

Sustainable Health Care Financing in Southern Africa

*Papers from an EDI Health Policy Seminar
held in Johannesburg, South Africa, June 1996*

Edited by

Allison Beattie
Jane Doherty
Lucy Gilson
Eytayo Lambo
Paul Shaw

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At the time of writing, Allison Beattie was a consultant to the Human Resources and Poverty Division of the World Bank's Economic Development Institute. Jane Doherty is leader of the Health Economics Financing Group at Witwatersrand University's Center for Health Policy. Lucy Gilson is senior research officer at Witwatersrand University's Center for Health Policy. Eyitayo Lambo is a health economist at the World Health Organization/AFRICA. Paul Shaw is principal human resource economist in the Human Resources and Poverty Division of the World Bank's Economic Development Institute.

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Foreword

This publication contains papers presented at a senior policy seminar held in Johannesburg, South Africa, in June 1996, and summarizes the proceedings. Participants included delegations from the southern African countries of Angola, Botswana, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe. The Center for Health Policy, University of Witwatersrand, South Africa; the World Health Organization's Regional Office for Africa; and the Economic Development Institute of the World Bank jointly sponsored the seminar.

The purpose of the seminar was to examine two facets of sustainable health care financing. On the one hand, participants discussed ways to raise additional revenues for health, including the "do's" and "don'ts" of user fees, experience with prepaid risk-sharing mechanisms in rural areas, formal health insurance, and improved modes of public-private collaboration. On the other hand, they concentrated on ways to use available resources more effectively to extract more value for the money. Topics included orienting public health resources toward primary health care, improving control of and accountability for district financing, improving hospital efficiency through cost containment and contracting out, and making more effective use of donor funding.

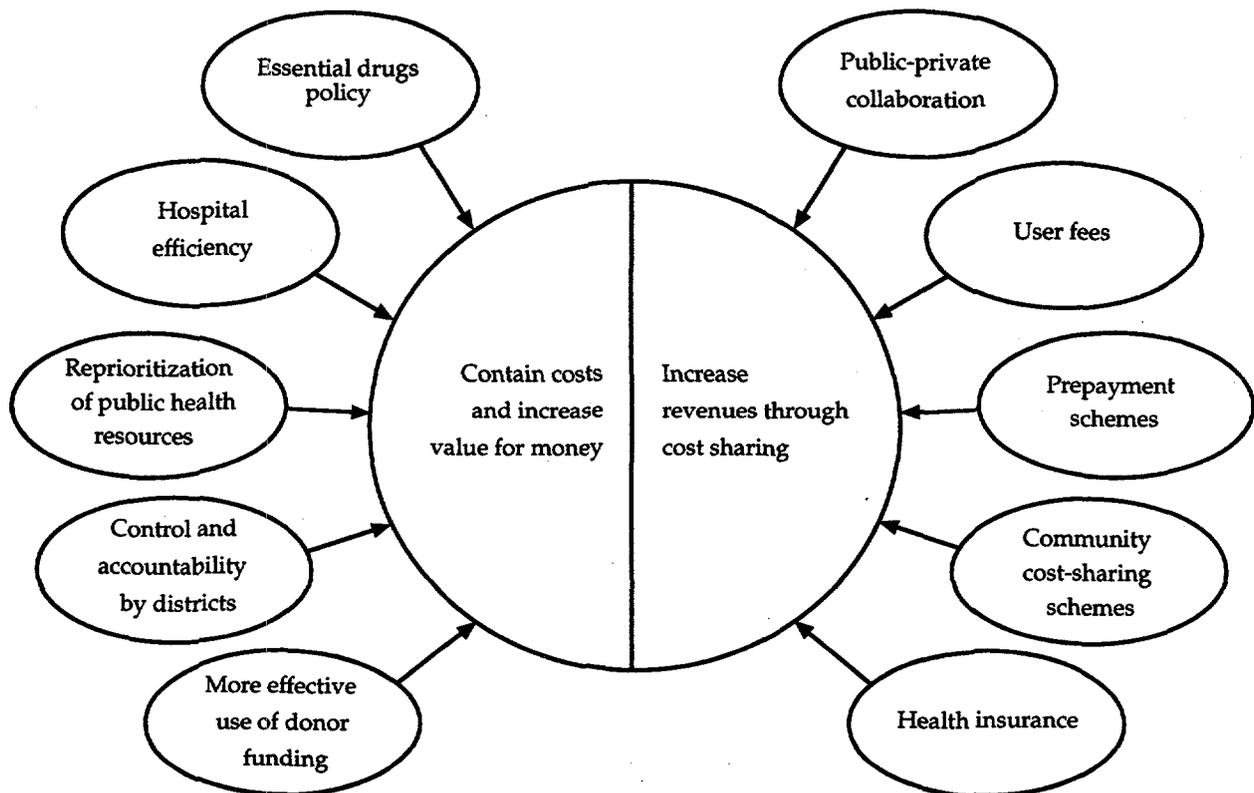
By widely disseminating the seminar's proceedings, the Economic Development Institute and its partners seek to contribute to the knowledge base on health care reform and financing issues in the low- and middle-income countries of Africa and elsewhere. By presenting the original papers, as prepared and submitted by the participants, this publication honors the collaborative spirit of the seminar whereby policymakers from different countries shared their experiences and lessons learned in search of their common goal, to improve the health and well-being of their populations.

Vinod Thomas
Director
Economic Development Institute

Preface

The topics discussed at the seminar fall into two broad categories, namely, those concerned with ways to increase the pool of available resources and those that examine how to control costs and use resources more efficiently. These two dimensions are depicted in figure 1.

Figure 1. Mechanisms for Reforming Health Financing Systems



An emphasis both on increasing revenues and on obtaining more value for money through cost sharing suggests the need to adopt a more balanced approach toward sustainable financing reform than the literature generally subscribes to. This dual emphasis is becoming increasingly important to health planners because the availability of more funds for health does not necessarily translate into better health care outcomes. New

sources of funding, just like old sources of funding, can be wasted and inefficiently used. Thus sustainable health financing reform requires action on both fronts.

To illustrate the importance of obtaining more value for money, one need only consider the legacy of drug procurement, prescription, and use in many African countries. One study (World Bank 1994) concluded that of every US\$100 of public money spent on drugs in Africa, clients only used about US\$13 worth of drugs effectively. The same study laments the inefficient use of public funds, one-third to one-half of which often go to tertiary-level hospitals in urban areas and have little direct impact on the spread of preventable communicable diseases or the dismal health conditions of the poor in predominantly rural areas. Development experts tend to agree that in most African countries, donor funding could be coordinated and used more effectively, especially given that many donor programs are neither in synchrony with one another nor with government planning cycles.

However, increasing revenues takes on immense significance in southern Africa, because governments' capacities to raise revenues through income and sales taxes tend to be limited and often unstable. In most countries limited capacity to raise revenues through income taxes is associated not only with high levels of poverty, but also with high levels of self-employment in farming and the nonformal sector, where tax collection mechanisms are weak or nonexistent. Moreover, when revenues from sales taxes and import or export duties fluctuate—depending, for example, on good or bad harvests—governments also find that maintaining revenue collections and honoring budgetary commitments to ministries, including ministries of health, is extremely difficult. These factors have stimulated widespread discussion about alternative forms of cost sharing for better health in Africa.

The advantages of cost sharing as a possible solution to the shortage of resources can quickly evaporate, however, if the authorities do not take care to implement reforms in a way that ensures the health system's overall sustainability. For example, poorly designed reforms can have a negative effect on societal goals such as equity, worsening the plight of those communities most in need. Likewise, clients or patients are unlikely to support reforms such as user fees or prepaid community health insurance schemes unless they feel they are receiving better quality care in return. Fortunately, Africa is gaining experience in managing dilemmas such as these that can be shared across countries in the region.

While a seminar of only five days duration cannot treat all the above issues in sufficient depth, the papers, presentations, and discussions assembled here touch both sides of the challenge, often bringing unique country experiences to bear or underscoring key issues and concerns that merit further policy analysis and discussion. This publication is therefore intended to serve as a benchmark of understanding and concerns on which to build future analysis, training, and action.

Part I of this publication consists of two chapters. The first chapter places different health financing policies in the broader context of health sector reform and presents the key themes that emerged from the seminar. The bibliography at the end of the chapter includes useful material from the current literature for further reading. The second chapter synthesizes the material and discussions presented at the seminar by topic.

Parts II and III reproduce the overview and country papers that international experts and country representatives presented. Note, however, that some of the information in these papers may have changed in the intervening months since the seminar.

References

World Bank. 1994. *Better Health in Africa: Experience and Lessons Learned*. Washington, D.C.

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Executive Summary

A five-day seminar on sustainable health care financing held in Johannesburg, South Africa, in June 1996 brought together senior policymakers from 10 southern African countries. The seminar was jointly organized by the Economic Development Institute of the World Bank, the Regional Office for Africa of the World Health Organization, and the Center for Health Policy of the University of Witwatersrand in Johannesburg. The participating countries were Angola, Botswana, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe.

Approximately 80 participants attended the seminar, including 23 senior policymakers from national health departments or ministries of health, 7 senior policymakers from national finance departments or ministries of finance, 11 representatives of major nonprofit private health care organizations, and 22 representatives of international agencies and donor organizations (see appendix 1).

The seminar's objectives were to

- Review options, initiatives, and models for sustaining financial resources and improving efficiency that countries in the region are currently implementing or considering
- Identify successful approaches toward and bottlenecks inherent in assuring effective implementation of sustainable financing initiatives
- Examine the equity and poverty implications of different financing strategies
- Identify research priorities, policy analysis, and training needs required to improve national capacities to mobilize sustainable resources for health.

Eight financing reform topics pertinent to initiatives being undertaken within southern Africa were discussed during the seminar, namely:

- User fees
- Prepayment schemes
- Health insurance schemes
- Public-private collaboration
- Reprioritization of resources for primary health care
- District control and accountability
- Hospital efficiency
- Effective donor funding.

These topics fall into two broad categories of health financing reform, namely, reforms that seek to increase the pool of available resources and those that aim to control costs and use resources more efficiently. The financing aspects of drug policy reforms were not discussed during the seminar because of

limited time and the highly specific and detailed nature of such reforms. Similarly, the detailed aspects of resource planning were not addressed in a systematic manner.

The main lessons that emerged from the seminar were as follows:

- Financing reforms are closely intertwined with one another and with other types of reforms, and should not be seen as ends in themselves. Financing reform should be concerned with the sustainability of the health system as a whole.
- Some financing reforms could have a negative effect on societal goals such as equity if designed or implemented without these goals clearly in mind.
- The process through which financing reforms are implemented is crucial to their success.
- Sustainable financing of health care is not solely about raising more money for health. It is equally concerned with getting more value for money from existing funds.
- Different ways of raising more revenues for health often have varying impacts on efficiency and equity within a national health care system.

With regard to these lessons, the seminar concluded that

- As health financing reform is extremely complex, careful strategic planning during the policy formulation and implementation stages is required to increase the likelihood of success.
- National health and finance departments and ministries must communicate with each other about the planning and implementation of new reforms.
- The sharing of experiences and lessons learned with other countries, especially within the same region, is valuable when planning reform.
- Joint planning and collaboration with the private voluntary and private for profit sector is important, because health financing reforms have a systemwide impact.
- Planners and day-to-day decisionmakers in the region would benefit from more in-depth training in the implementation of health financing options.

The seminar demonstrated that the southern African region possesses a growing body of expertise in the area of health care financing. A priority of all the participating countries was to learn more about how to implement reforms successfully. The international agencies and donors participating in the seminar have a role to play in helping southern African countries access international and regional expertise on the implementation of reforms in health care financing.

Part I—Seminar Proceedings

1

Sustainable Financing in the Broader Framework of Health System Reform

Following an explanation of why the topic of health financing reform has gained prominence in southern Africa, this chapter summarizes the broad themes that emerged from the seminar's module-based discussions (see chapter 2 for a detailed account of each module) and reflects on how each theme relates to international debate. The themes represent lessons the seminar participants had learned through their collective experience of implementing reform, and may be useful for future reform efforts in southern Africa and elsewhere in the developing world.

Health Financing Reform in Southern Africa

Many countries worldwide are devising reforms intended to bring about fundamental and sustained change in their health sector policies, institutions, and implementation processes (see World Bank 1993, 1994). In the southern African region, as in other developing regions, a number of issues have stimulated reform (see Mogedal, Steen, and Mpelumbe 1995), for example:

- People are increasingly becoming aware (because of the spread of democratization) that quality health services need to be provided more efficiently and equitably to larger constituencies of people.
- Health services are being threatened by economic recession, which is leading to cutbacks in recurrent budgets and a decline in capital development.
- Demographic patterns and diseases are changing—urbanization, the emergence of HIV/AIDS, the resurgence of diseases like malaria and tuberculosis, and the rising incidence of noncommunicable diseases and diseases attributable to lifestyle—thereby placing different demands on health services than in the past.

In southern Africa, as in other parts of the developing world, health care planners who are interested in reform have to deal with various constraints. These constraints limit the impact of health services on health status, especially at the primary level, and include the following (see Cassels 1995; Zwi and Mills 1995):

- The inefficient distribution of scarce resources. Hospital care still consumes most expenditures, salaries absorb the bulk of recurrent costs, and urban areas get more resources than rural areas.

- Poor systems for budgeting, for disbursing, for purchasing, and for monitoring expenditures that have failed to achieve an equitable distribution of health care resources.
- Lack of access to health care for populations that are disadvantaged because of such factors as location, age, sex, poverty, unavailability of services, unemployment, and bad planning or management of services.
- Services that do not respond adequately to local needs. For example, the poor quality of many services leads to underutilization, unmotivated and poorly trained staff, long waiting periods, inconvenient clinic hours, inadequate drug supplies, lack of confidentiality, financial exploitation by the private sector, and no safeguards against dangerous treatments.

As all these constraints are caused in part by a scarcity of resources, health care planners have become preoccupied with reforms that secure more adequate financing for health care and ensure greater value for money. Yet while some documentation of developing countries' experience of different health financing reforms is emerging, the real impact of these reforms remains relatively unknown (see Gilson and Mills 1995; Janovsky and Cassels 1996; Kutzin 1995a; Shaw and Griffin 1995; World Bank 1993, 1994). Some reforms do not appear to have achieved their stated objectives. This is of increasing concern to international agencies and donors who actively promoted such reforms in the past, often based on their success in industrial countries. Such failures are obviously also of concern to southern African countries, many of which are in the early stages of implementing financing and/or more comprehensive reforms. This concern has led to an intense interest among these countries to learn from international experience with reforms, as well as to share and compare their own experiences within the region, particularly with regard to implementation. It is this interest that brought the participants together at the seminar.

Key Themes of the Seminar

The seminar covered eight types of financing reforms that fall into one of two major categories of health financing reforms, namely: those that seek to increase the pool of available resources and those that aim to control costs and use resources more efficiently. Chapter 2 presents the discussions pertaining to each type of reform. The following paragraphs summarize the key themes that emerged during discussion and debate at the seminar. They cut across all the different types and categories of reform and help to locate health financing reform within the context of wider health sector reform. These themes relate closely to debates occurring in other parts of the world.

Financing Reform Should Be Seen as Part of a Reform Package

Participants emphasized that financing reform is not an end in itself. Rather, financing mechanisms should be seen as the means to achieve and sustain fundamental health system goals such as equity, efficiency, and improved health status. When considering the sustainability of financing reforms, their impact on the sustainability of the health system as a whole should be taken into account. As each financing reform carries its own costs, advantages, and liabilities, each should fit into a broader framework of health sector development to ensure that it is appropriate for the needs and capacity of each country.

No financing reform is likely to be successfully implemented in isolation. Most reforms are related and must be undertaken in combination with other mechanisms. Some reforms are half-way stops on the road to other objectives. For example, user fees may be implemented as an initial or preparatory step to other cost-sharing schemes, such as prepayment or formal insurance schemes.

Likewise, financing reforms may be necessary, but are not sufficient for achieving broader health system goals. Indeed, financing reforms usually require larger changes in the organization and delivery of health systems and can have major effects on incentives and the quality of care. Thus even though decentralization may be fundamentally an organizational reform, it requires, and in turn influences, financing

reform. Similarly, the mechanisms aimed primarily at increasing resources for health, such as user fees and insurance, require organizational and institutional reform to be implemented successfully.

The combination of mechanisms used for reform and the approach adopted to address the health sector's deficiencies will vary in each country according to several internal factors. Seminar participants identified such factors as, among others, the overall vision of health service development; the existing sources of finance; the current management of finance; the range and type of service providers; and the prevailing economic conditions and other factors outside the health sector, such as rural development, literacy, the political system, and local-level organization (Kutzin 1995a).

An approach to determining what reforms are appropriate or desired was suggested at the seminar. It involves defining a strong vision for health sector development that is elaborated in a national health plan. The plan could use the following questions as a general guide:

- What facilities and services are available in the health sector?
- What is needed to achieve stated objectives?
- What do various interest groups want?
- What can individuals and society as a whole afford?

The Possible Negative Impacts of Financing Reforms on Equity Should Be Taken into Account

The second point raised throughout the seminar was that equity and efficiency are often competing goals. While the intent of financing reforms may be to give the poorest members of society greater access to health services, poorly designed financing mechanisms can have negative effects on equity. For example, equity can be compromised if health financing reforms do not explicitly provide for poor or rural populations and/or if the quality of care is not improved, including improving the availability of drugs.

In some cases, even the intended efficiency gains of reforms can be compromised. For instance, efficiency gains are lost if the rich capture resources targeted toward the poor or if a reform fails to protect the poorest members of society from having to pay for health care.

Many of the discussions during the seminar emphasized the need to create a balance between increasing resources and making health care financially sustainable, and protecting access to health care, especially for the poorest segments of society. In particular, participants noted that reformers should take into account the potential impact of a reform on efficiency and equity prior to its implementation and should pay more attention to this than they have tended to do in the past. They cautioned that in this regard, they should distinguish between willingness to pay—a concept that has recently attracted a lot of interest—from poor households' ability to pay.

The Implementation Process Is Extremely Important for Achieving Successful Reform

The third point that emerged was that even though a policy may be appropriate, it may never be implemented. Political, organizational, and institutional constraints may distort policy proposals, or even prevent their implementation in any form. Thus apart from developing appropriate policies in terms of content, planners should apply careful management strategies to the process of policy formulation and implementation. Such planning could include the following:

- Anticipating problems in, or resistance to, reform proposals and taking steps to deal with these before implementation
- Phasing the introduction of reforms to enable unforeseen problems to be identified and addressed before large-scale introduction
- Negotiating with, and marketing reform proposals to, all stakeholders (for example, other government departments, health care providers, communities, and donors) to help unite disparate interests behind the proposals and lessen opposition at the time of implementation

- Using a systematic approach to reform implementation that recognizes the need to develop the required skills and systems, such as management and administrative skills, information systems, financial tracking and disbursement systems, assessment and monitoring skills, and regulatory frameworks, and to effect organizational and institutional change
- Clarifying the objectives of reform to facilitate the evaluation of the reform process (even clarifying the definitions of terms such as decentralization is essential to planning, implementing, and subsequently evaluating objectives).

Ease of Implementation

Table 1.1 shows the kinds of reforms that are relatively easy to implement. In general, the less radical or complex a reform program is, the easier it is to implement. The seminar discussed how a phased approach to implementation may improve the likelihood of success. A phased approach enables unforeseen problems to be corrected as they arise and allows time to develop broad public support as well as the support of

Box 1.1. Framework for Planning and Evaluating Health Financing Policy

1. Context of reform

- Pre-existing health finance institutions, financial flows, and incentives
- Epidemiological and demographic profile and service utilization patterns
- Macroeconomic and other extrasectoral conditions
- Systems for policymaking, policy analysis, and use of information
- Initial assessment and major perceived problems in the health sector

2. Type of reform

- Description of the specific reforms being implemented
- Intended changes in health finance institutions, financial flows, and incentives
- Description of other relevant reforms being implemented
- Expectation of how the reforms will address identified health sector problems

3. Process of implementation

- Description of the actual process of reform implementation
- New health finance institutions, financial flows, and incentives
- New systems for policymaking, policy analysis, and use of information

4. Assessment of the effects of reforms

- Equity
- Efficiency
- Sustainability
- Acceptability

5. Policy feedback

- Systems and processes for transmitting evaluation information to policymakers
- Integration of evaluation into the policymaking process

6. Synthesis of conditions with consequences for the effects of reform

- The financing reforms
- Other health policies
- Institutional conditions
- Managerial capacity in the health sector
- Extrasectoral factors

Source: Kutzin (1995b).

Table 1.1. Characteristics of a Policy Affecting Its Implementation

<i>Less problematic</i>	<i>More problematic</i>
Simple technical features	Complex technical features
Marginal change from status quo	Comprehensive change from status quo
One-actor target	Multi-actor target
One-goal objective	Multigoal objective
Clearly stated goals	Ambiguous or unclear goals
Short duration	Long duration

Source: Cleaves (1980).

specific interest groups. It also allows time for the development of relevant skills and systems to support the reform. However, to achieve real change, implementing radical reforms may sometimes be necessary (Mogedal, Steen, and Mpelumbe 1995).

A Framework for Planning and Evaluating Health Financing Reform

The participants generally agreed that health financing reforms are complex, their impacts are not fully understood, and their mode of implementation is crucial in determining their success or failure. While this sentiment led some participants to caution against overhasty reform measures, it also emphasized the need to plan thoroughly for both policy formulation and implementation, with planners, wherever possible, learning from other countries' experience, especially other southern African countries.

While no one framework is likely to capture all the elements that require scrutiny and strategic planning, box 1.1 reproduces a useful approach to planning and evaluating health financing policy. Many of the elements summarized in the box featured prominently in the reports and recommendations of the seminar's working groups.

References

- Berman, P. A. 1995. "Health Sector Reform: Making Health Development Sustainable." In P. Berman, ed., *Health Sector Reform in Developing Countries: Making Health Development Sustainable*. Harvard Series on Population and International Health. Boston: Harvard University Press.
- Cassels, A. 1995. "Health Sector Reform: Key Issues in Less Developed Countries." *Journal of International Development* 7(3):329.
- Chernichovsky, D. 1995. "What Can Developing Economies Learn from Health System Reforms of Developed Economies?" In P. Berman, ed., *Health Sector Reform in Developing Countries: Making Health Development Sustainable*. Harvard Series on Population and International Health. Boston: Harvard University Press.
- Cleaves, P. 1980. "Implementation Amidst Scarcity and Apathy: Political Power and Policy Design." In M. Grindle, ed., *Politics and Policy Implementation in the Third World*. Princeton, New Jersey: Princeton University Press.
- Frenk, J. 1995. "Comprehensive Policy Analysis for Health System Reform." In P. Berman, ed., *Health Sector Reform in Developing Countries: Making Health Development Sustainable*. Harvard Series on Population and International Health. Boston: Harvard University Press.
- Gilson, L., and A. Mills. 1995. "Health Sector Reforms in Sub-Saharan Africa: Lessons of the Last 10 Years." In P. Berman, ed., *Health Sector Reform in Developing Countries: Making Health Development Sustainable*. Harvard Series on Population and International Health. Boston: Harvard University Press.
- Gilson, L., S. Russell, and K. Buse. 1995. "The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy." *Journal of International Development* 7(3):369.

- Kutzin, J. 1995a. *Experience with Organizational and Financing Reform of the Health Sector*. Strengthening Health Services Paper No. 8. Geneva: World Health Organization, Division of Strengthening of Health Services, National Health Systems and Policies Unit.
- _____. 1995b. "Health Financing Reform: A Framework for Evaluation." Revised Working Document. World Health Organization, Division of Strengthening of Health Services, National Health Systems and Policies Unit, Geneva.
- Janovsky, K., and A. Cassels. 1996. "Health Policy and Systems Research: Issues, Methods, and Priorities." In K. Janovsky, ed., *Health Policy and Systems Development: An Agenda for Research*. Geneva: World Health Organization.
- Mogedal S., S. H. Steen, and G. Mpelumbe. 1995. "Health Sector Reform and Organizational Issues at the Local Level: Lessons from Selected African Countries." *Journal of International Development* 7(3):349.
- Reich, M. R. 1995a. "The Politics of Health Sector Reform in Developing Countries: Three Cases of Pharmaceutical Policy." In P. Berman, ed., *Health Sector Reform in Developing Countries: Making Health Development Sustainable*. Harvard Series on Population and International Health. Boston: Harvard University Press.
- _____. 1995b. "The Politics of Agenda Setting in International Health: Child Health Versus Adult Health in Developing Countries." *Journal of International Development* 7(3):489.
- Shaw, R. P., and C. C. Griffin. 1995. *Financing Health Care in Sub-Saharan Africa through User Fees and Insurance*. Washington, D.C.: World Bank.
- Walt, G. 1994. *Health Policy: An Introduction to Process and Power*. London: Zed Books.
- _____. 1996. "Implementing Health Care Reforms: A Framework for Discussion." Unpublished paper. London School of Hygiene and Tropical Medicine, London.
- Walt, G., and L. Gilson. 1994. "Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis." *Health Policy and Planning* 9:353-70.
- World Bank. 1993. *Investing in Health: World Development Report*. New York: Oxford University Press.
- _____. 1994. *Better Health in Africa: Experience and Lessons Learned*. Washington, D.C.
- Zwi, A. B., and A. Mills. 1995. "Health Policy in Less Developed Countries: Past Trends and Future Directions." *Journal of International Development* 7(3):299.

2

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.

Box 2.1. Recent Experience in Swaziland

Government and mission facilities provide the bulk of health care in Swaziland. Although both types of institutions charge fees, the rate of fee increases at mission services far outstripped that at government facilities. By 1984, mission facility fees were 50 percent higher and were recovering twice the income than equivalent government facilities. This disparity in fees and collection rates resulted in increasing demand for government services and underutilization of mission services. In some areas where mission facilities were the principal provider of care, however, patients had little alternative but to pay the higher mission fees, which called into question an important goal of the health service: equity of access to care regardless of ability to pay. In response to this growing problem, fee structures at mission and government facilities were standardized so as to remove barriers to access to care; to raise utilization of mission services; and to reduce pressure on government services, particularly hospitals.

An important result of the fee standardization was the loss of income to mission facilities, which the government planned to compensate them for. Combined with such actions as increasing the number of private beds and improving collection practices, the rate of cost recovery in government facilities increased significantly, but still remained well below the rate of mission facilities. Although the utilization of services at mission facilities has increased, the quality of care has suffered and the government has not been able to compensate the missions sufficiently for their loss of revenue. This is partly because revenue collection at government services has not been as high as expected.

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

<i>Effect on</i>	<i>Possible positive impacts</i>	<i>Possible negative impacts</i>
Efficiency	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

mechanism, continuous drug supplies, sound management, and decentralized decisionmaking in which communities are fully involved and the principal implementing agents of effective local strategies.

IMPACTS ON EFFICIENCY, EQUITY, AND UTILIZATION. The impact of user fees on efficiency is linked to their impact on service utilization. If user fees deter individuals from obtaining care when they need it, equity will diminish. An efficient exemption mechanism will protect the very poor from having to pay fees and, therefore, allow them continued access to services. (The very poor are unlikely to make frivolous use of free services because of the large amount of time and high travel costs that they often face.) However, little research has been conducted into how decisions about household expenditures are made, and how user fees affect health seeking behavior is not yet clear. Table 2.1 endeavors to provide a balanced perspective on possible positive and negative consequences of user fees for equity and efficiency.

An important caveat concerning user fee systems is that without careful planning and complementary improvements in the quality of services and in community participation, they are likely to be weak mecha-

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

Box 2.2. Developing and Implementing a Community Health Fund in Tanzania

Tanzania has recently embarked on major health sector restructuring and reform. One component of a range of health financing options includes the implementation of the community health fund (CHF) based on a prepayment system to ensure sustainable, good quality health services in rural areas. Tanzania already has a history of strong local community organization, and this has facilitated the growth of community dispensaries, central institutions in the provision of health care services. The introduction of the CHF coincides with a broad decentralization of health services to the district level.

The CHF aims to broaden the pool of resources available for delivering primary-level care and to share risks and benefits among large pools of households (about 50,000 individuals in each pool). Services to be covered at the health dispensing or clinic level have been clearly defined and include maternal and child health (including deliveries), basic curative and chronic disease care, and preventive and promotive health services. Participating households will be identified by a health card at a cost of US\$2.57 per person per year. At a later stage, hospital services will be added and premiums will rise as a result.

An exemption mechanism has been developed, and those who cannot pay and cannot work in exchange for payment will be given health cards at no cost. However, local communities will provide work in exchange for cards for those who are able to work (such as maintaining roads or building health facilities or housing for health workers).

Members of the scheme will choose a provider where several exist in the village, and may change providers at given intervals if they are dissatisfied with their care. Payment for health cards is expected to be in cash, and the scheme will therefore be introduced at harvest time. After two years of planning and preparation, the first pilot study began in July 1996 and is expected to expand to nine districts in the next two years. After problems encountered in these pilot districts have been addressed, the scheme will expand to other areas.

The scheme relies on effective community leadership, emerging competition among local providers, good financial planning, and a good resource allocation formula to target the poorest. Important assumptions made in preparing the scheme for pilot testing include the following:

- Political approval and support for the scheme exists at both local and central levels.
- Householders will understand the principle of cost sharing and join the scheme.
- The government (and donors) will match the funds local communities raise.
- Health care providers will cooperate and will compete for CHF patients.
- CHF members will be able to distinguish between good and poor providers.

At the same time, the planning process has identified several risks to successful implementation, namely:

- Unanticipated problems deriving from the political or economic climate or operational problems may cause the CHF plan to be delayed or shelved.
- Capacity at the district level may be inadequate to support smooth implementation.
- Inflation may erode the value of CHF contributions, and thus CHF purchasing power over time.
- Both the fund itself and the payment collection process may be vulnerable to financial mismanagement.

- 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 by-pass 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

<i>Positive effects on equity</i>	<i>Negative effects on equity</i>
<ul style="list-style-type: none"> • Richer people cross-subsidize care for the poor. • More people have access to good quality care. • Prepayment is well-suited to self-employed farmers, who tend to be poorer at some times of the year than others. • Prepayment and decentralized control over resources by communities often help redress geographical inequities in public expenditures for health. 	<ul style="list-style-type: none"> • 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. • 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.

- *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.

Box 2.3. Zimbabwe's Experience with Health Insurance

Zimbabwe is currently exploring the feasibility of introducing a social health insurance scheme as part of a broad reform program aimed at improving efficiency and increasing equity in its health service. The social health insurance fund will be developed out of the existing private, industry, and employer-based health insurance schemes, of which 23 currently exist. It ultimately aims to incorporate the entire population.

The objectives of the social health insurance fund are to increase coverage, accessibility, and equity by increasing the resources available for health care in the public sector and improving cost-effectiveness and cost recovery programs. A new, central organization that will cooperate with local organizations will administer the scheme. Participation will be mandatory for those in formal employment, with wage-based premiums collected through payrolls. The informal sector will participate on a voluntary basis, with payments timed for ease of payment, for instance, after the harvest.

The benefits package will be clearly defined, and all patients will have a choice of health care provider. Providers will be reimbursed on a capital grant system. Public sector providers will retain a percentage of the funds collected for local health activities, while the government will subsidize administration, management, and supervision costs. The capital grants system aims to promote competition between providers, thereby improving quality, efficiency, and value for money.

At this stage, the authorities are planning a pilot test of the social insurance fund using one province as a model. The pilot test will evaluate client views, the conditions for and logistics of establishing the fund, the fee collection process, management issues, and concurrent cost containment activities. Local capacity will be assessed and strengthened as necessary. Current plans to decentralize Zimbabwe's health service will be accelerated in the pilot province, as decentralization is considered a prerequisite for successful implementation of the social insurance fund.

The planning process is just beginning and many hurdles still have to be overcome. The planning and implementation stages will be conducted slowly and carefully to learn from mistakes early on in the process. Nonetheless, many potential problems have been identified already, and include substantial problems, such as the lack of community participation in health care in the past, the absence of managerial and analytical capacity at the local level, the inexperience of public sector providers, and the lack of experience with decentralization.

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

Table 2.3. Conditions Required to Make Expanding Insurance to the Employed Population Feasible

<i>Condition required</i>	<i>Description</i>
Size of target population	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.
Quality of health service infrastructure	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.
Contribution collection mechanisms	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.
Specialized and general education	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.
Legal and regulatory framework	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.
Other conditions	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.

amount spent. Employers will want benefits for their workers, but low premiums to keep the costs of production 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.

Box 2.4. Scenarios for Achieving Equity Goals through Formal Insurance

1. The newly insured population switches from relying on "free" public care to cost-sharing schemes, thereby freeing up public resources for the uninsured.
2. The newly insured population continues to use publicly provided care, but the following conditions must all be met:
 - Insurance must cover the full cost of public care.
 - The health resources released by insurance payments must be greater than the subsidies used to expand insurance cover plus administrative costs.
 - Any net gain in health revenues is targeted to the uninsured.

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

		<i>Provision</i>	
		<i>Public</i>	<i>Private</i>
<i>Financial</i>	<i>Public</i>	<ul style="list-style-type: none"> • Government funding and provision • Care free at point of service • National health service 	<ul style="list-style-type: none"> • Services contracted to private providers • Government subsidy to mission facilities
	<i>Private</i>	<ul style="list-style-type: none"> • Supplementary direct user charges • Private beds in public hospitals 	<ul style="list-style-type: none"> • Private health care funded by private insurance • Health maintenance organizations • Services by nongovernmental organizations

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

Box 2.5. Continued

Outsourcing takes several forms. Some government health departments are planning to use private companies for nonclinical services such as laundry, catering, and vehicle maintenance. Proposals to develop a district health system and planned reforms to the delivery of primary care both consider the possibility of using accredited private providers to deliver care to public patients on a capitation or other basis. For example, in one area private doctors provide care to public patients in exchange for bed privileges in the local public hospital.

