Implementing Health Financing Reforms in Southern Africa

This chapter captures the main points discussed in the seminar and deals with each module in turn. The modules are divided into two groups that reflect the framework discussed in the Preface (see figure 1). The first group concerns the mobilization of additional resources through such means as user fees, prepayment schemes, formal insurance systems, and partnerships with the private sector. The second group of modules concerns the optimization of existing resources, including reprioritizing public resources for primary health care (PHC), district control and accountability, hospital efficiency, and coordinated donor funding.

Each section in this chapter draws on the overview and on country papers presented at the seminar, insights from the breakaway sessions, interventions during the plenary discussions, and other discussion during the course of the seminar. The chapter’s main goal is to reflect the content of the seminar as a whole as well as the participants’ interests and concerns.

Mechanisms for Mobilizing Additional Resources

Policymakers face continual pressure to mobilize additional resources to sustain national health systems. Some sources are more popular than others.

User Fees

User fees are a common financing mechanism used to increase resources available to the health care system and to recover a portion of costs. Many African countries that have tried for many years to offer free health services to their populations are now introducing user fee systems at the hospital and/or the primary level. Some countries that have always maintained user fee systems are currently reforming their systems to ensure equity of access to government and mission facilities (box 2.1).

**DEFINITION.** User fees are fees paid by patients at the point and time of receiving health care services. They can differ by patient group (wealthy and poor), services received (preventive, curative, or chronic illness), or among facilities (such as between public and private facilities or primary-level and hospital-level care) and may cover all or part of the actual cost of the service.

**OBJECTIVES.** The objectives of user fees may be narrow or more broadly based.

The most common objective of user fees is to generate revenues. Many countries aim to use the additional revenues raised from user fees to upgrade services by improving drug supplies and availability, raising the quality of care, or extending coverage.
By extension, this concern for generating revenues to improve services relates to a broader goal: achieving sustainability in health service delivery. Sustainability can be defined as the capacity to generate, over time, sufficient, reliable resources to deliver continued and improved health care for a growing population with a minimum of external inputs. It requires sufficient inputs into the health system, the effective and efficient use of these resources, and the delivery of services on a continuous basis. However, the generation of revenues alone is not enough to ensure sustainability.

A possible benefit of user fees is to improve equity if the relatively wealthy pay fees and governments use these revenues to improve and subsidize services for the poor. However, participants raised this only once during the seminar as an explicit aim of user fee policy. To the contrary, some participants suggested that their user fee policies would help curb unnecessary utilization.

Some participants also indicated that one objective of user fees was to educate both facility managers and patients about the cost of health care. The aim is to inculcate the concept that health costs money, and thereby direct communities away from the previous practice of receiving free health care.

**ALTERNATIVE MODELS AND EXAMPLES.** Two common models of user fees are the standard system and the Bamako initiative.

The standard system is rooted in concerns about the inefficiencies and inequities of health care systems around the world. This system assumes that fees produce resources and also foster efficiency by creating appropriate referral mechanisms and encouraging the reallocation of resources to the primary level. Equity benefits are expected as a result of increasing coverage of and quality of care delivered to the poorest members of society and of protecting the poor from the full burden of health care costs. This model should be applied nationwide, initially at referral hospitals, and then downward through the system to primary-level facilities. The fee system should be accompanied by a decentralization of control over resource use to regional or district levels so that equity and efficiency benefits are realized at a local level.

The Bamako initiative model evolved in response to poor primary care achievements in several African countries. The Bamako initiative model is implemented at the PHC level and aims to raise and control funds at the local level through community-based activities that could also be national in scope. Its intent is to ensure that local communities spend revenues to improve quality shortfalls. The nature of the financing mechanism is left to the community to decide upon and manage, and could thus take the form of user fees, a prepayment scheme, or a local tax system. The community could also establish an exemption mechanism along with criteria for exemption if appropriate. The Bamako initiative model requires good management skills in the community. Its overall objectives are to achieve a sustainable resource
**Table 2.1. Possible Effects of User Fees**

<table>
<thead>
<tr>
<th>Effect on</th>
<th>Possible positive impacts</th>
<th>Possible negative impacts</th>
</tr>
</thead>
</table>
| Efficiency | • Graduated fee scales encourage users to seek care at appropriate facilities.  
• Fees accompanied by quality improvements such as continuous drug supplies encourage utilization and better use of available resources. | • Poorly planned fee scales may encourage irrational use of health services if higher levels of care cost less to use.  
• Retaining all fees at the facility may encourage inefficient provider behavior, giving providers an incentive to overprescribe services. |
| Equity | • Exemption mechanisms can protect the poorest.  
• Bamako-type approaches can contribute to decentralization, retention, and control of user fee revenues by poorer communities, thereby allowing them greater control over purchasing needed medicines.  
• In conjunction with quality improvements, the negative effects of fees on the poorest may be offset, or may even result in higher utilization. | • Fees by themselves, that is, without exemption mechanisms, are more likely to dissuade the poor to use health services and have less influence on utilization patterns of the wealthy.  
• Pure user fee systems are more likely to enhance inequities in access to health care than those that allow for risk sharing and/or prepayment.  
• The necessary reallocations of funds collected from user fees to ensure continuous improvement in health care for the poor have seldom taken place.  
• Exemption mechanisms are hard to implement and administer on a large scale and may actually benefit wealthier groups (such as civil servants).  
• Regional inequity could increase if a resource redistribution mechanism to offset the greater fee raising capability of better-off regions is not in place. |
| Other | • Fees may strengthen local skills in management, accounting, resource management, etc.  
• Fees have been able to cover large proportions of nonsalary costs, which may have improved perceived quality. | • Fee systems alone are unlikely to generate sufficient resources to close the growing resource gaps.  
• The cost of administering exemption systems may significantly reduce cost recovery levels.  
• Fees have to be kept low because household incomes are low, and therefore may cost more to administer than is collected. Weak accounting and resource management could further undermine revenue collection. |
nisms for improving efficiency, and could actually promote inefficiencies. Problems with implementation can prevent the realization of “fees-plus-quality” improvements and exacerbate inequities. Furthermore, revenue collection must be accompanied by activities aimed at containing costs, particularly where fee retention may create incentives for overprovision of services. Although fees have generated enough revenues to alter the perceived quality of care at some facilities, they must be complemented by a broader range of actions if they are to enhance the sustainability of health systems.

**Strategies for Implementation.** The participants examined lessons other regions have learned about ways to overcome some of the potential hindrances to successful implementation. The participants emphasized the value of the following:

- Using different fees for different levels of care
- Adopting well-planned and implemented price discrimination (for example, exemption mechanisms) to protect the poor
- Employing simple fee structures to reduce implementation problems
- Ensuring that private voluntary organizations such as mission facilities and government facilities charge comparable fees to avoid undesirable utilization effects
- Promoting community acceptance of fees (and the importance of social marketing)
- Linking fees to inflation and increasing them annually
- Retaining some portion of the revenues collected at individual facilities to provide health workers with an incentive for collecting them
- Planning the implementation of user fee policies carefully
- Introducing new policies in a phased manner so that the necessary skills at each level of the health system be strengthened and capacity expanded.

