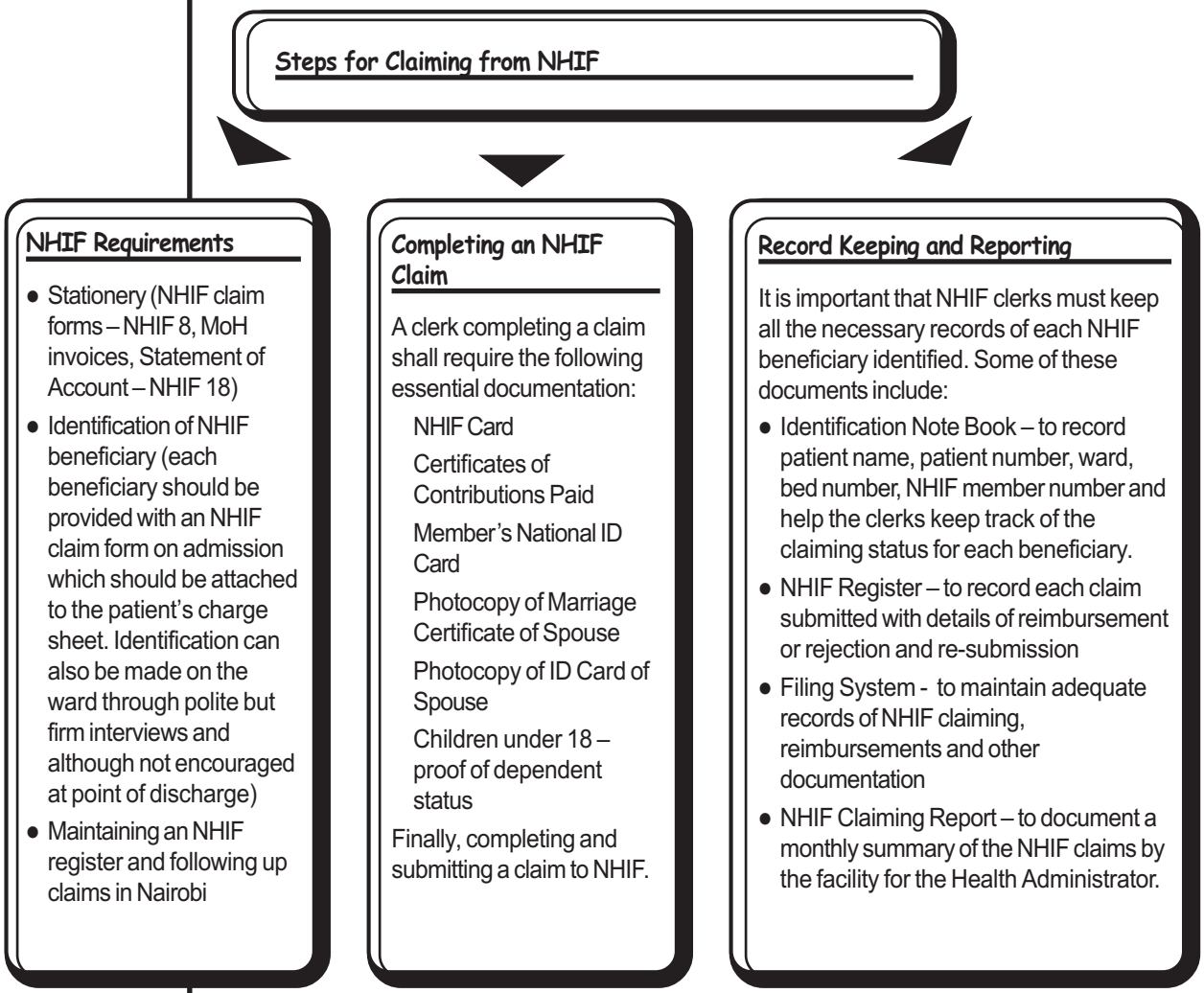


Figure 2.2.2 Claiming from NHIF

Task 2.2.1 In groups of six "First Things First"

Re-arrange the following NHIF claiming tasks in a logical order.