With the planned advent of mandatory hospital insurance coverage for the formally employed, private insurance companies will develop hospital insurance packages that rely on public facilities (at cost recovery rates) for service delivery. The cost will still be cheaper than private health care provision. Public hospitals may start responding by improving room amenities, serving better food, and so on.

An important shortfall in the capacity for collaboration is the absence of adequate information systems and standards by which to monitor services. Mistrust exists between the public and private sectors, and while the private sector is searching for ways to remain sustainable, the public sector is looking to redress the serious imbalances in access to health care and the health care professions inherited from the apartheid era.

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

<i>Effect on</i>	<i>Positive effects</i>	<i>Negative effects</i>
Efficiency	<ul style="list-style-type: none"> • Better use of available resources. • Higher outputs for resource inputs where private companies can perform better. • Comprehensive health services would decrease opportunity costs and missed opportunities. 	<ul style="list-style-type: none"> • Private sector fee-for-service payments may be inefficient, motivating physicians to over-prescribe services. • Lack of monitoring capacity or contract negotiating skills may lead to inefficient private contracts.
Equity	<ul style="list-style-type: none"> • 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. • Comprehensive health services would increase equity of access. 	<ul style="list-style-type: none"> • 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).
Sustainability	<ul style="list-style-type: none"> • Pooling resources in the public and private sectors might increase sustainability. 	<ul style="list-style-type: none"> • Prices are pushed up through collaboration (e.g., fee-for-service or contract monopolies).

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

Box 2.6. The Health Sector Recovery Program in Mozambique

Mozambique has emerged from a long period of civil strife, when it lost many gains in the delivery of primary health care to its largely dispersed population. During this time, access to rural areas was diminished, and combined with large movements of people into urban areas, many PHC facilities were lost or became nonfunctional. In addition, resources were put into urban areas to meet the growing demand for care. Now that the government once more has access to rural areas, the delivery of PHC is back at the center of the health system's agenda. Declining external support has further signaled the need to restructure health services to improve efficiency and equity. By developing a strategic plan of action, Mozambique intends to direct resources away from urban areas, especially hospitals, to rural health centers and health posts.

The reconstruction plan that is driving the reform process initiated an evaluation of existing facilities, human resources, and problems. Based on this evaluation, the government has developed a strategy for upgrading existing facilities that focuses on rehabilitating facilities, training health personnel, improving drug supplies, strengthening managerial capacity at provincial and district levels, decentralizing health services, and improving the coordination of donor funding. The plan sets targets for achieving quality improvements, upgrading the number of trained staff, and expanding the PHC infrastructure. The rehabilitation of district hospitals is an important component of expanding the PHC network.

Initiatives aimed at improving financial sustainability include raising user fees, improving collection procedures, and exploring the possibility of a community prepayment scheme.

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.

Box 2.8. South Africa: Hospital Efficiency on the Agenda

Several factors are contributing to a growing funding gap in South Africa's public hospital system. Tight fiscal policy has led to slow real growth in the overall health budget, a situation made worse by the rapid pace of reallocations of health budgets, both between provinces and between hospitals and primary health care services. This circumstance has been aggravated by the deteriorating capacity of the hospital system to recover costs through user fees. These developments have had a severe impact on the hospital system, leading to poor staff morale, low quality of care, and declining public confidence in the hospital system.

To address these multiple and severe problems, a new vision is required for the public hospital system that consists of at least the following specific strategies:

- Ensuring adequate funding of the public hospital system through decisions about what size of hospital system is affordable (including the total bed stock and staffing complement) and about how to improve cost recovery by public hospitals
- Rationalizing and reallocating hospital resources on the basis of detailed, nationally accepted, and affordable guidelines that include such items as bed to population ratio and staff to work load ratio
- Restructuring the hospital system into an appropriate referral hierarchy
- Developing a system for rational planning of future resource allocations
- Ensuring efficient resource use at the hospital level by strengthening hospital management capacity and developing detailed clinical guidelines for district, regional, and central hospitals
- Developing efficient and accountable hospital management systems
- Ensuring effective labor relations policy and management
- Creating effective relationships between the public and private hospital sectors that contribute positively to the public hospital system.

The critical implementation steps for such a vision are

- Developing consensus at the provincial and national levels, as well as with key stakeholders, on goals and strategies
- Ensuring that hospital policy issues are high on the general policy and political agenda of the public health sector
- Developing an appropriate, workable timetable for hospital reform.

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 their 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.

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

<i>Allocative efficiency</i>	<i>Technical efficiency</i>
Put in place an efficient referral network: <ul style="list-style-type: none"> • Ensure adequate PHC facilities • Establish incentives to attend lower level services first (such as higher fees for non-referred patients) • Improve satellite hospitals 	Management: <ul style="list-style-type: none"> • Information systems • Support services (contracting out, improved efficiency, standardized equipment needs) • Drugs policy (activate essential drug lists, improve distribution mechanisms, reduce waste and theft) • Management system (use professional managers, boards, or trustees)
Monitor hospital performance: <ul style="list-style-type: none"> • Establish performance norms • Gather information on outputs and quality • Introduce incentives to achieve agreed standards • Grant autonomy to individual hospitals 	Human resources policy: <ul style="list-style-type: none"> • Direct control over staffing needs (hiring and firing, job descriptions) • Better employment packages (nonfinancial benefits, incentives to work in rural areas) • Clear job descriptions for management, clinicians, and support staff • Staffing norms, including mix of personnel, skills • Clinical treatment protocols
Coordinate with the ministry of finance: <ul style="list-style-type: none"> • Introduce performance-based budgeting, which requires benchmarks, accounting and financial planning capacity, information • Make contracting arrangements • Arrange payments to hospitals 	Cost recovery mechanisms: <ul style="list-style-type: none"> • Fees retained at the point of service • Higher fees for private patients (matched by incentives to attract private patients, such as better hotel-type services) • Good accounting capacity and means-testing mechanisms

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-

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.

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

Box 2.10. Using Donor Funding Effectively: The Case of Zambia

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.

Part II—Overview Papers

3

The Lessons of User Fee Experience in Africa

Lucy Gilson

*Center for Health Policy, Department of Community Health,
University of Witwatersrand, South Africa,
and Health Economics and Financing Programme,
London School of Hygiene and Tropical Medicine, United Kingdom*

User fees for health services are not new in Africa. A few countries in anglophone Africa, for instance, Ethiopia, Namibia, and South Africa, have had national user fee systems for years, while in many others, charges have historically been applied in both governmental and nongovernmental facilities (Nolan and Turbat 1995; Russell and Gilson 1995). However, since the 1980s the number of African countries implementing some form of user fee system has grown considerably. Governments have come to see user fees as a critically important alternative to tax-based financing for government health services in Africa, even in countries such as Kenya and Tanzania, which had previously provided government care free at the point of use. Recent surveys show that most African countries have now introduced some form of fee system for government facilities. Fourteen of the 15 African countries Russell and Gilson (1995) surveyed and 28 of the 37 African countries Nolan and Turbat surveyed (1995) have done so.

This chapter focuses on African countries' experience with introducing and implementing user fees for health care to draw lessons concerning their potential as a mechanism for supporting sustainable health care financing and the critical issues that need to be considered in implementation. It draws heavily on a number of cross-country reviews of user fee experience. These reviews emphasize that countries have not realized many of the theoretical benefits of user fees because of implementation difficulties. Thus presenting case studies of good practice is difficult. Rather, the most discernible lessons pertain to implementation problems and requisites for surmounting them.

Objectives of Fee Systems

National policymakers cite raising revenues as their main objective for introducing user fees. Subsidiary objectives stress that revenues are needed to improve services, for example, by improving drug availability and the general quality of health care and extending coverage (Nolan and Turbat 1995; Russell and Gilson 1995).

Although never explicitly identified as an objective of user fees, the desire to raise revenue and improve services can presumably be related to a concern to enhance the sustainability of health systems. Financial sustainability can be defined simply as generating sufficient reliable resources to enable continued and improved provision of health care for a growing population. However, a broader definition, rooted in review of the role of external support to health systems, suggests that system sustainability is the capacity of the health system to function effectively over time with a minimum of external inputs (La Fond 1995). Achieving sustainability in this sense requires the capacities to

- Secure sufficient resources to enable improvements in the effectiveness of health care
- Use resources effectively and efficiently to meet health needs
- Perform these functions on a continuous basis
- Perform these functions with minimum external inputs.

In other words, generating revenues through some sort of financing mechanism is insufficient by itself to ensure sustainability. Additional measures to redress existing inefficiencies in resource use and to enable any additional revenue to be used effectively over time are vital elements of a sustainable and effective user fee system (Adams and Harnett 1995; Gilson 1995).

International analysts have also suggested that using revenues from user fees to improve the quality of services will generate efficiency and equity gains through their impact on utilization (Griffin 1992; Shaw and Griffin 1995; World Bank 1987, 1993).¹ However, while some countries have employed user charges to foster efficiency-related objectives, such as discouraging unnecessary use and preventing by-passing of lower level facilities, only one of the countries surveyed by Nolan and Turbat (1995) explicitly identified improving equity as an objective.

Fee System Models

Nolan and Turbat (1995) identify two broad models of user fee systems that African countries have adopted. The differences in these models may underlie some of the differences in country-specific objectives.

The standard model is rooted in concern about existing inefficiencies and inequities within health care systems around the world. It assumes that fees not only produce resources, but also offer efficiency and equity benefits. Efficiency benefits result from the introduction of price signals, which offer patients incentives for using the referral system appropriately, and facilitate the reallocation of resources to more cost-effective primary health care. The equity benefits result from the use of resources in ways that benefit the poorest (such as improvements in the coverage and quality of primary-level care), and from the use of exemptions or differential charges within fee systems to protect the poor from their full burden (Gilson, Russell, and Buse 1995). This model might be applied nationwide within a country initially for curative hospital services, but also accompanied by decentralization over the control of resources to regional or district levels. This would facilitate the use of revenues in ways that promote efficiency and equity.

In contrast, the Bamako initiative (BI) model is rooted in Africa's experience of poor primary-level care (Jarrett and Ofosu-Amaah 1992). The model emphasizes that revenues should be raised and controlled at the primary level through community-based activities that are national in scope, and so are distinguished from "more isolated attempts to initiate community participation and financing in health services" (McPake, Hanson, and Mills 1992, p. 10). The BI model sees community participation in management as the critical mechanism for ensuring that revenues are used in ways that address the persistent quality weaknesses of primary care, and that the health system is accountable to the users of health care. Thus under this model,

1. Shaw and Griffin (1995) cite evidence of people's willingness to pay in several contexts, whereas other analysts emphasize the difference between willingness to pay and ability to pay and the need to investigate these two dimensions separately (for example, Gilson 1988; McPake 1993; Russell 1996).

the community should determine the financing mechanism that is adopted, which might be a user fee system (with or without a community-determined exemption mechanism), prepayment, or some form of local taxes. Overall, "the attainment of sustainable financial resources, assured essential drugs and sound management, and decentralized decision-making in which the communities themselves are fully involved, are the principal strategies" of BI programs (Jarrett and Ofosu-Amaah 1992, p. 166).

Francophone countries appear to be more likely to implement the BI model of community financing than the standard model (Nolan and Turbat 1995), while anglophone and lusophone countries may implement both models at once. For example, Kenya has both a BI program to initiate, fund, and sustain community-level pharmacies in some districts, and a national cost-sharing program in which the government has gradually introduced user fees across all levels of government facilities except dispensaries. Both programs were first initiated in 1989. The BI programs built on earlier experience with community-based health care initiatives, whereas the cost-sharing program reversed the previous policy of no charges at government facilities.

The design of both models suggests that sustainability is an implicit objective. Its proponents see the BI model in particular as a strategy "towards the long-term sustainability of PHC [primary health care] into the next century" (Jarrett and Ofosu-Amaah 1992, p. 165). It is intended to raise revenues and ensure effective resource use through the development of community management capacity, and thus permit self-reliance. Although less strongly emphasized, the decentralization of control over resource use to regional or district levels, identified as an element of the standard model, can also be seen as a strategy for developing the capacities necessary to ensure sustainability. Nonetheless, no country, even those engaged in implementing BI programs, has identified actions important for sustainability, such as developing community management or enabling community participation, as ultimate objectives of their fee systems (Nolan and Turbat 1995; Russell and Gilson 1995). The failure to emphasize such objectives for fee systems may explain some of the implementation difficulties that countries have experienced.

Impacts on Efficiency, Equity, and Sustainability

The available evidence about the potential impact of fees is both limited and equivocal. The most commonly available information concerns the impact of fees on utilization levels and patterns and the amount of revenues raised through fees.

Utilization, Efficiency, and Equity

The efficiency and equity impact of fees depends partly on their influence over utilization patterns. In addition, fees may influence provider behavior, and so have consequences for efficiency, while fee systems may be associated with parallel actions that influence the distribution of benefits and burdens associated with using health care (which is critical for equity). The evidence about these effects is, however, conflicting, because fee systems have been implemented in different ways in different countries, and often not as theory suggests would be best practice. The following summary of impacts is largely drawn from four recent reviews of experience: Gilson and Mills (1995); Gilson, Russell, and Buse (1995); Kutzin (1995); Nolan and Turbat (1995).

With respect to efficiency, the impacts are as follows:

- Although the supporting evidence is limited, in theory, fees may encourage more efficient utilization patterns if
 - They are graduated by level of the system
 - A by-pass fee is introduced in areas where the primary care network is adequate, and referred patients are exempted at higher levels of the system

- They are associated with quality improvements that promote utilization at the primary level.
- Lack of coordination within a fee system may generate inappropriate utilization patterns. For example, when lower levels of the health system charge higher fees than higher levels of the system, this is likely to encourage greater use of less cost-effective care. Again, limited evidence is available to support this contention.
- Investigators have shown that fees encourage inefficient provider behavior, such as overuse of unnecessary services or polypharmacy, when the resulting revenue is retained at the point of collection (see Kutzin 1995 on China; McPake, Hanson, and Mills 1992 on BI programs).
- As the travel and time costs of seeking care are usually high, there is unlikely to be any unnecessary utilization (“frivolous use”) to discourage through fees (Abel-Smith and Rawall 1992).

With respect to equity, the impacts are as follows:

- Fees by themselves tend to dissuade the poor from using health services more than the rich and are associated both with delays in accessing care and with increased use of self-medication and informal sources of care (Booth and others 1995).
- Evidence suggests that if fees are associated with quality improvements, as in community financing schemes of the BI type, this offsets their negative impact on utilization, and the introduction of fees plus quality improvements may even generate utilization increases among the poorest (Litvack and Bodart 1993).
- A few studies show that the nature of the payment mechanism has an important influence on its utilization and equity impact. 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 (Diop, Yazbeck, and Bitran 1995), but fees levied for services received (such as drugs) are less likely than general consultation fees to discourage utilization (Collins and others 1996).
- Fees do not appear to generate adequate revenue or to be associated with the resource reallocations necessary to enable substantial and sustained improvements in health care for the poor.
- The implementation of both formal and informal exemptions or sliding scales that could protect the poor from the full burden of fees is usually ineffective, because they do not in practice protect the poor, and may instead benefit more wealthy groups, such as civil servants.
- The differential implementation of fees between geographical areas within a country can create geographical inequities, particularly if regions whose income levels differ are expected to recover similar proportions of their costs.
- No investigations have been carried out of poorer households’ ability to pay fees, that is, of the impact of fees on household budgets, on consumption and investment decisions, and therefore on the processes contributing to sustainable livelihoods and the household production of health.¹ Yet the limited available evidence suggests that in Zambia, for example, “sizable numbers of people who require medical attention and have previously obtained it are staying at home, and in some cases, dying, because they cannot afford to pay” (Booth and others 1995, p. xi).

Overall, therefore, fee systems represent weak mechanisms for improving the efficiency of utilization, and may promote inefficiencies in provider behavior. At the same time, the way that fee policies have been implemented in the past has prevented the realization in practice of the potential benefits of fees plus quality improvements. Instead, fees have sometimes had the unintended and undesirable effect of exacerbating existing inequities.

Revenue Generation and Sustainability

Experience indicates that national user fee systems have generated an average of only around 5 percent of total recurrent health system expenditures, gross of administrative costs (Gilson, Russell, and Buse 1995;

Table 3.1. Cost Recovery Levels in National User Fee Systems, Selected Countries and Years (percent)

<i>Country and year</i>	<i>Cost recovery level^a</i>
Belize, 1989	2.0
Botswana, 1983	2.8
Burkina Faso, 1981	0.5
Burundi, 1982	4.0
Côte d'Ivoire, 1986, 1993	3.1, 7.2
Ethiopia, 1984–86	15.0–20.0
Ghana, 1987, 1990–91	12.0–13.0, 5.0–6.0
Guinea Bissau, 1988	0.5
Kenya, 1993	2.1
Lesotho, 1991–92	9.0
Mali, 1986	1.2–7.0
Mauritania, 1986	12.0
Mozambique, 1985, 1992	8.0, 1.0 or less
Senegal, 1986	4.4–7.0
Swaziland, 1984–85, 1988–89	2.2, 4.6
Zimbabwe, 1991–92	3.5

a. Ranges reflect differences in reported figures.

Source: Gilson, Russell, and Buse (1995).

Kutzin 1995; Nolan and Turbat 1995). Experience also suggests that revenue levels vary over time, sometimes increasing because of improved implementation practices, but sometimes falling as a result of inflation or such problems as war or economic recession. Thus while some countries have achieved higher levels of cost recovery than others, their sustainability is unclear. Ghana, for example, initially managed to recover more than 10 percent of total recurrent government expenditure, but this fell to around 5 percent after a few years (table 3.1).

Fees may, nonetheless, generate considerable proportions of the total nonsalary recurrent expenditure within individual health facilities, for example:

- In BI districts of Benin, 43 to 58 percent of recurrent costs
- In some health zones of Zaire, 97 percent of nonsalary operating costs (Creese and Kutzin 1994)
- In Guinea, more than 100 percent of operating costs (Knippenberg and others 1990).

This revenue may enable significant quality improvements at the facility level, and has certainly led to an improvement in perceived quality in some community financing schemes of the BI type (Kutzin 1995). Nonetheless, the available information suggests that revenue generation from user fee policies in public facilities will likely be inadequate to address the large and growing resource gap that is causing the quality shortfalls that exist in public (as well as in most private) health facilities in many African countries (Gilson, Russell, and Buse 1995; La Fond 1995; Nolan and Turbat 1995; Russell and Gilson 1995).

In many African countries revenue generation levels are constrained by the need to keep fees low, because household income levels are low. In addition, the administrative costs of implementing a fee system, including the costs of the exemptions necessary to safeguard equity and public health objectives, further reduce cost recovery levels (Gilson, Russell, and Buse 1995). Poorer, rural areas will inevitably generate lower levels of income as a result of both influences.

Weak accounting and resource management practices and skills further undermine revenue generation levels. Assessing the impact of fees on system sustainability, therefore, also requires consideration of the contribution of fee systems to the development of the other capacities required to achieve sustainability. Yet this is an area that few studies have specifically assessed. A few country experiences demonstrate the limited impact of user fees on system sustainability.

Two Tanzanian studies of decentralization (Gilson, Kilima, and Tanner 1994; Mogedal, Steen, and Mpelumbe 1995) suggest that a chicken and egg relationship exists between user fees and decentralization policies, which both fee system models emphasize as being important for sustainability. Although limited financial resources undermine the effectiveness of decentralized administration, the effective implementation of a user fee system to redress that constraint would itself require a strong, decentralized management structure. According to Mogedal, Steen, and Mpelumbe (1995, pp. 363, 366):

The districts are not well equipped for meeting the challenges of diversity, cost effective care, intersectoral action and cost sharing. . . . When new policies are introduced, they are not followed by appropriate attention to structures, and changes in structures and systems are not sufficiently linked, leading to a situation when the desired improvements do not take place. Reforms such as . . . user fees may contribute to lower quality, and weakened accountability and transparency.

In Niger, Diop, Yazbeck and Bitran's (1995, pp. 234–35) analysis of pilot cost-recovery schemes led to the conclusion that

For access to quality health care for rural populations to be sustained, cost recovery should not only be accompanied by quality improvement measures, but also by cost containment measures. . . [such as] drug policies which promote the acquisition of essential generic drugs in competitive markets, and human resource programs which strengthen management capacities and control drug consumption costs at health facility and district levels.

Kenyan experience (Collins and others 1996; Russell and Gilson 1995) emphasizes the importance of establishing good management systems to complement user fee systems, by guiding local-level decisionmaking and ensuring appropriate control of resource use (box 3. 1).

Overall, therefore, although fees do generate revenues that can make some difference to the perceived quality of individual health facilities, fees must be complemented by a broader range of actions if they are to enhance the sustainability of health systems.

Bottlenecks to Effective Implementation

Experience suggests that four groups of constraints undermine the effective implementation of fee systems (Collins and others 1996; Gilson and Mills 1995; Gilson, Russell, and Buse 1995; Kutzin 1995; Nolan and Turbat 1995) as follows:

1. Poor design of fee systems as shown in
 - Complex fee structures that are difficult to administer, for instance, itemized billing
 - Types of fees, such as general consultation fees, that deter patient utilization because they are not linked to care received
 - Failure to revise fees annually in line with inflation, thereby undermining the amount of revenue generated
 - Complex and/or unworkable exemption mechanisms, which require too much information and are costly to administer
 - Fees implemented at low levels within the system where little revenue can be generated
 - Lack of coordination between fee levels across the health system, possibly generating perverse utilization incentives, for instance, to use higher level care before lower level care, and inequities, for example, inappropriately differentiated fee levels between areas.
2. Poor capacity for local-level financial management and fee system implementation as shown in
 - Lack of financial management skills throughout the health system, but especially at the district or community level
 - Absence of appropriate financial management information and audit systems that support management rather than simply seeking to prevent misuse of finances

Box 3.1. Kenya's Facility Improvement Fund

Key design features of Kenya's Facility Improvement Fund include

- Collecting facilities retain 75 percent of revenues collected and return the remaining 25 percent to the district to be used for preventive and promotive care.
- The Health Care Financing Secretariat of the Ministry of Health provides national guidelines to the district and hospital management bodies responsible for revenue use at the local level.
- The guidelines identify eleven items on which Facility Improvement Fund revenues can be expended within facilities (for example, maintaining building, obtaining emergency drugs, setting up and operating amenity wards for paying and insured patients, preparing public information materials) and prevents their use for items funded by basic budget allocations.
- At the hospital level, the hospital management team prepares an annual Facility Improvement Fund expenditure plan, which is scrutinized and approved by a range of bodies at the district level, some of which include representatives of the wider community, before it is sent to the Health Care Financing Secretariat for final approval.
- A group within the district health management team prepares an annual plan for the use of the 25 percent of revenues submitted to them, which is again scrutinized and approved by various bodies at the district level, some of which include representatives of the wider community, before being sent to the secretariat for final approval.
- New accounting and reporting systems were introduced throughout the system to enable review of total revenues earned relative to services provided (including exemptions).

- Lack of information with which to target the poorest effectively through exemptions
- Limited local authority to take appropriate resource use decisions without reference to higher authorities
- Limited effectiveness in collecting fees, thereby undermining revenue generation rates and revenue use for quality improvements
- Lack of guidance on financial management and control practices, for instance, on how to determine who is eligible for exemptions, on how to account for revenue generated, or on procedures for using revenues
- Failure to retain fees locally, thereby undermining the incentive to collect them and use them for local-level quality improvements
- Total retention of revenues locally, leading to limited redistribution of resources between geographical areas with different capacities to raise revenues
- Absence of procedures that would allow monitoring of the impact of policy implementation.

3. Weak supporting systems as demonstrated by

- Poor quality public services that undermine the population's willingness to use them, for instance, drug shortages or poor staff attitudes
- Inadequate human resource policies that do not promote or sustain staff morale
- Inadequate drug supply and distribution systems
- Operational inefficiencies within the health system that contribute to quality failures, for example, drug wastage and abuse, leading to shortages
- Limited funding for the supervision and support needed at the primary level
- Inadequate management information systems that do not, for example, allow resource use to be related to services provided
- Organizational structures that generate weak and conflicting lines of accountability, both downward to the community level or upward to technical supervisors.

4. Contextual constraints such as

- The population's lack of experience in paying for public health services, which generates an unwillingness to pay for them, especially when they perceive the services as providing only low quality care
- The weak banking and communication systems, which undermine local-level financial management and the potential for support

- A variety of sociocultural and political constraints at both the local and national levels that allow richer groups to be incorrectly exempted and prevent the reallocation of resources to primary health care, which would benefit the poorest members of society the most.

Lessons of Experience

Experience has provided some useful lessons in terms of where and when to implement fees, how to design more effective fee systems, and how to implement fee systems.

Where and When to Implement Fees

The first lesson of experience is that the current practice of fee system implementation has clear potential to harm equity, has only a limited impact on the efficiency of utilization, and ensures that fees by themselves are only weak mechanisms for achieving sustainability.

Focusing on the standard model, (Gilson, Russell, and Buse 1995, p. 391) conclude that "reaching the poor through public policy is not a simple process of aiming at a target. Numerous factors will mediate and alter policy outcomes, ensuring that effective implementation does not follow rational analysis." In their review of schemes of the BI type Nolan and Turbat (1995, p. 45) also suggest that "concentrating the implementation of meaningful cost recovery at the health center or health post means that the greatest potential source of revenue is not being exploited. Moreover, such an approach is likely to have adverse efficiency and equity implications."

In addition, the potential impact of fees on absolute affordability is critically important to their equity impact, and yet this issue remains underresearched. In the constrained economic contexts many African countries face, household strategies for coping with the parallel demands of reduced household income and increased prices for basic household needs are already overstretched (Kanji and Jazdowska 1993; Pinstrup-Anderson 1993). Thus payment of increased health care fees will represent an unacceptable burden on households that may lead them to delay seeking treatment, to use informal, and less effective sources of health care, or to marginalize impoverished families further (Booth and others 1995; Gilson 1988; Russell 1996). According to Russell and Gilson (1995, p. 68), researchers should pay more attention to understanding better the mechanisms mediating the impact of fees on ability to pay:

In particular, their [fees'] potential effect on different types of household and user behavior needs to be assessed. This may involve willingness and ability to pay studies and more qualitative research exploring community responses to user fees. Such research may indicate, for example, that fees in some rural settings within a country are inappropriate due to the large proportion of patients who would need exemptions, the lack of revenue such fees would generate, and the impact that such fees would have on financial access to essential services in the area (see also Adams and Harnett 1995).

Generating higher revenue levels without harming equity only appears possible where risk-sharing arrangements allow fees to be charged that cover costs for those insured against the need for hospital care (Nolan and Turbat 1995). Studies indicate that hospitals in Brazil, China, Korea, and Zaire can recover close to 100 percent of total hospital recurrent expenditure by setting fee levels that are high relative to costs, and by having fairly widespread insurance systems that reimburse hospitals for insured patients (Barnum and Kutzin 1993). A longitudinal survey of Kenya's experience with user fees indicates that between 1991 and 1992, the level of fee revenue generated by provincial hospitals tripled and that generated by district and subdistrict hospitals doubled. This occurred as a result of increased prices and strengthened billing systems that, in particular, tapped resources from those covered by health insurance. In the first six months of 1993, 62 percent of the total revenue generated at provincial hospitals and 48 percent of that generated at district hospitals came from National Hospital Insurance Fund claims and cash fees.

As a result of such experiences, various analysts suggest that fee implementation should focus on the hospital level and should be associated with risk-sharing mechanisms and exemptions (Adams and Harnett 1995; Barnum and Kutzin 1993). Nolan and Turbat (1995), for example, propose the following three alternative strategies for increasing cost recovery at this level:

- The imposition of *substantial in-patient fees*, combined with the promotion of insurance for the formally employed and the provision of generous exemptions
- The imposition of *substantial fees for private wards* in public hospitals selected only by those willing to pay more for better hotel-type services, possibly combined with the promotion of insurance coverage for the formally employed
- The imposition of *affordable fee levels* using simple fee systems, such as a per day fee up to a maximum level, in conjunction with some exemptions and much improved collection procedures.

The choice of strategy depends on the extent of institutional capacity, and the first option requires much greater capacity than the other two.

Overall, therefore, the evidence suggests that governments should exercise caution in introducing fees for three main reasons. First, reviewing the level of the health system at which to introduce fees remains important, even where the alternatives seem limited. Second, seeing fees as part of a wider package of health care financing policies rather than as the central or only strategy for addressing current resource constraints is also important. Within this package, fees may be a first step toward, for example, developing risk-sharing mechanisms, but should not be seen as an end in themselves. Third, as “managerial and organizational factors are central determinants” (Kutzin 1995, p. 16) of the impact of fees on key health sector goals, any fee system must be devised carefully.

Designing More Effective Fee Systems

The bottlenecks to designing and implementing effective fee systems point to various lessons for the design of any fee system (see table 3.2). However, these lessons also have more general relevance, because they emphasize the need for a policy package to complement and support the introduction of fees.

The Process of Implementation

Addressing the problems of effective fee policy implementation requires consideration of the process of policy development and implementation. The influence of contextual factors over effective design, for example, requires consideration of how to promote a supportive environment in which to introduce fees. Recent reviews of health sector reforms also point to the importance of a comprehensive, rather than selective, process of reform, based on careful analysis of problems, and leading to the development of appropriate implementation strategies (Frenk 1995; Mogedal, Steen, and Mpelumbe 1995). Possible stages in such a process include the following:

- Stage 1
 - Identifying problems likely to affect the implementation of a broad fee system design, such as poor quality health care, lack of willingness to pay, opposition from critical stakeholders
 - Collecting baseline data by which to assess the impact and effectiveness of implementation, for example, ability to pay data
- Stage 2
 - Reviewing the fee system design and planning ahead of time how to deal with the problems likely to be encountered during implementation as far as possible
 - Identifying the factors constraining and facilitating effective implementation
 - Developing strategies to offset likely constraints to implementation

Table 3.2. Lessons of Experience for Policy Design

<i>Fee system design</i>	<i>Complementary government policies</i>	<i>Contextual support</i>
<ul style="list-style-type: none"> • Implementing simple fee structure linked to treatment received, for example, prescription fee • Having affordable price levels • Using simple to apply exemption categories wherever possible, for example, focusing on users' characteristics or including some simple procedures for identifying the poorest • Advertising the price structure within health facilities • Coordinating the price structure across health system levels, for example, graduated between levels • Readjusting prices periodically • Retaining some revenue at the point of collection for use in quality improvements • Providing guidelines to promote revenue use for quality improvements • Developing community management mechanisms at the primary level 	<ul style="list-style-type: none"> • Implementing a financing policy framework • Maintaining existing levels of government funding for the health system as a whole • Developing complementary risk-sharing financing mechanisms • Developing a resource reallocation mechanism favoring relatively underresourced geographical areas and more cost-effective services • Promoting community solidarity mechanisms that can assist the poorest • Developing community management mechanisms that ensure accountability at the community level • Implementing policies to support sustainability • Developing an effective reward and discipline system for health staff, including training • Instituting an effective drug procurement and supply system • Ensuring effective management and clinical supervision and support for the local level • Putting in place management-oriented information systems that allow monitoring, for example, by providing data on revenue collected and revenue use patterns • Developing skills and systems to enable decentralization over the control of collected fees • Establishing effective audit procedures to ensure accountability at the local level 	<ul style="list-style-type: none"> • Developing institutional capacity within the health system to provide support to local-level decisionmakers • Developing adequate leadership and advocacy skills within the health sector to develop political support for appropriate design and policy • Providing wider institutional support, for example, banking and communication facilities • Ensuring consumers' willingness and ability to pay • Developing professional ethics to counterbalance health workers' responsiveness to financial incentives

Source: Bennett, Russell, and Mills (1996); Gilson and Mills (1995); Jarrett and Ofosu-Amaah (1992).

- Stage 3
 - Taking steps to develop key prerequisites for effective implementation
 - Initiating the initial implementation of fees
 - Monitoring the impact and effectiveness of fees
 - Instigating operational research to support implementation
- Stage 4
 - Reviewing and revising the approach to fee implementation
 - Starting the next stage of implementation.

Mogedal, Steen, and Mpelumbe's (1995, p. 366) study of health sector reforms and organizational issues in Botswana and Tanzania emphasizes the importance of stages 1 and 2:

Critical dysfunctions in the system need to be thoroughly analyzed to decide how they relate to policy and structures as well as systems . . . Our findings may suggest that reform is likely to be more successful if undertaken in a situation where there is public demand on the system for better quality and higher relevance. This will make it more of a political issue, and help to hold health workers accountable.

A review of Kenyan experience (Collins and others 1996) that compared an initial implementation strategy involving the introduction of fees across all facilities simultaneously, and a system in which fees were introduced in a phased manner, also indicates the influence of the implementation strategy on the impact of a fee system. According to Collins and others (1996, pp. 60–61) the first approach

did not permit testing of fees and systems, proper training of staff or adequate supervision. As a result, implementation was weak and when problems emerged they were so widespread that the Ministry of Health was unable to take corrective action. In contrast, re-implementation in phases over two years allowed time for testing fees and systems and for proper training and supervision. Phasing down from the referral hospitals was a good strategy in that quick success was demonstrated in generating revenue, senior medical and administrative staff at those hospitals became useful advocates of the program and staff at each level helped in the training and supervision of the next level.

Although few similar studies of fee implementation are available, reviews of other reform experiences have stressed similar lessons. Cheema and Rondinelli (1983, p. 313), for example, specifically suggest that

Decentralization can be implemented most successfully if the reform process is incremental and iterative. Those aspects or programs that are least likely to be opposed, and for which there is adequate administrative capacity, should be expanded as political support and administrative competence increase . . . Policy implementation, in many cases, must be experimental.

The implementation strategy therefore has a critical influence over the development of an effective policy package. For example:

- Advocacy before, during, and after implementation is a critical element in garnering the political support that is often required to enable effective implementation.
- Information strategies undertaken before implementation of a new fee system can develop community awareness and understanding of such a system, and so offset utilization decreases.
- Prior improvement of the quality of care provided in government health facilities can enhance community acceptance of fees.
- Involvement of a wider range of interested actors or stakeholders in the process of developing and implementing policy can both inform that process better and attract their support for the process. Particularly critical are the service providers, who must implement the policies, and the community, which must accept the policies.