Finally, the seminar discussed a phased strategy for successfully implementing user fees. The main emphasis of this staged approach is to plan the process carefully, to build capacity slowly, and to phase in user fees both by level of care and by geographic region. Rapid implementation on a large scale can be hazardous, in that problems identified during the process are much harder to correct and implementation capacity may be uneven across levels of care and geographic regions. Possible stages in a phased strategy include the following:

- **Stage 1**
  - Identifying problems likely to affect implementation, for instance, poor quality of health care, lack of willingness to pay, opposition from critical stakeholders
  - Collecting baseline data to assess implementation impact and effectiveness (ability to pay)
  - Collecting baseline data about the actual cost of services to develop a fee schedule

- **Stage 2**
  - Reviewing the proposed fee system and planning how to address anticipated problems, for example, appropriateness of fees for different types of services, whether to introduce an exemption mechanism, criteria for exemption
  - Identifying factors likely to facilitate and constrain implementation, for instance, capacity to administer exemptions
  - Developing strategies to offset likely constraining factors
  - Selecting a pilot area or level of care, say, hospitals, for initial implementation and community education to phase in the fee system

- **Stage 3**
  - Taking steps to develop key prerequisites for effective implementation, such as informing the public and posting fee schedules in visible places
Implementing Health Financing Reforms in Southern Africa

- Beginning initial implementation of fees
- Monitoring the impact and effectiveness of fees
- Carrying out operational research to support implementation, for example, ability to pay at the household level, capacity to administer exemptions

- Stage 4
  - Reviewing and revising the approach to fee implementation
  - Moving to the next stage of implementation, for instance, extending fees to other regions or levels of care.

Prepayment Schemes

As health providers in the developing world increasingly charge user fees, communities have felt the need to plan for the future costs of their health care. This has led to the emergence of prepayment schemes. In southern Africa, Tanzania is among the first countries to introduce such a scheme (see box 2.2).
**DEFINITION.** Prepayment schemes are voluntary lump sum payments by households for services provided by local health facilities when a user fee system is in place. Payment is usually in cash, but may also be in kind, and a package of benefits and conditions is clearly defined for those who have contributed to the fund. Coverage may be applied to entire households or to adults only, and additional copayments may be required for drugs. The fund is managed locally.

**OBJECTIVES AND BENEFITS.** An important objective of prepayment schemes is risk sharing among a large group of individuals. Risk sharing allows people to obtain health care when they fall ill and might otherwise not be able to pay out-of-pocket user fees. Prepayment schemes are attractive because they aim to protect subscribers from bearing the full cost of health care when they fall ill and are least able to pay. The following are other advantages of prepayment schemes:

- They broaden the resource base for health care in poor rural communities where individuals may not have the cash required by both user fees and more formal kinds of insurance schemes year-round. For example, payment is often made once a year at harvest time, which accommodates people with seasonal incomes. Payment in kind also protects those with little cash.
- Income from prepayment schemes may be used to fund additional health care activities such as community education programs, which may not receive formal government funding.
- Prepayment schemes rooted in community support and involvement promote decentralization policies.
- Prepayment schemes can revitalize local health facilities and help to rationalize referral patterns as care is free or relatively cheap at the point of first contact.

Funds raised from prepayment schemes can be used to improve quality, but are usually not sufficient to cover total costs. Additional funds are generally required from tax-based revenues or donor funding. Thus, prepayment is only one element of a larger health financing strategy.

**PREREQUISITES FOR SUCCESS.** While prepayment schemes can be advantageous and can broaden health policy goals, their success depends heavily on several elements. The most important of these elements are as follows:

- **Social cohesion within the community.** The community that intends to initiate a prepayment scheme should have a cohesiveness expressed through local organizations or perhaps through other cost-sharing schemes, such as burial societies.
- **Conducive economic environment.** The economic conditions that facilitate community-based prepayment schemes include the absence of war, drought, and other local disasters that would disrupt the normal delivery of services. Furthermore, funds should be well managed, and where possible invested to counteract the effects of inflation. The latter is particularly important because funds are collected only once a year, and where inflation is high, their value may be eroded quickly.
- **Minimum population size.** If the participating population is too small, it may not generate enough funds to cover the cost of health services the group requires.
- **No adverse selection.** Prepayment schemes are usually voluntary, but mechanisms should be put in place to avoid the possibility that those who are likely to be sick are the only ones who join, otherwise risk sharing between the healthy and the ill and between the wealthy and the poor is diminished and costs rise. These mechanisms can include restricted joining periods (such as once a year) and/or making it mandatory for entire households to join rather than selected individuals within the household.
- **Level and structure of scheme.** The community should participate in setting the payment level and time of collection. Fees should not be too high for the local population to afford.
- **Integration into the district health system.** The revenue generated should allow for the use of local public health facilities to cross-subsidize the poor and attract more resources into the public system.
- **Adequate financial and institutional support.** Additional tax-based revenue is likely to be needed to meet
funding requirements. Managerial and administrative support may also be needed to start the scheme and ensure its smooth operation, particularly at first. Decentralization of the health care system is essential to success, so that local health facilities can adapt their range of services, quality of care, and management to suit local needs.

- **Good management.** Fund collection, income management, and benefit disbursement must be done rigorously and carefully. Management can be local through a village or commune committee, through the health district, or through a multitiered arrangement, but normally can only be done in conjunction with a decentralized health service. Administrative costs should be kept low.

- **Simultaneous cost containment.** To prevent escalating costs, measures should be taken to curb costs through effective management and improved efficiency.

- **Good quality of care.** For continued participation in the scheme, scheme members must have a positive perception of the quality of care.

- **No moral hazard.** Moral hazard is introduced when individuals use health services more often than they would if they were not members of the scheme. Moral hazard can be reduced by maintaining copayments for drugs, establishing conditions of use, and restricting referrals.

### Effects on Efficiency and Equity

As with user fees, the impact of prepayment schemes on equity and efficiency is related to utilization, both of the scheme and of health care facilities by scheme members. Prepayment schemes can promote efficiency in health care use if they encourage members to use services at the appropriate level of care. If patients can bypass first-level services without penalty and use hospitals without a referral letter, the cost of care provided to scheme members may rise. This is more likely to happen if the perceived quality of primary-level facilities is poor or if the prepayment scheme covers only hospital-level services. Therefore, the design of the prepayment scheme should encourage rational utilization of services at all levels of care.

The administrative costs associated with the scheme should be kept as low as possible, for example, by keeping any exception mechanisms simple, to maximize the funds available for health care services. One way to keep administrative costs low is to use existing organizations to manage schemes. Efficient scheme management will contribute to overall improvements in health care delivery.

As noted earlier, to prevent inflation from adversely affecting the viability of the scheme, especially where funds are only collected annually, income should be invested appropriately. Payments should be increased each year in line with the inflation rate.

Table 2.2 sets out some of the possible positive and negative effects of prepayment schemes on equity.