1. **Follow up claims frequently with NHIF**
2. **Identify NHIF beneficiaries at or soon after admission**
3. **Maintain a good filing system**
4. **Complete an NHIF claim**
5. **Collect and photocopy essential documentation and don't charge patients**
6. **Set up and maintain Identification Book and NHIF register**
7. **Establish an NHIF Claims Office**
8. **Appoint a Health Administrator to supervise NHIF claiming**
9. **Keep accurate financial accounts**
10. **Prepare an NHIF Claiming Report on a monthly basis**

SESSION THREE

Expenditure planning

Aim

The aim of this session is to encourage the participants to develop and use appropriate skills and systems to ensure that funds are accounted for and expenditures are properly made.

Learning Outcomes

At the end of the session participants will be able to

1. Demonstrate a clear understanding of their role and responsibility in the expenditure planning process for both 75% and 25%
2. Set clear priorities and budget for the use of funds
3. List the requirements for the approval of Authority to Incur Expenditure (AIE) requests
4. Follow the local purchase procurement procedures
5. Develop costed expenditure plans

Session Summary

A. Responsibilities for Facility Expenditure Planning (75%)
B. Responsibilities for District P/PHC Expenditure Planning (25%)
C. Guidelines on Use of Funds
D. Expenditure Approval Requirements
E. Procurement Procedures

Time

1 hour 30 minutes

Materials

Resources	Handouts/reference material
Flipchart/Chalk board	Operations Manual Part 1
OHP	
Markers	
Easel	

A: RESPONSIBILITIES FOR FACILITY EXPENDITURE PLANNING – 75%

Key Information

The primary purpose of the cost sharing programme is to improve patient care and the quality of services at Ministry of Health facilities.

The expenditure planning process should be followed to ensure:

- revenue is spent in a timely manner and according to expenditure guidelines established by the Ministry of Health
- accountability
- improvements to quality of care

The table below illustrates responsibilities for planning, approval and implementation of expenditures of the 75% funds:

Table 2.3.1

Team	Task/ Responsibility
Hospital Management Team (HMT)	Prepares FIF Annual Plan
Hospital Executive Expenditure Committee (EEC)	Confirms FIF Annual Plan; prepares 1/4ly sub-AIE requests; directs expenditure according to GoK procurement regulations and prepares monthly Payments Report, itemizing all expenditures
District Hospital Management Board (DHMB)	Reviews, requests modifications and approves annual plans and AIE requests
District Accountant	Certifies availability of uncommitted funds for the facility in bank
Provincial Medical Office (PMO)	Issues AIEs on behalf of the Accounting Officer

B: RESPONSIBILITIES FOR DISTRICT P/PHC EXPENDITURE PLANNING

Key Information

The other important objective of the cost sharing programme is to strengthen preventive and primary health care. As outlined in the last session, 75% of the funds generated by Ministry facilities is to be used by the facility that generated the funds and 25% remains with the district for district P/PHC activities.

The table below details responsibilities for planning, approval and implementation of expenditures of the 25% P/PHC funds:

Table 2.3.2

Team	Task/ Responsibility
PHC Core Team	Consults with all relevant district health staff (FP, AIDS, KEPI Coordinators); Prepares Annual Plan and 1/4ly AIE requests for use of FIF revenue for P/PHC
District Health Management Team (DHMT)	Confirms FIF Annual P/PHC Plan Prepares 1/4ly sub-AIE requests
District Hospital Management Board (DHMB)	Reviews and approves Annual P/PHC Planand sub-AIE requests
District Accountant	Certifies availability of uncommitted funds in bank
Provincial Medical Office (PMO)	Issues sub-AIEs in accordance with current FIF expenditure rules

C: GUIDELINES ON USE OF FUNDS

Key Information

Expenditure guidelines are the basis for determining whether a request for a sub-AIE to spend FIF revenue can be approved by the DHMB and the PMO.

The specific guidelines and regulations for use of FIF revenue are contained in Ministry of Health circulars. These guidelines and regulations change from time to time. The officer-in-charge of cost sharing at each facility and in each district is accountable for having a copy of the most recent circular on expenditure guidelines. This information should be communicated to all facility and district staff involved in planning for the use of cost sharing revenue.