- Gradual implementation, for example, by introduction in hospitals first, can allow policies to be developed, tested, and adjusted in response to experience, thereby limiting the potentially major negative consequences for efficiency, equity, or sustainability.
- Gradual implementation also allows development of the capacity needed to enable sustainability through a process of learning by doing, which is perhaps more effective than simple training.
- Phased or differentiated implementation within a country can allow policies to be developed in response to the different circumstances of different geographical areas. However, differential development must be monitored to guard against geographic inequities.

Conclusion

The evidence suggests that user fees alone are unlikely to accomplish equity, efficiency, or sustainability objectives. Moreover, when fee policies are poorly designed and implemented, they can actually undermine equity goals. Fees should, therefore, be seen as only one element in a broader health care financing package that should, in particular, include some form of risk sharing. Although fees may be a critical step in allowing the development of other financing mechanisms, for instance, high hospital fees promote insurance coverage, their implementation must be tied to this broader package to limit the possible equity dangers that are clearly associated with them. Within this package fees have a greater potential role within hospitals than at the primary care level.

Achieving equity, efficiency, and, in particular, sustainability requires implementing a broader policy package to develop the skills, systems, and mechanisms of accountability critical to ensure effective implementation. Some local control of revenues, particularly if fees are introduced at the primary level, is an element of this package, but equally important are supporting systems, such as those associated with drugs and human resources. In addition, the process of policy development and implementation is itself an important aspect of this package, as it enables the development of the full range of capacities necessary to ensure sustainability.

Policy analysis is a useful tool for strategic management in the health sector and for developing processes that help the effective implementation of any health care financing reform. A simple analytical model identifies the four key factors that governments should consider when developing any fee system: the context of implementation, the actors influenced by implementation, the content of the policy package, and the process of its implementation (Gilson and Mills 1995; Walt 1994; Walt and Gilson 1994). Use of this model in the early stages of policy development can ensure that the contextual factors that influence appropriate design of the policy package are identified and addressed, and that the critical actors who might undermine implementation are identified and their concerns clarified. Based on such an assessment, policymakers can then judge whether or not, when, and how to implement a fee policy.

References

- Abel-Smith, B., and P. Rawall. 1992. "Can the Poor Afford 'Free' Health Care: A Case Study of Tanzania." *Health Policy and Planning* 7(4):329–41.
- Adams, A., and T. Harnett. 1995. "The Poor and Cost Sharing in the Social Sectors of Sub-Saharan Africa." Human Resources and Poverty Division, Africa Technical Department, World Bank, Washington, D.C.
- Barnum, H., and J. Kutzin. 1993. *Public Hospitals in Developing Countries: Resource Use, Cost, Financing*. Washington, D.C.: The Johns Hopkins University Press.
- Bennett, S., S. Russell, and A. Mills. 1996. "Institutional and Economic Perspectives on Government Capacity to Assume New Roles in the Health Sector: A Review of Experience." PHP Departmental Publication no. 22. London: London School of Hygiene and Tropical Medicine.
- Booth, D., J. Milimo, G. Bond, and S. Chimuka. 1995. "Coping with Cost Recovery." Report to the Swedish International Development Authority. Development Studies Unit, Department of Social Anthropology, Stockholm University, Stockholm.

- Cheema, G. S., and D. A. Rondinelli. 1983. "Decentralization and Development: Conclusions and Directions." In G. S. Cheema and D. A. Rondinelli, eds., *Decentralization and Development: Policy Implementation in Developing Countries*. London: Sage.
- Collins, D., J. D. Quick, S. N. Musau, D. Kraushaar, and I. M. Hussein. 1996. "The Fall and Rise of Cost Sharing in Kenya: The Impact of Phased Implementation." *Health Policy and Planning* 11(1):52-63.
- Creese, A., and J. Kutzin. 1994. "Lessons from Cost Recovery in Health." Paper prepared for the workshop on The Social and Economic Effects of Alternative Methods of Financing Education and Health Services in Developing Countries, February 28-March 2, Institute of Development Studies, University of Sussex, Brighton, U.K.
- Diop, F., A. Yazbeck, and R. Bitran. 1995. "The Impact of Alternative Cost Recovery Schemes on Access and Equity in Niger." *Health Policy and Planning* 10(3):223-40.
- Frenk, J. 1995. "Comprehensive Policy Analysis for Health Sector Reform." In P. Berman, ed., *Health Sector Reform in Developing Countries*. Boston, Massachusetts: Harvard University Press.
- Gilson, L. 1988. "Government Health Care Charges: Is Equity Being Abandoned?" EPC Publication no. 15. London: London School of Hygiene and Tropical Medicine.
- _____. 1995. "Management and Health Care Reform in Sub-Saharan Africa." *Social Science and Medicine* 40(5):695-710.
- Gilson, L., and A. Mills. 1995. "Health Sector Reforms in Sub-Saharan Africa: Lessons of the Last 10 Years." *Health Policy* 32(1-3):215-43.
- Gilson, L., P. Kilima, and M. Tanner. 1994. "Local Government Decentralisation and the Health Sector in Tanzania." *Public Administration and Development* 14(5):451-78.
- Gilson, L., S. Russell, and K. Buse. 1995. "The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy." *Journal of International Development* 7(3):369-402.
- Griffin, C. 1992. "Welfare Gains from User Charges for Government Health Services." *Health Policy and Planning* 7(2):177-180.
- Jarrett, S., and S. Ofosu-Amaah. 1992. "Strengthening Health Services for MCH in Africa: The First Four Years of the Bamako Initiative." *Health Policy and Planning* 7(2):164-76.
- Kanji, N., and N. Jazdowska. 1993. "Structural Adjustment and the Implications for Low-Income Urban Women in Zimbabwe." *Review of African Political Economy* 56(March):11-26.
- Knippenberg, R., B. D. Levy, R. Osseni, K. Drame, A. Soucat, and C. Debeugny. 1990. "The Bamako Initiative: Primary Health Care Experience." *Children in the Tropics* 184/185. Paris: International Children's Center.
- Kutzin, J. 1995. "Experience with Organisational and Financing Reform of the Health Sector." Current Concerns Strengthening Health Services Paper no. 8. WHO/SHS/CC94.3. Geneva: World Health Organization.
- La Fond, A. 1995. *Sustaining Primary Health Care*. London: Earthscan.
- Litvack, J., and C. Bodart. 1993. "User Fees Plus Quality Equals Improved Access to Health Care: Results of a Field Experiment in Cameroon." *Social Science and Medicine* 37(3):369-83.
- McPake, B. 1993. "User Charges for Health Services in Developing Countries: A Review of the Economic Literature." *Social Science and Medicine* 36(11):1397-1405.
- McPake, B., K. Hanson, and A. Mills. 1992. "Implementing the Bamako Initiative in Africa: A Review and Five Case Studies." PHP Departmental Publication no. 8. London: London School of Hygiene and Tropical Medicine.
- Mogedal, S., S. H. Steen, and G. Mpelumbe. 1995. "Health Sector Reform and Organisational Issues at the Local Level: Lessons from Selected African Countries." *Journal of International Development* 7(3):349-68.
- Nolan, B., and V. Turbat. 1995. *Cost Recovery in Public Health Services in Sub-Saharan Africa*. Washington, D.C.: World Bank.
- Pinstrup-Anderson, P. 1993. "Economic Crises and Policy Reforms during the 1980s and Their Impact on the Poor." In World Health Organization, *Macroeconomic Environment and Health*. Geneva: World Health Organization.
- Russell, S. 1996. "Ability to Pay for Health Care: Concepts and Evidence." *Health Policy and Planning* 11(3):219.
- Russell, S., and L. Gilson. 1995. "User Fees in Government Health Services: Is Equity Being Considered? An International Survey." PHP Publication no. 15. London: London School of Hygiene and Tropical Medicine.

- Shaw, P., and C. Griffin. 1995. *Financing Health Care in Sub-Saharan Africa through User Fees and Insurance*. Washington, D.C.: World Bank.
- Walt, G. 1994. *Health Policy: An Introduction to Process and Power*. London: Zed Press.
- Walt, G., and L. Gilson. 1994. "Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis." *Health Policy and Planning* 9(4):353–70.
- World Bank. 1987. *Financing Health Services in Developing Countries: An Agenda for Reform*. Washington, D.C.
- _____. 1993. *World Development Report 1993*. Oxford, U.K.: Oxford University Press.

4

Aims and Performance of Prepayment Schemes

*Eyitayo Lambo, World Health Organization
Regional Office for Africa, Brazzaville, Republic of Congo*

Patients can either pay the full cost of health care as and when they use a service, or they can pay through a variety of other methods, which are often called social financing. Africa has experience with three broad types of social financing arrangements for health care, namely, government health services provided for the population as a whole financed by general tax revenues; traditional, formal insurance arrangements for public and/or private sector employees, for example, government-mandated health insurance for all employed workers financed by taxes on employee wages and payroll taxes; and community-based insurance and prepayment plans, for instance, community-sponsored prepayment and rural insurance plans under which households or adults pay a fixed sum once or twice a year, and sometimes a copayment at the time of use of services. One of the major distinctions between the second and third types of financing arrangements is that while the second type is usually formal and compulsory, the third type is voluntary.

Health care provided by the government and supported by taxes, which includes free government health care as well as services in government facilities that charge user fees for cost recovery, is the most dominant form of social financing in Sub-Saharan Africa. However, those involved in health financing reforms or general health sector reforms have recently begun to pay more attention to traditional health insurance. In many African countries its scope is still limited by the small size of the formal sector. Indeed, it is the limited size of the formal sector, and hence the marginal growth of formal health insurance systems, that had led to policymakers' increased interest in a variety of community-based, rural insurance and prepayment schemes. Employers and other groups in several African countries have also developed some insurance prepayment and health benefit plans.

This chapter focuses on community-based prepayment schemes, which are also referred to as a decentralized form of risk sharing. Under such schemes, each year households or adults pay a certain fixed amount of money or make an in-kind contribution. An appropriate management structure is then assigned the responsibility of administering the funds to support services at particular health facilities. Benefits are defined for those who have contributed to the fund, and some conditions are usually spelled out for claiming those benefits.

Objectives of Prepayment Schemes

When people do not earn income on a regular basis, they can find paying directly for health services, that is, paying user fees, difficult when they fall sick. They can also find paying monthly or quarterly health insurance premiums impossible. People in the informal sector in Africa fall into this group. Unless the government provides such people with free health services, they have somebody such as a relative who can pay on their behalf when they are sick, or they have some other means of access to health services, they might be denied access when they need them. This could be catastrophic.

Prepayment schemes offer a way out of this dilemma, as they provide participants with the opportunity to pay a premium in advance, in return for which they receive free or reduced cost health care if they fall ill. Therefore a major objective of prepayment schemes is to protect subscribers from high, and otherwise unaffordable, health care costs at times when they are least able to pay. This objective can be extended to include limiting the effects of fluctuations in seasonal income on people's ability to purchase care by collecting a contribution when their cash incomes are highest. This helps to guarantee that rural dwellers have ongoing access to health care, even during seasons when much of the rural population has little cash.

Prepayment schemes have other explicit and implicit objectives. They could serve as an equitable way to pay for care, because the cost of treating illness is spread among both the sick and the healthy, particularly in the absence of adverse selection.¹ Prepayment plans (as opposed to fee-for-service schemes) can also be used to finance community health education on such subjects as family planning and nutrition. The scheme could, in principle, be designed with the objective of introducing a degree of cross-subsidization, so that those with higher incomes could bear a greater share of cost. The scheme could also serve as a way to foster decentralization, given its potential to promote community involvement in the provision and financing of health services while maintaining access to free, or virtually free, health care at the time of illness. In addition, a prepayment scheme could strengthen the referral system by stimulating the use of underutilized health centers and promoting the use of secondary and tertiary care via screening and referral lines. This could ultimately facilitate the efficient use of health resources at all levels. Finally, a prepayment scheme could be developed to raise more health resources, thereby supplementing public resources, but through risk sharing instead of user fees, which impose a financial burden solely on the ill.

Prepayment schemes can be tailored both to participants' needs and to local conditions. The participants are, for example, the clients of a rural health center or the population of a community, province, or even the country. Prepayment schemes are rarely financed only by the subscribers' contributions, however. Successful implementation usually requires tax-based subsidies from the government, donor support, or both. Thus prepayment schemes should be seen as part of a government's overall health care financing strategy.

Approaches and Options

Approaches to and options for prepayment schemes can be reviewed from many vantage points, including their scope, the year of establishment, the unit of coverage, the annual subscription fee, the number of members, members' entitlements, and their management. Their geographical coverage can be nationwide or district based. Examples of nationwide schemes include the health card program in Thailand, the national health card insurance scheme in Burundi (*la carte d'assurance maladie* or CAM), the Abota village health insurance scheme in Guinea Bissau, and the proposed prepayment scheme for the informal sector in Zambia. District-based schemes include the Masisi health district prepayment scheme and the Bwamanda prepayment scheme in Zaire and the Nkoranza health insurance scheme in Ghana.

1. Adverse selection arises when those people that tend to be most at risk of ill health, for instance, those with chronic illnesses, infants, and the elderly, are far more prevalent in the membership of a prepayment plan than those facing more normal risks of ill health.

Payment can be made in cash or in kind, although most of the reported schemes to date involve cash payment at some agreed time. These include all the schemes listed above except the proposed scheme in Zambia, which would accept payment in kind from a limited list of agricultural commodities. Another scheme that accepts payment in kind is a health plan sponsored by the National Dairy Development Board in India. Cash crops harvested by subscribers are marketed through a cooperative, and subscribers' premiums are deducted from the sales.

The membership unit can be individuals, households, or entire villages. The Masisi health district prepayment scheme in Zaire and the proposed Zambia plan use individual membership. Households are the membership unit for Thailand's health card program, Burundi's CAM scheme, Ghana's Nkoranza health insurance scheme, and Zaire's Bwamanda prepayment scheme.

The basis for premium payment can be either by individual or by household. Of all the schemes cited, only the health card program in Thailand and the CAM program in Burundi require payment on a household rather than an individual basis. Using the household as a basis for payment means that households pay a fixed amount irrespective of their size. This helps combat adverse selection, because an entire household is more likely to demonstrate a more normal distribution of health risks than a single individual.

Benefits can be comprehensive, covering all primary health care services at the village level as well as referral services provided above the village level. Alternatively, they can be facility-specific, for example, covering hospital care only. Thailand's health card program, Guinea Bissau's Abota village health insurance scheme, Zambia's proposed prepayment scheme, and Burundi's CAM scheme all offer comprehensive benefits, whereas Zaire's Masisi health district prepayment scheme covers only direct hospital admission costs. The Nkoranza health insurance scheme in Ghana covers the full costs of admissions in medical, surgical, and maternity wards at a specific hospital, while the Bwamanda prepayment scheme in Zaire covers inpatient care at the local hospital.

Service delivery can be by community health workers with referral to other public health facilities as in the Abota scheme in Guinea Bissau, the rural cooperative insurance scheme in China, and the health card program in Thailand; directly by public or other providers as in the Masisi, Nkoranza, and Bwamanda schemes; or indirectly by public providers as in the case of CAM in Burundi.

Options for managing schemes include village or commune committees as in China's local health insurance scheme, Burundi's CAM scheme, and Guinea Bissau's Abota scheme; the health district or health zone as in Zaire's Masisi and Bwamanda schemes; or a multitiered approach as found in Ghana's Nkoranza health insurance scheme. Table 4.1 summarizes the various approaches and options.

Key Success Factors

Four of the twelve schemes included in table 4.1 have been well documented: the CAM scheme in Burundi, the Abota village insurance scheme in Guinea Bissau, and the Masisi health district prepayment scheme and the Bwamanda prepayment scheme in Zaire. Two of the schemes are considered to be relatively successful, namely, the Abota and Bwamanda schemes, with the latter being more successful, while the other two have not been successful. Indeed, the Masisi health district prepayment scheme performed so badly that it is no longer in existence. Based on these four experiences, box 4.1 presents some of the factors that could facilitate the success of prepayment schemes.

Investigators who have looked at the Bwamanda scheme have suggested that the health zone was the appropriate level and structure for the organization of this geographically-based prepayment plan for several reasons: (a) the existing health zone organization kept collection and administrative costs low; (b) the size of the population, between 100,000 and 150,000 people per zone, made a risk-sharing arrangement possible; and (c) the structure of the zone, with the relationship between referral hospitals and health centers facilitated community involvement, which is vital for the success of a prepayment scheme. In support of organizing a prepayment scheme on a district basis, Moens (1990, p. 1319) reached the following conclusion:

Table 4.1. Some Characteristics of the Selected Prepayment/Insurance Schemes

Scheme	Characteristics						
	Scope	Year established	Unit of coverage	Number of members	Annual subscription fee	Members' entitlements	Management
National health card insurance (CAM), Burundi	Nationwide	1984	Household	About 23% of the population	FBu 500 (\$1.85)	Free health services at public health facilities, but first contact at health center and subsequent referrals	Commune committee
Nkoranza health insurance scheme, Ghana	District	Not known	Individual	Not known	Not known	Full cost of admission in medical, surgical, and maternity wards at St. Theresa Hospital	Some district structures
Abota village health insurance scheme, Guinea Bissau	Nationwide	1980	Individual	200,000 (20% of the population in 1988)	About \$0.62	Free treatment at village health unit and free services at higher levels if referred	Village committee
Goalpara Cooperative Health Society, India	Villages	Not known	Household	150 out of 170 households in the village	Rs 18 in cash or in kind (rice or labor)	Free doctor consultation in dispensary and drugs at cost; free periodic public health activities	Village health committee
Raigarh, Ambikapur Health Association, India	Villages	Not known	Individual	75,000	Rs 5 or 2 kilograms of rice	Free community health services and drugs; free health center services including maternal and child health clinic; hospital care free after paying entrance fee up to ceiling of Rs 1,000	Individual health centers
Saheed Shibsabkar Saba Samity, India	Villages	Not known	Individual	6,800	Rs 2 for those with annual incomes of less than Rs 1,000 and Rs 5 for those with incomes greater than Rs 1,000	Free consultation at outpatient clinic; drugs at cost and free maternal and child health care	Not known

Table 4.1. Continued

Scheme	Characteristics						
	Scope	Year established	Unit of coverage	Number of members	Annual subscription fee	Members' entitlements	Management
Sewagram, India	Villages	Not known	Household	At least 75% of households in the area (23 villages covered, total number of insured is 44,390)	8 payali of sorghum for the landless; 2 payali of sorghum per acre extra for landholders or the equivalent in cash	Free community health services, drugs, and mobile services; free hospital care for unplanned illness episodes and 25% subsidy for anticipated illness episodes	Village health worker and village health committee
Tribhovandas Foundation, India	Villages	Not known	Household	Approximately 1/6 to 1/5 of all households in 317 villages covered	Rs 10	Free community health services and subsidized drugs; 50% subsidy for hospital care	Milk societies and the foundation
Health card program, Thailand	Nationwide	1983	Individual	2.7 million or 5.1% of total population in 1987	B 300 per household with cover for 4 members	Free health services in Ministry of Health and Population facilities, but with first consultation at health center and subsequent referrals	Villages committee
Bwamanda prepayment scheme, Zaire	District health zone	1984/85	Individual	65,000 by 1992	About \$0.40	Cost of in-patient care in Bwamanda zone hospital	Health zone, particularly the hospital
Masisi, Zaire	Health district	1987	Individual	6.7% (of 12,000) initially, and about 26.4% later	\$1 per person	All direct admission costs, including deliveries and chronic care	District authorities
Proposed prepayment scheme, Zambia	Nationwide	Not yet	Individual	Not known	In cash or in kind from a limited list of commodities	Curative aspect of the basic package, including referral to secondary and tertiary levels; drugs along with any laboratory tests deemed medically necessary	Not known

Box 4.1. Factors Likely to Lead to Successful Prepayment Schemes

- Appropriate institutional context, level, and management structure
- Low collection and administrative costs
- Appropriate premium to cover the costs of providing benefits
- Adequate population size to facilitate risk pooling
- Integration of scheme into the national, provincial, or district health system
- Sound financial management
- No or limited adverse selection
- No or limited moral hazard
- Cost containment
- Adequate backup support
- High quality of services
- Social cohesion among subscribers
- Conducive economic environment

A relatively small scale increases the likelihood to have some homogeneous communities and to have manageable health systems. The district seems the most appropriate level in that respect. Lessons learnt from different district experiences could then be translated in a more detailed set of recommendations and suggestions for implementation in other settings. The Bwamanda experiment in North East Zaire is a nice illustration of the relevance of launching similar schemes at district level, whereas the Burundi scheme, implemented on a nation-wide basis, illustrates the lack of community involvement in and control over a top-down designed scheme.

The level of community participation and participants' involvement in the scheme's design, implementation, and evaluation is an important success factor. Many conditions influence this factor, including

- The level of the premium in relation to people's incomes
- The imposition of user fees at health centers and referral facilities
- The time of payment
- The mode of payment
- The unit of payment (household or individual)
- The general economic environment
- The distance from people's homes to health facilities and associated transportation costs
- The population's awareness and acceptance of the scheme's benefits
- The quality of services.

Premium Level and Timing

Investigators note that the appropriate level of the premiums in the Bwamanda and Abota schemes contributed to their relative success, while the inappropriately low level of premiums, which had not been adjusted since 1984, contributed to the Burundi scheme's relative lack of success. The low fees charged at health centers also undermined the scheme. The Burundi scheme was simply not designed in a way to render it financially sustainable.

The timing of the premium payment in the Abota and Bwamanda schemes also contributed to their success. In the Masisi scheme, when the subscription period was changed from April to September, the subscription rate increased from 2.7 to 28.8 percent of the target population. The individual subscription basis adopted in the Abota and Bwamanda schemes also contributed to the large size of the membership, while the household basis used in the Burundi scheme was one of the factors responsible for the low rate.

Economic Environment

In the Bwamanda scheme, a stimulating economic environment associated with the activities of the Center for Integrated Development Project was a facilitating factor. Among other things, the project provided an investment opportunity for the scheme's funds that yielded a compound interest rate of 2.5 percent per month (equivalent to an effective annual yield of 34.5 percent) in 1989. This helped offset the effects of rampant inflation in the country.

Travel Distance and Costs

The Masisi scheme demonstrated the significance of how far subscribers lived from the health facility and the cost of travel to and from the health facility on the subscription rate. This led to a conclusion by Moens (1990, p. 1319) that:

The indirect costs which patients and their families face in the case of admission are often higher than the direct costs. Therefore, the suggestion could be considered to take into account the distance factor, rather than the socioeconomic factor in any attempts to introduce differential rates in prepayment schemes launched in similar rural settings.

Public Awareness

People were much more aware of the schemes and their benefits with the relatively successful Abota and Bwamanda schemes than for the Burundi and Masisi schemes. Awareness should not only be expected at the beginning of the scheme, but should be sustained throughout the life of the scheme to maintain the demand for membership.

Quality of Services and Integration in the Health Care System

Just as the quality of services is important for the success of a user fee scheme, it is also crucial to the success of a prepayment scheme. Observers note that the Bwamanda scheme provides high quality care in terms of general indicators, such as the drug supply, staffing levels, and infrastructure. Willingness to pay, and hence, high enrollment, was observed in the Abota scheme, because of the link between payment and drug availability. By contrast, in the Burundi scheme the quality of care in public health facilities was said to be poor, with drugs shortages a common occurrence. A similar observation was made in the Masisi scheme.

All the schemes reviewed appear to be reasonably well integrated into the country's health care system. This means that participation in the scheme assures subscribers of free services, not only at the first point of contact in the health services delivery system, for example, a health post, but at other levels based on referral. This is an important factor in the success of prepayment schemes, because the appeal of risk-pooling schemes lies in their ability to protect people against catastrophic financial losses when they are ill or injured. Such costs usually occur at hospitals. If scheme participants are required to pay fees at a higher level of the health care system, the scheme is likely to be unattractive and to offer inappropriate incentives. In the Abota scheme, since 1983 patients referred by the village health workers to the public health facilities have been exempted from paying consultation fees on showing evidence of membership in the scheme. Furthermore, in its 10-year (1984–93) plan, the government of Guinea Bissau emphasized the role of village-based primary health care, thereby making the efficient functioning of the Abota system part of the country's health strategy. In the case of Bwamanda, the prepaid health plan is completely integrated into the health delivery system of the health zone. It has no separate administration or personnel. Indeed, the health zone—at its own financial risk and through salaried personnel—provides all hospital services to a group of enrollees who voluntarily pay a fixed premium in advance that is unrelated to the extent of service use.

Management

Good and appropriate management is important for the success of any prepayment scheme. This depends on whether the scheme is managed in a decentralized way, the existence of adequate managerial skills at the district or subdistrict level, the investment of unused revenue or premium income to preserve the fund's value in the face of inflation, and the level of control to reduce fraud and other risks. Though all schemes reviewed were, to some extent, managed in a decentralized way, only the Bwamanda scheme fulfilled the other three management requirements.

Adverse Selection and Moral Hazard

Adverse selection and moral hazard are two important threats to any health insurance or prepayment scheme. The extent to which these two problems occur affects a scheme's degree of success.

A scheme experiences adverse selection when people with a high risk of sustaining a severe illness or injury and the chronically ill dominate the scheme. When they do so, they tend to demand more services, including more costly hospital services, which leads to rapid depletion of the scheme's revenue base.

Moral hazard occurs when members of an insurance or prepayment scheme use services more frequently than they would have done had they not been members. This is common when membership in a scheme entitles participants to unrestricted access, unless the scheme is modified by a consultation fee or copayment at the time of service.

The occurrence of adverse selection is a function of the nature of the subscription unit (individual or household) and the proportion of eligible people who join the scheme. The subscription unit can be controlled, but the latter cannot unless the scheme requires a minimum subscription rate before it comes into effect, as with the Abota scheme, which required 75 percent membership among villagers, and Thailand's health card program, which required 35 percent of villages as the minimum enrollment. Investigators have shown that the individual subscription basis has a greater chance of minimizing adverse selection than household subscription, particularly when the premium does not vary with the size of the household. Apparently this is one of the reasons the Masisi scheme failed.

The occurrence of moral hazard is influenced by the time of premium payment, the level of the premium relative to the cost of services at various levels of the health system, the enforcement of referral rules, and the incentives provided for nonuse of benefits provided to a subscriber. One of the reasons the Burundi scheme was unsuccessful was that new subscribers could join at any time. This meant that a non-CAM patient could pay the user charge at a health center (the amount was relatively low compared with the premium), but on referral to a hospital, could purchase a CAM card to obtain free hospital care. The ineffective functioning of the referral system contributed to the failure of the Masisi scheme, and also to the low success of the CAM scheme, while both the Abota and Bwamanda schemes achieved relative success partly because of the well-functioning referral system. The Thailand scheme minimizes moral hazard largely because of the incentives given to discourage unnecessary use of services. Specifically, a health cardholder's subscription can be renewed free of charge if that person did not use the card in the previous year. Also, a cardholder may choose to pay user fees at the time when health service is sought, with a 10 percent discount for minor illness and retain the card for use should major illnesses strike.

The Bwamanda scheme minimizes the risks of adverse selection and moral hazard by mandating that if one member of a family joins the scheme, the others must also join. Enrollment takes place in March or April after the second harvest, thereby limiting the time when new members can enroll. Imposing a 20 percent copayment not only helped reduce unnecessary use of services, but also reduced the impact of inflation. Moreover, before patients are hospitalized, they must be referred from a health center, and a provider at the hospital has to confirm the need for admission.

Social Environment

The social environment, specifically, the extent of social cohesiveness among households and communities, is important for success. Experiences to date suggest that the more cohesive the local social environment, the more likely the scheme will succeed. The whole of Sub-Saharan Africa seems to satisfy this condition, because the extended family system is not only practiced, the norm is that people must be each other's keeper. The Abota scheme is said to be well integrated into the sociopolitical culture of the communities in Guinea Bissau, and in many respects, it has the characteristics of a social institution.

Bottlenecks to Overcome

The major bottlenecks to overcome in the implementation of prepayment schemes are as follows:

- Inadequate membership for risk pooling, and hence insufficient funds to pay for member services
- Inability of many people to subscribe because of poverty
- Ineffective management of the scheme
- Nonprovision of services of good quality
- Inflation
- Adverse selection
- Moral hazard.

If these bottlenecks are not overcome, they are the major causes of failure of schemes.

Inadequate fund size, as noted earlier, could arise from inadequate membership, an inappropriate premium level, or both these factors. Adopting a systematic approach to determining the premium level would help resolve these problems. Such an approach takes into consideration the population's ability to pay as well as the likely costs of providing the scheme's benefits. Intensive social marketing of the scheme before and after its establishment is also important to enhance, as well as sustain, adequate demand.

No matter how well the premium level is determined, not everyone will be able to pay. However, the genuinely poor should not be denied access to health services, thus the scheme's designers should take extreme care to identify such people and make provisions for them to be exempt from payment. The exemption mechanism should be such that those who can afford to pay do not get exempted.

The management of prepayment schemes requires a minimum level of management skills, which are usually in short supply in the rural areas of developing countries. This is one of the reasons why a prepayment scheme organized on a district-level basis may be more successful than one organized on a village-level basis, because the needed management skills may be more available at the district level. The administration of a prepayment scheme at the district level also has the advantage of broadening the enrollment base. In any case, no matter at what level the scheme is organized, the management skills of those who will administer it are likely to need strengthening.

Poor quality services are likely to be minimized if contributions to the scheme are retained at the district or regional level and used to improve services at the local level. Thus effective decentralization of health services financing and provision is an important strategy for overcoming the problem of poor quality services.

The problem of inflation can be addressed in at least two ways. The first way is to ensure that the premium is reviewed from time to time and adjusted as necessary. The second is to invest that portion of the scheme's fund that is not used in such a way that the average returns from the investment at least equal the average rate of inflation. This requires financial management skills.

Economic Impacts of the Scheme

The economic impacts of a prepayment scheme can be evaluated in terms of its efficiency, equity, and sustainability. Efficiency relates to resource use, administrative efficiency, and financial efficiency. Resource

use is related to the problem of moral hazard. As noted earlier, prepayment can lead to substantial moral hazard if the organization of health services lacks basic "rationalization." Rationalization of the referral system, reflected in clearly specified entitlements for scheme members, allows the use of health services at the appropriate level. Rationalization requires that the first level of care functions in an acceptable way to provide value for money, that criteria for referral are used at that level, and that people have confidence in the services provided. At the hospital level, specific criteria for admission and standard guidelines for clinical case management could be designed. If the health system is not functioning rationally, then prepayment for hospital care will lead to unjustified by-passing of first-line facilities.

Administrative efficiency relates to the cost of implementing the scheme relative to the scheme's revenues. It is related to the level of the premium, the size of the membership, the management structure, and inflation. The experience of Bwamanda provides some lessons for attaining administrative efficiency. There, the level of the premium was appropriate and its affordability contributed to the large membership. No new structures were created to manage the scheme. Instead it was integrated into the health zone system, and as a result administrative costs were limited to about 5 percent of the premium. Premiums and hospital fees have been adjusted regularly to maintain purchasing power. In addition, some of the funds were invested to dampen the effect of inflation. The scheme achieved financial efficiency because of its administrative efficiency. Between 1986 and 1996 the scheme's annual income statement revealed a profit, and since 1991 a slight deficit.

Concerning equity in a prepayment scheme, two issues are important: maintaining equality between individual households within the population who join the scheme, and not excluding those who can not afford to subscribe. With regard to equality among households, in an environment where accessibility to health facilities, particularly to hospitals, is a problem because of travel distance and costs, the payment of a subscription fee penalizes those households that live far from the hospital and who are less likely to use hospital services. In the context of equal needs, uniform premiums would result in these latter households actually subsidizing the hospital care of those living close to the hospital. If corrective measures are not taken, this may contribute to a lack of incentives for more remote populations to participate in the scheme. The option of using a sliding scale of premiums and fees according to distance between place of residence and the hospital could be experimented with. In the case of the poor, the community must be able to identify those households that cannot pay the premium and propose measures to safeguard their equal access to health services.

The various ways in which some prepayment schemes reviewed have attempted to ensure equity include

- Sliding membership fees, for instance, membership fees related to income
- Payment in cash or in kind, so that nonavailability of cash is not a barrier
- Referral charges related to distance to the hospital, that is, the greater the distance the smaller the charge
- Financial backup for schemes that do not mobilize adequate funds because of a high proportion of poor among the population
- Nonexclusion of those who are poor from services.

For a scheme to be sustainable, backup support from outside the immediate environment covered by the scheme (for instance, from the district level to a village-based scheme or from the national level to a district-based scheme) might be needed. The support could be in the form of the government guaranteeing a constant supply of drugs at affordable prices and/or constant supervision to ensure the effectiveness of control measures and scheme management. The backup support would be most needed during the initial years following implementation until the subscription rate reaches a level that guarantees financial sustainability.

Broader Systemic Impacts

Prepayment schemes require substantial decentralization in decisionmaking from the ministry of health to lower levels of the health system, as well as local management of resource systems generated by the scheme. Their success, as already discussed, is therefore largely dependent on the availability of good managers at the district or community level. Management skills are, however, usually lacking at that level. Consequently, where a prepayment scheme succeeds, it reflects improved management at the community or local level. Such a development is not only beneficial to the development of the health sector at the local level, it can also facilitate socioeconomic development at the local level, because the same people will lead the development process at that level.

With the availability of management skills at the local level, the ministry of health will be more inclined to decentralize decisionmaking and other health management functions to the local level. The decentralization of the management of public sector health facilities within a flexible planning framework is needed to give agents within the health care system a greater sense of responsibility and encourage more efficient resource utilization. Ultimately, this could foster a well-defined role for the central government, which would be limited to policymaking, regulation, and the provision of information.

