**THE KENYA MEDICAL TRAINING COLLEGE – BONDO CAMPUS**

**DEPARTMENT OF CLINICAL MEDICINE**

**LECTURE NOTES FOR LEVEL II 2017/2018 ACADEMIC YEAR**

**MODULE 35: HEALTH SYSTEMES MANAGEMENT II (30 HRS)**

**BY**

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**UNIT 1: FINANCIAL RESOUCE MANAGEMENT (6 HRS)**

# **INTRODUCTION**

* 1. **Financial resource management policy**
	2. The role of parliament, treasury, the controller of budget and the auditor general in public financial management

***NB: students to review chapter 12 of the Kenyan constitution.***

* 1. **Sources of healthcare financing**

Health resources in Kenya come from two broad sources: public and private.

**Public sources** include the following:

* Government through general taxes (personal income tax, company tax, value-added tax, fuel tax, and import and excise duty)
* Loans from bilateral and multilateral agencies
* External grants (including charitable donations by foreign governments or organizations)
* Social insurance (mandatory insurance payments by employers and employees)

Donor funds (i.e., loans and grants) are channeled through general budget support (on-budget) and project support (off-budget). Off-budget funds form a substantial share of the total development

partners’ support (about 70%).

**Private sources** of funds include the following:

* Households (direct payments by consumers to health providers)
* Employers (firms paying for or directly providing health services for their employees)
* Private, pre-paid health insurance plans (where households make voluntary payments to private health insurance companies in return for coverage of pre-specified health service costs)
* Donations (charitable contributions made in cash or in kind)
* Voluntary organizations or nongovernmental organizations (NGOs) n
1. **BUDGETING AND REVENUE ALLOCATION**

A budget is a framework within which the decisions on the inflow of finance into the organization and its outflow as expenditure on real resources are planned, implemented, recorded and reported. A budget is related to a specific period of time, usually the financial year. In the Kenyan ministry of health at facility level, its done every quarterly.

* 1. **The main functions of an organization's budget**

The organization's budget performs three major functions:

* Planning;
* Financial control;
* Accountability or stewardship
* Motivation
* Communication
* Coordination

Planning

The budget is a key instrument by which an organization decides what it is going to do in the future and how it is going to finance the resources required. The budget as a plan is forward looking. In preparing a budget for the following financial year the figures being examined are hypothetical or conjectural. The income and expenditures they represent have not actually occurred but are projections of a likely future scenario.

Financial control

Financial control refers to the processes by which the receipt of revenues and outflow of expenditures are recorded, monitored and adjusted to ensure that the budget is managed honestly, efficiently and effectively.

The minimum requirement is financial probity, followed by good housekeeping. More demanding than these is using financial control to help ensure efficiency and effectiveness in relation to organizational objectives.

Using a budget for financial control means recording all revenue inflows and payment outflows. In contrast to the budget as a plan, the budget as the record and report of past financial transactions is backward looking.

Accountability or stewardship

The financial records are also the means of ensuring and demonstrating that money has been spent for the purposes intended. Probity is satisfied so long as the money has not been spent fraudulently or wastefully. The traditional financial audit aims to ensure this and to check that systems are in place to prevent fraud and waste.

However, whether money has been spent efficiently and to achieve maximum effectiveness within the amount available is much more difficult to assess. Auditing for value for money is a more recent development in accounting.

Motivation**:** Budgets are often serve as a means of motivating managers to strive towards the achievement of organizations objectives. They do this by acting to internal standards that will be accepted by the manager as his own target thus providing a motivational force

Communication: budgets are devices for communication. The plans summarized in the budget are read and interpreted throughout the firm, thus budgets are important channels of communicating certain types of information that will enable managers in different parts of the organization to coordinate their activities more efficiently

Coordinating**:** a budget is important for effective coordination. The various departmental managers will expect to coordinate one another so as to be able to determine manpower needs, facilities and other resources in the organization.

* 1. **The budget cycle**

The planning, financial control and stewardship functions of the budget are sequentially related through four main stages of the budget cycle: acquisition, allocation, implementation and evaluation.

Acquisition

Most of the budget for state-funded organizations is usually announced just before the beginning of the financial year, and additional income may flow in throughout the year. As the open systems model stresses, an organization's income is dependent on its flow of information and output into the task environment. In this sense all the activities of an organization affect its income flow.