### Implementation Strategies

Countries that wish to implement prepayment schemes should follow the same kind of planning process as for a user fee system. In particular, the need to identify and plan for potential bottlenecks to implementation. However, lessons from other countries indicate that some additional considerations are important, namely:

#### Table 2.2. Possible Effects of Prepayment Schemes on Equity

<table>
<thead>
<tr>
<th>Positive effects on equity</th>
<th>Negative effects on equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Richer people cross-subsidize care for the poor.</td>
<td>- Households far away from a health facility will use it less often because of time and travel costs. This can be avoided if those living far away pay less than those who live close by.</td>
</tr>
<tr>
<td>- More people have access to good quality care.</td>
<td>- Those who cannot afford to pay have less access. This can be prevented through exemptions for the very poor, sliding scales related to subscribers’ incomes, payments in kind, and financial backup for weak schemes where much of the population is poor.</td>
</tr>
<tr>
<td>- Prepayment is well-suited to self-employed farmers, who tend to be poorer at some times of the year than others.</td>
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</tr>
</tbody>
</table>
• **Assessing experience from existing and failed projects.** Much can be learned from the experience of other schemes, both from their detailed conditions and benefits and the wider health and economic context in which they operate. For example, the community health fund pilot in Igunga District, Tanzania (box 2.2) is accumulating considerable experience on required preplanning and client consultations, costing exercises needed to determine premiums and scales of benefits, provider attitudes, and so on.

• **Ensuring sustainability.** Prepayment schemes are likely to require government or external assistance in several forms: (a) funds for salaries, supplies, and equipment and building maintenance; (b) supervision of and support for clinical activities and for scheme management and administration; and (c) regulation, monitoring, and evaluation. The important point here is that a prepayment scheme does not replace broader public sector responsibility for health service delivery. It aims to supplement public sector resources and improve the quality of care and value for money in a context where many individuals find user fees too difficult to pay when they are ill.

• **Defining benefits.** During the seminar there was considerable discussion and lack of clarity about the definition of benefits covered by prepayment schemes. Some prepayment schemes cover all services at specified health care facilities, whereas others define specific eligible services, such as primary-level or hospital care. Some schemes demand that patients pay for drugs or make small copayments for services. In any event, each prepayment scheme must define both the services and the facilities the scheme covers. Much will depend on what households, communities, and their governments can afford, and on what services can realistically be provided for the funds available. The seminar also discussed exemption mechanisms and concluded that they are necessary, but complicated, and the determination of who should be exempted was not made explicit.

• **Ensuring availability of local management skills.** Decentralization of health services is essential to successful prepayment schemes. Decentralization in general, and prepayment schemes in particular, require good managers at the district or local level. Participants stressed management capacity as important, but often lacking, in local health districts. Skills in facility management, financial planning, negotiation, evaluation, and information management were among the most important capacity shortfalls identified. Ministries of health form an important link between communities and are responsible for policymaking, capacity building, training, regulation, and information support.

• **Agreeing on the roles of different health care providers.** The cooperation of all providers (public, private, voluntary, and private for-profit) is required to bring them into the scheme as registered providers. This requires agreement about fees paid to providers and the scheme’s conditions and benefits. Seminar participants debated whether scheme members should have a choice of provider and whether this choice should be limited in any way. Some participants suggested that a lack of choice would lead to poor quality, because providers would have no incentive to assure that their clients were satisfied. Others, however, believed that unconstrained choice would not be sustainable. In any event, participants generally accepted that all providers would need to be monitored for quality and compliance with the schemes’ regulations.

• **Providing information and marketing.** Information about the quality of care and the range and cost of services is important for implementation. The provision of information to communities is also essential, both at the time of implementation and throughout the year to generate and sustain interest in the scheme.

**Health Insurance Schemes**

Some countries in southern Africa, such as South Africa and Zimbabwe, have considerable experience with health insurance, although coverage has yet to be extended to the broad population. Other countries are considering formal health insurance systems, for example, for civil servants or for employees of companies in urban areas. Health insurance is a topic of major interest in the region, because it includes the advantages of risk pooling, is seen as a way to increase the level of resources for health, and is the predominant mode of financing in most middle- and high-income countries.
DEFINITION. Health insurance is primarily viewed as a means of offsetting catastrophic financial losses associated with severe illness or injury through risk pooling among many people. Insurance schemes can be compulsory and cover a whole population as through a social insurance fund, or they can be limited to those in the formal employment sector. They may be voluntary, as in the case of private commercial or nonprofit coverage; publicly managed; or prepayment schemes. They may apply to some or all levels of health care, with or without restrictions.

No countries in southern Africa have a health insurance scheme that provides national coverage. However, Zimbabwe (see box 2.3) and South Africa are both in the process of developing a health insurance policy that would extend the reach of their current medical aid societies.

OBJECTIVES. The objectives of a health insurance system will depend on the perspective of the stakeholder. For the government, the objectives are to

- Mobilize additional nongovernmental resources and transfer some or all of the cost of health care to those who can afford to pay
- Change the source and pattern of provider payments and related incentives to keep down costs within health schemes so as to slow down growth rates
- Improve technical efficiency by separating the financing and provision of services, thereby introducing competitive mechanisms into the health sector
- Expand access to health services by transferring resources from those who can afford insurance to the poor.

In addition to some of the objectives above, providers may seek to raise their own salaries and improve their working conditions by attracting a large pool of private patients. This, however, can reduce equity and increase costs. Insured people may aim to consolidate or expand their current benefits while minimizing the
amount spent. Employers will want benefits for their workers, but low premiums to keep the costs of pro-
duction down.

**Feasibility of Expanding Insurance Coverage.** Expanding insurance coverage is one of several financing options available to the health sector to help it achieve equity and efficiency in health care. The feasibility of health insurance depends on many factors that are often beyond the control of the health system. Table 2.3 presents some of these factors.

Expanding health insurance to cover informal sector workers has important equity implications, because this expands coverage to those most in need. Lessons from other countries indicate that some conditions in addition to those identified in Table 2.3 need to be in place to make the extension of coverage to the informal sector feasible. These conditions are as follows:

- **Policy decisions.** Decisions defining universal coverage as mandatory and plans for implementation should be clear. This requires that the government have administration systems capable of organizing the informal sector and identifying who needs subsidies.
- **Banking system.** An efficient banking system must be in place to facilitate the flow of funds and information, matched by a high degree of corporate and public integrity and social solidarity.
- **Implementation process.** As with all forms of health financing, the implementation process should be carefully planned and slow. The fastest transition from partial coverage to full coverage nationwide occurred in the Republic of Korea over a period of 12 years. Korea had clear government policy, a strong local government to conduct means testing, and an economic growth rate of more than 10 percent per year in real terms. The authorities should evaluate alternative ways of drawing the informal sector into health insurance schemes, of which the most obvious is prepayment schemes.