Successful implementation of prepayment schemes can not only improve the access of people with irregular sources of cash income to health services at the local and referral levels and enhance the efficiency with which the services are used, but can also facilitate the provision of other basic, health-related services to subscribers or communities. Such services include water and sanitation, nutritious food supplies, health education, and family planning services. Those managing the schemes might be able to provide such services from the revenues generated. Alternatively, they could be publicly provided as a result of a reallocation of public resources freed up by the use of prepayment scheme funds.

Conclusion

In Sub-Saharan Africa, the government finances health care for the majority of the population, who are usually poor and live in rural areas, through tax revenues and foreign aid. Worsening economic conditions have reduced governments' capacity to provide adequate resources, while donor funding has not been as forthcoming as in the past for many reasons. Public health facilities are generally underfunded, overcrowded (hospitals), or underutilized (health centers); have insufficient or unmotivated personnel; and often lack basic drugs. Thus individual households are already spending a high proportion of their income, both in cash and in kind, on drugs and health services, particularly from the private sector.

The imposition of user charges to recover part of the recurrent costs of drugs, maintenance, and services has been a long-standing practice, particularly in private (mission) hospitals. It has, however, played a limited or marginal role in the public sector. The often quoted assertion that people are willing and able to pay for services is questionable, because the definitions of ability and willingness remain unsatisfactory. In any case, the call for cost recovery in public health facilities raises the knotty problem of equity. Specifically, the issue is how the poor and seriously sick can be assured access to adequate treatment and protected from economic losses they cannot bear. Some argue that this will be possible only if the economic effects of disease and treatment are distributed among an adequate number of people. An extension of this argument underscores the need for risk sharing in the form of insurance schemes.

The establishment of centralized, formal, national health insurance schemes to cover catastrophic health risks for all people in any of the countries in Sub-Saharan Africa is at best a long-term objective. This is because the development of such schemes is closely tied to the size of the formal sector, which currently includes no more than 10 percent of the eligible age group in any of the least developed countries of Sub-Saharan Africa. In addition, the organizational requirements for setting up such schemes are beyond the means of most of these countries.

Thus decentralized, informal, risk-sharing or prepayment schemes need to be promoted, particularly in rural areas. Such schemes are more flexible than formal insurance schemes and leave room for learning by doing. However, such schemes tend to lack the necessary administrative backup and stability. If they are to be fully developed so that they become a major health financing strategy, the structures charged with their management need to be supported and mechanisms to strengthen transparency and accountability will need to be developed. Governments and donors will also need to provide the necessary financial backup, particularly at the early stages of development.

For new schemes, to capitalize on the strengths and avoid the weaknesses of existing schemes, in-depth study of as many schemes as possible is necessary to understand fully the factors that determine success or failure. As Korte and others (1992, p. 9) put it: "It is necessary to look into factors that strengthen group cohesion, and which create or maintain the degree of solidarity it takes to form a risk sharing collective."

So that rural areas can initiate schemes that are appropriate for their populations, central or district levels of government should develop guidelines or protocols to help local or district health planners and managers assess the preference for and willingness to pay for prepayment schemes in their localities and help the managers manage such schemes.

References

- Korte R., H. Richter, F. Merkle, and H. Gorgen. 1992. "Financing Health Services in Sub-Saharan Africa: Options for Decision Makers during Adjustment." *Social Science and Medicine* 34(1):1-9.
- Moens, F. 1990. "Design, Implementation and Evaluation of a Community Financing Scheme for Hospital Care in Developing Countries: A Prepaid Health Plan in the Bwamanda Zone, Zaire." *Social Science and Medicine* 30(12):1319-24.

5

Health Insurance for the Formal Sector in Africa: Yes, But...

*Joseph Kutzin
Health Economist, Analysis, Research, and Assessment Division,
World Health Organization*

Health insurance can be organized in many different ways, with different implications for the organization and delivery of health services. At a minimum, it is a way to pay for health care and to ensure access to services by providing a mechanism for sharing the risk of incurring medical expenditures among different individuals. This definition implies that (a) the use of health services is tied to a financial cost, and (b) people are able and willing to use the insured health services when they perceive themselves to be sick. The latter point reflects the importance of physical access to services of an acceptable quality. To be effectively insured, therefore, implies both financial protection and access to desirable services.

Countries and communities have implemented health insurance schemes that differ along a number of dimensions. One of the more important dimensions relates to the extent of the population covered by insurance. In many countries governments require coverage for the entire population and implement such coverage effectively. This coverage is financed either through general tax revenues (as in Canada, Finland, Sweden, the United Kingdom) or through mandatory earmarked contributions from employers, from employees, and sometimes from the government to a health insurance fund (for instance, Belgium, France, Germany, Korea). In other countries, insurance coverage is not universal. These countries tend to have a mix of schemes, including some for which the government mandates coverage of a defined segment of the population, and others for which participation is voluntary (for example, China, Kenya, Thailand, the United States). In countries without mandatory universal coverage, people who work in the formal sector of the economy are much more likely to be covered by insurance than those in the informal sector, because organizing contributions and large risk pools for this group is easier.

This chapter examines health insurance systems that are focused on people who work in the formal sector of the economy (and their dependents). Theories of what is possible are combined with a review of what has actually happened in practice in an attempt to identify the conditions that make expanding insurance coverage for the formal sector both feasible and desirable. The distinction between feasibility and desirability is important to remember. Public policy objectives in the health sector include improving health status, equity, efficiency, acceptability (to providers and users), and sustainability. Expanded coverage with health insurance may be a means to achieve progress on these objectives, but the pursuit of broad coverage through insurance is not an end of policy.

By assessing the conditions needed for health insurance to be feasible and desirable, the chapter looks at the appropriateness of strategies to expand coverage for formal sector workers in African countries. Some of these conditions are within the span of control of health sector decisionmakers. These relate primarily to the specific policies of the insurance scheme, the regulatory environment, and the organization of the health system. Other conditions are associated with broader issues of political economy and the relative power of different interest groups in society. Still other conditions relate to a country's level of economic, institutional, and managerial development. Countries can be expected to be at different stages with respect to many of these conditions. Therefore the appropriateness of expanding insurance coverage for the formal sector is likely to be different in different African countries.

Box 5.1 provides a glossary of terms used in connection with health insurance.

Common Problems Facing Health Systems in Africa

Countries in Africa (and in most other parts of the world) face an array of health care financing problems that leave their health systems far from achieving the objectives of good health status, equity, efficiency, acceptability, and sustainability. The main problem is simply a shortage of government budgetary resources for health care relative to increasing demand and need for care. One manifestation of the budgetary shortfall is a deterioration in the quality and effectiveness of publicly provided health services (Shaw and Ainsworth 1995). In a macroeconomic climate that, since the 1980s, has been characterized by slow or no growth in national income or government budgets, and often a per capita decline in real terms, governments are seeking ways to limit their financial responsibilities for health services (ILO 1993). The reforms being considered or implemented constitute strategies to improve the use of existing resources and/or mobilize additional nongovernmental resources for health.

In addition to an absolute shortage of resources going into the health sector, patterns of spending in most countries cause or reflect an inequitable and inefficient allocation of inputs and services. The clearest example of this is the concentration of government resources in large, urban hospitals. On average, people who live in urban areas have higher incomes than those in rural areas, yet the urban bias in government health spending means that the costs of gaining access to good quality care are highest for the most remote, and usually poorest, groups of the population. Moreover, evidence from several countries, for instance, Indonesia (Ministry of Health, Indonesia, 1995), Kenya, and Tanzania (Griffin and Shaw 1995), indicates that nonpoor people tend to consume more publicly financed hospital care per capita than poor people, which implies that they receive a disproportionate share of government subsidies. This pattern of government resource allocation may also be inefficient because the most cost-effective clinical interventions that health systems can provide are those that are most appropriately delivered in a health center or other nonhospital setting.¹

High levels of waste and other forms of technical inefficiency also plague health systems. These problems are a threat to any gains that reforms to improve cost-effectiveness by reallocating resources might achieve (World Bank 1994).

Health Policy Objectives

To assess the appropriateness of any policy tool, including health insurance, for achieving health policy objectives, one must first define these policy objectives explicitly and identify the main obstacles to achieving

1. If the population is able and willing to pay for basic out-patient services on an out-of-pocket basis, however, a pattern of government health resource allocation targeted only at high cost referral services might be efficient from an overall sectoral perspective (Hammer and Berman 1995). This implies that government funds would provide insurance against high cost, low probability events, while private sources would pay for other personal health services. In practice, however, no government has proven able to target its hospital subsidies so precisely.

Box 5.1. Glossary of Selected Health Insurance Terminology

<i>Adverse selection</i>	Phenomenon that can occur in the context of voluntary enrollment of individuals into health insurance schemes. When a scheme covers a disproportionate share of people with a high probability of incurring expensive medical costs, this can jeopardize its financial viability.
<i>Benefit package</i>	Services and the means of accessing services that the insurance scheme covers.
<i>Budgets</i>	Periodic allocation of funds to (or on behalf of) health facilities. The total amount of the allocation is determined in advance.
<i>Capitation</i>	Fixed payment to providers per person enrolled in the insurance scheme. Providers paid by capitation bear the financial risk of providing a defined package of services to their beneficiary population.
<i>Catastrophic costs</i>	These are costs arising from treatment of an illness that are extremely high relative to individual or household income. Catastrophic costs are usually associated with expensive referral hospital care.
<i>Case-based reimbursement</i>	Retrospective payment of an administratively predetermined amount per case or episode of illness. Individual services are bundled into distinct case categories that are reasonably homogeneous with respect to resource cost, and providers are reimbursed a fixed amount per case in each category.
<i>Coinsurance</i>	Percentage of the total charge for a service that those covered must pay for out-of-pocket.
<i>Contribution mechanism</i>	The means by which funds are mobilized for insurance. Sources of funds include allocations from general tax revenues, mandatory contributions for an identifiable insurance fund, and voluntary contributions.
<i>Copayments</i>	Flat amounts that those covered must pay out-of-pocket for each service used.
<i>Cost sharing</i>	Any direct payment the users of health services make to the providers of services. Modalities of cost sharing include copayments, coinsurance, and deductibles.
<i>Coverage</i>	This refers to the beneficiary population, for instance, the percentage of people who are covered by insurance or defined population groups (such as employees and dependents) who are covered.
<i>Covered services</i>	See benefit package.
<i>Deductibles</i>	Amount that those covered must pay out-of-pocket before the benefits of the insurance program become active.
<i>Excluded services</i>	Services or methods of using services that are not covered in the benefit package of an insurance scheme. Individuals are liable for the full costs of excluded services.
<i>Fee-for-service reimbursement</i>	Retrospective payment per item of service provided, that is, payment after those covered have reported the use of covered services. Fee-for-service reimbursement rates can be determined either by market forces or through administratively determined or negotiated fee schedules.
<i>Fund holder</i>	The institution responsible for spending the prepaid contributions for insurance (see purchaser). Fund holders are usually third party, public or private insurance funds, but can also be providers. In the latter case, some functions of insurer and provider are integrated in a single institution.
<i>Gatekeeper</i>	The institution or individual responsible for determining access to referral services. The gatekeeper function is usually the responsibility of the provider of first contact primary care.
<i>Moral hazard</i>	Impact on an individual's demand for care of an out-of-pocket payment that is less than the cost of providing services. Because insurance, including centrally tax-funded services, covers some or all of the costs of service use, individuals tend to use more services than if they faced the full cost of care.
<i>Provider payment</i>	The mechanisms by which resources are allocated from the insurance fund (or national health service) to institutional service providers (for instance, hospitals) or individual service providers (for example, doctors). Options include the following: budgets or salaries, capitation, fee-for-service reimbursement, case-based reimbursement, and various combinations of these options.
<i>Purchaser</i>	The institution responsible for purchasing health services from providers. This always includes the insurance fund itself, but some schemes involve additional purchasers as well, including entities that are also service providers. See fund holder.
<i>Risk pool</i>	Group of people covered by the same insurance scheme.
<i>Risk rating</i>	A basis for determining an individual's or group's contribution (premium payment) to a health insurance scheme. In a risk-rated scheme, the contribution rate is determined by an individual's or group's expected cost of service use rather than by their level of income (as in a social insurance scheme).
<i>Salaries</i>	Similar to budgets, but applies specifically to health workers. Salaries are prospectively determined allocations.
<i>Social health insurance</i>	System of financing care through contributions to an insurance fund that operates within a tight framework of government regulations. Social insurance usually involves mandatory, earnings-related contributions by employers and employees.
<i>Supplier-induced demand</i>	Phenomenon that arises from patients' reliance on providers for information about their need for specific services. While not necessarily harmful—an important function of providers is to inform patients about their condition and the available treatment options—the potential for costly and possibly harmful overuse of services exists where providers benefit financially from the treatment they recommend and provide. Supplier-induced demand is the reason why fee-for-service reimbursement causes cost escalation.

them. While the relative weight given to the different objectives of health policy varies from country to country, the objectives are fairly general and may be defined as improving equity, efficiency, acceptability or quality, sustainability, and health status. This chapter describes only equity and efficiency in detail. The other objectives are considered, where relevant, as elements of these two broad policy goals.

Equity in the health sector has several dimensions (Wagstaff and Van Doorslaer 1993). Equity in financing care implies that payment for health care is related to individuals' level of income, irrespective of their medical need. Equity in the receipt of care implies that access to and use of services of an acceptable level of quality is based on medical need, irrespective of individuals' ability to pay. Assuming that health care improves health, this second dimension should be closely related to a third, which is equity in health status. Equity in health status implies a pattern of health and disease in society that is not related to the distribution of income and wealth. Although analysis of equity issues usually involves comparisons across income groups, investigators should also consider other aspects of possible inequities, for example, differences in the receipt of care relative to need by gender, age, or ethnicity.

Efficiency is also multidimensional. Allocative efficiency within the health sector refers to the extent to which sectoral resources are distributed to their most cost-effective uses. Allocative efficiency is also a relevant concept for assessing the size of the health sector in the national economy. Thus policies can affect allocative efficiency by shifting the distribution of resources within the health sector or between the health sector and the rest of the economy. Technical efficiency is a narrower concept. It refers to the management and use of resources that have already been allocated within the sector. Analyses of technical efficiency try to determine if services are produced at the lowest cost possible for a given allocation of resources, and thus often focus on the extent to which poor management practices or inappropriate incentives generate waste. A third dimension, which is related to technical efficiency, is administrative efficiency. This is concerned with the costs of managing the health system (WHO 1993). Ability to administer the health system efficiently is also an important element of institutional sustainability.

Health Insurance Objectives

Expanding or changing the role of insurance in health systems can provide policymakers with a useful tool for addressing the health system problems described earlier to some extent. The need to mobilize additional nongovernmental sources of funds is the main impetus for a focus on health insurance as a policy option, but insurance can also be a way to expand access to care and to change the pattern of spending in a manner that improves the efficiency of resource allocation and use. Indeed, in many industrial countries and some middle-income countries the principal motivation for reforming health insurance systems is not to mobilize additional resources, but to control the rapid growth in government (and private) health spending. These countries have focused on changing incentives within health financing schemes to slow down the growth rate of expenditure. Another objective has been to improve technical efficiency by introducing competitive mechanisms into the health sector. Finally, expanding insurance coverage implies lowering financial barriers to access, and should thus enable a greater number of people to get the care they need.

From the perspective of government health policymakers, the likely objectives of health insurance are those just described, which relate to broad efficiency and equity goals. However, other organized groups in society are likely to have different, or at least additional, objectives. Three important groups are associations of health service providers, for instance, medical associations; formal sector workers, that is, civil servants and those who work in the private formal sector, who are probably already covered by insurance or will be the first to be covered; and employers. Important objectives of health insurance for providers are to raise their income levels and to increase their access to new technologies that could enable them to improve the quality of care. For the initial group of insured people, an important objective is to consolidate and expand their benefits, including greater choice and shorter waiting times, while trying to minimize the amount that they have to contribute to the scheme. Employers may be interested in providing good health benefits for their workers, but they also wish to keep their premium contributions as low as possible to

minimize their overall production costs. In this respect, they may be important strategic allies of government health policymakers. Understanding the interests of key stakeholders is essential if governments are to have a chance of achieving their aims.

Expanding Coverage: Questions That Government Should Ask

Is expanding health insurance coverage for the formally employed population feasible? If so, will such an expansion be consistent with the government's health policy objectives? For policymakers to answer these questions, they will have to address a number of issues. This section suggests a framework for addressing these issues and provides evidence from country experience to illustrate their importance.

Before getting into the issue of expanding coverage, note that the current situation in relation to health insurance varies considerably across African countries. Estimates of population coverage with either compulsory social insurance or private health insurance range from zero or near zero to 25 percent in Kenya (Monasch 1996). Some countries have government-run (or organized) systems of social insurance, others rely primarily on private insurance (also referred to as medical aid schemes), and still others use a combination of the two. The important point is that countries need to address the current situations they are facing, in addition to determining whether or not to promote expanded coverage. While the information in this section is presented as issues related to the expansion of coverage, much of the discussion, especially with respect to equity and efficiency, is relevant to government policy as it relates to the existing health insurance situation in their countries.

As noted earlier, an expansion of health insurance coverage can increase health sector revenues, reduce financial barriers to care for the insured, and improve the efficiency of resource allocation and use. Where insurance coverage is universal and cost sharing, for instance, copayments, is limited or nonexistent, this reduces financial barriers to access for the entire population. However, universal coverage is not feasible, and does not exist in countries where a relatively large percentage of the population works as self-employed farmers or in the informal sector, because of the difficulty of organizing premium collections for these people or of targeting subsidies for their purchase of insurance. Nevertheless, some have argued (Griffin and Shaw 1995, for example) that governments should encourage the expansion of insurance coverage for the relatively small formal sector, because this could ultimately benefit the poorer, uninsured population. The argument for this is that newly insured persons would switch from public to private providers, thereby freeing government resources to be targeted more precisely to the provision of cost-effective services for the poor, uninsured majority.

Other authors have raised concerns that expanding insurance for the formal sector could exacerbate inequities between insured and uninsured people. The concern is that the methods used to encourage the expansion of coverage invariably involve some type of government subsidy for people who are relatively well-off economically. Moreover, there is no guarantee that the government health budget freed by this process will be better targeted, either to the poor or to more cost-effective services (Bennett and Ngalande-Banda 1994; Kutzin 1995).

How valid are these arguments? Those responsible for the health sector in each country must evaluate the issues for themselves. To do so, they need to address the following questions:

- Feasibility questions
 - What are mechanisms for expanding insurance coverage to people who work in the formal sector of the economy?
 - What are feasible strategies in the medium and long term for expanding insurance to poorer segments of the population?
- Desirability questions
 - How can insurance coverage be expanded without subsidizing its purchase to the extent that the government does not end up concentrating even more of its limited resources on a relatively well-

off segment of the population? In addition, how can the authorities limit subsidies for the use of government health services by the insured population?

- What can the authorities do to limit the possibility or the effects of a diversion of scarce health human resources from public to private patients that an expansion of insurance coverage may induce?
- What mix of incentives and regulations should the government use to organize service delivery and contain costs within the insurance scheme(s)?

The rest of this section analyzes each of these questions, using country experience if it is available, in an attempt to identify the conditions that countries must meet to make the expansion of insurance coverage possible and to have desirable effects on health objectives.

Feasibility

The possibilities for expanding coverage can be divided into two aspects: expanding coverage to the formal sector and expanding coverage beyond the formal sector.

EXPANDING COVERAGE TO THE FORMAL SECTOR. Insurance coverage of workers in the formal sector of the economy can be increased in two ways. The first is for the government to make such coverage compulsory, either by creating a social insurance scheme funded through a tax on employers and employees, or by mandating that employers provide insurance (or directly provide or reimburse health services) for their workers. The second is for the government to provide incentives to employers and individuals to encourage them to purchase insurance.

Several African countries have social insurance systems financed through mandatory employer and employee contributions that cover health services for employees in the formal sector (for example, Burundi, Cameroon, Côte d'Ivoire, Kenya, Senegal). Where these schemes cover civil servants, the government contributes in its role as employer. In a few countries, private employers are required to provide coverage for their employees' health care costs, either by reimbursing their health expenses (Zaire) or by creating company or intercompany medical clinics (Madagascar) (Griffin and Shaw 1995; ILO 1993; Shepard 1995).

For a system of social health insurance to be feasible, a number of administrative requirements have to be met. First, mechanisms for collecting contributions must be in place, with the level of contributions defined as a percentage deduction from income. Because this requires having a common, agreed measure of income, this nearly always involves a payroll tax on employers and employees in the formal sector of the economy. The difficulty and cost of doing this for people working in the informal and agricultural sectors means that social health insurance functions most easily when most of the population is working in the formal sector. In addition, given that a number of other payroll taxes, such as pensions, unemployment insurance, and workers' compensation, already exist in most countries, an important feasibility issue is the effect of an additional tax on employers' total wage bill. Thus an increase in unemployment that may be induced by the introduction of this tax constrains the feasibility of social insurance (Normand and Weber 1994).

A second set of administrative requirements for social insurance to be feasible relate to what might be called the national infrastructure. This includes the presence of a core of well-educated administrators who could be trained to run the system. Some of the needed training and skills include data collection, statistical analysis, claims handling, financial management, the economics of incentives and provider behavior, and negotiation. In addition to this need for people with specialized skills and training, the general population should be sufficiently literate and numerate to understand the scheme. Another element of the national infrastructure is the development of appropriate legislation to codify the scheme into law, coupled with an ability to enforce these new laws. Features of the system that should be specified in legislation include issues of membership and population coverage, the means by which the scheme will be financed, the nature of the social insurance fund or funds (organization, decisionmaking authority, responsibilities, and accountability), the relationship of the scheme with providers, and the definition of the benefit package to which those insured will be entitled. Finally, the country's health service infrastructure must be able to provide the

legislated benefits. To this end, the government should develop an overall plan for developing the health services that specifies responsibilities for covering the insured and uninsured parts of the population (ILO 1993; Normand and Weber 1994).

Governments in some African countries have not created a compulsory insurance scheme, but they do provide financial, that is, tax incentives for employers to purchase private health insurance on behalf of their employees rather than mandate employer contributions. In South Africa and Zimbabwe, for example, a percentage of employers' contributions to medical aid schemes are either tax deductible or tax exempt (Bennett and Ngalande-Banda 1994; Pillay 1995). In Tanzania, no information is available on the government's tax treatment of employer sponsored health coverage, but a survey of large, urban employers found that most provide some type of health coverage for their employees (Griffin and Shaw 1995).

For incentives to be effective at expanding insurance coverage, the government's will and capacity alone are insufficient. Where coverage is voluntary, individuals and employers must perceive the benefits of insurance as outweighing its costs. Thus premiums should be lower than the expected cost of using care, and those insured must perceive the quality of care as adequate. To achieve this, several conditions must be satisfied:

- User fees must exist. This is not generally an issue where the insurance would cover private providers, but the implementation of user fees in government health facilities is a prerequisite for using insurance as a way to help finance public facilities.
- The insured group must be large enough so that the risk of incurring high cost health events is sufficiently spread to keep premium levels down. The size of the group depends on the size of the formal sector and the number of insurers active in the market.
- The scheme should be designed in a way that keeps premiums low. Design features for improving the internal efficiency of health insurance schemes are discussed in more detail later, but an important point is that the services covered by insurance should initially focus on relatively high cost, low frequency events. Governments can affect benefit design directly if insurance is organized in a single government scheme, or through regulations or incentives for the benefit packages provided by private insurers.
- The organizers of the scheme need information on health spending and utilization and risk patterns to be able to set premiums at levels that would be self-financing.
- If insurance is a new development, the government can support its development by identifying funds to provide start-up capital to meet its initial operating costs.
- Insurance needs to be organized and managed in a manner that keeps administrative costs as low as possible (Griffin and Shaw 1995).

EXPANSION OF INSURANCE COVERAGE BEYOND THE FORMAL SECTOR. Equity is clearly related to the level of coverage health insurance schemes achieve. As people with lower incomes are brought into the insurance system, this reduces an important barrier to access for those who need coverage the most. Thus insurance can be a powerful mechanism for improving equity in the receipt of care within the covered population (Griffin and Shaw 1995). Based on the experience of both industrial and developing countries that have been able to achieve universal coverage with health insurance, one can identify a number of conditions for the expansion of coverage and improvement in equity. Some of these conditions are under the control of health sector decisionmakers, but others are largely outside their control (Kutzin 1995; WHO 1995). The conditions relate to the specifics of policy decisions, to a country's administrative capacity, to macroeconomic circumstances, and to broader issues of culture and historical development. The conditions are as follows:

- National policy should make universal coverage mandatory and establish a clear plan for moving in this direction. This requires that the government have in place administrative systems capable of organizing people in the nonformal sector of the economy, identifying people for whom insurance premiums will have to be subsidized, and targeting subsidies to these individuals.
- Levels of income and the percentage of the population employed in the formal sector of the economy must exhibit growth.

- The national banking system must be efficient, and a high level of administrative capacity to facilitate the flow of funds and information must be available. The population at large must be relatively literate and numerate, and specific skills and systems related to the business and management of insurance must also be present, for instance, negotiation, data analysis, auditing, and accounting.
- A high degree of integrity and probity in corporate and public affairs is needed, because the expansion of insurance schemes involves pooling an increasingly greater amount of funds.
- Countries that have achieved universal coverage also appear to have a history and culture conducive to social solidarity. As with integrity, this is difficult to measure, but is essential for insurance to be expanded successfully on a large scale. Patience and commitment to making the insurance scheme as extensive as possible are essential, especially because the initial groups to be covered will be powerful advocates for consolidating and expanding their own benefits, rather than for expanding the scheme in general.

This is a soberingly long list of conditions, and governments should seriously consider their commitment to national social insurance before proceeding down this path. In most countries that have achieved universal coverage, such as Costa Rica, the Czech Republic, Germany, and Japan, the transition from partial to full coverage of the population took between 40 and 100 years. The fastest country to make this transition was Korea, which did so in 12 years. This occurred in the context of a clear government commitment to universal coverage, a strong local government system able to implement regular means tests to identify those in need of subsidies, and an economic growth rate per capita that averaged more than 10 percent per year in real terms during this period (WHO 1995).

Perhaps more relevant to African countries is the need for the government to support the development of insurance schemes for the rural and urban informal sectors of the economy. While this is beyond the scope of this chapter (see chapter 4 in this volume), governments may have an important role to play in relation to these schemes, even though the limited number of examples for which good documentation exists only involve governments minimally (see, for example Moens and Carrin 1992 or Shepard, Vian, and Kleinau 1990 for a description of the prepayment scheme in the Bwamanda health zone of Zaire). Where prepayment and insurance schemes for people in the informal sector exist, governments should try to learn about them and try to coordinate them into the overall development of the health system. This might ultimately lead to a coordination of benefits and financing systems across schemes in a country, thereby expanding the overall pool of the insured population.

Desirability

If the government institutes policies to expand health insurance coverage for those in the formal sector, will the distribution of government subsidies for health become more or less equitable? And what will happen to access to care, not only for the insured, but for the entire population? The answers to these questions depend on a number of conditions, many of which can be affected by policy. The poorer, uninsured part of the population could benefit if the newly insured group self-finances the scheme, and if they move from public to private sources of care. This would allow government health funding to be focused more narrowly on those who would still use the public delivery system (Shaw and Griffin 1995). In other words, the technical conditions for equity improvements to result from expanding insurance for those working in the formal sector of the economy are as follows:

- Newly insured people must switch to privately financed care to such an extent that the sum of the public revenues liberated by this switching is greater than the government subsidies, for example, tax relief, used to expand insurance.
- For newly insured people who continue to use government health facilities, charges need to be set at rates high enough to recover costs fully, or possibly to allow for some cross-subsidization of services

for the uninsured. This requires government providers to determine the costs of care and to ensure that people covered by insurance are charged at a rate that is at least equal to that unit cost.

- Newly freed government resources must be retained in the health sector and be targeted to services used by the poor.

The limited available evidence indicates that countries have had difficulties in meeting these conditions, and therefore expanded coverage of the formal sector with health insurance has usually worsened inequities. For African countries a major constraint on equity is that the size of the formal sector is quite small and relatively well-off in economic terms. Promotion of insurance initially skews resources toward this part of the population, and governments have not demonstrated their willingness or ability to put the other conditions in place that would permit public resources to be refocused on the poor. Thus if expansion of insurance is to improve equity, this depends not only on how the scheme is financed, but also on the government's broader allocation policies governing health resources (Bennett and Ngalande-Banda 1994).

In Burundi, for example, a compulsory social insurance scheme for civil servants, members of the armed forces, employees of parastatals and universities, and their dependents was the cause of great inequities in the use of government subsidies for health. Employers, namely, the government or government-supported bodies, funded this scheme through a 7.5 percent payroll contribution, 3 percent of which was deducted from employees' salaries. In 1991 public expenditure on the services consumed (largely in the private sector) by this economically advantaged group, who made up about 6 percent of the population, came to about 30 percent of total government health expenditure (World Bank 1993). Even if this insurance scheme caused all its beneficiaries to move from public to private sources of care, which is an extreme assumption, the public resources freed by such a shift are unlikely to have offset the amount the government spent to provide insurance for them.

A compulsory insurance scheme for Indonesian civil servants provides further evidence of the inequities that can arise when governments create such schemes for their employees. This scheme has created additional equity concerns because the main benefit it provides is free use of public hospitals, and the reimbursement rates are actually below the cost of providing services. Thus in this scheme, the purchase of insurance is subsidized through the government's employer contribution and the use of services is also subsidized through below cost charges in public hospitals. A World Bank study found that the scheme used public hospitals at a rate that was five times the national average (Prescott 1991). This situation may be relevant for many African countries where reimbursement rates for private patients in public hospitals may recover less than the full costs of care, thereby leaving the government to pay the remainder for private patient services.

Inequities in the financing and receipt of care are also possible in countries that promote insurance through tax incentives. In South Africa, for example, employers' contributions to medical schemes are tax deductible and are a tax free benefit for employees. As in other countries, these tax benefits constitute government subsidies to a relatively well-off segment of the population. Health insurance schemes cover 19 percent of the population, but expenditures on behalf of this group represent nearly 50 percent of total health spending (Pillay 1995).

Given these examples, governments need to be cautious when considering expanding insurance for a relatively well-off segment of the population. Health insurance schemes in Africa and in countries elsewhere with relatively small formal sectors tend not to be self-financing. Instead, they usually involve a substantial element of subsidy. Why has this occurred? One answer to this question is that the countries have not met the technical conditions specified earlier. However, this leads to further questions of why they have not met these technical conditions. Evidence from country experience is insufficient to answer these questions conclusively, but the answers are probably not of a "technical" nature. Instead, the issues are likely to involve administrative capacity and the political power of well-organized interest groups.

For a health insurance scheme to free resources that the government can reallocate, the cost of the scheme must be minimized. This implies the need for strong administrative capacity. Where the insured use public

hospitals, governments must be able to calculate the costs of in-patient care, especially for "amenity" rooms that the insured population is likely to use, not just the average cost of a hospital stay, and routinely update this information so that they can set reimbursement rates at a level that will cross-subsidize the public sector.

From the perspective of power politics, the insured population, while relatively small, may be well organized given the important economic role of the formal sector. It may thus be in a position to put pressure on the government to expand insurance benefits, and possibly to have the government directly subsidize their contributions. Professional organizations of providers, such as medical associations, may also be a powerful force that pressures the government to increase the level of reimbursements the insurance fund pays them.

Any of these factors would limit the possibility that insurance could generate a surplus for redistribution to the uninsured. If the government is truly committed to using insurance for the formal sector to increase the resources available to the uninsured, it will need to use political skills to support its technical objectives. This might involve launching public education campaigns and building strategic alliances with other organized groups, such as employers and possibly associations of private insurers, that are interested in keeping down the costs of providing insurance.

The lesson from experience is not that expanding insurance is certain to worsen equity, but rather that the methods chosen to promote such an expansion must be part of an overall strategy to establish the conditions needed to improve equity. Expanding insurance coverage could be part of a broader program to reduce inequities, but by itself, it could easily make things worse. As those who have promoted the expansion of insurance for the formal sector in Africa correctly note, however, substantial inequities already characterize existing health systems (Griffin and Shaw 1995). Governments need to consider their options for improving equity in the financing and receipt of care and determine if measures to expand insurance coverage for the formal sector constitute the best policy choice. As part of this assessment, they need to determine the likelihood that they will be able to meet the technical conditions required for insurance expansion to improve equity. Meeting these conditions will likely demand investments in administrative capacity and attention to the politics of policy implementation.

Retaining Scarce Health Personnel to Serve "Public" Patients

Even if the government puts policies in place to promote expanded insurance coverage in a way that should yield a net increase in revenues available to serve the noninsured, poorer segment of the population, the expansion of the private sector induced through growth in insurance is likely to induce a shift in human resources from the public to the private sector. This could prevent insurance from improving equity in the receipt of services, as fewer skilled providers per capita are likely to remain in the public service. Thus policymakers should ask what the impact of expanded insurance is likely to be on the distribution of skilled human resources in the health sector, and whether they can identify and implement policies to stem the brain drain from the public to the private sector.

Evidence on the distribution of staff in the public and private sectors and how it relates to insurance coverage suggests that this distribution may be even more inequitable in terms of urban-rural differentials than that of overall resources (WHO 1995). In South Africa, for example, the relative growth of the private sector during the last decade has resulted in there being four times as many people per doctor in the public sector as in the private sector (Pillay 1995). Thus one can assume that expanding insurance coverage will expand private provision, including the development of private for-profit hospitals. Private facilities are likely to be more attractive to providers, because they offer the possibility of greater earnings (funded by insurance) and better working conditions. As formal sector employees tend to be concentrated in urban areas, an expansion of insurance coverage for this group may exacerbate urban-rural differences in the availability of skilled health providers. The growth in private sources of care would probably mean a movement of human resources from the public to the private sectors within urban areas, and would also attract public providers from other parts of the country.