Allocation

This is the budget planning or preparation phase, and is the stage we have been largely considering so far in examining how to link budgeting to health objectives.

Implementation

At the beginning of the financial year, the budget planned for that year becomes the anticipated flow of income and expenditure for the forthcoming year. As the year unfolds, the actual flows of income and expenditure are compared with the anticipated ones. These comparisons are used to monitor and confirm the budget. The financial data recorded during implementation are used for auditing and budget evaluation.

Evaluation

This involves looking back over the previous year's income and expenditure and judging how effectively, efficiently and equitably resources were used. Evaluation is an essential part of a rational approach since step 3, the selection of the best alternative, cannot be undertaken without such evidence.

Value-added measurement of organizational effectiveness is one way of providing data for evaluation. Other methods rely more on the qualitative and intimate knowledge of the organization and its environment acquired by effective managers and on which they base their assessments of appropriate action.

* 1. **Types of budgets**
		1. **Incremental (line-by-line) budget** – This is a budget worksheet listing expense items on separate lines. This is usually divided into salary and non-salary expenses. The worksheet may include several columns for the amount budgeted for the current year, the amount actually spent year-to-date, the projected total for the year based on the actual amount spent, increases and decreases in the expense amount for the new budget, and the request for the next year with an explanation attached.

This line-by-line budget has the advantage of simplicity but the disadvantage that it discourages cost-efficiency. Managers ensure that they spent the entire amount budgeted for the year to avoid budget cuts in the next year.

* + 1. **Zero-based budget –** This is a budgetary approach that assumes the base for projecting next year’s budget is zero. Managers are required to justify all activities and every proposed expenditure, regardless of the level of expenditure in previous years. Every expenditure for the new year must be justified in view of organization’s objectives and current environment.
		2. **Fixed budget** – A budget in which budgeted amounts are set regardless of changes that occur during the year such as volume of patient, unanticipated inflation
		3. **Variable budget** – A budget developed with the understanding that adjustments to the budget may be made during the year based on changes in revenues, patient volume, utilization of supplies, and other expenses.
		4. **Fiscal budget** – A specified 12-month period during which operational and financial performance is measured.
		5. **Operating Budget**

This is also known as Revenue-and –expense budget or annual budget. It is the organization’s statements of expected revenues and expenses for the coming year. It coincides with the fiscal year of the organization which in the public sector in Kenya corresponds to the calendar year –January to December. The operating budget reveals an input-output analysis of expected and revenues and expenses.

The **revenue budget** for a nursing unit may represent the patient care income expected for the budget period. The **expense budget** consists of salary and non-salary items. Among the factors that nurse managers might include in their operating budget are personnel salaries, employee benefits, medical and surgical supplies, drug and pharmaceuticals, office supplies among others.

**Advantages and Disadvantages of Budgeting**

**Advantages of budgeting**

The advantages of budgeting include:

* Budget plans for detailed programme activities
* Help fix accountability by assignment of responsibility and authority
* State goals for all units, offer a standard of performance, and stress the nature of the planning and control process
* Encourage managers to have careful analysis of operations and to base decisions on careful consideration
* Minimize hasty judgments in decision making
* Can expose organizational weaknesses and allow corrective measures to be taken
* Resources can be projected and waste minimized
* Financial matters can be handled in orderly fashion and activities of organizations can be coordinated and balanced

**Disadvantages of budgeting**

The disadvantages of budgeting include:

* Only aspects of organization activities that are easy to measure are considered in budgeting as budget convert all aspects of organization performance into monetary values
* May become an end in itself instead of a means to an end.
* Budgeting is only a tool of management but cannot take the place of management. Budgetary goals may sometime supersede the organization’s goals and gain autocratic control of the organization
* Danger of over-budgeting making the budget cumbersome and expensive
* Time consuming and expensive
* Require skill and experience for successful budgetary control
* Danger of rigidity: budgets require forecasting but his can be uncertain because budgetary control is subject to human judgment, interpretation and evaluation
1. **Facility improvement fund-FIF**

FIF also known as cost-sharing are revenues generated from user charges and insurance claims. These revenues are retained separately by the boards and are supplementary to budget allocations from the Treasury. They are supposed to be deposited into the hospitals deposit (FIF) account.