<table>
<thead>
<tr>
<th>Condition required</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of target population</td>
<td>The relative size of the formal and informal sectors will affect decisions about feasibility. Collecting payments from the informal sector can be expensive and difficult.</td>
</tr>
<tr>
<td>Quality of health service infrastructure</td>
<td>An adequate network of primary and higher level of facilities should be available for members of the scheme to use. Services should be of an acceptable quality. If there are not enough facilities or the perceived quality of care is low, people will be reluctant to join the scheme.</td>
</tr>
<tr>
<td>Contribution collection mechanisms</td>
<td>Implementing a new payroll tax (given the likelihood of other taxes on the payroll) may be difficult. Unwanted consequences for employment levels may result. A payroll tax requires administrative capacity and can be expensive.</td>
</tr>
<tr>
<td>Specialized and general education</td>
<td>Administrators running the scheme should have high-level skills in accounting, management, financial planning, and other areas. The user population will benefit if they have the levels of literacy and numeracy required to understand the scheme.</td>
</tr>
<tr>
<td>Legal and regulatory framework</td>
<td>The framework must address decisions governing membership, population covered, method of finance, organization, and decisionmaking authority of the fund, relationship of the fund to providers (both public and private), the benefit package offered by the fund, and conditions of use.</td>
</tr>
<tr>
<td>Other conditions</td>
<td>The benefits of joining the scheme must be perceived as worthwhile. Therefore premiums have to be affordable and a user fee system should be in place that requires those who do not join the scheme to pay out-of-pocket for services at both private and public sector facilities. Low premiums require a large enough population to spread risk. The design of the scheme should discourage unnecessary or overuse of service, and may initially cover only high cost, low frequency events, which in turn requires information on costs of care. Administrative costs need to be as low as possible.</td>
</tr>
</tbody>
</table>
EQUITY IMPLICATIONS OF INITIATING OR EXPANDING INSURANCE COVERAGE. The introduction or expansion of health insurance schemes implies important consequences for equity. First, by raising new sources of revenue for health, insurance can free up resources that could then be better targeted to subsidize the noninsured, poor population. Second, by pooling risk among better-off, healthy people and worse-off less healthy people within communities, districts or regions, the relatively rich cross-subsidize the relatively poor. If poorly planned, however, health insurance could exacerbate inequity by favoring higher-income groups, especially if higher-income groups also tend to capture public subsidies intended to promote coverage. Box 2.4 outlines possible scenarios for achieving greater equity in the distribution of resources through health insurance policies.

The release of resources for use by the uninsured is the critical axiom by which equity gains can be achieved through insurance schemes. However, redirecting resources is not easy, and several conditions are necessary:

- **Administrative conditions**
  - The capacity to run schemes efficiently must be available so as to keep administrative costs as low as possible. This includes collecting premiums, paying claims, and monitoring providers.
  - The detailed costs of efficiently provided services in public facilities must be known so that reimbursement rates can be set in ways that recover the full costs of treatment, but also encourage cost containment.
  - The capacity must exist to target increased public revenues at services consumed by the uninsured.

- **Political conditions**
  - Commitment to using insurance expansion as a means to increase government resources for the poor must be clear.
  - Pressure from insured groups to consolidate and increase their benefits must be closely monitored and negotiated.

Resource transfers must be closely monitored and audited. A central point raised at the seminar was that insurance cannot be considered an end in itself, but should be judged as a means to achieving better efficiency, equity, acceptability (quality), sustainability, and health status. Health insurance expansion should thus take place in the context of broader health policy developments.

In considering their options, governments need to consider equity in both the financing and the delivery of care. For example, is expanding insurance coverage for the formal sector first the best policy choice? Can the government meet the technical conditions required for insurance funded by payroll taxes, as well as the political, administrative, and policy conditions? Will the expansion of insurance help address the priority problems facing the health sector or make them worse?

**Summary.** Health insurance is a complex policy instrument. It requires multiple interactions within and beyond the health system. It is difficult to implement; requires good managerial, information, and accounting capacity; and entails considerable start-up costs. All countries face the challenge of developing effective insurance schemes as they progress from less to more developed economies. The challenge is to be aware of...
the options available and plan implementation carefully to avoid the many mistakes other countries have experienced.

**Public-Private Collaboration**

Public-private collaboration is another way to make the best use of available resources for health by tapping the relative strengths of private versus public providers. Many countries have developed links between their public, private voluntary, and private for-profit sectors. In Lesotho, Malawi, and South Africa the government has subsidized mission health services for many years, and Namibia, South Africa, and other countries are exploring different forms of public-private collaboration, including contracting and outsourcing of specific services (see box 2.5).

**Definition.** Public-private collaboration is formal or informal cooperation between the public and private (voluntary and for-profit) sectors in the provision and/or financing of health care services. Table 2.4 shows the possible relationships between the public and private sectors, with collaboration implied in all cells but the bottom right.

**Objectives.** Interest in public-private collaboration has recently increased for several reasons: (a) the dwindling level of public resources for health, (b) the recognition that private providers can play an important role in improving equity, and (c) the pressures to contract out to private providers as a way to improve efficiency and reduce costs.

Public-private sector collaboration has the following objectives:

- To increase the pool of resources available for health care
- To share facilities and common or expensive resources to maximize efficiency
- To ensure a coherent and equitable distribution of resources throughout a country
- To rationalize the management of health care
- To curb the brain drain by allowing opportunities for clinicians to straddle both public and private services
- To broaden the pool of resources across income groups
- To improve the quality of care.

Public-private cooperation is not a new or recent activity. Many countries have been subsidizing mission facilities and other nonprofit health care organizations out of public funds for decades. However, increasing resource constraints have led governments and private sector organizations to explore new ways of collaborating.

**Table 2.4. Relationships between the Public and Private Sectors**

<table>
<thead>
<tr>
<th>Financial</th>
<th>Provision</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public</strong></td>
<td>• Government funding and provision</td>
<td>• Care free at point of service</td>
<td>• Services contracted to private providers</td>
</tr>
<tr>
<td></td>
<td>• National health service</td>
<td></td>
<td>• Government subsidy to mission facilities</td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td>• Supplementary direct user charges</td>
<td>• Private beds in public hospitals</td>
<td>• Private health care funded by private</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Health maintenance organizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Services by nongovernmental organizations</td>
</tr>
</tbody>
</table>
Box 2.5. Public-Private Collaboration

Lesotho

The private, nonprofit health sector in Lesotho accounts for 40 percent of health care services at the primary level. Collaboration between the Ministry of Health and private organizations, for instance, the Private Health Association of Lesotho (PHAL) and the Christian Health Association of Lesotho (CHAL), has occurred in the past in various ways. For example, although the ministry has taken responsibility for training health personnel, both sectors participate in training community health workers and traditional birth attendants.

Even though the ministry provides a 35 to 40 percent subvention to private providers, disparities in fees charged at different kinds of facilities are growing. This has resulted in unequal access to health care services and increasing pressure on government hospitals, because patients who cannot afford to pay at private facilities self-refer to district or central hospitals. Recently, the ministry, CHAL, and PHAL signed a memorandum of understanding whose objective was to improve accessibility and equity by standardizing quality, fees, and conditions of service for health workers. In addition, contracts have been signed with private doctors that allow them to see patients in public hospitals in exchange for bed privileges and consultancy facilities in public institutions.

Problems remain, however, including the lack of standardized guidelines and protocols for care, the unequal resource levels of different regions in the country, and the lack of clarity about respective roles in the delivery of the agreed range of services. Furthermore, capacity to negotiate and resolve some of these problems is lacking (particularly on the part of CHAL). The result has been a continuing decline in the quality of care, together with rising costs, continued overutilization of government facilities, a brain drain to the private for-profit sector, and an increasing urban bias of personnel. Poor financial planning, a lack of basic data, and poor staff morale as a result of working conditions have exacerbated these problems.