Use of Funds

As noted above, cost sharing revenues are meant to improve the quality of patient care. Treasury allocations are meant to provide for salaries and personnel allowances, water and electricity, patient food, essential drugs and other basic facility requirements. The development budget is expected to cater for capital construction, facility expansion, vehicle purchase, and major equipment purchase.

Task 2.3.1 Individually and then in pairs

Study the following list of expenditure categories and put a tick against those you think are *allowable expenses* under the FIF revenue expenditure guidelines. Share your responses with a colleague and discuss them further.

1. **50 tins of high gloss paint to paint wards 8,9 and 10**
2. **Expanding the maternity wing**
3. **Emergency drugs and dressings**
4. **Laboratory and Xray supplies**
5. **Essential stationery - receipt books, inpatient charge slips and registers**
6. **Basic drug supplies**
7. **Water and electricity**
8. **New engine for the hospital ambulance**
9. **In-patient drug kits**
10. **Surgical supplies and gloves**
11. **Posters for public information, education and communication**
12. **Milk for children in the nursery**

D: EXPENDITURE APPROVAL REQUIREMENTS

Key Information

It is important to understand that *sub-AIE requests* for the use of cost sharing revenue can be approved only when certain conditions have been satisfactorily met. Some of these conditions include:

- The request is consistent with the rules on Use of Funds
- The request is consistent with the **Special Requirements** listed below
- All the routine reports have been submitted and are up to date
- The Accountant has certified that the necessary funds have been collected by the facility and are available in the bank – and have not been committed for other purposes
- The written sub-AIE has all the required information

Special Requirements

In order to build in appropriate measures of accountability in the use of cost sharing funds, there are certain special requirements that apply to the planning, approval and use of FIF funds.

Some of these special requirements apply for the following categories of expenses:

- Maintenance of equipment and buildings – requests must state explicitly the

exact building or piece of equipment involved and the type of maintenance or repair that is required.

- Vehicle expenses – list the vehicles to be supported with the funds and clearly state the purpose
- Drugs and dressings – all requests must be accompanied by proposed list of drugs to be purchased, signed by the Medical Superintendent and Hospital Pharmacist; scheduled drugs are purchased only if they are not available from MSCU within the time required.; the purchase of non-scheduled drugs must be approved by the Hospital Drugs and Therapeutics Committee.

E: PROCUREMENT PROCEDURES

Key Information

Cost sharing revenue is generally spent through local procurement procedures. Hospitals experiencing unwarranted delays due to District Tender Boards, District Treasuries, or other factors should immediately inform the PMO so that corrective action can be taken.

The Government of Kenya Supplies Manual (1978), Chapter 6, Procurement and Purchasing, contains detailed descriptions of the relevant procedures for purchase of drugs and medical supplies. Procedures and levels of purchase are notified through circulars as they are updated from time to time.

Levels of Local Procurement

For individual hospitals and districts, *ordinary* local procurement of drugs and medical supplies is done through:

- petty cash
- local purchase
- hospital quotation
- district tender board

At Provincial General Hospitals the following additional procedures must be used for expenditure of 75% funds:

- quotations will be opened by the Executive Expenditure Committee
- all accountable documents (LPOs, LSOs) will be kept safely by the Health administrator and issued to user points as and when required

- The Medical Superintendent of the PGH (and not the MoH) will sign all approved PGH cost-sharing LPOs and LSOs.
- The senior Health administrator will ensure that all LPOs and LSOs are entered in the respective vote-book before they are signed and sent to the district accountant for signature

Emergency Local Procurement

Hospitals provide inpatient and emergency services 24 hours a day. As such there are occasionally life-threatening emergencies for which specific drugs and medical supplies are needed urgently.

There are two alternative methods available for emergency local procurement:

1 **Emergency District Tender Board**

The District Commissioner who is the Chair of the DTB can constitute an emergency DTB meeting to deliberate on emergency procurement within a very short time. The quorum is five members and the amounts involved should be above K shs 30,000.

2 **Authority from the Accounting Officer**

There are other special circumstances where an emergency DTB might not be feasible.