Cost sharing revenue is to be used to improve the quality of health services in facilities and support district-level preventive and primary health care (P/PHC) services (policy has since changed)

* + 1. Guiding Principles of the Cost Sharing Programme

The guiding principles of the cost sharing programme are:

* 100% local retention of revenue: Currently 75% of such revenue is allocated to the health facility collecting the funds and 25% to preventive and primary health care activities (P/PHC).
* Local planning for the use of revenue: Facility-level planning for use of facility funds, and district-level planning for use of P/ PHC.
* The revenue is additive and "no-year": That is, Treasury should not reduce MOH allocation because of cost sharing revenue, and unspent funds can be carried to the next fiscal year.
* Inpatient and outpatient fees higher at hospitals, lower at health centers, and lowest (or free) at dispensaries.
* Vigorous pursuit of National Hospital Insurance Fund (NHIF) reimbursement for inpatients, which enhances the equity of the programme.

Protection of vulnerable groups through discretionary waivers for the poor and exemptions for specific target services.

* + 1. Managing cos-sharing for success

Lessons on **good management** that have emerged from successful facilities are as follows:

* **There is no progress without people.** Both medical and administrative staff are closely involved in cost sharing activities. They receive support from the Health Management Boards and Health Management Teams.
* **Set performance targets.** It is vital that targets are set so that facilities and board members know how much revenue should be collected. Without targets it is not possible to tell if a facility is doing well or not.
* **Monitor performance**. Good record keeping involves maintenance by officers in charge of a chart showing actual collections against targets. Monthly reports on performance against targets are prepared and discrepancies investigated. Officers in charge walk around the facility from time to time, observing 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 the facility level, most of the collections should come from outpatient treatment fees, from drug items issued, and from inpatient NHIF claims. If officers in charge focused their efforts on these collections, the bulk of the revenue would be collected.
* **Spend money to make money.** To encourage departmental staff to participate fully, a percentage of the revenue collected by a department should be spent in the same department. Funds should be used to make selective, visible improvements (e.g., fixing up the waiting area), and to ensure that registers, receipt books and other critical stationery are always in supply.
	+ 1. Fees, exemptions and waivers

Changes in fees, waivers and exemptions are always clearly stated in MOH circulars. All concerned staff and board members should be informed immediately of changes.

Exemptions and waivers are meant to ensure that no Kenyan is denied essential health services. An ***exemption*** is an automatic excuse from payment based on the patient meeting certain criteria set down in circulars by the Ministry of Health. If the patient fits the criteria (e.g., is of a specified age or has one of the listed illnesses), they do not pay.

A ***waiver*** is a release from payment based on financial hardship. Patients must request a waiver and judgement must be made as to whether or not the patient is truly a hardship case.

DHMBs/ HMBs are expected to review institutional reports on waivers and exemptions on a regular basis.

* + 1. Cash collection and NHIF claiming

Specific procedures for cash collection and NHIF claiming are laid down in the cost sharing manuals listed in Annex A. DHMTs/ HMTs should be held accountable for implementing these procedures.

The three major sources of cost sharing revenue should be:

* Outpatient treatment fees;
* NHIF claiming; and
* Inpatient cash collections.

NHIF claiming should be a major source of revenue for hospitals. Significant revenues can be collected, provided nursing and administrative staff collaborate in claiming. The major reasons for under-reimbursement are:

* Failure to identify NHIF beneficiaries in the hospital;
* Failure to complete claims once a beneficiary has been identified; and
* Failure of NHIF to pay claims promptly and in full.

Efficient cash collection requires that: all departments offering chargeable services maintain a patient register; each facility has a small number of conveniently located collection points; the best staff are placed at the most important (profitable) collection points; and all collection points have cash boxes and/ or safes. Registers must also be maintained for daily cash collections, NHIF claims, and expenditures.

Inpatient cash collections are also a major source of hospital cost sharing revenue. But some facilities collect less than one-third of expected inpatient revenue. Collection losses are due to absconders, death (wrongly treated as an exemption by some facilities), lack of proper collection systems, and fraud by staff involved in the collection process.

The support of inpatient nursing staff is absolutely essential to the achievement of inpatient cash collection targets. Where nurses are supportive of the cost sharing programme, hospitals have high inpatient cash collection rates. Where they are indifferent or against cost sharing, collections are poor.

* + 1. Expenditure planning

Planning and budgeting for the expenditure shall be executed in accordance with the District Plans and in collaboration with the District stakeholders.