No empirical work is available to illustrate the impact of expanding health insurance on the distribution of skilled health personnel. Thus, identifying with confidence the conditions needed to limit the potentially harmful consequences of such expansion for equity in the availability of providers is difficult. In technical terms, a sufficient quantity of skilled providers is needed to provide services to the insured population without absorbing staff who previously served the uninsured. Related to this, the income that insurance provides to private providers should not be so great that it diminishes the ability of the government health services to attract staff (WHO 1995). African governments have tried to introduce policies to retain skilled staff in the public delivery system. For example, Lesotho and Zimbabwe have implemented bonding, whereby workers are obliged to stay in their positions for an agreed length of time, and Nigeria and Zimbabwe have raised public sector salaries. However, these policies do not seem to have been effective. Another option that has been used in Malawi and Zimbabwe is to allow private sector physicians to practice in public hospitals in return for them agreeing to treat public patients free of charge (Bennett and Ngalande-Banda 1994). The problem of staff retention in the public sector is not specific to health insurance expansion, but can clearly be exacerbated by it.

The question of how to retain staff in the public sector in the context of an expanded private sector has no obvious answer. Governments need to develop more policy options, including internal reforms to improve salaries and working conditions in the public sector, and other measures involving agreements or contracts with private providers to serve public patients. In any event, policymakers need to be aware of the likelihood that policies to expand insurance coverage for the formal sector are likely to skew the availability of services further, because of the drain of skilled providers from the public to the private sector and increased concentration of service providers in urban areas.

Encouraging Efficiency Within Insurance Schemes

The issues addressed in the preceding sections of this chapter dealt primarily with equity. Governments should also be concerned with the efficiency of insurance schemes for the formal sector for two broad reasons. First, efficiency is an objective in its own right, and governments should try and promote this in all parts of the sector to improve social welfare. Second, where insurance schemes cover a relatively small and privileged part of the population, internally efficient schemes are essential to the government's ability to promote overall sectoral equity. The reason for this is that if the costs of the insurance scheme are kept under control, the pressure for the government to increase subsidies to the insured population via the employer contribution to social insurance for civil servants or tax relief for the voluntary purchase of insurance is reduced. This, in turn, means that the insurance scheme is more likely to free up resources that the government can target to the uninsured. Thus efficiency in the insurance subsector is essential for achieving overall equity in health resource allocation.

As Shaw and Griffin (1995) noted, risks must be pooled on a large scale for insurance to be efficient, and thus for premium levels to be kept as low as possible. Government policies to encourage large groups to form may facilitate this for existing systems of health insurance. If a country has a limited or no private health insurance market, a large group can be created through a single government-run scheme or a single scheme managed by an autonomous government agency or a not-for-profit firm. In some countries existing legislation needs to be changed for risk pools to be increased. In Senegal, for example, legislation requires each private firm with more than 100 employees to form its own insurance group. This results in several groups that are exceedingly small from the perspective of insurance, and caused the Senegalese social health insurance system to run into financial difficulties (Vogel 1988). Where such legislation exists, the government should revise it to facilitate the amalgamation of employer-funded groups into larger risk pools.

Governments can affect the efficiency of health insurance arrangements in several other ways. These include incentives and regulations for private insurers and providers or the government directly acting as the insurance fund. Key elements of the tools available include regulating or defining the benefit packages, the means by which services are accessed, and the methods by which insurance schemes pay providers.

Irrespective of whether they are publicly or privately administered, the aspect of health insurance schemes that appears to have the most important implications for efficiency is the role of the insuring, that is, fund holding, institution. Where it acts simply as a financial intermediary that collects premium payments and reimburses claims, as in public insurance schemes in China and unmanaged private schemes in South Africa, the United States, and Zimbabwe, the volume of services consumed tends to rise dramatically, increasing total costs. In systems where the insurer functions as an active purchaser of services in pursuit of savings and efficiency, as with fund holding arrangements, cost increases have been limited (Kutzin 1995; Kutzin and Barnum 1992).

Abundant evidence from around the world, for example, China, the Czech Republic, Korea, South Africa, and the United States, demonstrates that fee-for-service reimbursement of providers by insurers causes rapidly rising costs, because of the incentives generated to provide excess services. Because patients depend on providers for information as to their treatment needs, and because fee-for-service payment creates an incentive to increase the volume of services to increase providers' incomes, this payment mechanism leads providers to "induce" demand for referral services. Thus policymakers should avoid unregulated fee-for-service reimbursement (Barnum, Kutzin, and Saxenian 1995; WHO 1995). Governments can define other forms of provider payments for social insurance schemes, such as capitation. Where private insurance exists, governments should encourage insurers to use alternatives to fee-for-service, perhaps through tax incentives that limit the deductibility of premium payments for insurance using fee-for-service, while maintaining deductibility for insurance that uses other methods of paying providers.

Prospective and retrospective controls on the volume of care can limit the risk of inefficiency from fee-for-service systems to some extent, but implementing these effectively requires substantial administrative capacity and a highly developed information infrastructure. Case-based retrospective reimbursement, such as hospital payment for diagnosis-related groups, is, from a technical perspective, an improvement over fee-for-service systems, because it pays for outputs rather than inputs. Such systems require sophisticated and expensive methods to monitor providers and update payment rates, and therefore are probably not feasible in poor countries (Kutzin 1995).

An important function that is essential for cost containment is that of the gatekeeper who controls access to more expensive referral services. This function is an important element of the health systems in many industrial countries, such as Denmark, Finland, Ireland, New Zealand, Portugal, Sweden, and the United Kingdom. Thus it is used in many nations that have effective national health systems or social insurance systems. In these countries, a general practitioner with whom the covered person is affiliated generally performs the gatekeeper function. In many other countries, gatekeepers are a feature of private insurance schemes. They exist, for example, in the private health maintenance organizations that are found in Chile, the Philippines, South Africa, the United States, and elsewhere. The power of the gatekeeper function is strengthened in systems where gatekeepers are at financial risk for their clinical decisions (Kutzin 1995).

Another way to reduce insurance costs is to limit the benefits these schemes cover to high cost, low frequency health events. These events are often referred to as catastrophic, and catastrophic insurance coverage protects individuals against these costs. If the insurance pool is large enough, catastrophic coverage can be inexpensive, because the risks are spread over a large number of people. This approach can be effective for financing hospital care for the insured population (Griffin and Shaw 1995). Although it might not seem appropriate to leave primary care uncovered, formal sector employees probably can and will pay for their ambulatory care out-of-pocket. Nevertheless, this approach may entail some problems. Unless effective administrative procedures, such as gatekeeping, mandatory second opinions, or the insurance fund's approval of admissions are in place, this type of insurance might cause overuse of hospitals and a greater concentration of resources at this level, because those insured will have a strong incentive to ask their providers to treat them in a way that minimizes their out-of-pocket costs. Alternatively, limiting the benefits to catastrophic coverage might prove difficult politically. Experience from several countries such as the Czech Republic and Thailand suggests that the formal sector and civil servants will fight to expand their benefits in such programs, and their demands can prove difficult for governments to resist. Indeed, expansion of benefits may be more likely than expansion of the population being covered (WHO 1995).

The same political obstacles cited previously as hindrances to generating a surplus from the insured population that can be reallocated to the health services used by the uninsured are likely to limit the government's ability to encourage efficiency within insurance schemes. For example, physicians will resist attempts to change from a system of fee-for-service reimbursement, and the insured population is likely to resist other changes, such as the introduction of gatekeepers, that will limit their choice of service providers. However, governments may well share a common interest with employers in keeping the costs of insurance schemes under control, and should actively collaborate with them to push for efficiency-oriented reforms.

Conclusions

Irrespective of whether or not a government should attempt to expand insurance coverage for the formal sector, many countries already have health insurance schemes in place that need major reforms. Many of the measures suggested to improve equity apply to existing as well as to new or expanded schemes, and should be considered as possible areas of government action. In addition, governments can act to reduce existing inefficiencies in the insurance sector.

In theory, gains in equity and efficiency can arise from the promotion of expanded insurance coverage for the small, formal sector, but the conditions needed to achieve them are stringent and require strong government commitment. Unless these conditions are met, this type of insurance promotion will worsen existing inequities by causing a greater share of government funds to be absorbed by wealthier population groups and not freeing up resources for the poor, and by exacerbating inequities in the distribution of health human resources, especially physicians' services. In addition, expanding insurance will not improve allocative efficiency, and might even make it worse through a greater concentration on urban, tertiary care. Evidence reveals a large gap between the desired effects of insurance expansion and actual observed effects. The reasons for this probably have a lot to do with the impact of powerful interest groups on the design of government policies.

Government policy choices and priorities should be rooted in the existing realities of institutional and economic development and oriented toward the pursuit of the broad policy objectives of equity and efficiency. When considering any policy option, such as policy with respect to health insurance in the context of a relatively small formal sector, the general question that policymakers should ask is, "What are the priority problems facing the sector, and will this option, that is, expanding insurance, help or make things worse?" Each country must find its own answers to this question.

References

- Barnum, H., J. Kutzin, and H. Saxenian. 1995. "Incentives and Provider Payment Methods." *International Journal of Health Planning and Management* 10(1):23-45. Also available with the same title: Human Resources Development and Operations Policy Working Paper no. 51. World Bank, Human Development Department, Washington, D.C.
- Bennett, S., and E. Ngalande-Banda. 1994. *Public and Private Roles in Health: A Review and Analysis of Experience in Sub-Saharan Africa*. Current Concerns Series, Strengthening Health Services Paper no. 6. WHO/SHS/CC/94.1. Geneva: World Health Organization, Division of Analysis, Research, and Assessment.
- Griffin, C. C., and R. Paul Shaw. 1995. "Health Insurance in Sub-Saharan Africa: Aims, Findings, Policy Implications." In R. Paul Shaw and Martha Ainsworth, eds., *Financing Health Services through User Fees and Insurance: Case Studies from Sub-Saharan Africa*. Discussion Paper no. 294. Washington, D.C.: World Bank, Africa Technical Department.
- Hammer, J. S., and Peter A. Berman. 1995. "Ends and Means in Public Health Policy in Developing Countries." In Peter A. Berman, ed., *Health Sector Reform in Developing Countries: Making Health Development Sustainable*. Boston, MA: Harvard University Press.
- ILO (International Labour Organisation). 1993. "Health Care Under Social Security in Africa: Taking Stock of Experience and Potential." Working Paper. Social Security Department, Geneva.

6

Public-Private Collaboration in Health: Issues and Implementation

Ellias E. Ngalande-Banda, Ministry of Finance, Malawi

During the 1980s, the so-called lost decade, many Sub-Saharan African countries went through a period of economic turbulence. For most, this was also when they embarked on structural adjustment programs aimed at a wide range of reforms. Such reforms, some of which are still being implemented, have not spared the health sector. Perhaps the best example of reforms in the health sector is policymakers' preoccupation with the issue of public-private collaboration in health. In the last five years or so, researchers have been exploring different aspects of this subject. Interest in this topic can be traced to an interregional meeting that the World Health Organization's Division of Strengthening of Health Services organized in July 1991 (WHO 1991).

Public-private collaboration is being extensively explored for a variety of reasons. One reason is the dwindling of resources in the health sector, combined with increasing demands on the sector. This is especially apparent in the area of human resources, largely doctors, which are concentrated in the private sector. Policymakers see public-private collaboration as one way to tap resources that have moved away from the public sector. Another reason is that with the implementation of various reforms in many countries, dual systems of health care provision are inconsistent with the many prescriptions in favor of market determination (for a full exploration of the market characteristics of the health sector see Bennett 1991). Yet another reason is that governments have come to recognize that the dual system of health care provision is promoting inequities by leaving large areas completely unserved by "free" public facilities introduced at independence. Finally, an epidemiological transition has taken place, with a shift from a prevalence of communicable diseases to noncommunicable diseases and injuries.¹

After the decline in popularity of independence movements, the public sector is increasingly being perceived as inefficient. This dissatisfaction with the role of the government has also promoted collaboration with the private sector.

1. Although this transition may not have taken place in the developing countries, the pressure for greater private sector participation from international financial institutions and bilateral donors may have been motivated in part by this phenomenon (see Bennett 1991, p. 1).

Table 6.1. The Public-Private Mix in Health Financing and Provision

		Provision	
		Public	Private
Financing	Public	<ul style="list-style-type: none"> • Government funding and provision free at point of use 	<ul style="list-style-type: none"> • Services contracted to private providers • Government subsidy to mission facilities
	Private	<ul style="list-style-type: none"> • Supplementary direct user charges • Private beds in public hospitals 	<ul style="list-style-type: none"> • Private health care funded by private insurance • Health maintenance organizations • Services by nongovernmental organizations

Source: Adapted from Bennett and Ngalande-Banda (1994, p. 3).

This chapter examines these issues in the context of southern Africa. The discussion is intended to generate further debate of the issues surrounding public-private collaboration in the region. As this subject is new and complex, this chapter does not aspire to present all the different models of collaboration available.

Organization of Health Sectors

At the risk of overgeneralizing, health sectors in most countries in southern Africa are characterized by the presence of two health subsectors, namely, the traditional and the modern. Missionaries introduced modern health care as a complement to their religious activities. After gaining independence, most governments introduced a strengthened public sector presence in the modern health subsector, which has existed alongside the traditional subsector.

The private subsector as used here covers "all those organizations and individuals working outside the direct control of the state, that is, both for-profit private companies and individuals and nonprofit private organizations" (Bennett and Ngalande-Banda 1994). This subsector is extremely diverse and incorporates elements of both the traditional and the modern. Whereas it may have been correct to group all the religious missions' health facilities as nonprofit providers, recent changes in the health sector mean that some of these providers now have a for-profit orientation. This chapter does not cover the traditional subsector.

A useful way to characterize the different players in the health sector is to distinguish between their methods of financing and providing health services. This is done in table 6.1.

While the degree to which any of the four models may be present differs from one country to the next, all have some combination of the elements presented in table 6.1. Increasingly, however, countries are tending to embrace private financing and public provision, as evidenced by the number of countries currently contemplating the introduction of user charges in public hospitals.

A further development is the acceptance of private financing and provision as complements to public sector efforts, and it is this that has led to the growth in the private for-profit sector that is increasingly evident in a number of countries. The evidence indicates that this has been taking place in Tanzania after a period of being disallowed (Bennett and Ngalande-Banda 1994) and in Malawi following the amendment of the Medical Practitioners' and Dentists' Act.

Resource Mobilization and Distribution

The role of mobilizing resources is best left to the government, which has the necessary instruments of coercion, persuasion, legislation, and regulation, coupled with the means for enforcement. However, the government

does not always achieve the optimal distribution of resources. Even though Sub-Saharan Africa as a whole receives funds from donors equivalent to 10.4 percent of its health expenditure, resources are unequally distributed throughout economies, especially within health sectors.

After several decades of independence, many countries still have areas that the public sector does not serve. This unequal distribution has placed a great deal of pressure on governments to accept some partnership with private providers, such as missions, which have tended to locate in remote areas. The unequal distribution of health facilities is prompting governments to explore ways to reduce inequity by granting concessions to private providers.

Approaches and Options

Public-private collaboration can be in provision, in financing, or in some combination of the two. Historically, in southern Africa the private sector has, in most instances, been providing modern as well as traditional health care longer than the public sector. In addition, because the private sector may be endowed with facilities absent in the public sector, collaboration can enable the public sector to gain access to superior facilities. In some countries the best hospitals may belong to the private sector. For these and other reasons, the most commonly used method of collaboration as it relates to sharing facilities is contracting.

With dwindling financial resources, another form of collaboration now commonly found in the region is based on financing. Under this arrangement, the private sector is called upon to help finance health care through insurance schemes or payment of user fees. Other more complex arrangements can also be found that combine aspects of both provision and financing.

Contracting

Contracting or outsourcing is a way to combine public financing with private provision (McPake and Ngalande-Banda 1994). Just as with other types of contracts, this arrangement makes use of a normal market exchange that is formalized in advance by a contract that specifies the services to be provided and the fees to be paid. The provider of the service could be another public institution; however, public health sectors are increasing contracting out to private institutions.

The best examples of contracting out are found in the areas of nonclinical services. The argument is that the health sector should concentrate on providing medical care rather than ancillary services such as catering, laundry, and security. The private sector can undertake these activities more readily, because monitoring and evaluating performance is easier in these fields, unlike in clinical services, where establishing the expected and actual quality of the outcome is difficult. Health policymakers also believe that these activities can be outsourced without compromising the quality of health care. There are indications that these arrangements are either contemplated or currently practiced in Lesotho (catering and security services), Nigeria (laboratory services), Uganda (catering, elevator services, and the management and maintenance of steam and boiler houses), and Zimbabwe (laboratory and equipment maintenance).

In other contexts, the public sector contracts out certain services as a way to combat the brain drain from the public sector. In Namibia, private general practitioners are contracted to provide surgery in remote rural areas for an agreed fee (Bennett and Ngalande-Banda 1994). Elsewhere, doctors are permitted to admit private patients in public hospitals in return for attending to public patients.

Health Insurance

Governments are increasingly trying to cope with resource constraints in the health sector by resorting to expenditure sharing between the public and private sectors. One way they do this is by introducing insurance schemes. Insurance schemes are also used to spread the cost of the risk of falling ill.

The most common of the different types of insurance schemes are (a) social health insurance, which is also referred to as national health insurance, especially where it covers the whole population; (b) employer-based schemes; (c) community-based health insurance; and (d) private health insurance. (For a discussion of these schemes see Bennett and Ngalande-Banda 1994.)

Besides offering the opportunity to spread the cost of the risk of falling ill, insurance schemes may have the added flexibility that expenditures against unpredictable illnesses can be met at the time that the household has the financial means to do so. This is especially true in the case of community-based schemes, to which contributions can be solicited at the time that most households are likely to be able to afford the premium payments, such as during the harvest.

Other Forms of Collaboration

A third approach that a country can use is to recognize fully the strengths and weaknesses of different providers and financiers in the health sector and to attempt to build a viable system based on the sharing of responsibilities. In many Sub-Saharan countries, mission hospitals and ministries of health have developed lasting relationships where the latter pays the salaries of staff working for the former, for instance, in Ghana, Malawi, Namibia, Tanzania, and Zimbabwe. This is essentially a way to safeguard the financial viability of the mission facilities. Other forms of collaboration involve paying lump sum grants (subsidies), seconding health personnel, providing relief from duty and taxes on imports (Bennett and Ngalande-Banda 1994), cooperating in staff training, and carrying out research and developing policy (in the case of South Africa).

In almost all cases where appropriate umbrella organizations exist, such as nonprofit organizations that manage mission health facilities, an important motivating factor for their establishment is the receipt of certain incentives, for example, public subsidies and tax exempt status. In return, the organizations have to meet specific conditions or agree to certain undertakings. In the case of Tanzania, for example, audited accounts must be provided to receive any assistance, while in Malawi subsidies for salaries are only for local staff (Bennett and Ngalande-Banda 1994). Note that suitable umbrella organizations are most prevalent in the nonprofit subsector as opposed to the for-profit subsector.

Implementation Mechanisms and Strategies

The last section touched upon some of the ways in which countries have fostered collaboration. The most common and successful conduit seems to be organizing a number of providers into umbrella organizations. Running parallel to this is the carrot and stick mechanism (Bennett and others 1994). What this means is that the government can foster collaboration by granting incentives (the carrot) or by setting regulatory mechanisms (the stick). Almost all countries use these approaches in various forms; however, some common steps are involved in successful implementation of these mechanisms.

Identifying and Phasing in Public-Private Collaboration

One important step toward successful collaboration is recognizing what is possible. The first step is to take stock of what institutions are available in the country to assess possible kinds of collaboration. Countries have found the easiest form of collaboration to be between the ministry of health and local government facilities in the provision of preventive primary health care services. In Malawi, for instance, these two facilities tend to be within close proximity to each other.

Financial collaboration requires there be some minimum support structures. Many countries do not have structures that can support insurance schemes or the introduction of user charges. They should therefore evaluate what forms of financial collaboration can work, and perhaps attempt this type of collaboration later.

Collaboration in service provision can also become tricky. For contracting to work, for example, the country needs to have some providers who have the infrastructure to support the scheme. This is important, because otherwise contracting could result in the deterioration of services, or even in acute shortages.

Requisites for Success

One of the important attributes of the private sector that could benefit the public sector through public-private collaboration is that people tend to perceive private providers as more efficient than public providers. They believe that, in general, private facilities are better managed, private providers allocate resources optimally, and services are superior than those public facilities provide. Nurturing this perception through collaboration is important for both collaborators. Thus designers of collaboration mechanisms should pay close attention to clear contract terms, appropriate pricing, and standards for quality monitoring.

By contrast, in some instances people view private providers as too preoccupied with making profits, and this perception should be downplayed through collaboration. For example, if collaboration results in the introduction of fees at public facilities, health care consumers will have to be convinced that the benefits of public provision, namely, universal coverage, will be retained in the process of collaborating with the private provider.

The success of collaboration will also depend on how well the collaborators' intentions are communicated to the community. Depending on the social marketing done, people can view a community-based insurance scheme either as a way in which the government is renegeing on its responsibility to care for the poor, or as a way in which it is spreading the risk away from the poor. Thus each collaborative scheme must be evaluated on the basis of its implications for the users, and appropriate steps must be taken to ensure that its beneficiaries understand such implications.

Bottlenecks to Overcome

Collaboration encounters three main bottlenecks that it must overcome: capacity, availability of collaborators, and harmonization.

Many developing countries lack the capacity to manage collaboration. Successful collaboration in provision requires managerial skills that are often in short supply in the health sector. In addition, because of resource constraints, collaboration has to take place amid shortages, which requires ingenuity on the part of all those collaborating, but especially the government, which must also regulate. Similarly, financial collaboration requires the existence of financial systems to handle the complex accounting and auditing procedures required. In the case of insurance mechanisms, for example, both the health care provider and the insurance provider must adhere to certain accounting, reconciliation, and auditing procedures. Furthermore, the government needs considerable capacity to regulate insurers and monitor their behavior to avoid such problems as risk skimming and cost spirals associated with fee-for-service third party payers.

As concerns the availability of collaborators, successful examples of collaboration in many developing countries involve the nonprofit and public sectors. Where private providers are unwilling to form an umbrella organization, successful collaboration often becomes a problem. Simukonda (1992) lists some of the philosophical problems that can contribute to the failure of social welfare agencies to get organized. Note that in many developing countries the private sector is both extremely small and lacks the capacity to get organized.

A final consideration is the need for harmonization. This can take many forms. One area of harmonization that is proving important for collaboration in many countries is the need to harmonize user fees between private and public providers. Many countries have as many as three different fee structures: one for the private for-profit subsector, one for the private nonprofit subsector, and one for the public sector. In Malawi the harmonization of user charges has been under discussion since the early 1990s, and does not seem to be any closer to being resolved now than then.

Economic Impacts on Efficiency, Equity, and Sustainability

The previous section noted that people tend to perceive the private sector as more efficient than the public sector. This is because the private sector responds to market signals, although such a response can produce undesirable effects in health care. However, another reason is that the private health subsector is significantly

more decentralized than the public health subsector. This being the case, individual units are considerably more accountable than their public subsector counterparts.

One of the impacts of collaboration is that it can engender a move toward decentralization of decisionmaking and resource utilization. This can improve the efficiency of the entire health care system. Another avenue through which efficiency can come about is by accelerating the introduction of user fees systemwide, the effect of which, at least in theory, is greater allocative efficiency.

Public-private collaboration can also foster equity. In many countries, particularly in rural locations, vast areas are either not served by health care facilities or, where they are, the facilities are of different types. In many rural areas the only health facilities are mission facilities, which charge for their services, while in other areas services are free. Collaboration, in so far as it would require harmonization, would either require payment for all services or all services would be completely free.

A final impact is on sustainability. As much as most newly independent African governments wanted to be able to provide their populations with free health care, the majority have not been able to do so. They are increasingly having to rely on cost recovery from users, and to guarantee a reasonable quality of care, the resources of the public and private sectors have to be pooled. The most direct way to achieve this is through direct payment for actual services received, as is done through user fees.

Collaboration can also have a negative impact on sustainability when private providers take advantage of contracting arrangements to introduce cost-push elements into the system. This is common in the case of for-profit providers who can take advantage of loyalties established with consumers to inflate contract prices. Perhaps the best examples of such behavior can be found in insurance markets.

Broader Systemic Impacts

To the average user of the health care system, the impact of collaboration may be to simplify information that has to be processed on population characteristics, epidemiological profiles, disease burden, use, ability to pay, availability of providers, fees, entitlements, and so on. The health sector is notorious for imperfections in information flows. Through collaboration consumers could access this information by interacting with the system at any one point. For example, in some Sub-Saharan African countries patients can access both modern and traditional forms of health care without leaving a public health facility. Similarly, in many countries in the region, babies born in any type of health facility have equal access to immunizations through collaboration between the public and private providers. Such collaboration can improve on the reach of medical interventions within the community by being able to work through any system available.

The effect of collaboration on decentralization was mentioned earlier. Collaboration will not only ease the management of the health system at the local level, but also at the central level, where some easing of congestion will take place. In a number of countries free services seem to encourage overutilization of the services. Collaboration would standardize the level and quality of services, provide more resources to the sector, spread the consumers (and the rate of utilization), and curb unnecessary consumption.

One problem associated with private sector providers is that they place too much emphasis on curative rather than on preventive care. To overcome this, governments have provided such preventive measures as vaccinations and family planning interventions to private providers at no cost. With collaboration, providing such services through a shared cost structure may become easier.

Conclusion

Public-private collaboration is a complex and evolving research field. The complexity comes about because the roles of both governments and the private sector are changing all the time. It also comes about because the provision of health care in the region has always been divided among many providers. Furthermore, the emergence of HIV/AIDS in southern Africa as the main killer disease of the 1990s is also adding to this complexity.

This chapter has surveyed some of the issues that require attention in efforts to foster greater collaboration. Many countries are experimenting with a number of different models, and this chapter could not possibly do justice to all those efforts. The author hopes that this chapter will stimulate the sharing of specific country experiences, which will enrich the analysis.

References

- Bennett, S. 1991. "The Mystique of Markets: Public and Private Health Care in Developing Countries." PHP Departmental Publication no. 4. London School of Hygiene and Tropical Medicine, London.
- Bennett, S., and E. Ngalande-Banda. 1994. "Public and Private Roles in Health: A Review and Analysis of Experience in Sub-Saharan Africa." Strengthening Health Services Paper no. 6. World Health Organization, Geneva.
- Bennett, S., George Dakpallah, Paul Garner, Lucy Gilson, Sanguan Nittayaramphong, Beatriz Zurita, and Anthony Zwi. 1994. "Carrot and Stick: State Mechanism to Influence Private Provider Behavior." *Health Policy and Planning* 9(1):1-13.
- McPake, Barbara, and Ellias Ngalande-Banda 1994. "Contracting Out of Health Services in Developing Countries." *Health Policy and Planning* 9(1):25-30.
- Simukonda, Henry P. M. 1992. "Creating a National NGO Council for Strengthening Social Welfare Services in Africa: Some Organizational and Technical Problems Experienced in Malawi." *Public Administration and Development* 12(5):417-31.
- WHO (World Health Organization). 1991. "The Public Private Mix in National Health Systems and the Role of Ministries of Health." Report of an interregional meeting, July 22-26, Hacienda Cocoyoc, Morelos, Mexico.

7

District Control and Accountability in Botswana's Health Care System

*Patrick P. Molutsi, Senior Lecturer,
Department of Sociology, University of Botswana, Gaborone*

Health care financing reform is currently a top priority on the development agendas of many countries, donors, and financial institutions across the world. Although the reasons and the urgency for health care financing reform differ from one country to another, the trend and objectives are the same. All countries recognize that public financing, traditionally the main source of health care financing, is proving both inadequate and unsustainable.

Developing countries, in particular, are in danger of losing the impressive achievements in health and education they made in years past when they were experiencing better economic growth rates. In the face of shrinking public budgets, many countries must find additional sources of health care financing. A number of countries are diversifying their sources of health care financing to include individuals, communities, local authorities, nongovernmental organizations, and the private sector. Botswana has followed the trend by undertaking significant health care financing reforms since the beginning of the 1990s (Government of Botswana 1991; Moalosi 1991).

The concepts of user fees, community participation, and medical aid are currently receiving more emphasis than in the past. This chapter addresses a number of health care financing reforms with specific reference to district-level health care financing and control in Botswana.

Health Care Development

Botswana has performed impressively in the social sector in the three decades since independence. For instance, the number of rural health posts increased from 244 to 302 and rural clinics from 51 to 131 between 1984 and 1990 (Moalosi 1991). The number of primary and district hospitals also increased from 20 to 24 during this period. This trend has continued in the 1990s, though at a much slower rate, because emphasis in the health sector has shifted from infrastructure development to manpower training and management issues (Government of Botswana 1991). On the whole, Botswana's 1.5 million people enjoy good health care, although the benefits have been distributed unequally (Government of Botswana 1991; Lauglo and

Molutsi 1994). Public funding through central government grants has dominated health care financing, even at the district or local authority level.

Unintended Consequences of Centralized Health Care Financing

The extended period of centralized health care financing in Botswana over the last two decades has had far reaching negative consequences. These can be summarized as follows:

- Massive central government financing pushed out private, nongovernmental, and local authority funding. Most mission hospitals and clinics became reliant on grant-in-aid from the central government. The annual grant increased proportionately over time from around 30 percent from the government and 70 percent from missions or donors to the current ratio of 90 to 10 percent.
- Self-reliance and self-help by communities, an important health care strategy, was undermined. Facilities built and managed by communities were of low quality both in structural terms and in service provision. These facilities have since been upgraded or replaced by modern purpose-built ones. Even where communities were involved in selecting family welfare educators and where village health committees were established to oversee and supervise health care programs and health workers at a facility level, the community's role remained minimal. The family welfare educators had greater allegiance to their employer, the central government, than to the communities they served, and village health committees were weak as health program supervisors at the village level.
- User fees were increasingly neglected and irrelevant as determinants of health care quality. Between 1975 and 1993 the consultation fee at public health facilities remained at P 0.40, or around US\$0.20. Other charges for beds and operating theaters also remained exceptionally low in government health facilities. There were even attempts in the early 1980s to do away with most of the charges because of high collection costs (Moalosi 1991).

The overall effects on the health sector were major improvements in quality, but not necessarily in efficiency.

In the early years of independence, between 1966 and 1975, a shortage of public resources in general, particularly for the health sector, encouraged the diversification of health care financing. The government lacked funds, but the population's health was poor. The country had few health facilities of any significance. In addition, the roads were bad; most of the population depended on polluted surface drinking water; and the general level of hygiene of homes and their surroundings was poor, because most households lacked toilets or any other method of hygienic disposal of different types of waste. At this time the main health care financiers were the government, Christian missions, and local communities. Across the country, church organizations and communities established mission hospitals, clinics, and health posts. Poverty-stricken communities—especially following a devastating drought between 1964 and 1966—contributed labor and management services to health facilities, while mission agencies raised funds for construction, drug procurement, and salaries of health personnel. The government focused its limited resources on upgrading the country's few hospitals and constructing some clinics in densely populated areas.

In short, this early period was characterized by a strong ethos of community self-help and self-reliance; by limited, but diversified, sources of health care funding; and by relatively high user fees. However, the quality and efficiency of health care delivery remained major concerns. Hence, both infant and maternal mortality remained high and communicable diseases went uncontrolled. It was under these circumstances that Botswana adopted elements of the primary health care approach much before its formal introduction and international sanctioning in 1978. Community participation, intersectoral collaboration, and preventive health care were central to the country's health care system during the late 1960s and early 1970s.

Management of the Health System

Before 1986 when regional health teams were transferred to the districts, Botswana operated two parallel health care systems, one at the local or district level and the other at the central government level. The

system was cumbersome and expensive. Hence following the reorganization of the Ministry of Health in 1984, regional health teams were integrated into district health teams. On the whole, the process has gone smoothly except for constraints noted by Lauglo and Molutsi (1994), which include the following:

- Financial decentralization has not yet occurred. This hinders the work and management decisions of district health personnel, local leaders, and community health committees.
- Human resources staff have also remained largely centralized at the Ministry of Local Government, Lands, and Housing (MLGLH). Thus local authorities have no influence over the transfer and promotion of staff.
- Coordination of activities between the Ministry of Health and the MLGLH (which is responsible for administering local authorities) remains problematic.
- Conditions of service for central government staff seconded to local authorities differ significantly from those for local authority employees, which results in poor working relationships.

However, decentralization is proving to be more efficient in the use of scarce human and financial resources. The following section draws heavily on empirical studies of five districts in Botswana conducted by Lauglo and Molutsi (1994) for the Ministry of Health between 1992 and 1994.

Resource Allocation at the District Level

Financial resources are allocated within the framework of national development plans (NDPs). The process for preparing a NDP, which is the responsibility of the Ministry of Finance and Development Planning, is long and complex. The ministry circulates copies of the NDP before it is finalized to ensure that its priorities match those of other ministries. Changes are seldom made before the NDP is sent to parliament.

The current NDP exhibits some lack of coordination between the MLGLH and the Ministry of Health in relation to health. The MLGLH continues its commitment to build more health facilities. Its target is 10 more clinics, 25 more health posts, and 5 more maternity wards at an estimated cost of P 30 million in 1994. However, the Ministry of Health's main priorities are developing manpower, developing a good health information system, improving organization and management, and expanding the National Health Institute.

All district council development grants are channeled through the MLGLH, where they are administered by planning officers. All planning officers in the central ministries are Ministry of Finance and Development Planning officers seconded to the ministries. All central government planning officers interviewed for the study (Lauglo and Molutsi 1994) said that they identified with the ministry in which they were placed and not with the Ministry of Finance and Development Planning, which one planning officer viewed as "the enemy...we have to fight with them for our money."