In an attempt to address these problems, the ministry aims to strengthen its management capacity, review the agreement with CHAL, introduce an insurance scheme for civil servants, and pursue decentralization of health sector management. It is also exploring links with burial societies in relation to some form of prepayment scheme. To improve its relations with the nongovernmental organization sector, the ministry plans consultations on planning, monitoring, and evaluation of health services.

Malawi

In Malawi, the Ministry of Health, mission services, and military services have collaborated since before independence. The ministry subsidizes the mission services and pays their debts when required. In addition, the ministry is responsible for setting staffing regulations and policymaking.

To regulate private providers more carefully, the authorities have recently
- Delineated the clear obligations of both the mission services and the Ministry of Health
- Audited mission services’ records
- Divided the country into health delivery areas to rationalize facility supervision and referral networks
- Improved mission service nurse training schools by seconding Ministry of Health nurses.

Future collaboration will focus on strengthening existing links through
- Participating in a multisectoral collaboration unit
- Operationalizing the health delivery areas
- Addressing differential fee structures through patient cost-sharing schemes.

South Africa

The private sector in South Africa consumes 61 percent of available health resources, even though it serves just over 20 percent of the population. Although 42 percent of health services consumed by the black population originate in the private sector, these are mainly out-of-pocket payments rather than secure, insurance-based services. With spiraling costs making private health services increasingly unaffordable, new methods of improving sustainability are being explored, including managed health care, increased public-private collaboration, and care based on a minimum package of services

Public-private collaboration is developing in two main directions: outsourcing and private financing of public health facilities.

Continued
APPROACHES AND OPTIONS. Collaboration between public and private sectors can take place on many levels. Three common forms of cooperation are as follows:

Contracting out or outsourcing. Outsourcing requires good capacity for regulation, negotiation, and the development of explicit standards for quality, output, and performance. Outsourcing usually involves the public sector contracting to private organizations for the following services:

- Nonclinical services (laundry, security, catering)
- Clinical services (x-ray and laboratory services)
- Management contracts for entire facilities such as hospitals.

Health insurance. Private insurance companies that are employer-based, community-based, social, or private may reimburse their members for services they receive from public facilities.

Other forms. Collaboration may also occur in the following ways:

- Partial financing of nonprofit mission services
- Duty and tax relief for medical supplies, insurance premiums
- Personnel secondment between sectors
- Use of public facilities such as hospital beds by private clinicians.

IMPLEMENTATION STRATEGIES AND BOTTLENECKS TO OVERCOME. Implementation of public-private collaboration requires identifying forms of cooperation that would be practical, would be of value to both sectors, and would promote efficiency and equity in the health care system. These activities may include broadening provision of some clinical services through private practitioners (such as immunizations and other preventive activities) and sharing facilities and equipment or other activities. Collaboration should meet certain conditions to maximize its potential, namely:

- Clear contract terms
- Appropriate pricing
- Standards for quality monitoring
- Marketing to the community (information, education, and communication).

However, several bottlenecks could prevent successful collaboration unless they are addressed:

- **Capacity.** Capacity is required to manage collaboration; to negotiate contracts; to handle accounting, monitoring and auditing procedures, and information systems; and to regulate insurers to avoid such problems as risk skimming and cost spirals with fee-for-service third party payment. Outcomes and quality have to be monitored, and providers of both clinical and nonclinical services should be...
Table 2.5. Possible Effects of Public-Private Collaboration

<table>
<thead>
<tr>
<th>Effect on</th>
<th>Positive effects</th>
<th>Negative effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency</td>
<td>• Better use of available resources.</td>
<td>• Private sector fee-for-service payments may be inefficient, motivating physicians to over-prescribe services.</td>
</tr>
<tr>
<td></td>
<td>• Higher outputs for resource inputs where private companies can perform better.</td>
<td>• Lack of monitoring capacity or contract negotiating skills may lead to inefficient private contracts.</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive health services would decrease opportunity costs and missed opportunities.</td>
<td></td>
</tr>
<tr>
<td>Equity</td>
<td>• Could increase if more individuals have access to better quality care or if greater efficiency leads to freed resources that are targeted at the poor.</td>
<td>• Could suffer if the benefits (e.g., access to providers, better quality care) of collaboration were captured by the wealthy and freed resources were not targeted to the poor, or if differing access to providers persisted (i.e., different fee structures).</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive health services would increase equity of access.</td>
<td></td>
</tr>
<tr>
<td>Sustainability</td>
<td>• Pooling resources in the public and private sectors might increase sustainability.</td>
<td>• Prices are pushed up through collaboration (e.g., fee-for-service or contract monopolies).</td>
</tr>
</tbody>
</table>

Regulated through a legal framework that guides the process of collaboration within the context of national health policy goals. The possible role of professional associations in relation to monitoring needs to be explored.

- **Availability of collaborators.** In some countries the private sector may be small and lack the capacity or scope to contract its services to the public sector, or private competitors may not be present at all. In such instances the government should encourage competition through education and perhaps through changing the regulations governing private providers.

- **Harmonization.** Different kinds of providers should provide a similar range of services and use similar fee structures. However, this requires that governments involve nongovernmental organizations (NGOs) in the planning process and in policymaking to ensure their involvement in service development.

- **Relations between public and private health providers.** Public and private (particularly NGO) providers should not view each other as opposing forces, but as allies. The relative status of for-profit and not-for-profit organizations in relation to government policymaking remains a contentious issue. For example, should the government be involved in donor funding to NGOs? Who is ultimately accountable for funds donated for health sector services and development? A forum where these issues can be discussed already exists in Malawi, and could be useful elsewhere.

**Impacts on efficiency, equity, and sustainability.** As with other health reform interventions, public-private collaboration has the potential to affect efficiency and equity either positively or negatively depending on the circumstances under which the collaborative process occurs (see table 2.5).

**Mechanisms for Optimizing the Use of Resources**

Optimizing the use of existing resources, or in other words, extracting greater value for money, is the second broad dimension of sustainable financing. The remainder of this chapter discusses various options for accomplishing this.

**Reprioritizing Public Health Resources for PHC**

One way to reprioritize public health resources is to divert larger shares of government funding to primary health care. Although many countries have tried to implement such policies as suggested in the Alma Ata
declaration, hospitals, particularly those in urban areas, still consume the vast majority of available funds. Reprioritizing resources for PHC-level activities would divert resources away from hospitals to other levels of care that are more cost-effective and more accessible to most people.

**DEFINITION.** Reprioritizing public health resources for PHC refers to increasing the sustainability of the health service by improving allocative efficiency, that is, distributing resources to different levels of care and different health programs, to ensure that adequate funds are shifted from expensive (urban) hospitals to more cost-effective and equitable PHC services. Improving technical efficiency at the facility level helps to ensure cost-effectiveness and quality of care.

**OBJECTIVES.** The intent of reallocating funds is to

- Maintain adequate resource flows to primary-level facilities and other activities where cost-effectiveness is high and the need is greatest
- Curb the consumption of resources by hospitals, which in many countries tend to absorb the bulk of public health care resources (as much as 50 to 70 percent) even though they reach fewer people than PHC
- Implement policy directives whose objective is to allocate resources efficiently within the health care system to achieve the greatest output for available inputs.