For example, a mass fatal road traffic accident where medical supplies may have to be collected directly and quickly from a local pharmacy. In such a case, a letter must be obtained from the Accounting Officer (Permanent Secretary). The Permanent Secretary's letter along with an invoice would then be presented to DTB for ratification at a later date. The circumstances surrounding such a procurement should be clearly explained to the Accounting Officer.

Procurement Limits

As mentioned above, procurements of goods and services using cost sharing revenues is governed by the government procurement and tendering regulations that are spelt out in specific Treasury Circulars and in force at any given time.

The latest procurement limits are summarized in the table below:

Table 2.3.3

Level of Purchase	Procedure
Up to Kshs 10,000 per item per purchase	Petty Cash – Purchase against cash from Imprest Account. Full details must be recorded in supplies records.
Kshs 10,000 to 30,000	Local Purchase – Purchase on Local Purchase Order (LPO, S20) of urgently needed items available locally. Verbal quotations must be obtained and recorded on S20. Order must not be split to keep them under Kshs 30,000 limit.
Kshs 30,000 to 200,000	Hospital Quotation – Purchase on Local Purchase Order, S20. Written competitive quotations on Request for Quotations, S10 needed and is adjudicated departmentally.
Kshs 200,000 to 1million	District Tender Board Quotation – quotation raised and adjudicated by the District Tender Board.
Kshs 1m to 5 million	District Tender Board Open Tender – submitted to DTB for adjudication and approval
Over Kshs 5 million	Submitted to Central Tender Board adjudication and approval

SESSION FOUR

Accounting

Aim

The aim of this session is to inform and encourage participants to rise to their own best level of performance and capabilities to ensure that revenues are maximized, funds are accounted for, and expenditures are properly made.

Learning Outcomes

At the end of the session participants will be able to

1. Demonstrate a clear understanding of the various levels of accounting procedures laid down for accounting for cost sharing funds
2. Describe the operations of the cost sharing (FIF) bank accounts
3. Compile and analyze accounting reports

Session Summary

A. Accounting System
B. Levels of Accounting Procedures
C. Banking Operations

Time

2 hours

Materials

Resources	Handouts/reference material
Flipchart/Chalk board	Exchequer and Audit Act
Marker pens	
OHP	

A: ACCOUNTING SYSTEM

Key Information

Cost sharing revenues are deposited at the district in special Bank accounts and are NOT returned to Treasury or MoH headquarters.

Accounting for both collections and expenditures is, however still made to District Treasury, who post transactions into the MoH ledger accounts. Accounting is done through a Health Care Services Fund in accordance with the requirement of the Exchequer and Audit Act, Cap 412. A copy of this Act is available as Handout 5.1

Under the Health Care Services Fund, separate account codes are used for the following transactions under class 4 (Funds and Deposits) of accounts:

- 75% portion of the collections for each facility
- P/PHC funds used for the 25% portion of all collections made in the District
- Expenditures made by each facility
- Expenditures made for P/PHC activities

B: LEVELS OF ACCOUNTING PROCEDURES

Key Information

In order to encourage and maintain maximum financial management control of cost sharing revenues it is important that certain accounting procedures and requirements are accomplished at various levels.

The table on the next page presents a summary of some of these important procedures:

Table 2.4.1

Level	Procedure
District Treasury (District Accountant)	• Requests and issues out official receipt books to facilities • Maintains a reporting schedule and chart for all collectors • Maintains a separate Cash Book for recording bankings and payments. Each banking is supported by Receipt Vouchers and each payment is supported by a Payment Voucher. • Completes form RGAS/03 "A" in duplicate and forwards weekly to the Paymaster General • Maintains a Manual Ledger with a separate folio for each facility • Conducts monthly bank reconciliations
Health Facility	• Maintains a counter-foil Receipt Books Register (FO13) • Uses official receipts to collect user fees • Keeps departmental Pay Registers • Maintains Cash Analysis and Inpatient Billing Books • Banks all collections intact • Maintains a Vote Book • Submits various accounting records to District Treasury on a weekly basis
District Medical Officer of Health	• Keeps Cash Analysis Book for banking and payments • Maintains a Vote Book for each facility • Makes monthly reconciliations with District Treasury Records
Paymaster General	• Uses form RGAS/03 information to prepare RGAS/04 and to make adjustments between the District Suspense Account and the District Cash Control Account
Ministry of Health headquarters	• Prepares journal entry vouchers • Reconciles records with District Treasury records

C: BANKING OPERATIONS

Key Information

Each facility is expected to maintain a current account with an authorized commercial bank in the district. They are also encouraged to maintain an additional high interest savings/deposits account for surplus funds that are not immediately required.