Local authority officers manage funds allocated for development. Additional requests for money need to be justified by a project memorandum to the senior planning officer at the MLGLH. Experienced planning officers noted that the ministry had never turned down one of their project memoranda. The MLGLH confirmed that it never refuses to accept a well-justified project memorandum.

The ethos of planning is firmly based in a bottom-up approach. Local authorities are responsible for village development committees, which the central government established in 1968. Development proposals are brought to the district level, where district development committees consolidate them into district development plans, which the NDP is supposed to take into account. In reality the processes that produce the district development plans and the NDP are not synchronized in a way that allows the district development plans to contribute to the NDP. Senior planners in the central ministries openly acknowledge this situation.

Annual Budgets for Development Projects

Senior planning officers and desk officers at the MLGLH who have been granted project money control development funds. For the first time, the current planning period allows districts to change the amount of money they spend each year on a project as long as the total at the end of the plan period stays within the project budget.

Recurrent Estimated Expenditures

Preparations for the recurrent budget commence when the Ministry of Finance and Development Planning sets the ceilings on recurrent spending. The personnel ceilings are given first, which according to one senior planner allows no room for deviation. A ceiling on finances and personnel is given to each ministry and is passed on to the district councils. Council departments are asked to prepare their own recurrent budget proposals, which are consolidated by senior officers for approval by the Council Finance Committee.

The MLGLH then begins a round of annual discussions on recurrent budgets with each district. The ministry tries to visit each district, although district teams from remote areas sometimes meet ministry staff at a local town. The district teams usually consist of the council secretary, council planning officer, treasurer, principal personnel and training officer, and the district administration. Heads of departments do not normally participate in budget discussions.

The MLGLH considers its visits to the districts as an important part of involving the districts in decisions about recurrent budget allocations and prides itself on these discussions as an example of its bottom-up decisionmaking philosophy. The districts perceive things differently. The local authorities view these discussions as times when they must present their requests and be prepared to argue for them. Local authority officers have commented on being treated roughly during the talks and being abruptly cut off during discussions.

Public officials acknowledge that the link between capital expenditures and the recurrent cost ramifications of development projects has been weak in the past, which carries implications for later recurrent budgets. To some extent this has not been an insurmountable obstacle, because councils have been able to overspend by applying to parliament for supplementary funds. However, since 1993 supplementary funds have been severely curtailed.

Financial Planning at the District Level

District administration officers see their role as preparing, monitoring, and implementing development activities, but have little, if anything, to do with preparing councils' recurrent budgets. They are responsible for preparing recurrent budgets for district administrations. In addition, each district prepares an annual district development plan. The chairs and secretaries of the district development committees are actively involved in preparing the plans. In some districts, they share these responsibilities with the council secretary and CPO.

The council chairs described their role in planning in different ways. One suggested that they were bringing their communities' views, as expressed at the village development committees and village health committees, to the council. Another said that his planning role was fulfilled in council committees, a third saw his role as linking the community and the council.

Chairs do not play an active role in the recurrent budget, but limit their contributions to work on council committees. They do not normally participate in discussions with the MLGLH about ceilings, although in 1992 they were invited to participate. This has not been repeated, perhaps because the ministry did not perceive their participation as successful.

Our original assumption was that CPOs were key informants about the planning of health services. However, during the study we found that they limit their role to development planning, that is, the use of the capital budget. Seminars and workshops are financed under the development budget and can fall within the scope of the CPOs' work, although their main health work has been the development planning of new facilities. CPOs are also responsible for advising on the recurrent cost implications of planned development projects, but as one noted, "This is the weakest link in the planning process."

Most district medical officers interviewed participated to some degree in preparing the council health department's budget estimates, although one subdistrict district medical officer left it to the section heads, who took it to their respective heads at district headquarters to be consolidated there.

The Management of Primary Health Care Services at the Local Level

Given Botswana's commitment to decentralization, an examination of issues concerning primary health care management at the local level is important. This section focuses on the influence of local politicians and on how councils manage the health services they are expected to provide.

Financial Resource Allocation

The authorities generally see health services as a priority sector, although in a few instances they give priority to water, education, or roads. A senior planning officer at the central level commented that districts are not expected to be able to prioritize among social services, which reflects what happens at the central level. All the district medical officers felt that health did not get special priority or the attention it deserved.

Financial Control

Council officers were asked about how much scope they had for making line item changes in the recurrent budget and the development budget. The perceived scope for making individual decisions varied widely. Some chief executive officers thought they had no room for making changes to the recurrent budget. Another was unable to make any changes other than those affecting salaries and wages. Their perceived scope for decisionmaking did not seem to depend on whether they were at subdistrict or district headquarters.

Once the budget is agreed, the chief executive officers can approve all items within the budget, or at least to a high limit, without central approval. No changes in salaries and wages can be made at the local council level. Two officers noted the availability of supplementary funds if they overspent their budgets.

Some staff were aware that they only make recommendations to the central government, which then approves their estimates. Others perceive the same process as being decided at the local level. Senior health managers felt they had considerably less leeway than the chief executive officers in spending from the recurrent budget once it had been approved. A number noted that the council secretary had to decide everything. Some heads of department have commitment control, in that they have the authority to spend within their approved budgets, while others find that even after their budgets have been agreed, they must get permission from the council secretary to make purchases. One subdistrict had to have all purchases approved by senior health managers at the district headquarters. One staff member summed up the situation saying: "We are dealing with two ministries, in Gaborone and at district headquarters." Matrons and chief health inspectors do not necessarily feel that they need to go to their district medical officers for approval to spend. Some noted that everything they do is with the approval of the district medical officer, indicating that they have never encountered problems.

Control over the development budget at the district level is more limited. Most chief executive officers felt that they could not make any changes in line items without MLGLH approval. However, at least one CPO was aware that changes could be made during project reviews and through project memoranda.

Similarly, approval of items in the development budget are more difficult to obtain at the district level. Some chief executive officers can approve items up to a certain limit, but most nonhealth officers said that everything had to be applied for through a project memorandum to the MLGLH. One experienced CPO noted that he had never been refused the use of money if funds were left over after a project and were within the same sector. The MLGLH planning unit confirmed this, and said that it rarely turned down a well-justified project memorandum. The role of donors is significant here, in that one CPO has found that changes are possible between sectors if a donor is not involved.

Council health staff also find it difficult to influence the development budget, although changes can be made in the seminar plan, which is partially financed by development funds.

Personnel Management

The overall vacancy level of staff deployed by district local government (DLG) in established posts is 8 percent, but levels are higher among certain technical grades. According to DLG records, vacancy levels for districts in the study ranged from 5 to 9 percent, which does not support the contention that vacancy levels are higher in remote districts. One possibility is that more expatriates are filling posts in the remote districts, thereby hiding recruitment difficulty differences between districts.

As council chairs are not generally involved in recurrent budget discussions with the MLGLH, they are not normally party to discussions on personnel ceilings. Neither are they involved in the allocation of staff at the district level. As noted earlier, the personnel ceilings are set by the Ministry of Finance and Development Planning and given to the MLGLH, which in turn sets them for each district. At the district level, this means that each post requested must be well justified, that is, based on known and accepted criteria. The DLG notes that in the past three years, districts have usually been given the staff they requested, because they have become better at justifying their requests.

Until recently, local councils were able to recruit staff up to salary grade B4, which includes family welfare educators. In an effort to decentralize further, some of the personnel functions are being transferred to the council level. A government paper on decentralization (Government of Botswana 1993) recommends that districts should be able to recruit and appoint staff up to the C3 salary grade within five years.

Once staff have been allocated, DLG personnel, matrons, and chief health inspectors can deploy and transfer them within their districts. They usually take into account distances between facilities, attendance figures, and the remoteness factor. Some districts have a policy of rotating staff within the district to share the burden of covering remote facilities. However, transferring staff requires paying a substantial transfer allowance, which hinders the systematic implementation of such a policy. District medical officers seldom play an active role in intradistrict transfers although they could, theoretically, refuse to approve a transfer should they so desire.

Just as matrons and chief health inspectors can freely deploy the staff allocated to them around the district, they can also either use staff with specialized surveillance skills appropriately or decide that they are needed for other duties. Even though a number of community health nurses are deployed in the districts, apparently many are not in positions to use their community health skills, but have been given responsibilities in clinics.

Lessons Learned

Several useful lessons can be drawn from Botswana's experience at the district level, namely:

- Botswana's highly developed and well-functioning planning culture allocates resources efficiently at all levels based on clearly defined needs and priorities.
- Accountability and control are emphasized and exercised through the system of annual plans, budgets, and local auditing.
- Relatively rigid administrative procedures limit political interference and promote planned expenditure.
- District authorities operate at comparable levels with the central government, thereby ensuring consistency and understanding.

However, there are also a number of constraints to be noted here. These include the following:

- Centralized funding limits local priority setting and flexibility.
- Insistence on rigid procedures centralizes the process and limits diversification of funding sources.
- Genuine local autonomy is compromised.
- Community participation is reduced and local expertise required by the primary health care approach is lost.

- Planning and resource allocation dominated by development is limited.
- Operational and contingency planning opportunities are lost.

Conclusion

Botswana has embarked on a major health policy reform that may have some lessons for other countries in a similar situation. The reform is in line with world trends, and focuses on diversification of health care financing, efficient use of resources, and equity issues. To date this reform is progressing well. The decentralization strategy adopted in 1984 has helped efforts to increase the efficient use of scarce resources, even though a number of constraints remain.

References

- Government of Botswana, Ministry of Finance and Development Planning. 1991. *National Development Plan 7, 1991–1997*. Gaborone: Government Printer.
- _____. 1993. "The Government Policy and Action Paper on Decentralization." Gaborone.
- Lauglo, M., and P. Molutsi. 1994. *Decentralization and Health Systems Performance: The Botswana Case Study*. Gaborone: University of Botswana.
- Moalosi, G. M. 1991. "Cost Recovery in Botswana Health Sector: An Assessment of Policy Options." Botswana.

8

The Hospital Strategy Project in South Africa

*Monitor Company, Health Partners International,
Center for Health Policy, and National Labor and Economic Development Institute, South Africa*

This chapter reviews the critical problems identified and the key recommendations that emerged from the Hospital Strategy Project. It also describes how these fit together to provide an integrated vision and strategy for South Africa's public hospital system.

Critical Problems

Situation analyses carried out by the Hospital Strategy Project identified a complex network of interlinked, systemic, and institutional problems that contribute to some of the failings of the public hospital system. Together, they have led to a negative spiral of declining or static real budgets, increasing demoralization of staff, declining quality of care, and rising loss of public confidence in the system. The following paragraphs describe the problems.

Hospital Funding

Several factors are contributing to the severe and growing funding gap the public hospital system is facing. Tight fiscal policy has led to slow real growth in the overall health budget, despite growing demand for health services as a result of population growth, urbanization, and epidemiological factors. The situation has been made worse by the rapid pace of reallocation of health budgets, both between provinces and between hospitals and primary health care services. This has left large parts of the hospital system facing substantial budget deficits and without the time or resources to adjust to these resource constraints in a rational and controlled way.

This chapter is an edited version of the executive summary of the first volume of the final report of the Hospital Strategy Project, prepared in 1996. A consortium of four companies undertook the project under contract to the national Department of Health, and with the support and involvement of the nine provincial departments of health. Dr. Broomberg (leader of the Hospital Strategy Project) did not present this paper at the conference; instead, he presented some of the preliminary findings of the project. These findings have since been superseded by this executive summary, which is now an official policy document of the national Department of Health.

This situation has been aggravated by the poor and deteriorating capacity of the hospital system to recover costs through user fees. Poor cost recovery is attributable to a combination of problems, including inappropriate revenue and budgetary policies that provide managers with no incentives to collect fees, poor structure of and pricing in the user fee schedule, poor collection systems at the hospital level, and a large and growing shift of paying patients away from public to private hospitals. The current functioning of the user fee system also undermines the equity of the hospital system, because subsidies are not effectively targeted at the poor.

The size of the hospital funding gap and the speed at which hospitals are being forced to adjust to it are having extremely negative effects on the hospital system. In the absence of rational planning approaches and tools, provinces are being forced to make crude—across the board budget cuts—without regard to the particular needs of individual institutions. This undermines staff morale and quality of care and reduces public confidence in the hospital system.

Distribution, Allocation, and Use of Hospital Resources

The hospital system is characterized by inefficient and inequitable distribution of financial, physical, and human resources, with a heavy bias toward urban areas and academic hospitals. The impact of this is made worse by the absence of effective systems and capacity for rationalization, for rational future allocations, and for efficient resource use at the micro level. These problems have been further aggravated by budget constraints and the rapid reallocation of resources away from hospitals to primary health care.

Hospital Management

Management of the hospital system is characterized by extreme overcentralization, with hospital managers having almost no authority to manage their own institutions. This has led to severe underdevelopment of management systems, structures, and capacity at the hospital level and to a distorted management culture. The net effect of all these problems is demoralization of hospital managers and severe undermanagement of hospitals, most of which are simply administered by provincial head offices rather than actively managed. These problems are aggravated by poor remuneration and career paths for managers, which prevents the public system from attracting and retaining good managers. Overcentralization has also undermined the legitimacy and functioning of hospital boards, thereby diminishing the accountability of and public trust in the hospital system.

Labor Relations Policy and Management

Antagonistic labor relations, which have improved only minimally in recent years, have plagued the public hospital system. This situation is due to a combination of problems in labor relations policy and management. On the policy level, an effective labor relations framework for the public service is lacking. On the implementation and management level, severe problems are caused by the highly centralized nature of bargaining and of the handling of all labor relations matters, by poor management systems for handling personnel matters, by extremely limited personnel management and labor relations skills and capacity at all levels, and by resistance by some elements of management to progressive labor relations policies.

These factors have resulted in the isolation of both hospital management and workers from policymaking and negotiations, and have resulted in ignorance, a lack of trust, and a culture of adversity. The overall effect is thus a cycle of poor labor relations, which overwhelms the machinery set up to deal with these problems, which further worsens conflict, lowers morale, and reduces productivity.

Relationship between the Public and Private Sectors

Interaction between the private and public sectors in the hospital system does not generate any of the potential positive effects of such interactions, but instead has a strongly negative net effect on the public sector. This occurs in several ways. To begin with, the rapid expansion of the private hospital sector in recent years has

undermined public provision by draining large numbers of highly skilled staff out of public hospitals and by drawing increasing numbers of paying patients out of the public hospital system. This has been a particular problem in smaller towns and cities, but is manifest throughout the country. The private health insurance system also exploits public hospitals by "dumping" expensive cases on the public system once their benefits have been exhausted in private hospitals. In addition, insured patients frequently claim to be uninsured, and thus do not pay for their care at public hospitals.

Together, these various factors translate into a fairly substantial subsidy from the public to the private sector, a perverse and undesirable situation, particularly considering the already generous public subsidy granted to private health care through tax concessions on contributions to medical schemes. This situation is not, however, attributable simply to exploitative behavior by the private sector. Instead, it is the result of a complex interaction between a poor regulatory environment and gaps in government policy, which private sector players naturally exploit. These regulatory and policy issues will, therefore, have to be comprehensively addressed if the potentially positive contribution of the private sector is to be realized.

A New Vision and Strategy

To address these multiple and severe problems, a new vision is required for the public hospital system. This vision can be expressed through a number of objectives that are consistent with the principles of the national health system currently being implemented by the Department of Health and the provincial health administrations.

The overall goal of the public hospital system is as follows. The public hospital system will create and support a national network of dynamic, efficient, responsive, and accountable hospitals, which will deliver high quality, affordable, and accessible health services to all South Africans and will act as the supportive backbone of the national health system.

To attain this overall objective, the public hospital system has specific goals to ensure

- Equity in access to hospital services, which implies that all citizens should have equal access to adequate standards of hospital care for equal need, regardless of their income or place of residence
- Decentralized management of all hospitals, with as much delegation of authority and responsibility as possible to each hospital
- Maximum efficiency in the distribution and use of all hospital resources
- Accountability to the community and responsiveness to the needs of patients and their families
- Full integration with and support to the district-based primary health care system and the wider health care system
- Responsible stewardship of public funds
- Creation of a safe, fair, and stimulating working environment for all hospital workers.

Strategic Approach

To attain these objectives on a sustainable basis will require a new, integrated strategic approach. This should consist of at least the specific strategies outlined in the following paragraphs.

ENSURING ADEQUATE FUNDING. Hospitals will be unable to meet the objectives outlined earlier without sufficient, sustainable funding to ensure adequate capital investment, and to ensure that the system is able to attract and retain adequate numbers of skilled and motivated staff. While the total share of public health spending currently allocated to hospitals is clearly too high in relation to spending on primary health care services, making sure that the extent of reallocation and the pace at which this is done do not damage the already precarious hospital system is vital, especially given the tight fiscal policy environment and its impact on overall health budgets. While these reallocations will be achievable in the medium term, attempts to achieve them too quickly will pose a serious risk of further undermining the hospital system's ability to

support the primary health care system, thereby defeating the original purpose of the reallocation. In this context, the following specific measures will be required:

- *Taking decisions on the affordable size of the hospital system, including the total bed stock and staffing complement.* South African bed to population ratios are already falling behind countries at similar income levels, and they may have to be held at present levels or be reduced over time to ensure sustainability and affordability. The current Hospital Strategy Project recommendation as an ideal for the whole country is 2.64 acute beds per 1,000 people for the public sector. As the recent national facilities audit estimates the current supply at 2.3 beds per 1,000 people, this suggests that current levels are not far off the ideal. However, what ultimately matters is the affordability of the total number of beds in the country, which is itself determined by assumptions as to the numbers and skill mix of hospital staffing establishments and by total hospital budgets.

The Hospital Strategy Project conducted analyses of affordability using two assumed levels of staffing, the first a realistic lower level and the second an optimum level. Budget estimates were based on current hospital budgets projected to the year 2000, and on the Department of Health's medium term expenditure framework, which assumes additional hospital revenues through user fees and an additional financing mechanism. The population was assumed to continue to grow at the present rate. When current budget estimates were used, application of realistic lower staffing levels indicates that a maximum of 2.18 acute beds per 1,000 people will be affordable in the year 2000, which is 17 percent lower than the ideal level of 2.64 per 1,000 and 5 percent lower than the current level of 2.3 per 1,000. If optimum staffing ratios are assumed, however, the maximum affordable bed ratio is reduced to 1.83 per 1,000, which is 31 percent lower than the ideal and 26 percent lower than current levels.

The situation is quite different when the medium term expenditure framework estimates are applied. In this case, the ideal level of 2.64 beds per 1,000 will clearly be affordable at the optimum staffing level. This analysis clearly emphasizes the importance of securing the additional funding assumed in the medium term expenditure framework. If, however, additional funds are not secured, difficult decisions will have to be made on the appropriate balance between total bed numbers and the numbers and skill mix of hospital staffing to ensure affordability. In the view of the Hospital Strategy Project, flexibility in regard to patterns of staff numbers and skill mix will be constrained in the short to medium term. This implies that should additional funds for hospital services not be forthcoming, policymakers may have to confront the need to reduce the supply of hospital beds over time, and they may also need to reexamine the planned balance of resources between primary health care and hospital services.

- *Improving cost recovery by public hospitals substantially.* This will require changes in regulations to allow hospitals to retain some proportion of revenue earned through user fees and other income generating activities. Regulations that prevent hospitals from using their property and other capital assets to produce income should also be removed. Changes to the structure and pricing of the user fee schedule will also be required, and to the implementation of cost recovery systems at the hospital level. Critical decisions will need to be made on how to prevent the current hemorrhage of paying patients out of public hospitals to the private sector. This will require difficult decisions on the licensing of private hospitals and on how the public hospital system can and should compete with private hospitals, including whether private wards should be opened within public hospitals.
- *Taking decisions on sources and levels of additional funding for the public hospital system.* This may occur through a mandatory insurance mechanism linked to use of the public hospital system, or through some other mechanism. At a minimum, medical schemes should be obliged to provide a reserve to cover the costs of treating their members in public hospitals. This will prevent the current dumping of patients on public hospitals when their benefits are exhausted.

RATIONALIZING AND REALLOCATING HOSPITAL RESOURCES. Financial, physical, and human resources should be rationalized and reallocated so as to ensure equitable and efficient distribution between geographical re-

gions, hospital types, and levels of care. To ensure that the rationalization and reallocation process is effective and does not undermine equity or efficiency, the following points are critical:

- *Undertaking rationalization and reallocation on the basis of detailed, nationally acceptable, and affordable guidelines.* These will have to cover such items as bed to population and staff to workload ratios. In the absence of such tools, attempts at reallocation are likely to be crude, and may well undermine an already precarious hospital system.
- *Taking difficult decisions about reallocation.* These decisions will need to be taken about the extent of the shift of resources from the hospital sector to primary health care, as discussed earlier.
- *Undertaking the rationalization and reallocation process in a carefully structured and planned sequence.* Specifically, district and regional hospital services should be developed and strengthened prior to any attempts to devolve services away from central-level hospitals. Failure to follow this sequence will undermine central hospitals prior to lower-level hospitals being ready to manage an increased patient flow.
- *Implementing the process slowly and ensuring support.* The rationalization and reallocation process should be implemented in a slow, controlled fashion, and should use change management processes to ensure full support from hospital staff and communities.

RESTRUCTURING THE HOSPITAL SYSTEM. In addition to the rationalization process, the roles of different hospitals within the system and the referral relationships between them will need to be defined and adjusted. The following points are relevant in this context:

- *Agreeing on a consistent classification method for hospitals and on the relative roles of each hospital type will be essential.* This should be followed by developing clear missions for each hospital, covering specified catchment populations, and determining level of care commitments and expenditure ceilings.
- *Developing referral maps.* These will be necessary to cover referrals within and between provinces.
- *Preparing for transition.* Once hospitals have been classified and referral maps drawn, plans for the transition of hospitals from their current to their new roles should be drawn up and implemented.
- *Developing an effective referral system.* This will need to include clinical and referral guidelines, obligatory referral procedures, and by-pass fees.

DEVELOPING A SYSTEM FOR RATIONAL PLANNING OF FUTURE RESOURCE ALLOCATIONS. Even before full rationalization and restructuring is achieved, ensuring that planning for future resource allocation supports the long-term goals of equity and efficiency will be essential. This will require the following:

- *Preparing service provision and staffing guidelines.* Detailed, nationally acceptable and affordable guidelines for service provision and staffing, as discussed earlier, will be needed.
- *Preparing planning, procurement, and maintenance guidelines.* Detailed guidelines for capital development planning and for procurement and maintenance of equipment will also be needed.
- *Developing capital development plans.* Detailed capital development plans, based on the national affordability guidelines, the capital development guidelines, and the findings of the national facilities audit, will also be called for.

ENSURING EFFICIENT RESOURCE USE AT THE HOSPITAL LEVEL. Even assuming efficient and equitable resource allocation, major changes are still required to attain efficiency in resource use at the hospital level. Critical elements of this strategy include the following:

- *Implementing the necessary strategies.* The various strategies discussed later to strengthen hospital management capacity, structures, and systems will have to be implemented.
- *Developing clinical guidelines.* The development of detailed clinical guidelines for district, regional, and central hospitals will also be necessary.

DEVELOPING EFFICIENT AND ACCOUNTABLE HOSPITAL MANAGEMENT. Many of the objectives cannot be achieved without radical restructuring of the current approach to managing the public hospital system. Specifically,

this will require implementing the national policy on decentralized hospital management. Critical elements of this policy include the following:

- *Delegating authority.* Substantial powers over personnel, finances, procurement, and other critical management functions will have to be delegated to hospital management.
- *Realigning the role of the Provincial Health Administration.* A shift in the role of the Provincial Health Administration is necessary from its current executive and administrative line management role to one in which its main functions are to set guidelines and broad policy and to provide critical support for hospital management.
- *Establishing hospital boards.* The establishment of representative, accountable hospital boards as statutory bodies with clearly defined and significant governance powers is also called for.
- *Developing appropriate structures and systems.* Modern, efficient management structures and systems should be developed.
- *Recruiting hospital managers.* Skilled and motivated hospital managers need to be recruited, developed, and retained.

ENSURING THE PRESENCE OF AN EFFECTIVE LABOR RELATIONS POLICY AND MANAGEMENT. Substantial improvements to the management of labor relations in the hospital system are essential if the strategies of efficient service delivery and fairness in the workplace are to be achieved. Improving the current poor situation will require the following specific strategies:

- *Developing an integrated, coherent labor relations policy framework for the health sector.* This can be accomplished by integrating current labor relations policy developments and other developments in the public service into health policy and management frameworks.
- *Implementing the principles of cooperative governance into bargaining and other labor relations processes.* This can be achieved by integrating hospital management into these processes, establishing appropriate structures, and developing a joint vision of labor relations between hospital management and other staff.
- *Developing an effective communications strategy.* This will facilitate communication between staff and management at all levels on key labor relations issues.
- *Introducing alternative dispute resolution procedures.* Such procedures as arbitration and mediation should be introduced into the health sector, both to resolve disputes and to develop effective communication and working relationships.
- *Developing capacity to manage labor relations.* This should be done at both the provincial and hospital level through revised recruitment policies and through extensive training and development programs.

CREATING AN EFFECTIVE RELATIONSHIP BETWEEN THE PUBLIC AND PRIVATE SECTORS. Several changes to government policy and regulations are required if the robust and growing private health sector is to make a positive, and much needed, contribution to the public hospital system. These changes will need to address the current perverse subsidies from the public to the private sector, and should reverse this situation. The following specific measures are relevant in this context:

- *Controlling the expansion of the supply of private hospital beds in such a way as to minimize the negative impact on the public hospital system.* Clear criteria for licensing private hospitals are required, backed up by a strong licensing authority. Where a new private hospital will have a negative impact on the public system, licenses should not be granted. Instead, efforts should be made to accommodate the demand for private beds within public hospitals.
- *Having the public hospital system compete with private hospitals to attract paying patients and private practitioners back into the public hospital system.* This will increase revenue generation, and will also have positive effects on the quality of care and on public confidence in the system. If this strategy is to succeed, however, it will require making difficult choices about such issues as allowing controlled private practice and opening up private wards within public hospitals. It will also require charging

insured patients who use public hospitals at least full cost or above, attempting to ensure that such patients declare their status as insured, and making sure they settle their bills.

- *Enacting regulations to prevent the dumping of private patients on public hospitals when their benefits are exhausted.* This could be achieved by requiring that all private health insurance schemes set aside a reserve of a fixed minimum amount to cover the cost of care when their members are treated in public hospitals.
- *Exploring creative public-private partnerships in all aspects of hospital service delivery.* Other countries have successfully used several creative mechanisms that could be applied in South Africa to encourage the private sector to make a positive contribution to the public hospital sector. Examples include using private sector expertise for various aspects of hospital management and service delivery, using spare capacity in private hospitals for public patients, and establishing creative partnerships with private practitioners.

Critical Implementation Steps

A number of critical implementation steps will be required if this new vision for the hospital system is to be translated into reality. These include the following:

- *Developing consensus at the provincial and national levels and with key stakeholders on the goals and strategies outlined.* The Hospital Strategy Project has gone a long way toward developing consensus on several of the objectives and strategies; however, some points remain controversial, and formal adoption within the normal policymaking channels of government is still required. Further consultation with key stakeholders, such as employee organizations, will also increase the chances for successful implementation.
- *Ensuring that hospital policy issues are high on the public health sector's policy and political agenda.* While the emphasis of much of current health policy on primary health care services has been appropriate and timely, ensuring that hospital policy issues are given similar attention is now essential. As noted earlier, hospitals constitute the supportive backbone of the health sector, and failure to deal with the current crises the hospital system is facing will prevent attainment of the primary health care objectives of the national health system.
- *Designing an appropriate, workable timetable for hospital reform.* Many of the objectives and strategies form part of a medium- to long-term vision for the hospital system and will not be achieved in the short term. Failure to realize the distinction between this vision and short-term objectives will lead to poor decisions and to disillusionment, thereby undermining the prospects for genuine reform in the medium to long term. This does not imply that no immediate actions are required. On the contrary, numerous urgent and immediate actions and strategies should be implemented as soon as possible.
- *Developing detailed, systematic implementation plans.* The proposed strategies are numerous and complex. Detailed, carefully developed, and systematic implementation plans will therefore be critical to successful implementation of this comprehensive vision and strategy. Such implementation plans should focus on the sequencing and prioritizing of strategies, on the resources required for implementation, on the respective roles of the Department of Health and of public health administrators, and on the requirements for outside assistance where this is necessary.

Conclusions and Next Steps

The analysis, research, and consultative process undertaken by the Hospital Strategy Project has generated consensus on a new vision for South Africa's public hospital system and on most of the critical aspects of an integrated strategy designed to achieve that vision. Agreement has been reached on a wide range of detailed and far-reaching proposals to restructure the public hospital system. Where consensus does not yet exist or is not required, this project has provided the framework and detailed proposals to allow the Depart-

ment of Health and public health administrators to move rapidly toward consensus positions and policy decisions. This project has thus provided a detailed road map to help the government and other stakeholders in the complex and challenging task of moving from an antiquated, inefficient, and inequitable hospital system to a modern, effective, equitable, and responsive one.

However, none of this will be achievable without careful and systematic attention to the process of implementing these various strategies. While the full project report makes detailed recommendations on implementation, none of this will have any impact unless the relevant authorities at the national and provincial levels devote time, energy, and resources to the implementation process. In this context, the Hospital Strategy Project is concerned that numerous competing priorities and a lack of resources and capacity will prevent adequate attention being devoted to the implementation process. If this occurs, the substantial investment already made in this project and the opportunity presented in the detailed strategies will go to waste. To avoid this, a number of specific measures will be required, including the following:

- A policy decision should be taken at the highest levels that endorses, after any necessary amendments, the vision and strategy outlined here and commits the Department of Health and public health administrators to achieving this vision and implementing the strategies within a defined timetable.
- The Hospital Coordinating Committee should be tasked with coordinating the implementation of the integrated strategy outlined here and should be required to report to the Health Ministers Forum on progress at defined intervals.
- Careful attention should be paid to the respective roles of the Department of Health, public health administrators, and any other stakeholders in the implementation process. The Hospital Coordinating Committee should be given responsibility for drawing up a document that outlines these respective roles and should request stakeholders to commit themselves to taking on these roles.
- Attention should also be paid to the resources, skills, and capacities that the Department of Health and public health administrators will require to ensure successful implementation. Specifically, decisions should be made about whether, when, and to what extent outside assistance will be required in implementing these strategies. Once these decisions are made, funding and technical assistance should be arranged in a timely manner to ensure that the current momentum is not lost.

Part III—Country Papers

The papers in this section were prepared by representatives of the country delegations attending the seminar. They have been formatted for this publication with minimal editorial changes.

9

User Fees in Swaziland

Prepared for the Ministry of Health, Swaziland, by Maphalala Nomaxhule, United Nations Development Programme; Dumsane E. Masilela, Ministry of Finance, Swaziland; and Thulani Matsebula, Ministry of Health, Swaziland

This chapter examines the evolution of user fees in Swaziland's health system since independence. The country's health system includes both government and mission operated health facilities at all levels of care, such as hospitals, health centers, and clinics. The chapter does not cover industrial and independent private health facilities, as they operate on a commercial basis.

User fees in public health facilities have been in place since British rule in colonial times. The authorities introduced fees as a form of tax on indigenous people and as another source of government revenue. The criteria for establishing fee levels were independent of the communities affected. Until 1974, the fee schedule used in Ministry of Health (MOH) facilities was the one left behind by the colonial government. The fees charged at different levels of care, such as hospitals and clinics, were almost identical for the same services. They tended to be nominal amounts and did not generate substantial revenue. The revenue collected from fees was remitted to the Ministry of Finance through the Treasury Department and became part of the government's revenues. During this time, income from fees grew by 6.6 percent per year in current prices, but declined by 2.2 percent per year in constant prices. By 1985 the real value of revenues generated from fees was only one-third of its real value in 1970.

During the same time, missionaries had established themselves within communities and were engaged in educational and health activities in addition to religious activities. The mission health facilities operated with funds from overseas donations, supplemented with income raised from user fees. The criteria for setting fees in the mission health facilities were presumably dictated by costs and the flow of donations. Mission health facilities set their own fee levels independent of prevailing MOH fees. Missions revised their fees periodically and submitted them to the government for approval before implementation, so that the authorities could ensure that price levels were not acting as a barrier to health care. The government's prime concern was the affordability of health services to the average citizen and not cost recovery.

Financial pressures compelled mission health facilities to raise their fees regularly. By 1984, mission health facilities were charging, on average, at least 50 percent more for similar services than MOH facilities.

For example, in 1983 the RFM hospital alone had an estimated income from fees equivalent to twice the total of such revenues collected by all government facilities. Higher collection rates at mission facilities were attributed to higher fees, incentives to collect fees (such as retention of fees at the facility level), near cost recovery rates from private patients, and income from providing ancillary services to external doctors.

With higher fees at mission health facilities, MOH facilities were being overcrowded and mission facilities were underutilized. In most places, mission facilities did not coexist with MOH services. Thus, patients either had to use the nearest service, even if it was more expensive, or travel a considerable distance to a cheaper facility. Either way, some people bore a greater financial burden to obtain health care than others simply because of where they lived. The government put a mechanism into place for accommodating patients who were unable to meet the costs of health services. This involved acquiring a letter from a local tribal chief or a certificate of exemption from the district officer. Subventions from the government to mission facilities compensated missions for this group of patients.

By 1981, the much higher level of fees in mission health facilities led to a debate within the government on equalizing mission and government fees either by lowering mission fees or raising those at MOH facilities. A proposal to increase MOH fees was met with resistance from within the government, which viewed the provision of health care services as a public good. Thus the disparity in fees and utilization continued to grow.

In 1983 the government adopted a national health policy whose objectives included

- Improving the health status of the Swazi people by providing preventive, promotive, rehabilitative, and curative services accessible to all citizens
- Ensuring equal access to quality health care by all Swazis by phasing out geographic, financial, and cultural barriers
- Reorienting the health care system away from expensive, urban-based curative services toward rural-based, inexpensive promotive and preventive services.