**STRATEGIES FOR REALLOCATING RESOURCES TO THE PHC LEVEL.** Reprioritization can occur in several contexts. In some cases, previous gains in PHC activities that have been lost because of such reasons as civil war need to be restored (see box 2.6). In other cases large capital expenditures in the 1970s and early 1980s led to an expansion of the primary care network, but faltering economic growth thereafter affected countries’ ability to meet the networks’ recurrent expenditure requirements. Donor contributions to southern African health budgets have also been contracting in tandem with declining budget allocations to PHC in real terms. Finally, for some countries PHC has only recently been assigned priority as a policy goal. In South Africa, for example, giving priority to primary-level care is a new activity rather than a resuscitation of previous policies.

Plenary discussions at the seminar raised several issues concerning strategies for reallocating resources toward PHC as follows:

- Where PHC is defined as a collection of broad, multisectoral activities aimed at improving the underlying causes of poor health—such as inadequate water supplies, poor sanitation, inadequate housing,
illiteracy, and economic disadvantage—the health sector cannot be solely responsible for addressing all PHC needs. Many seminar participants considered that redefining PHC is an important component of reassessing the allocation of health resources within the health sector. Others felt that PHC should be adapted to suit local needs, and that strict definitions are therefore not required.

- A sustainable health service that balances PHC and hospital care requires a range of technical, administrative, and information skills.
- Even though hospital costs clearly need to be cut back over time, reprioritizing resources is hard to do in practice. Cost recovery at the hospital level using a number of financing mechanisms such as user fees or insurance can compensate for lost resources. Alternatively, the authorities can use various financing mechanisms to generate new funds for PHC activities.
- The allocation of resources in the health system involves tradeoffs, first, between levels of care; second, between quality and quantity; and third, between salary and operating costs.

**Cost Implications.** One way to anticipate the recurrent cost implications of PHC is to define and cost an essential package of PHC services using costs based on empirical studies at well-functioning health facilities. When combined with population figures and utilization rates, the authorities can determine the total costs of providing a package of PHC services and can break down the costs by region, sex, and individual service. This essential package approach provides information on how many services are required, the personnel and facilities needed to meet this need, and their associated costs. The authorities can then use this information to

- Determine the total budget requirements for PHC activities
- Allocate resources to major health service activities
- Decide how to spend the annual health care budget
- Help districts or regions to develop health care plans and assign target dates for their implementation
- Develop budgetary requirements for submission to the provincial or national health department
- Assist with identifying unmet needs or inequity between districts by comparing existing service delivery and resources with those proposed by the guidelines.

**Summary.** As with other reform initiatives, policies to distribute resources more efficiently and equitably require multifaceted strategies for implementation. Health service and financial planning should be clearly related to budgetary limitations. It should include mechanisms to increase technical efficiency and cost-recovery mechanisms where these are feasible. The process requires good information at all levels of the system, combined with skills related to facility and broader system management.

**District Control and Accountability**

Health officials increasingly see the devolution of control and accountability for health care finances to the district level as a way to make better use of health system resources and add value for money. District control and accountability allows individual districts to collect and disburse resources according to their particular requirements, and holding districts accountable for resources theoretically makes tracking funds and improving the efficiency of resource use easier.

The main prerequisite for improving district control and accountability is decentralization of the health sector, which enables districts to plan and implement their own services to meet local needs effectively and efficiently. Many southern African countries, such as Mozambique and South Africa, have begun decentralization. Botswana has been partially decentralized for many years, but is increasingly devolving control to the district level (see box 2.7). Given its importance to successful district control and accountability, the seminar discussion focused mainly on how to achieve decentralization.

**Definition.** Decentralization is the distribution of decisionmaking authority and executive powers away from the center and down to the lowest managerial level possible. Decentralization can be to regions or,
more commonly, to districts or health zones. The crux of decentralization is the devolution of control over resources, service provision, and human resource management to the local level. Its objective is not only to give districts the authority to control their own financial planning and management, but also to assume greater culpability in regard to the populations they serve.

**OBJECTIVES.** Decentralization is a fundamental component of health system reform aimed at achieving greater system sustainability (as opposed simply to financial sustainability). As such, it has several specific objectives. These are to

- Improve accountability in the health system by bringing decisionmaking authority, budget planning, and accountability for expenditures down to the level of service delivery
- Lead to more appropriate decisionmaking about what services are required and how these services should be delivered by people most familiar with local needs and costs
- Increase accountability, as well as management, through elected district health boards and other structures.

**ISSUES IN DETERMINING DECENTRALIZATION POLICY.** In formulating decentralization policy, governments must address several issues concerning the degree, scope, and content of decentralization. The seminar discussed which elements of the health sector should be decentralized and to whom, as well as the required skills and information systems for successful decentralization.

The core of decentralization is the devolution of control over resources to the local level. The tasks that should be decentralized include budgeting, planning, control over line items within budgets, and revenue generation and retention. Where a district has the capacity to generate revenues, ensuring that it also has the power to control its own resources is even more important to improve quality and efficiency of care. Local management of health care services is often placed in the hands of a district management team or a district health board, which may be appointed or elected.

Each district or health zone must have adequate management and financial planning capacity. In a centralized system, most capacity for planning and administration is concentrated in a relatively small group of individuals. However, in a decentralized system, these skills are required throughout the health system and the country. Some of the most important of these include

- **Systems**
  - Information systems to keep track of costs, services provided, drugs consumed, and so on
  - Planning networks that incorporate suggestions and feedback from local sources and stakeholders and liaise with NGOs
  - Accountability (checks and balances) both upward and downward throughout the system

- **Information**
  - Cost data by program and facility
  - Resource use by individual activity
  - Resources consumed by NGOs

**Box 2.7. District Accountability and Control in Botswana**

Botswana has made rapid gains in health sector development during the last two decades, and relatively few people now live more than 8 kilometers from a health post. Botswana has a partially decentralized system of health delivery, with health service areas having been delineated some time ago. Teams managing these areas participate in health planning and supervise local activities. Although they have little financial control over their own resources, Botswana has a long history of local urban and rural councils on which to build a stronger decentralized system.

The government is considering a new system under which local authorities will be expected to generate funds for health care and the central government will match these funds using a standard formula. Local authorities will thus be expected to expand their revenue base through property taxes, service charges, and so on. The local authorities will be able to spend the funds raised as they deem appropriate.
• Skills
  - Accounting
  - Financial management and planning
  - Priority setting
  - Negotiation with health service providers, NGOs, the ministries of health and finance, the community, and so on.

These skills in turn require basic, multidisciplinary training in economics, management, epidemiology, policy analysis, and clinical skills.

Several other financing initiatives have cited decentralization as a fundamental prerequisite for success. For example, mechanisms aimed at increasing resources available to the health sector (user fees, prepayment schemes, and insurance systems) require decentralized health systems to achieve their potential. Decentralization should thus be undertaken before cost recovery mechanisms are put in place in public health facilities.