The primary purpose of the cost sharing programme is to improve patient care and the quality of services at Ministry of Health facilities. The intent is to allow Health Management Boards and District/ Hospital Management Teams maximum flexibility in the use of cost sharing revenue.

**Planning responsibilities:** Responsibilities for planning, approval and implementation of expenditures of the 75% funds are as follows:

* Hospital Management Team (HMT) prepares cost sharing annual plan;
* Hospital Executive Expenditure Committee (EEC) confirms cost sharing annual plan and prepares quarterly AIE requests;
* District Accountant certifies availability of uncommitted funds for the facility in the bank;
* HMB reviews, returns to EEC/ HMT for modification as necessary, and approves annual plan and AIE requests;
* The PMO, on behalf of the Accounting Officer, issues AIEs;
* Hospital EEC directs expenditure according to GoK procurement regulations;
* Hospital EEC prepares monthly Payments Report, itemizing all expenditures; and
* HMB reviews monthly Payments Report to ensure proper expenditure of funds.

**Planning Cycle:** Planning for expenditure of cost sharing revenues should follow a routine schedule in line with the GoK budget cycle. Two types of plans are required, annual and quarterly.

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| **DOCUMENT** | **SUBMISSION DATE** | **EXPENDITURE PERIOD**  |
| 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 April | 1st April - 30th June |

Facilities are encouraged to spend cost sharing revenue in ways that contribute to visible improvements in the quality of patient care. HMBs should use their knowledge of their patients' needs and the needs of the community to plan the best use of cost sharing revenue. To encourage full collection of cost sharing revenue, preference in using such revenue should be given to those wards, outpatient services, and other units which achieve their collection targets.

HMB Finance Committee chairpersons should be thoroughly familiar with requirements for approval of AIE requests, which are outlined in the FIF Supervision Manual and occasional circulars.

* + 1. The Do’s and Don’ts of FIF
1. Every department must keep a complete revenue and service register;
2. Every health center, hospital and every district must maintain a cash collection analysis book and payments analysis book;
3. All purchases must adhere to GoK local procurement requirements;
4. Every collecting institution must submit a standard set of monthly cost sharing reports;
5. There must be no theft of public funds;
6. There must be no spending before banking; and
7. There must be no spending without a properly obtained AIE
	* 1. Cost-sharing program monitoring

Monitoring of cost sharing involves three main activities:

* Regularly reviewing key cost sharing performance reports to identify performance problems with individual facilities;
* Checking for fraud and abuse;
* Conducting supervision visits to district treasuries and health facilities to: (a) verify the accuracy of performance reports; and (b) ensure that correct actions are being taken in problem areas.

Routine performance reports: DHMB/HMB chairpersons and the relevant DHMB/HMB standing committees should regularly receive the following routine performance reports from the DHMT/HMT and review them:

* **District reports**, submitted to the District Health Management Board and to the DHCF, include: - Banking Report;
	+ Payments Report;
	+ Quarterly Workload and Revenue Report;
	+ Quarterly P/ PHC Integrated Planning and Reporting Form; and - Bank Reconciliation Report.
* **Hospital Reports**, submitted to the Management Board, PMO and to DHCF on a monthly basis include:
	+ Workload Report
	+ Collections and Banking Report
	+ Revenues Summary Report
	+ NHIF Report
	+ Payments Report
	+ Bank Reconciliation Report.

**Performance review questions:** A careful review of these reports should allow DHMB/ HMB members to answer the following critical questions:

* **Are cash collections sufficiently close to target?** Monthly collections should be compared with targets. Large gaps suggest either inefficient collection or theft.
* **Are NHIF collections sufficiently close to target?** NHIF reimbursements should be 50% of cost sharing revenue for most hospitals. Progress in improved NHIF collections should be monitored very closely.
* **Are available funds adequate for planned expenditures?** Cost sharing reports indicate amounts collected and amounts banked by facilities. DHMBs/HMBs must be very careful not to approve AIE requests that exceed collections for individual facilities.
* **Are 75% facility funds being spent as planned?** HMTs/ HCMTs prepare and DHMBs/ HMBs approve cost sharing expenditure plans. Reported expenditures should be compared against approved plans. Unauthorized deviations should not be accepted. Supervision visits should be made to verify that expenditures were actually made as stated in the cost sharing reports.
* **Are 25% PHC funds being spent as planned?** As with the 75% facility expenditures, P/ PHC expenditures should conform to approved plans. Unauthorized deviations should be investigated.
* **Are waivers and exemptions at expected levels?** In general, low rates of waivers and exemption probably mean that some patients are being denied essential services. High rates may suggest fraud and/or abuse.