The disparity in fees clearly stood in the way of achieving these broad health goals. The related policy regarding financial access reads:

A fundamental MOH policy is that no person should be denied health services because of an inability to pay for them. At present an inequity exists in that financial access to health services may vary among families of even similar socio-economic status, depending upon where they live and which sector provides the services in their area. A uniform fee structure will be established to participate in the financing of their own health services.

In a study commissioned by the MOH to rationalize health service financing, Adu-Boahene (1984) further supported this policy. The study recommended implementing a uniform fee structure for the MOH and mission to

- Increase the financial viability and geographical access to the nation's health services, both government and mission
- Ensure that mission facilities were more fully utilized by reducing financial barriers
- Reduce the intolerable pressure on the government's health facilities, particularly hospitals.

The government accepted the recommendations of this study, which were as follows:

- Establish a unified fee structure across all mission and government health facilities
- Equalize fees for all special services, such as X-rays and dental care
- Create a safety net system for those unable to pay
- Implement the new fee structure over a two- to three-year period
- Compensate mission facilities for any losses they incur as a result.

Approaches and Options

The MOH accepted the concept of a uniform fee structure and evaluated ways to design and implement a fair, yet administratively flexible, system. It applied three basic principles when developing the framework: health services provided had to be comprehensive, the inputs required to provide services had to be able to be broken down in some logical way, and the new structure had to be operationally effective. To determine the approach to be used in this rationalization process, the MOH consulted both mission and public sector service providers and consumers of care.

Comprehensiveness included the need for the fee schedule to capture all the main services common to both government and mission facilities, together with capacity to accommodate future changes in the product mix. In relation to the logical breakdown, the inputs required for each service were determined to establish an appropriate price. The location of services was also an important consideration in pricing, because some services were only available in some facilities, thereby making access more difficult. Operational effectiveness essentially concerned the administration of the fee system. The fee structure had to be designed in such a way that revenue collectors had access to simple, clear, and easily available information.

In developing the actual prices for different services, the MOH took five basic factors into account: ability to pay, overall contribution to revenues, administrative effectiveness, acceptability, and resource allocation. The ministry viewed ability to pay as the major factor in the choice of a fee structure, and thus had to determine how much the average Swazi could afford to pay. Lack of data on household savings and expenditure prevented a quantitative analysis, therefore the ministry used a qualitative assessment to estimate affordable prices. In pricing the services, the MOH explored the following three options:

- Option 1. Nurses would screen patients. Those the nurse referred to a doctor would pay more than those who saw only the nurse, but those who saw the doctor without screening would pay even more.
- Option 2. Nurses would screen patients, and those referred to a doctor would pay the same as those who saw the nurse only. Those who wanted to forgo screening and see a doctor only would be charged at the same rate as private patients.
- Option 3. Patients attending health clinics would pay less than those attending health centers, who would pay less than hospital patients, that is, the fee would depend on the level of facility. Most institutions surveyed favored this option as it involved little change in practices in force at the time.

The MOH finally adopted option 2 and set the price for a consultation at E 1 (about US\$0.20).

Implementation Mechanism and Strategy

The implications of unifying fees in the two types of facilities were extensive. First, the government would be required to put more resources into health care, particularly through the subventions to mission facilities, and therefore, government support for the proposal was required prior to implementation. Second, the accountant general was required to produce a new set of admission tickets that could be identified with the new fee schedule, and these had to be distributed to all MOH facilities by a set date. Third, all health facilities had to be informed about the changed fee structure. Finally, consumers of health care also had to be informed about the proposed changes.

The actual collection of revenues in the health facilities was identified as one of the areas of concern when addressing the issue of cost recovery. Mission health facilities had a much more efficient system than the MOH facilities. For example, outside normal work hours, nurses in mission hospitals are furnished with cash boxes and receipt books to collect and record money received from patients, which is submitted to accounts clerks the following day. Although this requires nurses' time, it ensures that fees are collected even when patients visit outside the working hours of the office staff.

In MOH clinics nurses routinely attend to patients as well as collect fees. In MOH hospitals, administrative staff collect fees before patients are seen to, but after normal working hours, on weekends, and on public holidays the administrative staff are absent, and levels of collection vary from facility to facility. In the case of Mbabane Hospital, for example, the nurses care for patients and then tell them to return the following day to pay. This results in lost revenue, as no mechanism is in place to follow up on unpaid fees. This has meant that substantial revenues for services rendered beyond normal working hours are lost, and apparently some patients take advantage of this loophole to receive free medical attention.

A study was undertaken to develop a pilot project on fee decentralization so as to evaluate the impact on collection rates (Collins 1991). The Pigg's Peak subregion was selected. Facilities in that region were asked to increase private patients' fees and were informed that they could retain a portion of the revenue collected, and could use these funds to improve the services offered. A further recommendation was that mission facility staff could provide technical assistance through meetings and/or part-time attachment to MOH facilities to help improve their capacity for revenue collection. This, however, has never been implemented.

Impact on Quality, Efficiency, Equity, and Sustainability

The introduction of the unified fee system has some impact on quality, efficiency, equity, and sustainability, though not in the desired direction in all cases.

Quality of Services

The implementation of uniform fees across all health facilities did have an impact on the quality of health care. Because mission health facilities retained the revenues they collected, maximized their revenue collection by charging private patients fees close to cost recovery levels, and provided ancillary services to private doctors at cost, they were able to maintain the quality of care provided to private patients. However, observers note that with the fee level falling behind the inflation rate and the cost of drugs rising, the quality of care available to public sector patients has declined in both types of facilities.

Efficiency

Before the unification of fees, mission facilities had been charging fees that allowed them to at least recoup their costs. As noted earlier, these facilities were accessible only to those who could afford the fees and were underutilized. With increases in output following the standardization of the fee structure, efficiency probably improved at these facilities, even though quality may have declined somewhat. In the MOH facilities, the absence of administrative staff to collect fees after hours caused a direct loss in revenue. A further weakness in the MOH health system is the low cost recovery rate for ancillary services.

In mission facilities, revenue collection increased during 1983/84–1989/90, although a decline was apparent in 1985/86, the year following implementation of the uniform fee structure. By 1988/89, revenues had recovered completely in mission facilities, and even surpassed the pre-unification rate. Mission facilities viewed the unification as beneficial, because removal of the fee barrier improved the utilization of their facilities. They also welcomed the subventions from the government to compensate them for the revenue losses. However, they were concerned that the rate at which the government was revising the subvention was insufficient to cover the replacement of fixed assets. They also expressed concern that they would be faced with cash flow problems while waiting for parliament to approve the government's budget between April and June.

Table 9.1 compares cost recovery rates between MOH facilities and mission facilities represented by the RFM Hospital and Nazarene clinics.

Table 9.1. Cost Recovery Rates in Mission and MOH Facilities 1982/83–1988/89
(percent)

Year	RFM hospital	Nazarene clinics	MOH facilities
1982/83	15.3	23.5	2.2
1983/84	13.7	20.0	2.2
1984/85	14.4	24.0	4.4
1985/86	7.2	25.0	6.3
1986/87	7.6	21.6	4.9
1987/88	10.9	19.7	4.8
1988/89	10.7	16.9	4.6

The table clearly shows that mission health facilities had a higher rate of cost recovery. An investigation revealed that this was due to the higher fees mission facilities charged private patients, to the greater numbers of ancillary services done for outside doctors, and to better collection practices. Another contributing factor is probably the mission facilities' incentive to collect fees because they are allowed to keep some of the fees they collect, while MOH facilities must forward revenues collected to the government. One suggestion was to pilot the retention of fees in government institutions. This was never implemented, hence no evidence is available as to how MOH facilities would perform were they allowed to retain a portion of the revenues collected.

Equity

Through the unified fee structure, health care became accessible to all citizens, regardless of where they lived. Exemptions for the very poor were maintained, but they will be streamlined to make the system more efficient, less vulnerable to abuse, and more dignified for the patient.

Sustainability

The increase in government fees was expected to generate sufficient funds to finance the subventions paid to mission health facilities to compensate them for lowering their fees. However, government revenue from fees has not kept pace with the amount required for the subventions. In 1995/96, for example, fees from government facilities amounted to only 10 percent of the amount required for the subventions. The reasons for the shortfall are both the low collection rate in government facilities and the failure to increase fees in line with inflation.

A 1990 study revealed that utilization of government and mission health facilities had increased after the implementation of the uniform fee structure. However, the changes in utilization varied between type of facility, service, and provider. Based on out-patient data, utilization of services appeared to have increased more at mission than at government facilities (table 9.2). This may have been related to the fact that fees had been increased at government facilities, but reduced at mission facilities.

Table 9.2 shows that government out-patient utilization increased by 1 percent while that of mission health facilities increased by 9 percent during 1984 to 1988. An interesting point is that out-patient utilization fell dramatically at both MOH and mission hospitals during the period. However, increased attendance at clinics more than compensated for this. One explanation is that government efforts to rationalize the utilization of primary health care facilities had succeeded.

In relation to the alleviation of pressure on MOH facilities, data constraints meant that measuring the effect of the fee structure on out-patients in relation to capacity was impossible, although the average utilization per clinic has increased both for government and mission facilities since 1984. In terms of in-patients, the results were mixed. Pressure appeared to have increased greatly at Mbabane Hospital, a government facility, which,

Table 9.2. Percentage Change in Utilization of Out-Patient Health Facilities 1984–98

<i>Facility</i>	<i>MOH facilities</i>	<i>Mission facilities</i>
Hospitals	-23	-26
Health centers	-8	42
Public health units	1	n.a.
Clinics	13	27
All	1	9

n.a. Not applicable.

according to 1989 data, was operating at 35 percent above bed capacity. Pressure appeared to have decreased at other MOH hospitals, some of which even appeared to be underutilized. Pressure increased at mission hospitals and health centers.

Policy Aspects of User Fees

To date, the government has not explicitly defined the purpose of user fees. Ability to pay and accessibility seem to have been the determining factors, while cost recovery has received little, if any, attention at the policy level. Numerous recommendations have been made to revise fees in line with inflation, but the government has not implemented them. This, in turn, has affected the level of subventions paid to mission facilities over the years. The current fee schedule needs to be revised in line with the cumulative inflation rate, phased in over a three-year period, and thereafter maintained in line with the annual inflation rate.

In addition, MOH facilities offer medical services to private patients at highly subsidized rates. This is the case even when patients are covered under medical insurance, which is tantamount to subsidizing the insurance companies. These fees need to be adjusted to recover the full cost of care.

As noted earlier, revenues from fees in mission facilities have been higher than in government health facilities. Fee retention is believed to be one of the contributing factors to this, as it acts as an incentive for improved collection practices. Collins (1990) suggested the piloting of revenue, retention, and utilization to ascertain whether the impact in MOH facilities would be the same as observed in mission facilities. This recommendation needs to be revisited and implemented.

The consultation fee in MOH facilities includes the cost of medicines. This means that drugs are provided at heavily subsidized prices. Given that the cost of drugs is fairly high, a revolving fund for drugs and catering services should be established, and patients should be charged for these services. The fund will help control costs and may facilitate a reduction in overall costs by reducing wastage and overprescription.

Another improvement would be a monthly revenue reporting system that would show losses due to unrecovered fees and why these fees were not collected. This should be done for each service at each facility, and could include details about revenues earned per service, revenues lost due to exemptions, the number of nonpayers, and total revenues received.

Conclusion

The MOH is currently undertaking a health sector study using a group of consultants who have just submitted their draft report. This presents a number of strategic options, including the following:

- Improve the financial management information system so that effective revenue planning and management can take place.
- Develop capacity for revenue monitoring and evaluation, which will enable appropriate adjustment to the user fee rates to be made over time.

- Establish a joint public and private efficiency working group that will
 - Undertake a comparative assessment of health service efficiency within a referral system oriented toward primary health care
 - Identify strategies for improving efficiency at the health center and hospital level
 - Develop measurable efficiency standards
 - Oversee the implementation of agreed upon strategies.
- Establish management boards at each facility level made up of community and facility representatives who will plan and oversee the implementation of strategies to enhance efficiency and will oversee the collection and use of fees.
- Increase cost recovery rates to their real value at all levels of the service delivery system.

In the medium to long term, the MOH needs to consider developing a private ward capacity at all hospitals. In addition, it should establish the quality and price mix that will maximize revenues and establish an enabling environment for the further development of insurance-based financing of high quality secondary and tertiary hospital care.

Two issues remain that could usefully be discussed, namely:

- Cost recovery is usually the first step toward privatizing public bodies. If the government were to allow the pricing of health services at cost recovery rates, would this not be better handled by private companies? One school of thought goes so far as to say that the government should completely forget about providing curative health care and concentrate on preventive care, which it should provide free of charge.
- Statistics reveal that significant positive changes in health are highly correlated with three factors, namely:
 - Improved education, especially for women
 - Access to clean water and adequate sanitation facilities
 - Availability of nourishing food.

While these three factors have little to do with MOH provision of health care services, perhaps the ministry should think about reallocating the resources currently devoted to fighting the symptoms of ill-health and devote them to the root causes of ill-health instead. This is an issue that most health economists dodge.

References

- Adu-Boahene, Yaw. 1984. "Health Services Fee Structure Rationalization and Government Financial Relationship with Mission Sector Health Services." Ministry of Health, Mbabane, Swaziland.
- Collins, D. 1990. "An Assessment of User Fees in Swaziland's Health Services." U.S. Agency for International Development, Mbabane, Swaziland.
- _____. 1991. "Decentralization of User Fees: Pilot Project Design." U.S. Agency for International Development, Mbabane, Swaziland.

10

The Community Health Fund in Tanzania

*R. M. Shirima, Community Health Fund Consultant,
Ministry of Health, Tanzania*

In collaboration with the World Bank and other donors, the government of Tanzania is pretesting a community health fund pilot in Igunga district as part of its health sector reforms. The main aim of the reforms is to explore various options for improving financial sustainability in the health sector, while at the same time honoring its strong commitment to equity. The government intends to establish community health funds in rural areas as one of the options for improving health care financing.

The government views community health funds as a way of ensuring greater security of access to health care, empowering households and communities in health care decisionmaking, promoting cost sharing with strong local participation, and providing a stimulus to local health care providers. It also views them as a complement to employer-mandated insurance funds that may be established to cover formal sector workers and civil servants.

From a household or client perspective, a community health fund will provide residents of a typical rural district with the opportunity to buy a health card. The health card will be sold at a flat rate agreed upon by the community. It will entitle card holders to a basic package of curative and preventive health services and will provide security of access to a dispensary and health center throughout the year. Households will prepay for the card at the time of year they are most able and willing to pay, probably at harvest time, while households with more regular sources of income will have the option of making installment payments.

Households will be fully informed about their entitlements and will preselect a public, private for-profit, or private not-for-profit provider from a network of available dispensaries. While they will choose their dispensary on joining the community health fund, normally the one closest to where they live, they will have the opportunity to change their source of health care as and when their committee approves such a change. Such changes are likely if households are not satisfied with the services they receive.

From the community health fund management perspective, funds will be pooled from many households in Igunga district, where 50,000 households live, thereby incorporating the fundamental insurance principle of pooling risk. This will enable the fund to cover expensive hospital costs for catastrophic illness or injury. Households unable to pay the membership fee will be classified as such by the ward committee and given a community health fund card prepaid by the community. Households unwilling to join the fund

will be required to pay predetermined user charges at health facilities. The community fund committee will set the level of these charges, but the government may regulate such fees if the need arises.

Community management of the fund will induce people to participate. Consultations indicate that village executive officers, among others, would be the preferred community health fund representatives.

While the community health fund will be subject to government regulation, it will be managed autonomously. The government is currently in the process of enacting legislation that will create district health boards in a bid to decentralize and devolve central authority to district health systems. The authorities envisage that the legislation will empower district health boards to provide management guidance for the community health funds. In addition, the boards will be able to negotiate with health care providers to honor the entitlements of health card holders, because the funds can attract many members, and given this market power will be in a good position to act on their behalf to "get a good deal."

From a health provider perspective, the community health funds represent a potentially reliable source of income and clientele. Where applicable, health centers and dispensaries will receive an up-front capitation grant to accommodate the health entitlements of households that have preselected the facility. The community health fund committees will approve dispensaries' purchase orders for drugs before district medical officers authorize purchases and payments from the fund account. With good management, capitation grants will empower providers to plan for their needs in advance, stock up on essentials such as drugs before clients demand them, and restore efficiency to the referral process by inducing dispensaries to provide better preventive and simple curative care.

From a government or regulatory perspective, providers who operate in conjunction with community health fund financing would contribute greatly to its goals of decentralization, particularly fiscal decentralization, and district-based care. This would, of course, require close monitoring and evaluation to ensure that health care standards are maintained. District health management teams (DHMTs) would continue to play this essential role by participating in hospital management boards, specifying standard treatment protocols, and ensuring that such protocols and other standards were maintained. In addition, the DHMTs are expected to pay more attention to public health issues, to provide assistance to communities, and to support the operation of their community health funds.

To capture the benefits of the community health fund approach, the suppliers of services must be able to respond in an efficient and cost-effective manner. Experience in Tanzania shows, however, that many gaps exist in performance and the quality of services. Thus some capacity building would be needed before introducing the community health fund system, otherwise its financial advantages would diminish. Client consultations reveal that people know full well that public providers often lack essential supplies, particularly drugs; that publicly managed facilities tend to be run down, and that rural areas are the most likely to lack good quality services. The aim of the community health fund pilot is to contribute to the government's health reform objectives by shedding light on how one particular financing mechanism can contribute to efficiency, equity, sustainability, decentralization, and private sector development.

Regarding financial sustainability and the government's cost-sharing policy, the community health fund concept is expected to offer the following advantages:

- Involving households and communities in "demand-side financing," whereby they share part of the cost of the health services entitlements they receive
- Promoting cost containment and cost savings associated with more efficient management and reduced waste among health care providers
- Exploring the option of including district-based civil servants and rural cooperatives in the community health fund, thereby increasing the number of members with regular incomes
- Increasing the understanding of the costs associated with providing different combinations of basic health services and of what people are willing and able to pay for a basic package of quality services through implementation and evaluation of the community health fund.

Initially the community health fund pilot will be subsidized by matching funds from the government, the World Bank's International Development Association, and other donors. Members' contributions will increase gradually until they can cover most of the costs.

Objectives

The main objectives of the community health fund approach are to close the financial gap in health care in rural areas. This will be achieved by ensuring the availability of good quality health care, in adequate quantities, accessible to all in a sustainable way year in and year out. This includes empowering the community to determine their own destiny on issues concerning their health in line with the principles of primary health care. However, the government should be ready to bail communities out in the case of failures in the health care delivery system.

The community health fund provides a financing mechanism for health care in rural areas based on secure access to health care at a time of critical need through prepaid health services and on risk sharing. Patients do not have to pay over the counter at the time of illness provided they have paid their community health fund contributions.

Risk sharing means that those who get sick will benefit from a fund where patients' contributions are greater than the outflow of funds. For such a pool of funds to function as it is meant to, decisionmaking powers and the authority to use funds must be put in the hands of community leaders. This will also enable negotiations with providers so that the patients can select the facility of their choice. Allowing patients to choose their providers will encourage providers to compete, thereby boosting efficiency in service provision, decreasing waste, and improving consumers' satisfaction. Providers who cannot compete might go out of business, which would help eliminate poor performers.

Finally, the concept includes creating and maintaining financial planning and management skills at the community level to perfect a resource allocation process that targets the worse off.

Design

On examining alternative financing options to support health sector reform, the government of Tanzania and the World Bank agreed to pilot the community health fund concept in Igunga district. Of particular interest to the designers of the pilot was willingness and ability to pay and communities' ability to set priorities for the use of the fund. The design work is now complete. After the Igunga district pilot, the fund will be introduced in nine other districts.

The design of the project is based on the assumption that the essence of strong community involvement is for the community to take on the responsibility for generating, using, and controlling financial resources to run an efficient health service. The central authorities have identified and costed a minimum essential health intervention package based on World Bank (1994) principles. This package covers prenatal, natal, and post-natal services; family planning; and the management of common conditions and chronic infectious illness.

The designers of the community health fund pilot took the following issues into consideration:

- *Broad population coverage.* To derive the benefits of risk pooling, the fund has to cover a large area, such as a district. An average district in Tanzania has about 50,000 households. However, during pretesting in Igunga, the communities preferred initial pooling at the ward level, although they will maintain one account for the whole district and one district health board to ensure easy fund management. The communities' decision was based on lack of certainty as to whether the funds would be used properly. Therefore initially, they want to be able to control their own funds and decide on their use until the fund's management is clearly defined and communities are assured that local governments and the central authorities will recognize the sole autonomy of the district health board

in controlling the funds. The next step will be pooling the funds at the district level to spread the risks further.

- *Attractive service entitlement.* Because of a shortage of funds, Tanzanian dispensaries are provided with an essential drugs kit paid for by the central government on a monthly basis, which has the effect of rationing essential drugs. In some areas this kit is insufficient to cover the whole month. Thus communities need to be assured that the community health fund will solve this problem and that the quality of health care provided is good.
- *Affordable membership contributions.* The project designers suggested a rate based on the cost of the minimum package, or US\$2.57 per person per year. The pretest established that communities in Igunga are only prepared to contribute US\$1.79 per person per year. By adding a matching World Bank contribution, actual community health fund contributions will amount to US\$3.58 per person per year. The government will have to continue to contribute funds at the present level and be responsible for epidemics and public health activities so that it can devote more attention to preventive measures. The funds that will be available are less than the US\$12 per capita recommended by the World Bank (1993).
- *Exemption policy for the poor.* Poor people unable to afford to buy a community health fund card will be given one so that they have access to the same benefits as contributors. The community will decide who should be exempted. At Igunga the poor will be categorized into two groups. The first group will include the disabled and those who cannot work. The second group will consist of the poor who could work if they had a job. These people will be given the card after performing work equivalent to their contributions on such activities as maintaining roads or building dispensaries or houses for health providers.
- *Flexibility in choice of facilities and/or providers.* Where more than one health care facility exists, the design gives communities a choice of facility. The fund's management will agree on the fees for different treatments with the management of facilities to avoid overcharging.
- *Efficiency and cost containment.* The community health fund is designed to stimulate competition among providers, through such means as capitation payments and fees for services.
- *Intercommunity equity.* The design encourages pooling at a higher level than individual communities to reduce inequalities between communities through risk sharing. Every household member will be entitled to the same package of care so long as they are community health fund members. Otherwise, they have access to the same services but will have to pay user fees.
- *Financial sustainability.* At present, the government and donors are financing all health activities at the community level, but the budget is insufficient to cover all expressed needs. Initially, communities will contribute a small amount and the government will contribute much more. Eventually communities will be expected to contribute more and the level of matching funds will be gradually eliminated. At this juncture the community health fund and government subsidies should be able to cover a more than adequate set of health services for communities. Thus the financing gap will have been closed by community financing and funding levels will be sustainable.
- *Compatibility with autonomy and fiscal decentralization goals.* The district health board will supervise the fund and help committees at the ward level to make informed decisions on the use of the funds to improve health care at the community level. The board will answer to the local council.
- *Contribution to health system reform.* The design is based on approved reforms. It helps to raise funds for the reforms and encourage decentralization to the facility level. The reforms encourage private providers' participation, and the design involves using all the actors in health provision (public, private for-profit, and private not-for-profit). Therefore, instead of the government covering all the costs of health care provision, community health funds will encourage private practitioners to move from towns to rural areas where they can be gainfully employed.

Costing

As mentioned earlier, a costing exercise was done in Igunga district during the pretest. The figure arrived at of US\$2.57 per person per year covers dispensaries and rural health center services only. This figure has yet to be corrected for inefficiencies in delivery costs of up to 30 percent, an upsurge in the use of services as drugs become available, and the cost of other services that were not captured in the costing exercise. The corrected figure will be US\$10.58 per person per year.

Thus community health fund contributions and matching funds are insufficient. The balance will come from the government, donors, and other contributions. As public health activities become effective, the anticipated increase in utilization will slow down while contributions will increase until a sustainable package is achieved.

Implementation

Each community health fund will have an autonomous status with a simple structure, large pooling of funds, and minimum administrative costs. As a long-term strategy, project designers envisage that autonomous district-level entities will be created to manage the funds. An act of parliament is required to establish the entities and put in place regulations and procedures for establishing the community health fund, guided by the results of the pilot.

In line with Tanzania's health reform strategies, the role of the government (which currently has a monopoly in the ownership and management of health facilities) will be shifted to setting standards, having a regulatory role, training, and monitoring and evaluating the health services. The management of the facilities will be passed to facility management committees or boards composed of community representatives. These management committees will be responsible for managing public health staff and coordinating with the DHMT on facility performance. The community health funds have been designed in such a way as to provide information on facility-based management, training requirements, and evaluation processes; to create accountability and transparency; and to reduce pilfering.

Community-based management will raise expectations on the demand side. Thus the supply side will need improvement to meet these demands. The government and interested donors must come together to strengthen district-based services. Providers will compete on a fee-for-service basis.

Efficiency and Effectiveness

The community health fund pilot took about two years to design. This gave its designers an opportunity to think about the anticipated economic efficiency in comparison with similar schemes in effect in other countries, including Burundi, Ghana, Guinea Bissau, Korea, and Thailand. These countries have indicated that improvements in the quality of health care will reduce the financial burden on households during illness and increase production by reducing mortality and morbidity. To test these ideas in Tanzania, the government intends to improve health care by ensuring drug availability, improving services, and emphasizing public health interventions to reduce the burden of disease.

To improve efficiency two interventions will be introduced, one to improve management at the district level and below, and the other to include public health activities, which will introduce the most cost-effective measures that have a direct impact on reducing the burden of disease. This will also involve careful coordination of all vertical programs in the district, such as immunization, tuberculosis and leprosy programs, and AIDS control.

The community health fund's main function will be to control costs through well-established district health boards with managerial capacity. The boards could use a variety of tactics to influence providers to extend services in the most efficient way, above all to avoid overprescribing and overcharging.

As concerns service costs, the system needs to ensure that providers spend their time catering to the sick rather than carrying out supplementary activities to increase their incomes. Also in relation to ability to pay, government measures to address poverty should take into account marketing systems, especially the sale of cash crops. The practice of borrowing cash crops from farmers instead of paying for them at the time farmers deliver the crops prevents farmers from planning how to use their money. If farmers are to pay their community health fund contributions at harvest time, this arrangement will have to be changed.

The health boards will have to work hand in hand with the other authorities in the community, such as primary cooperatives, education boards, other organizations, and nongovernmental organizations. The coordination of the activities of these boards at the community level is of crucial importance. The facility management committees will liaise closely with health management systems.

To improve public health services at the community level, project designers have suggested a rebate of 10 percent per year from the community health fund to the community based on the community devoting the proper attention to public health.

Experience in Igunga

The authorities selected Igunga district from among Tanzania's 113 administrative districts for pretesting for the following reasons:

- It is one of the 10 poor districts selected for a health and nutrition project.
- The DHMT demonstrated its responsiveness to innovations during the implementation of the health and nutrition project.
- The health and nutrition project has rehabilitated a number of dispensaries.
- The district team and leadership is strong and was willing to implement the pilot.
- The necessary political will was present.
- District communities showed interest in participation during the rehabilitation of the dispensaries.
- A plan to rehabilitate the district hospital, which will handle referral cases, is available.
- The Nkinga mission hospital is ready to participate as a private hospital.
- The district is one of the 10 pilot districts supported by the International Development Association, and thus using some of the money from the existing project to initiate the pilot is straightforward.
- The district's health problems are huge and deserve special attention.

The exercise commenced in December 1995 by way of meetings with regional leaders, district leaders, and technical teams that discussed pretesting the community health fund in Igunga district, with a view to preparing a pilot project. A comprehensive action plan for the pretest was prepared during the next six months. The action plan had two objectives, namely, to establish a community health fund at the district level through household contributions and to establish health boards. These objectives were to be attained by training the DHMT, district and ward authorities, and fund collectors and by mobilizing households.

The training activities informed participants about the concept of a community health fund and cost sharing and provided training in the relevant skills. The training for regional and district authorities provided information on the national health policy and proposals for health sector reforms. The DHMT training refined the proposals for implementing the community health fund pretesting and prepared the team to act as trainers for lower levels of management. The DHMT also decided on the composition of the community health fund board and developed criteria for selecting premium collectors, community mobilizers, and committee members at the ward level. Ward authorities reached consensus on how to select community health fund collectors, on terms of reference, on collectors' remuneration, on how to promote the community health fund, on exemptions, and on fund management.

Health providers and premium collectors raised many issues that required elaboration and clarification, including the difference between paying user fees and the community health fund. Table 10.1 compares the differences between the two methods of payment for health services.

Table 10.1. A Comparison of the Community Health Fund and User Fees

<i>Community health fund</i>	<i>User fees</i>
Patient pays before illness	Patient pays at the time of illness
Risks are shared	Risk is borne by individuals
Patient pays in small amounts	Patient pays in large amounts and may need to foot the whole bill
The decision to pay is under the patient's control	The patient has no choice once illness occurs and may not have the cash to pay
The household is empowered to make decisions about health care delivery	All the power and decisions are in the hands of providers
Those who cannot pay (poor households) are exempted by the community	Exemption of the sick poor is tedious and done by bureaucrats
Management and administration costs are low; most of the work is done by community committee members	Management and administration costs are high because of a heavy input load (e.g., cash boxes, receipts, many employees, high overhead costs)
No fee is assessed when the patient is ill, and the patient has full access to care	Patient pays for every visit and service
As CHF members increase, user fees will decrease	User fees die a natural death when all households join a CHF
Contributions are by personal choice	Fee is mandatory so long as the patient is not exempted
Non-CHF members will pay the cost of access to health care	The user fee will be determined by CHF members at the community level
The CHF demonstrates the social principle of sympathizing with the sick; social values are observed	Cash and carry; user fees constitute market-oriented costs and benefits; no social benefits
When a CHF member is sick, the CHF spends revenue; it therefore encourages the community to take preventive action (public health measures)	Under user fees, once you are sick you are a good client paying for services, which discourages preventive intervention, especially among private providers
Without patients, the CHF will survive as the risks are always there	Without patients, user fees will vanish, to the detriment of private providers

CHF Community health fund.

In Igunga district households' main sources of income derive from livestock and farming. Investigations of their willingness to contribute to the community health fund clearly indicated that they were prepared to pay T Sh 5,000 to T Sh 10,000 (US\$9 to US\$17) per family. Initially the government will match the fund by using International Development Association credits to encourage contributions. However, the need for government payments will change depending on the changed attitude of providers and more providers coming in to create competition. The government will continue to increase its present level of health sector financing, especially for disease prevention services, to reduce the number of cases requiring treatment.

Although the communities of Igunga district have shown a willingness and ability to pay, a number of risks had to be considered before pretesting. The main risk was the possibility that community members would misunderstand the concept, thereby creating social and political problems. A second risk was that the government and donors might not be willing to contribute to the fund. A third risk was that the district might not be able to handle the extra work, and that like other funds it might face misappropriation or misuse that would discourage contributions.

The pretest of the Igunga pilot ended in June 1996, and the entire district was piloted as of July 1996. The authorities expect to include nine more districts in the pilot within the next two years. Depending on

the results, a new project will be developed to start community health funds nationwide in the coming years, and donors will be invited to provide matching funds.

Conclusion

Unlike in Ghana, where it is already established, the concept of a community health fund is new in Tanzania. However, African countries differ from each other in their cultural and customary systems, thus governments need to be cautious when introducing new dimensions into health financing. Starting with a pilot provides an opportunity to assess risks and find out about the assumptions people will make, and to take these into account before implementation. Assuming that the experiences of Ghana, Guinea Bissau, and Thailand, for example, could be copied in Tanzania without modification would be naïve.

Introducing a new concept in any field of development starts with doubts. A community health fund is especially subject to doubts, because it changes the concept of "free" medical services to a service that costs. In addition, other sectors, such as education and sanitation services, are all looking at cost sharing. This change is also occurring at a time of political change from a one-party to a multiparty system, which places an additional strain on the economy and on social systems. Thus some argue that this is not an opportune time to bring in so many changes. However, the question is whether Tanzania can postpone health reform. The answer is that it could if a better alternative were available for addressing the disease burden and the problem of worsening health services. As it is, donors are becoming increasingly reluctant to grant requests for assistance. In addition, they are not prepared to continue to provide help unless a country demonstrates its serious intent to develop self-reliance and prove that it can sustain the developments envisaged.

Tanzania has no alternative but to implement social sector reforms, especially those concerned with different financing options. A community health fund is therefore essential as one vehicle that will contribute to the health care system and allow the sharing of responsibilities with communities. It is a self-reliant approach that will be sustainable.

References

- World Bank. 1993. *World Development Report: Investing in Health*. Washington, D.C.
- _____. 1994. *Better Health in Africa*. Washington, D.C.

11

Current Issues, Prospects, and Programs in Health Insurance in Zimbabwe

T. A. Zigora, Deputy Secretary, Ministry of Health and Child Welfare, Zimbabwe

Health care is receiving increasing attention worldwide, not only because of its intrinsic value, but also because of its enormous impact on available economic resources. At the same time, health care is becoming more expensive because of developments in technology and the resurgence of some diseases and the emergence of new ones, and consumer demand is on the increase.

Although the government of Zimbabwe has made significant strides in trying to redress the problems it inherited at independence, an analysis of the situation 16 years later shows that substantial geographical inequalities in access to health care still exist. Inequalities also exist in terms of access between the rich, who enjoy sophisticated services largely financed through medical aid societies (insurance companies), and the poor, who receive more basic services financed by the government.

While the government remains committed to the provision of affordable and accessible health care for all, the financing base is getting smaller. This has led to a deterioration in the quality of services and to poor morale on the part of health workers, who know that they can do much more to alleviate the pain and suffering of their patients, but are unable to do so because of a lack of resources. In addition, the authorities have identified a number of factors that have led to poor performance in the health delivery system, including the inefficient use of resources, a lack of incentives for health providers, the inappropriateness of regulations, and the inequitable distribution of resources between the poorer and better-off segments of the population.