**CRITICAL ISSUES AND BOTTLENECKS.** The participants raised a number of critical issues and practical problems associated with the complex process of decentralization as follows:

• *The relationship between the ministry of health, provincial authorities, and district authorities.* If districts take responsibility for their own health care services, what is the role of provincial or regional authorities? What guidelines, if any, should the ministry of health or the provincial authority establish for service delivery (range of services, output, human resource functions)? To whom will districts be accountable for their activities and resources? Given the uneven distribution of capacity throughout a country, how will equity between districts be maintained? What authority will be responsible for financing capital development or for determining what capital projects are required or take priority? How should money flow through the system to provinces and then downward to districts? Will decentralization create even more bureaucracy?

• *Ownership of and responsibility for hospitals.* Some delegates at the seminar did not feel that responsibility for hospitals, particularly third-level referral hospitals, should lie with the districts in which they are located, but that they should remain under the authority of the ministry of health.

• *The role and financial security of NGOs following decentralization.* NGOs are an important stakeholder in the decentralization process, as they often provide health care services to relatively poor households who are unable to access publicly operated facilities. Some NGO representatives at the seminar expressed concerns that they may not have the same financial security under a decentralized system that they currently enjoy with the central ministry of health.

• *The relationship between ministries of health and finance, and the implications of decentralization for budgetary allocations, financial systems, and accountability.* Can decentralization in the ministry of health occur independent of decentralization in other ministries, particularly the ministry of finance, and is it thus sector-specific or multisectoral? Budget allocations may be needed by activities of a multisectoral nature, rather than by facility or district, and substantial changes to financial planning and accounting systems would therefore be required before decentralization could occur in the health sector.

• *Resource requirements for decentralization.* Does decentralization cost more either initially or in the long term than a centralized system? Where will the funding to implement a decentralized system come from? What human resource capacity exists and how can it be developed? What are the implications for career development within a decentralized health system?

**THE WAY FORWARD.** For many countries, the way forward is to continue discussing and planning for decentralization. Many have adopted a slow, phased approach to encourage the development of capacity at the district level, the restructuring of budget and financial systems, and the ability to resolve problems as they occur. Some countries may phase in a decentralized system by first allowing districts to generate and retain their own funds. Districts may also begin participating in planning health budgets. For many countries, simultaneous developments in banking systems, information systems, and decentralization of other ministries will be necessary.
Hospital Efficiency

Improving the efficiency of public hospitals is a necessary complement to policies aimed at reprioritizing public resources for public health goods and services, because of the inevitable shift of resources away from hospitals to primary health care. Many industrial and developing countries have taken steps to improve hospital efficiency, because spiraling costs have made large hospitals increasingly expensive. In southern Africa, South Africa has recently completed an evaluation of its public hospitals to identify ways of increasing efficiency in the context of wider health reforms currently under way (see box 2.8).

**Definition and objectives.** Hospital efficiency has two key dimensions. One concerns the efficient allocation of resources to hospitals in relation to other levels of care. For example, when quality of care is poor at health centers, where unit costs of treatment are lower, people tend to self-refer to hospitals, where unit costs of treatment are much higher. Thus the most sophisticated, costly component of a health system is used to provide treatment that should be done less expensively at lower levels in the referral system.

The other dimension concerns the efficient internal management of available resources by individual hospitals, that is, their technical efficiency. A typical problem in this regard involves the purchase and maintenance of exceptionally costly high-tech equipment that is hard to justify in terms of demand and budgetary constraints. Thus hospital efficiency can be both an end in itself, as well as a means of freeing up additional resources for primary-level care.

**Current problems with existing hospitals.** Many problems exist in hospitals at all levels of the system, including district, provincial, and central or academic hospitals. Public hospitals can absorb the bulk of ministry of health spending (40 to 70 percent), and yet they do not serve the majority of the population.
Many public hospitals in southern African countries are overcrowded and inappropriately used, particularly where they try to fill the gap created by poor or nonexistent PHC facilities. This is exacerbated by the inability of many hospitals to maintain good support and supervision of PHC facilities in their regions or districts. Quality of care suffers and morale among health workers is poor. Many health workers, particularly doctors, have left the public system to work in private hospitals.

Although these problems have increased in recent years, some are deeply rooted in the colonial structures inherited at independence. The urban, hospital-centered, and curative bias of most health systems has been hard to redefine, while restructuring or closing down a hospital can be politically and financially difficult.

**Table 2.6. Strategies and Prerequisites for Improving Allocative and Technical Efficiency within Hospitals**

<table>
<thead>
<tr>
<th>Allocative efficiency</th>
<th>Technical efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Put in place an efficient referral network:</td>
<td>Management:</td>
</tr>
<tr>
<td>• Ensure adequate PHC facilities</td>
<td>• Information systems</td>
</tr>
<tr>
<td>• Establish incentives to attend lower level services first (such as higher fees for non-referred patients)</td>
<td>• Support services (contracting out, improved efficiency, standardized equipment needs)</td>
</tr>
<tr>
<td>• Improve satellite hospitals</td>
<td>• Drugs policy (activate essential drug lists, improve distribution mechanisms, reduce waste and theft)</td>
</tr>
<tr>
<td>Monitor hospital performance:</td>
<td>• Management system (use professional managers, boards, or trustees)</td>
</tr>
<tr>
<td>• Establish performance norms</td>
<td></td>
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<tr>
<td>• Gather information on outputs and quality</td>
<td></td>
</tr>
<tr>
<td>• Introduce incentives to achieve agreed standards</td>
<td></td>
</tr>
<tr>
<td>• Grant autonomy to individual hospitals</td>
<td></td>
</tr>
<tr>
<td>Coordinate with the ministry of finance:</td>
<td>Cost recovery mechanisms:</td>
</tr>
<tr>
<td>• Introduce performance-based budgeting, which requires benchmarks, accounting and financial planning capacity, information</td>
<td>• Fees retained at the point of service</td>
</tr>
<tr>
<td>• Make contracting arrangements</td>
<td>• Higher fees for private patients (matched by incentives to attract private patients, such as better hotel-type services)</td>
</tr>
<tr>
<td>• Arrange payments to hospitals</td>
<td>• Good accounting capacity and means-testing mechanisms</td>
</tr>
</tbody>
</table>

Many public hospitals in southern African countries are overcrowded and inappropriately used, particularly where they try to fill the gap created by poor or nonexistent PHC facilities. This is exacerbated by the inability of many hospitals to maintain good support and supervision of PHC facilities in their regions or districts. Quality of care suffers and morale among health workers is poor. Many health workers, particularly doctors, have left the public system to work in private hospitals.

Although these problems have increased in recent years, some are deeply rooted in the colonial structures inherited at independence. The urban, hospital-centered, and curative bias of most health systems has been hard to redefine, while restructuring or closing down a hospital can be politically and financially difficult.

**STRATEGIES FOR IMPROVING EFFICIENCY IN HOSPITALS.** Table 2.6 presents strategies for improving efficiency at hospitals discussed at the seminar. The strategies have been grouped together under two broad headings: technical efficiency (changes internal to the hospital) and allocative efficiency (wider changes required to the health system as a whole or to interministerial relations). Most of the strategies outlined in table 2.6 call for a phased approach to improving hospital efficiency. However, they all revolve around increasing hospital autonomy to some extent. Hospital management needs to have the authority and resources to improve efficiency relatively quickly and easily. This, in turn, requires more autonomy to control the resources available to each individual hospital.