**Performance targets:** In order to plan for expenditures and monitor departmental and facility collection performance, each facility and district must set targets for expected cash collections and NHIF reimbursements: If you don't know where you're going, you can't tell if you're getting closer.

Targets should be set at least once each year, usually in May. This way, targets can be used to prepare annual cost sharing plans. Targets should be revised whenever there are fee changes.

Setting of collection targets should generally be done by the DHMT/ HMT. The information needed for setting targets should be readily available from Medical Records/ HMIS staff at the district and facility level. The FIF Supervision Manual provides details on target setting.

**Visits to health facilities:** Regular visits to health facilities is critical to the proper establishment and operation of the cost sharing programme. Supervision should target problem facilities and districts, high revenue potential areas, and the functioning of control systems for revenue collection and expenditure. However, it is also useful to occasionally visit the best facilities to provide them with positive feedback on their work.

* 1. **Accounting and financial management documents**

Assignment

Discuss in groups and keep a current sample copy of the following government documents

* Voucher
* Imprest,
* vote book
* per diem form
* salary pay-slip,
	+ 1. Integrated Financial Information System- **IFMIS**

Integrated Financial Management Information System. It is an automated system that is used for public financial management. It interlinks planning, budgeting, expenditure management and control, accounting, audit and reporting

**What does the IFMIS System do?**

The IFMIS is designed to improve systems for financial data recording, tracking and information management. This is in response to increasing demands for greater transparency and accountability in the management of the public’s finances. The IFMIS system ensures higher degree of data quality improves workforce performance for improved business results and links Planning, Policy objectives and Budget Allocations.

The system also:

* Enhances reporting capabilities to support budget planning,
* Automates the procurement process: requisition, tendering, contract award and payment,
* Facilitates auto-reconciliation of revenue and payment with automatic file generation,
* Facilitates automated revenue collections for improved cash forecasting,
* Provides accurate and up to date information on the Government’s financial position.

# IFMIS in Kenya

The Integrated Financial Management and Information System (IFMIS) system was first launched in 2003 in Kenya. This however introduced only limited modules, with other financial management processes remaining manual.

 IFMIS Re-engineering was therefore deemed necessary to introduce a full cycle end-toend integrated approach for efficient and effective public financial management and service delivery to citizens.

 **When was IFMIS Re-engineering Launched?**

 IFMIS Re-engineering is an initiative of the Ministry of Finance to enhance efficiency and effectiveness in Public Financial Management (PFM). In February 28th 2011, the Deputy Prime Minister and former Minister for Finance Hon. Uhuru Kenyatta launched the IFMIS Re-engineering Strategic Plan (2011-2013).

 **What is IFMIS Re-engineering “Full Cycle End-To-End Processes”?**

IFMIS Re-engineering moved from the earlier adopted modular approach (modules loosely linked to the General Ledger (GL)), to a full cycle end-to-end integrated approach.

 **What are the Benefits of using the IFMIS system?**

The IFMIS Re-engineering has promoted transparency, accountability and responsiveness of public financial resources. Other benefits include curtailing wasteful spending and corruption, enhancing controls and audit procedures as well as strengthening fiscal planning and reporting. The system also:

* Enables efficient resource allocation mechanisms;
* Improves management information for decision making;
* Establishes effective links between key players in accounting and financial management;
* Improves financial controls by availing reliable and timely financial information,
* Improves accounting, recording and reporting through timely, accurate financial data provision;
* Accelerates the pace / scope of economic growth;  Enhances development partners’ confidence.

# IFMIS Re-Engineering Components

**Re-engineering for Business Results:** This component reviews the business processes for improved financial Management.

 **Plan to Budget:** A fully integrated process and system that links planning, policy objectives and budget allocation.

 **Procure to Pay:** To develop a fully integrated and automated supply chain management system.

 **Revenue to Cash:** Auto-reconciliation of revenue and payments with automatic file generation.

 **Record to Report:** Secure two-way interface with CBK for accurate, up to date information on the GOK financial position and the production of statutory reports real time.

 **ICT to Support:** Dedicated IFMIS support functions for software, hardware and infrastructure.

 **Communicate to Change:** IFMIS Academy for capacity building and continuous learning.