The Bank Account shall be operated by the following post holders:

- Medical Officer of Health/Health administrator
- District Accountant/Deputy District Accountant

Cheque books shall be kept by the District Medical Officer of Health or Health administrator. Cheques must be signed by one officer from the DMOH and one officer from the District Treasury.

The District Accountant shall advise on changes on signatories to District Commissioner, District Medical Officer of Health and District Internal Auditor.

Task 2.4.1 In groups of six

Using your practical field management experience in managing and accounting for cost sharing funds, discuss in your groups the strengths and weaknesses of the current accounting system and reporting requirements.

You may wish to use the following broad headings to steer your discussions:

1. **The Exchequer and Audit Act**
2. **The role of the District Treasury**
3. **Manual ledger accounts and reconciliations**
4. **Operation of bank accounts**
5. **The levels of procedure and nature of documentation**
6. **Methods of revenue collection**

A reporter from the group will document group findings and report to the plenary

"Rules of Thumb"

- BANK THE SAME DAY OR THE DAY AFTER
- LESS THAN 90% BANKING IS A PROBLEM AND SHOULD BE AVOIDED
- IOUs ARE NOT ALLOWED
- USE THE STANDING IMPREST PROPERLY
- IMPROVING THE QUALITY OF CARE IS THE BOTTOMLINE

SESSION FIVE

Quality of care and public information

Aim

The aim of this session is to encourage participants to appreciate the role of cost sharing in improving quality of care and to develop appropriate skills and techniques in seeking and utilizing public information to strengthen support for the programme.

Learning Outcomes

At the end of the session participants will be able to

1. Describe the various indicators of quality of care
2. Demonstrate a clear understanding of the factors that contribute to improved quality of care
3. Use different methods of informing the public about the benefits and achievements of the cost sharing programme

Session Summary

A. Quality of Care – Role of Cost Sharing
B. Measures to Improve on Quality
C. Local Public Information
   - Purpose
   - Methods

Time

2 hours

Materials

Resources	Handouts/reference material
Flipchart/Chalk board Marker pens Coloured Crayons Blu tack/masking tape OHP Transparencies	Operations Manual Part 1 – Policies and Organization

A: QUALITY OF CARE

Role of Cost Sharing

Key Information

The ultimate goal of charging user fees at all Ministry of Health facilities is to generate funds to improve the quality of care at those facilities.

Task 2.5.1 In groups of six

1. **What does Quality of Care mean to you?**

Discuss in your group, identify and agree on at least 5 major indicators of quality in a facility that are common for all of you.

Quality of Care means different things to different people. For patients, it may mean courteous staff and clean toilets. For physicians and nurses quality of care may mean repairing needed equipment or having fuel for the hospital ambulance.

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

Where do you start in quality improvement?

Subjective Aspects of Quality

- Start with improvements which are easily visible to large numbers of patients. These include:
- Staff attitude, efficiency, confidentiality, waiting time, clean waiting areas, painted walls, clean patient linens etc. You will realize that many of these areas where quality improvement is desired by patients depend more on good management than on financial resources.

Objective Aspects of Quality

- These involve certain fundamental aspects of quality such as clinical care, management of resources and supplies:
- drug quality and availability, general supplies, availability of clinical teams and treatment protocols, ability to conduct diagnostic tests and provide treatment that works etc.

This means that cost sharing revenues should be spent on things which directly promote patient satisfaction. And to do that well requires understanding *patient perspective* and taking actions to improve aspects of quality which may not require substantial resources.

Patient Perspectives on Quality of Care

Over the years several formal and informal patient satisfaction surveys have been conducted to assess patient opinions about the quality of services that they receive at Ministry of Health hospitals and health centres.

Naturally, patients visit a facility because they have a health problem. They expect to receive good care and attention.