**Effective Use of Donor Funding**

The participants discussed effective use of donor funding largely from the vantage point of better coordination and implementation of foreign assistance in synchrony with government-led national health strategies. The discussion focused on the experiences of two countries. This section does not attempt to be fully inclu-
sive, and all donors and countries attending the seminar did not share all the experiences discussed. Even within countries and among donors, experiences differed, for example, NGOs, ministries of health, and ministries of finance often had different perspectives, and individuals from the same donor organization sometimes held different views on the same issue. The discussion below seeks to document the range of sentiments expressed at the seminar.

**COUNTRY EXPERIENCES OF DONOR FUNDING.** Participants described the following experiences (see box 2.9 for a description of Angola’s experiences):

- Donors provide funding with conditionalities attached to it. Sometimes the conditionalities are overly taxing.
- Funding may be available for activities that do not form part of the country’s own health agenda. Inflexibility in funding conditions makes redirecting these funds toward more appropriate activities linked to a nationally formulated health strategy difficult.
- Countries may not have the capacity to coordinate donors to ensure that available funding is distributed around the country according to need rather than donors’ own interests. Security factors in some countries constrain where donor funding can be used.
- The conditions of accepting donor funding can be onerous with regard to reporting, evaluating, and monitoring each individual project. One effect of this is that the health service is divided into a series of independent projects each of which requires individual evaluation, auditing, and reporting.
- Sometimes too many technical advisors accompany donated funds. These have their own agendas and views about system development. They may or may not have experience in health or in the host country, and the ministry of health is rarely consulted before they are put in place. In addition, donors’ country representatives do not always have the authority to make decisions about funding and other matters.
- Governments usually lack knowledge about funding that NGOs receive directly from foreign sources, thus making it difficult to quantify the total budget envelope for health in the country and the true nature of budget deficits facing NGOs with which the government might help.

As a result of these experiences, many countries are adopting new policies and approaches for making donor funding more effective. For example, some countries are attempting to rationalize the distribution of funding through the health sector (both in relation to activities and geographical regions) by distributing areas of work according to a national health plan and strategic framework. Zambia is experimenting with “basket funding,” in which all funds go into a central pool to fund the national health plan as a whole (see box 2.10). Other actions that countries have taken in response to experience include

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**Box 2.9. Angola’s Experience with Donor Funding**

Angola is emerging from a long period of civil strife and faces the challenge of rebuilding its health system. It relies heavily on donor support, and the health sector is the third largest recipient of aid after emergency assistance and social development. Angola is currently addressing several problems in its relationship with donor agencies. The first concerns disease priorities. Whereas malaria is the biggest killer in the country, donors are providing more funding for HIV/AIDS research and service provision, which reflects donors’ interests rather than Angola’s needs. A second problem is the skewed distribution of aid through the country, which reflects the security situation. Some provinces are well served by technical assistance and funding, whereas others, often those most in need, are neglected. Continuing improvement in the security situation, accompanied by the opening up of roads and the disposal of mines should make targeting aid for these areas easier. A third problem is the lack of coordination between international NGOs, donor agencies, and the ministry of health in planning health sector activities. The ministry often finds out about funding for health activities through donors’ annual reports rather than before the funding takes place, and is therefore not in a position to ensure that appropriate activities are being funded. Finally, complex changes are currently taking place in Angola related to the peace process, the building of democracy, decentralization, and the development of a market economy. These complex processes affect the country’s capacity to absorb technical and financial assistance.
Zambia’s experience with donor funding has been to move away from individual donor support for projects that create complex administrative requirements and overlap in service provision to systematic and integrated support of the health sector through a “common basket” funding approach. The objective of this approach is to allow the Ministry of Health to use funds for government priorities rather than donor priorities. It is based on a secure government-donor dialogue and aims to foster donor coordination, to link health sector development with larger macroeconomic goals, and to make the use of resources transparent to facilitate long-term financial sustainability. The government has encouraged donors to support the Ministry of Health with financial assistance that will fund the ministry’s national health plan rather than technical assistance. The system requires a series of contracts (for example, between the ministry and donors, between districts and the ministry), each of which spells out the terms and conditions for expenditure and methods of auditing and reporting. In addition, donors have been asked not to establish local offices with technical officers based in the country.

The necessary requirements for a move in this direction include:

- An articulated and costed national health strategic plan or health investment policy
- A human resource development plan
- A health care financing policy that incorporates the restructuring and reorganization of health administration from the district level to the ministry of health
- Medical and drug requirements
- Equipment and transport needs
- Financial, administrative, and management systems support
- Physical infrastructure
- Resource requirements (capital and recurrent).

The success of basket funding depends on the following conditions:

- A uniform system of fund disbursement, procurement, auditing, and reporting, which in turn requires sound financial administration and management systems
- A single reporting system
- A monitoring and evaluation system based on institutional requirements rather than individual donor projects.

Positive achievements in overcoming obstacles include:

- The definition of a shared health vision among donors, the ministry of health, and NGOs
- A constructive dialogue
- A steady increase in accountability and transparency (overcoming mistrust)
- An agreement on reporting procedures, disbursement of funds, and auditing procedures
- An increase in assertiveness on the part of the ministry of health.

Remaining obstacles to be resolved include:

- The bilateral agreements that are still in place
- The logical planning framework most donors use to develop project documents
- The continuing donor support for vertical programs
- The supervisory missions that have not yet been eliminated
- The political turbulence in the country.

- Reporting and monitoring health projects as an annual activity, which leads to a single document that is distributed to all donors and interested parties, rather than reporting to each donor individually
- Moving away from auditing as the central reporting mechanism to increased use of output indicators and activity evaluation
- Recognizing that donors cannot always be coordinated, because they have their own constituencies, sovereign needs, goals, and agendas
- Increasing dialogue between the host country and the donor community to develop a sense of partnership.

**Donor agency perceptions of funding arrangements.** Representatives of the donor agencies acknowledged several of the points country participants raised. Some indicated that donors in general would be
willing to alter their funding practices under certain circumstances, for example, if a country had developed a strong vision about the direction its health system is moving in, and on that basis had come up with strategic plans to drive the vision—with costs, human resource requirements, financing strategies, and so on worked out—together with a plan for evaluation. To succeed, a strategic plan requires strong political commitment and a realistic and phased approach to reform.

**COMMON GROUND ON REQUIRED SKILLS.** Many participants from individual countries and donor agencies called for the development of skills required for initiating and continuing health sector reform. These included

- Networking with other countries to share experiences, build on strengths, avoid repetition of problems, and use regional expertise
- Initiating capacity building and institution building at the district, provincial, and ministry of health levels, especially in the areas of management, economic evaluation, administration, information systems, decentralization processes, and negotiation
- Developing economic evaluation tools (cost-effectiveness, cost analysis, financial planning) and new planning tools, such as planning led by recurrent expenditures or national health accounts
- Acquiring access to up-to-date manuals on necessary skills such as economic analysis
- Developing skills in policy analysis to begin a reform program and put into action some of the concepts discussed at the seminar
- Establishing communication and dialogue between the public and private sectors to develop a shared vision of health sector development
- Instituting operational research to monitor and evaluate progress, to modify reform approaches, and to identify areas of greatest need.