Patients expect:

- to be treated the same day
- to get drugs every time
- to get attention, courtesy and privacy
- not to wait in long queues for a long time
- to be served in order of attendance – "first come – first served"

At the same time, patients have several concerns about the care they receive. Many of these concerns are known to health staff.

Generally, patients are concerned about:

- shortages of drugs and other essential medical supplies such as intravenous fluids, needles and syringes, dressing materials, antiseptics, surgical supplies, Xray or laboratory supplies and cleaning materials
- long outpatient queues – caused in part by staff tardiness, long tea breaks and "back-door entry" into queue
- staff rudeness, lack of courtesy, apparent lack of concern for patients
- dirty washrooms and toilets in OPDs and the wards
- waiting unnecessarily long before they are informed that drugs or laboratory supplies are unavailable
- inadequate or tattered beds, bed linen, and patient uniforms

B: MEASURES TO IMPROVE QUALITY OF CARE

Key Information

Successful implementation of quality of care improvements will require money, time, commitment, awareness and follow-through.

It is important that senior staff such DMOHs, Medical Superintendents, Hospital Secretaries, and officers in-charge of health centres should prepare a plan of action for improving quality of care.

Specific action points could include:

- Frequent staff meetings – to share information and increase awareness
- Orient administrative support staff to health issues
- Queues and patient flow – where are the longest queues?
- Customer care – encourage staff to be more courteous and helpful
- Clean toilets and washrooms
- Improve confidentiality and privacy for out-patients
- Reduce or eliminate backdoor and corridor consultation
- Strengthen disciplinary procedure
- Establish information desks to answer enquiries and direct patients through the facility
- Improve signage – put up patient flow signs
- Monitor average lengths of stay (ALOS) – to improve service utilization
- Improve patient communications – inform patients as soon as possible so that patients are not needlessly kept waiting.

- Set up a functioning Outpatient Committee comprising Medical Officer or Clinical Officer in-charge of OPD, Nursing Officer in-charge of OPD, Records Officer, MCH Rep., and Reps. from other departments serving Outpatient. The main function of the committee will be to solve patient care problems and improve services through regular meetings.

C: LOCAL PUBLIC INFORMATION

Key Information

Patient and public acceptance and support of the cost sharing programme is vital for its continued growth and development. The Ministry of Health headquarters, the DHMBs, the DHMTs, and individual facilities must work collaboratively to inform patients and the public about the benefits of the cost sharing programme.

Patients, public and staff must be informed regularly at the facility and district levels about the collection and use of funds, and various IEC (information, education and information) campaigns must be used to publicize successes and discuss weaknesses.

Specific actions which should be initiated by the DMOH, Medical Superintendents, and officers in-charge at health centres include:

- Tell patients what you are doing *with their money* – put up a poster telling then how the funds they have paid are being used to benefit them.

For example,

Your cost sharing shillings at work

Your sheets are clean because of user fees

Your food is better because of user fees

This waiting room was painted using user fees

Posters should be located strategically and emphasize what patients can see and appreciate:

- Newly painted outpatient waiting area (OPD poster);
- Operating theatre which is functional again (surgical ward poster);
- Repaired x-ray machine (poster in the x-ray waiting area) or
- laundry machine (posters in all inpatient wards).

Keep DHMB, PMO and DHMTs informed by *communicating* with them (through meetings and circulars) when funds are used to improve local health services and the quality of patient care.

Tell MoH headquarters about the good things *you are doing*. In addition to formal routine reports, the Health administrator should, every few months, write directly to Afya House. This letter should mention the specific benefits which patients have received from cost sharing.

For example, rather than writing "We spent Kshs 1 million for a laundry machine", it should describe the impact: "Inpatients can now sleep on clean sheets because a new laundry machine was bought and installed and is now allowing daily washing of bed linen".

Task 2.5.2 In groups of four What Makes a Good Poster?

1 List at least four characteristics of a good poster. Share your list with another group and narrow the list to at least five common characteristics.

2 In your larger group produce at least two simple but attractive posters telling patients how the funds they have paid are being spent to benefit them.

3 Use blu tack or masking tape to put up your posters on the wall. A group spokesperson might be asked explain or to talk about your posters in plenary.

N O T E S