Zimbabwe's experience with user fees and private health insurance has shown that these two mechanisms for financing health care have negative consequences for equity. Similarly, while the donor community has given substantial assistance to Zimbabwe in the last few years, additional financial support from this source is unlikely to be sufficient to meet the anticipated shortfalls.

In the face of these problems, the government must first consider how the limited funds available can be used most effectively, and second identify new sources of financing. As part of the ongoing health sector reform initiative being undertaken in Zimbabwe, one priority has therefore been to improve the efficiency with which existing resources are allocated and managed. Efficiency in this context refers to both allocative efficiency (allocating resources to those activities with the highest return) and technical efficiency (increasing

Table 11.1. Private Health Insurance Schemes and Beneficiaries

Category	Open societies	Industry-based	Employer-based
Number of schemes	3	3	17
Total number of beneficiaries covered	363,852	242,596	80,119
Percentage of beneficiaries covered	53	35	12

the output from given resources). In conjunction with this, the government is determined to broaden the financing base by ensuring that every person employed in the formal sector is covered by health insurance by introducing a social health insurance scheme. This will be implemented alongside a community-based insurance scheme aimed at the informal sector that will be organized locally and based on voluntary participation and flexible payment mechanisms.

Social and Private Health Insurance Schemes

The concept of social health insurance is based upon risk sharing, that is, those who enjoy good health and do not consume health services should help pay for those who fall sick and need health care. This concept assumes that those who are healthy today will also be entitled to have a portion of their health expenses covered by others should they fall sick in the future. In contrast, private health insurance is based on the expected average cost of providing health services to all participants.

Currently, medical aid societies play an important role in financing the health care needs of a small section of the Zimbabwean community. In July 1995, as table 11.1 shows, some 23 private health insurance schemes covered 750,000 Zimbabweans and their dependents. Table 11.1 clearly shows that although employer- and industry-based programs are the most prevalent in terms of the number of schemes, they account for the smallest percentage of beneficiaries, and are in fact declining in numbers because of viability problems. Actual membership is believed to be in the region of 260,000, all of whom are employed in the formal sector. This suggests that about 17 percent of all those in paid employment, excluding agricultural and domestic services, are covered by employer-based schemes.

In 1994/95, the combined expenditures of the four largest societies amounted to Z\$ 654 million. Approximately Z\$ 60 million of this covered administration costs, with the rest going to benefits ranging from the basic package, which covered services at public facilities only, to the executive package, which included comprehensive service benefits.

Employer-based schemes are conglomerates made up by companies with large work forces, who put together in-house arrangements as part of their staff benefits. These societies have tended to suffer from a lack of professional management.

The civil service, engineering enterprises, and the commercial banking and construction sectors each provide industry-based schemes. The major weakness of this arrangement is that continued viability of schemes depends largely on the performance of the sector concerned. Poor performance leads to the collapse of the scheme and beneficiaries are left at risk.

Open societies enroll members from all walks of life as long as they can pay their monthly subscriptions. They have experienced problems such as self-selection, where sick people join, even though they may be unemployed or self-employed, so that the societies can bear their medical costs. In addition, some seek membership later in life when they are on a pension and find that they cannot afford their medical bills. Such societies are also concerned about the proportion of their members who suffer from HIV/AIDS.

Resistance to a Social Health Insurance Scheme

In addition to the reservations medical aid societies have expressed about the advisability of the government embarking on a social health insurance scheme, resistance from other quarters is also likely. The government

anticipated such resistance and organized a number of workshops for representatives of employer organizations, trade unions, medical aid societies, nongovernmental organizations, and donor agencies.

Trade union leaders have participated in the preparatory working groups and are firmly behind the idea. The authorities hope that employer organizations will soon come on board when they begin to appreciate the benefits of an efficient health service for their work forces. The government is seeking to create a partnership with the private sector, not to go into competition with it.

Experience with the recently introduced National Social Security Authority offers some valuable lessons. At its inception, pensioners, employers, and trade unions, who saw it as yet another government ploy to generate additional revenues, were opposed to it. However, the confidence building exercise that both the government and the authority embarked on has borne fruit, and these groups now appreciate the benefits of the scheme. The government has learned that an effective communications strategy is essential for garnering support from various stakeholders, and will make every effort to ensure that the various interest groups are part of that strategy.

Objectives of Social Health Insurance

By attracting additional funding to the health sector, the government hopes that social health insurance will permit it to focus its limited resources on the needs of the poorest and least served sectors of the population, thereby contributing to the attainment of equity. The social health insurance scheme is expected to increase the transparency of health financing in several ways, namely:

- By generating a source of funding that is earmarked for health purposes and is independent of the pressures on the general government budget
- By underpinning the move from a largely "free" health service to one where the costs of providing different services are clearly defined
- By providing consumers of health services with a sense of ownership of these services.

An independent social health insurance scheme that "purchases" health services on behalf of its members from the government and/or from private providers should provide a powerful impetus to improving efficiency by introducing incentives for a high quality and cost-effective service, as well as penalties for poor or inefficient service. However, none of these benefits will automatically accrue from the introduction of social health insurance alone. Much depends on the design and implementation of the scheme, the degree of consultation with beneficiaries and others, the ability to deliver improved quality and capacity, and the relationship between the new scheme and other health sector reforms.

However, while insurance can reduce or eliminate costs to the consumer for each episode of treatment, it may also lead to a misallocation of resources, and steps should be taken to guard against adverse selection (the tendency for the sick to be more likely to take out insurance than the healthy), moral hazard (the tendency for those insured to seek treatment more frequently than they would otherwise), and cost escalation. Care should also be taken to ensure that the scheme does not have adverse effects on the referral system.

Scheme Administration

The government has considered several options for administering the scheme as follows:

- Creating a new, centralized organization
- Using an existing organization such as the National Social Security Authority
- Assigning one or more of the medical aid societies to act as agents for government
- Implementing the scheme through local organizations.

For now the preferred approach is a mixed option that consists of a new, centralized authority that is working with a number of local organizations.

The costs of operating the social health insurance scheme can be divided into administrative costs and the cost of providing health care (which will depend on the benefit packages), the unit costs of providing such care, the demand for the services, and the extent to which other measures such as copayments and deductibles are built into the scheme. Cost and resource use studies, which have recently been conducted with assistance from the United Nations Children's Fund, have provided a rough indication of some of the costs of delivering the services at the rural health center and district levels. This work will form the basis on which future studies can be conducted.

In a survey recently conducted by Peat Marwick Management Consultants, when respondents were presented with a scenario of possible health service costs, when given the option of prepaying for services or paying on presentation at health facilities, 38 percent of all respondents at the clinic level and 70 percent of those at the hospital level opted to prepay into a social health insurance scheme. In terms of ability to pay, the survey showed that potential for a social health insurance scheme was considerable, and that people are currently spending substantial amounts on medical care, even by those in low-income groups.

Principles

The proposed scheme will take the following form:

- It will be simple and based on capital grants to primary-level providers. In return for capital payments, providers will be obliged to provide the set benefits package to consumers on demand. The capital grant will be shared on a predetermined basis between referral hospitals and the network of health centers that fall within each hospital's jurisdiction.
- Participation in the scheme will be mandatory for those employed in the formal sector. Contributions will be wage-based, with both employees and their employers paying the premiums. The existing tax collection system can handle this function adequately. In the informal sector, participation would be voluntary, with contributions set at a fixed rate and collected during periods of highest income, for instance, after the harvest.
- As an added incentive for participation, fees at public facilities—which have not been revised for some time—have now been brought into line with NAMAS rates, and the government has accepted the principle of automatic adjustments as and when the NAMAS/ZIMA negotiated tariffs are revised.
- The scheme will have an exemption policy for the poor. People whose income is below a specified threshold will be exempt. Those who do not fall into this category and choose not to participate will be required to pay for health care on a fee-for-service basis. The responsibility for screening individuals or households for exemptions should be removed from the Ministry of Health and Child Welfare and transferred to a more appropriate authority. The practice of having untrained personnel screen patients at the point of delivery does not lead to an equitable system.
- The basic benefits package will include primary care services and such hospital services as may be defined as core health services. These have already been determined for some levels of care. Individuals will pay for services outside the core package on a fee-for-service basis or through private health insurance. At a later stage, developing a more generous package within the social health insurance scheme should be possible for those who are willing and able to pay higher contributions.
- Contributors will have the freedom to choose their provider, that is, which health center they wish to attend. They will be allowed to switch health centers every six months if they are not satisfied with their first choice. All primary-level providers will have to be affiliated with a secondary-level hospital so that their patients are guaranteed referral to such facilities when required.

- Providers will be contracted to provide the specified core benefit package at no extra cost to the patient. They will be able to retain any surplus revenue within the institution. Surplus revenue is expected to be channeled toward activities that improve the quality of the services offered as dictated by the communities they serve.
- The insurance fund will be autonomous and will have a full complement of staff at the provincial level, with representation at the district level. Fund representatives at the village level and other designated centers, such as the health center committees that are already in place, will collect contributions from the informal sector.
- The fund will allow representatives and the villages they cover to retain a percentage of the funds collected as an incentive to promote participation in the fund. The revenue retained will be used for local health activities.
- The Ministry of Health and Child Welfare will decentralize the health system to give each facility the autonomy necessary to foster competition among providers. The current hospital advisory boards will be transformed into district health boards, and these will assume the role of provider, while the fund assumes the purchaser's role. Representation on the board will give communities a direct say in the management of the services in their localities. They will thus be better able to respond to consumers' perceptions of quality.
- To ensure that the anticipated supplier response to increased funding is realized and to generate competition among providers, a system of designated providers will be established. Medical practitioners and nurses will be allowed to open appropriate facilities in underserved areas as designated providers of the core package. This will help to solve many of the constraints of private sector participation in rural areas, which currently are served predominantly by government, mission, and local authority facilities. An increase in demand will provide opportunities for more designated provider practices to be opened.
- Budget allocations—which the government is expected to continue providing—will be used to pay for administrative, management, and supervision costs; for the costs of public health services; for coverage for the indigent and other target groups; and for expenses relating to national emergencies, such as droughts.

Implementation

Assembling a social health insurance package that will meet the needs of all Zimbabweans regardless of their economic or social status is a major undertaking. For this reason, piloting the scheme in one province and expanding it to the rest of the country based on the lessons learned is important.

The pilot study should shed light on how social health insurance can improve efficiency, provide a basis for equity and sustainability, support decentralization giving members a sense of ownership of their health facilities, and make private sector participation attractive. It will set the scene for developing the administrative and legal framework that will be essential for national implementation of the program. The pilot will also provide an opportunity for taking the views of a cross-section of society into account in the design and implementation of the scheme.

One of the prerequisites for selecting a pilot site is that well-managed facilities should be present, because to obtain the maximum benefits from the scheme, the suppliers of services must be able to respond to community demands in an efficient and cost-effective manner. Therefore before launching the pilot, the scheme's designers will have to assess the capacities of possible pilot site facilities and make any necessary improvements in their management capacities.

The pilot study will attempt to identify

- Promotional activities that will need to be undertaken prior to the nationwide launch
- Methods for enrolling members and likely client response

- Simple processes for setting and collecting membership fees
- Practical approaches for exempting the poor
- Ways to assess management and logistics requirements
- Cost containment mechanisms that will not compromise quality
- Mechanisms for ensuring financial controls on premiums collected, especially in rural locations.

A number of constraints need to be tackled before the pilot is launched. These include the following:

- Community participation and local awareness among the public, local government officials, and health workers is insufficient.
- Public providers have the right to retain the revenues they generate. A decision to this effect has already been taken and will shortly be implemented, even under current financing arrangements.
- Public providers should be empowered to have control over their resources, that is, their staff, equipment, transport, and buildings. They should also have the autonomy to develop meaningful partnerships with other stakeholders.
- Decentralization must be allowed to proceed more swiftly in the pilot province than elsewhere, even though this is an independent initiative that is not dependent on the success or failure of the social health insurance scheme. This will empower communities and enable them to have a positive influence on providers.

Table 11.2 shows the action plan for designing and implementing the social health insurance scheme.

Impacts on Efficiency, Equity, and Sustainability

If properly planned, a social health insurance scheme will lead to a general improvement in the quality of life of the people of Zimbabwe and provide the healthy work force needed for economic development. In terms of equity, the social health insurance scheme offers security of access to the poor and to women and children. The rich will be subsidizing the poor, while the healthy will be subsidizing the sick. Providers will not be able to discriminate against anyone as long as clients belong to the scheme.

Efficiency will be improved as ready access to health care services will bring more people into the modern health system. Because of the capital grants system, providers will be forced to contain costs if they are to survive, and because the benefits package emphasizes primary health care, providers will be persuaded to give priority to preventive programs.

The financial sustainability of the health care system will also improve because the scheme provides an opportunity for collecting contributions from the informal sector and payments will be scheduled for times when people can most afford to pay them. The contributions will become an additional source of revenue that providers can access, thereby ensuring that essential supplies and services are always available. As indicated previously, the increased competition among providers should serve to foster efficiency as each facility tries to retain all the members registered with it and attract even more to increase its capital grant.

The move toward decentralization should reinforce the scheme's positive benefits by allowing the decisionmaking process to be shifted toward local levels and the community. Capital grants to providers will promote competition and facilitate private sector participation through the contracting out of the supply and management of services where appropriate.

Conclusion

Clearly setting up a social health insurance scheme is a complex undertaking that calls for caution. The government does not pretend to have all the answers. Cooperation from the public and from interested local and international agencies and bilateral partners is absolutely essential if the scheme is to succeed.

Table 11.2. Activities and Time Frame for Implementing the Social Health Insurance Scheme

<i>Activity and time frame</i>	<i>Description</i>
Initiating memorandum (July 1996)	This document provides an outline of the general features of the proposed scheme.
Stakeholders' meeting (September–October 1996)	The relevant ministries held a meeting with other key stakeholders, including donors, to discuss the plan and solicit comments and other inputs.
Appointment of implementation team (October–November 1996)	A national team of experts was put in place to plan the implementation of the scheme and to provide technical support. The team includes experts in economics, financial management, social science, and law. Donors and other key stakeholders who wished to be involved also assisted.
Draft concept paper (November–December 1996)	The implementation team drafted a concept paper that detailed the plan's essential features and identified gaps in information, systems, and tools that require development, as well as publicity and training requirements. The team developed terms of reference and conducted studies of supply side capacity, facility management, legal framework, costing, and marketing.
National workshop (January–February 1997)	A national workshop was convened to review the draft concept paper and implementation plan.
Final concept paper (March 1997)	A concept paper was finalized based on the studies done and inputs from national workshops.
Preparation of the supply side (April–June 1997)	The scope of activities that need to be carried out was reflected in the final concept paper, namely: <ul style="list-style-type: none"> • Setting up management structures for service delivery • Recruiting, training, and deploying administrative staff • Preparing an inventory of existing facilities and equipment and required upgrading • Designating private practitioners and facilities • Ensuring a ready supply of drugs and essential medical supplies.
Setting up the fund and management training (May–June 1997)	Fund staff will need to be familiar with accounting procedures and other management tools, as well as banking arrangements.
Information, education, and communications strategy (April–June 1997)	Every citizen needs to be brought on board. Newspapers, radio, and television will be used to educate both the public and providers. Several workshops will be held in the pilot province focusing on providers, local authorities, and community leaders.
Launch of pilot (1997)	The launch was planned to coincide with the beginning of the financial year.

12

Public-Private Collaboration in Lesotho

*Prepared for the Ministry of Health, Lesotho, by
M. Nkuebe, G. P. Nchee, M. Makhakhe, and C. S. Ts'epe*

Lesotho, a country surrounded by South Africa, is 1,400 meters above sea level and is free from tropical diseases, which are a major problem in most other African countries. The government of Lesotho recognizes health as a human right and wishes to balance equity and social justice with efficient and cost-effective approaches to health care. Government policy is to support community involvement and participation in the delivery of health care.

Based on these principles, the Ministry of Health and Social Welfare's (MOHSW) mission is to maintain and safeguard the health and social welfare of individuals, families, communities, and the nation as a whole. Given this objective, the nation's health cannot be a matter for the MOHSW alone, but is the collective responsibility of communities, institutions, and other ministries. The MOHSW's role is to provide leadership and coordination.

Health care services in Lesotho have been and continue to be a joint venture between the government, nongovernmental organizations (NGOs), and the traditional sector. The NGO sector comprises nonprofit mission health facilities, coordinated by the umbrella body known as the Private Christian Health Association of Lesotho (PHAL/CHAL) and private for-profit doctors. PHAL/CHAL is regarded as a major partner in the provision of health services because of its scope—it serves almost 40 percent of the population—and history. The traditional sector consists of a network of more than 5,000 trained volunteer health workers and 8,879 licensed traditional practitioners.

Lesotho's health care delivery system is based on the foundations laid by religious missions in the 19th century. As a result of the Alma Ata declaration of 1978, to which Lesotho was a signatory, the country committed itself to "health for all by the year 2000." National policies shifted markedly from being purely curative toward the primary health care approach, which emphasizes health promotion and education, maternal and child health, family planning, accelerated immunizations, improved environmental conditions, and community participation in health care delivery. The provision of these services formed the focus of both the third and fourth national development plans (1982–91), which emphasized implementation of the health service area concept and initiated the process of collaboration between NGOs and the state in the health sector.

Objectives of Collaboration

The main objectives of collaboration with the private sector were

- To ensure clients' access to good quality health care under a requirement that clients should not have to travel more than 3 kilometers to a health facility
- To recognize and promote the participation and involvement of all parties interested in promoting primary health care in Lesotho
- To promote and sustain an equitable distribution of good quality health service to all citizens, particularly those underserved, irrespective of their geographical location, by the year 2000.

Approaches

The creation of the health service areas was one approach to drawing PHAL/CHAL hospitals into a unified primary health care network. Through this structure, both PHAL/CHAL and government hospitals became referral centers within each health service area, responsible for surrounding satellite clinics or health centers regardless of ownership.

With the establishment of the health service areas, the government and NGOs had to plan, implement, and monitor primary health care services jointly. In response to the high prevalence of diseases like tuberculosis, sexually transmitted diseases, and malnutrition, the MOHSW implemented a policy of ensuring that each health facility, regardless of ownership, possessed a copy of relevant clinical management protocols.

Capacity building in primary health care has been supported in the following ways:

- The MOHSW funds the education of medical personnel, nurses, and paramedics.
- The training of voluntary health workers and traditional birth attendants is a joint venture of both sectors, using the same educational materials and terms of reference. Voluntary health workers and traditional birth attendants are all offered the same incentives regardless of whether they work in association with public or private facilities. For example, they all receive free out-patient treatment for themselves and their close family members.
- A drug replenishment scheme is being phased in in both government and PHAL/CHAL facilities. Under this scheme voluntary health workers and traditional birth attendants are allowed to keep 15 to 25 percent of the proceeds made from the sale of certain drugs that they supply to their patients, while the rest of the money goes back to the facility to replenish the basic supply. The supervising facility determines which drugs are covered and their costs.

As concerns the financial aspects of collaboration, within its own facilities the government has established cost recovery mechanisms to recover a certain proportion of recurrent expenditure, which amounts to 10 to 20 percent depending on the level of the facility (health center, health service area, referral hospital). The government does not dictate to the private sector on what basis to levy fees. Note that the MOHSW is largely financed through donor grants and loans, while the government contributes about 7 percent of the total health budget. The major donors that have supported health care in Lesotho in the past and continue to do so include various United Nations agencies, the African Development Bank, the World Bank, the World Food Program, the Overseas Development Administration, the European Union, and the government of Ireland.

Donor support has shown a general downward trend. On the whole the multilateral agencies have maintained their contributions, while bilateral agencies have gradually decreased their support to the point of complete withdrawal by some. This has prompted the government to explore alternative mechanisms for mobilizing resources to ensure sustainability in the health sector.

By contrast, PHAL/CHAL is funded by a combination of user fees, which account for approximately 20 to 50 percent of recurrent expenditures, and by a subvention program financed by the government, which

Table 12.1. Total Revenues Collected, 1994/95

<i>Item</i>	<i>Government facilities</i>	<i>PHAL/CHAL facilities</i>
Revenue collected (m)	5,890.260	6,433.960
Expenditure (m)	78,437.980	16,542.683
Revenues as a percentage of total health expenditure	7.51	38.89

funds up to 35 to 40 percent of costs, depending on the level of the facility and the number of staff. Some facilities still receive support from missionary organizations, but this support is diminishing. Because they rely so heavily on user fees, PHAL/CHAL facilities have raised their fees at a faster rate than government facilities, which has gradually led to underutilization of PHAL/CHAL health services. Table 12.1 shows the disparities in user fees between government and PHAL/CHAL services.

The disparities created by the differential user fee charges at government and mission facilities directly contradicted the government's commitment to ensuring accessibility and equity in health service delivery. As a result, the government and the NGOs signed a memorandum of understanding in 1994. The intent of this memorandum was to achieve financial accessibility to quality health care by standardizing the fees levied in both government and PHAL/CHAL facilities. The memorandum of understanding also addressed the standardization of working conditions for all staff in these facilities.

Collaboration

Lesotho has a number of private for-profit general practitioners (41 in 1993), who collaborate with the MOHSW through part-time contracts. These contracts vary depending on the expertise that the doctor can provide, but generally stipulate a certain number of hours of service in public facilities. Such doctors are paid approximately M 2,000 to M 3,000 per month. In exchange, the contract doctors are provided with bed privileges and consultancy facilities for their private patients. Collaboration with traditional healers is regulated by the Universal Medicine Men and Herbalist Council Act of 1978. Stronger collaboration mechanisms are currently being developed, and the Association of Traditional Healers is now housed within the MOHSW headquarters.

Bottlenecks to Collaboration

Despite the willingness of all parties to collaborate effectively, several factors have hampered meaningful progress in various ways as follows:

- Standardized guidelines that would ensure effective collaboration in health delivery are lacking.
- The lack of clear clinical protocols and standards of service for both government and PHAL/CHAL facilities restricts coordinated progress in the implementation of primary health care. For instance, the health service area concept allocated health service area responsibilities uniformly without taking into consideration the economic ramifications for all stakeholders. Similarly, the memorandum of understanding was developed without considering the feasibility of some interventions and the roles to be played by other parties in conducting such interventions.
- Collaboration between the MOHSW and PHAL/CHAL is also limited by PHAL/CHAL's budgetary constraints, which limits its ability to staff its executive office. This results in inadequate representation at some of the key implementation mechanisms for the collaboration, for example, meetings.
- In response to the ever increasing costs of health care and health providers' struggle for survival, user fees have continued to rise, while the quality of care has not improved, resulting in underutilization of some facilities, particularly those owned by missions.

- The government facilities have continued to have a flow of donor support, which has enabled them to keep user fees low, resulting in overcrowding of facilities.
- A combination of negative factors, that is, the skewed distribution of personnel between urban and rural areas and PHAL/CHAL and government facilities, as well as the constant brain drain from Lesotho to neighboring countries, has hindered proper staffing of facilities and has negatively affected both collaboration and quality of care. This is further compounded by the political changes that have occurred in South Africa, which have increased the movement of skilled personnel and donors away from Lesotho.
- Inefficient revenue collection systems, poor financial planning, and inadequate management systems persist.
- Basic data that can guide effective strategic planning are lacking.
- Unsatisfactory conditions of service have led to low morale among health workers, creating an unwelcoming atmosphere for patients and making collaboration difficult.

Options

Although attempts to foster collaboration between the public and private sectors in Lesotho to achieve accessibility and affordability have met with some success, room for improvement exists. The government is embarking on a reform program with the following components that could help to strengthen collaboration further:

- Reviewing the health service area concept and the memorandum of understanding, which will include designing a new incentive package for voluntary health workers
- Strengthening the capacity of the various MOHSW units, such as the Planning Unit and the Human Resource Development Unit
- Introducing medical aid schemes for government and NGO employees
- Pursuing decentralization of the management of health services.

This approach will rely to a large extent on information collected through research work and consultancies currently in progress. In addition, the government is exploring possibilities for strengthening and collaborating with the widely accepted burial societies to take advantage of their approaches to lending, which communities with high unemployment could use for their health care needs.

Requisites for Success

Central to the continued success of collaboration are the following factors:

- Continuing close consultations between the government and NGOs in the policy formulation process
- Implementing mechanisms for joint bottom-up planning, monitoring, and evaluation of health programs
- Making resources available, both human and material, to implement the collaboration
- Obtaining full commitment by all parties and ensuring constant communication and consultation
- Achieving genuine involvement by communities in all relevant issues and maintaining respect for their cultural values.

Broader Systemic Impacts

In line with the objectives of collaboration, the government hoped that all stakeholders, including local communities, would receive equitable, accessible, and affordable services. Furthermore, the government hoped that collaboration would also improve management capacities and curb the exodus of professional and technical staff. However, because of inadequate preparatory work before decisions were reached

about adopting certain strategies for achieving meaningful collaboration, the following negative results have emerged:

- *Loss of credibility.* With the inception of the health service areas, the authorities had assumed that all parties would have a good resource base to implement the program. However, it has become evident that PHAL/CHAL could not raise adequate resources (both financial and human) to undertake health service area obligations successfully, and this has resulted in inequitable delivery of services. This situation has led to a vicious circle where all the parties (communities, the government, and providers) have lost faith in one another.
- *Complex management and duplication of services.* Facilities under different ownership have different support systems. Technical supervision may be from a nearby hospital, while logistic support might come from another source, resulting in duplication of efforts and difficulty in ensuring constant availability of needed supplies.
- *Frustration.* The low salaries paid in PHAL/CHAL facilities, as well as the harsh working and living conditions in isolated areas of the country, have caused a heavy migration of qualified staff to easily accessible areas, and this continues to deprive remote areas of good quality care.

Conclusion

The somber scenario that has serious negative affects on the national health system seems finally to have started to change. To be successful and meaningful, this change must be of a political nature, and must involve sound technical restructuring of the health sector. In this way reform and collaboration will provide a solid foundation for improving the health system, and hence the health status and quality of life of the Basotho.

13

Public-Private Collaboration in Malawi

Ministry of Health and Population, Malawi

Malawi is a landlocked country in southeastern Africa. It covers an area of 118,500 square kilometers and has a population of approximately 11 million people. Malawi's health status indicators are poor, with an infant mortality rate of 134 per 1,000 live births, an under five mortality rate of 234 per 1,000 live births, and a maternal mortality rate of 620 per 100,000 live births. The leading causes of death are nutritional deficiencies, pulmonary tuberculosis, pneumonia, anemia, meningitis, malaria, diarrhea, and measles. More than 30 percent of hospital admissions are currently due to HIV/AIDS and related diseases. Although deaths from AIDS are not reported as such, AIDS is probably among the top three causes of death (MOPH 1996).

The main health providers in Malawi are the Ministry of Health and Population (MOHP), which provides 60 percent of hospital beds; the Christian Health Association of Malawi (CHAM), which provides 30 percent of hospital beds; and others who provide the remaining 10 percent of beds. In addition, about 1,000 traditional birth attendants are scattered throughout rural areas along with some 18,000 traditional practitioners with no formal links to the MOHP. Health care in Malawi is delivered at four different levels: community rural health facilities, district hospitals, central hospitals, and special hospitals that provide health care to the mentally ill and to leprosy patients.

The philosophy of health care provision in Malawi is the primary health care approach based on the Alma Ata declaration. The primary health care concept and strategy are rooted in the community, and the emphasis is on outreach activities. Given the poor health situation in Malawi, the diverse nature of what has to be done to improve people's health status, and the multiplicity of health providers in the country, this chapter summarizes the methods used for collaboration in the health sector and describes the country's experience with these methods. The chapter discusses collaboration between public and private nonprofit organizations, public and private for-profit providers, and public providers and traditional healers.

Background

The provision of health care in Malawi was started by missionaries at a time when the colonial government was busy trying to develop the structure of a modern state system centered on political, administrative, and economic aspects that favored settlers' interests (Ngalande-Banda and Simukonda 1993). The pressure on the government to provide some social services, including health care, is believed to have come both from

Africans organized in native associations and missionaries. Thus by the 1930s the government had embarked upon a program of setting up district hospitals (Ngalande-Banda and Simukonda 1993). Missionaries (pioneers in this activity), the people themselves, and the government (despite its major preoccupation being to set up the structures of government) all saw the need for collaboration in the provision of health services. Thus the provision of district hospitals by the government at this early stage can be construed as complementing mission activities in providing facilities for patient referral as well as providing health services in areas that missionaries could not reach.

From the late 19th century to 1964, the government established 21 district hospitals, the special hospitals, and a number of dispensaries and health centers, along with a central referral hospital in Blantyre and a general hospital in Zomba. The government commenced the training of nurses, medical assistants, and other cadres. During the same period, various missionary establishments also expanded their services, covering wider geographical areas and establishing hospitals as well as training schools for nurses and paramedics where these were lacking. Local government authorities, estates, and other government bodies, such as the military, established their own health care units (Ngalande-Banda 1995).

No records of the forms of collaboration that existed then are available, but it is safe to conclude that this was informal, with no demarcation of the various roles and with no written policies in place. One thing that is clear is that although collaboration was informal, it was accepted by both the government and the missionary establishments. Evidence of this is that, for example, the government took it upon itself to provide specialist medical care and public health care early in Malawi's history, complementing health services the missionaries started. Note that before independence, any collaboration that existed was only between public and missionary hospitals, and no collaboration existed between public providers and traditional healers. Private for-profit organizations were not yet in place.

Current Collaboration between Health Providers

The period from 1964, the year Malawi gained its independence, to 1992 saw the growth of health service provision on all fronts. This partly reflects the fact that African countries, including Malawi, adopted social welfare systems that in many ways replicated the systems of their former colonial rulers or new ideological mentors. The growth was also partly due to the policy of the new government. During this period the missionary health services grew tremendously. For these providers to interact well with the government and with each other, they formed a charitable organization called the Private Hospital Association of Malawi, which later became the Christian Health Association of Malawi, incorporated in 1966 pursuant to the provisions of the Trustees Incorporation Act. The overall objective of this body was to develop mutual cooperation among its members to obtain an optimal level of health services delivery and patient care, to act for the benefit and welfare of the people of Malawi generally, and to facilitate cooperation between the government and CHAM members.

CHAM was established as an ecumenical organization that brought together Roman Catholics under the Episcopal Conference of Malawi and Protestants under the Christian Council of Malawi. It now has 148 church-related member health facilities that vary both in size and in the scope of services offered. The services offered are mainly curative and facility based, although more recently they have emphasized preventive services and primary health care.

CHAM's executive committee implements policies and decisions through the association's secretariat. Under the executive committee are subcommittees responsible for planning, administering grants, training, organizing health service delivery, and managing personnel and drugs. The MOHP is not represented on the executive committee or on any of the other subcommittees. Even though the MOHP is represented on the council, it does not have a decisive influence on CHAM's policies because of its non-voting membership status.

NGOs in the health sector do not fall under CHAM. They work independently of each other without any unifying body and each deals with the MOHP separately. Local authorities' health facilities operate maternity units, dispensaries, and health centers throughout the country. They provide only 3 percent of the services and have no unifying body. Other health providers, such as private for-profit organizations that came into being after independence, are organized through the Medical Council of Malawi. Traditional healers have an association, the Herbalist Association of Malawi, but not all healers recognize it.

The government has long recognized the need for collaboration in service delivery between the MOHP and its partners, especially CHAM. The National Health Plan of Malawi for 1986-5 states:

Special attention needs to be drawn to the coordination of the future activities of all health providers, especially CHAM, with those of MOHP. CHAM receives a subsidy from MOHP each year. CHAM training centres are an important source of manpower for the sector as a whole. The magnitude of the CHAM contribution to health services and training of health manpower coupled with the significant financial contribution that the MOHP makes, requires that close cooperation and coordination should take place.

In pursuit of this policy, since 1986 the MOHP has explored ways to improve collaboration in the health sector. The MOHP started by conducting a joint MOPH and local authority study on improving local authority health services. The study examined ways to rationalize and consolidate service delivery at the health center level. Among the recommendations were providing financial support to local authority health units, exchanging staff, having the MOHP supervise local authority health units, and providing in-service training. These recommendations are already being implemented.

Next was a joint MOHP-CHAM study with the objective of improving coordination and collaboration between the MOHP, CHAM, and other providers. As a precursor to this study, the MOHP was reorganized in 1987 to allow decentralization of responsibilities and functions to the regions and districts. The study revealed the following shortcomings:

- Poor communication between CHAM and MOHP headquarters
- Poor coordination within CHAM
- Poor coordination between all providers
- Disparities in health service utilization
- Poor patient referral system
- Poor supervision of facilities and services
- Lack of a legal framework for government financial assistance to CHAM.

Following the revelation of these shortcomings, recommendations were made and are presently being implemented, for example:

- A draft agreement between CHAM and the MOHP has been prepared that spells out the clear obligations of both parties and empowers the government to audit CHAM's accounts.
- Health delivery areas have been set up to facilitate supervision and patient referrals in a manner that eliminates duplication and waste of the sector's resources.
- The government is collaborating with CHAM to improve the quality of nurses' training schools by seconding nurse tutors to assist in CHAM schools.

As noted earlier, the Medical Council of Malawi oversees collaboration between public and private for-profit organizations. This collaboration is presently limited to maintaining standards of care and organizing patient referrals from private to public units. Public collaboration between the public sector and traditional healers is not good, because not all traditional healers recognize the Herbalist Association of Malawi. However, public providers and traditional birth attendants do collaborate in providing family planning services, and the MOHP has a unit responsible for traditional birth attendants.

Lessons Learned

From the foregoing pages, clearly the need to collaborate in the provision of health services in Malawi has always been present. All parties have been involved in the collaboration to varying degrees. The question now is how effective has this particular method of collaboration been, what lessons were learned, and how this collaboration can be improved.

Since before independence to the present, the approach to collaboration followed what one could call a "big brother approach," where the MOHP has consistently assumed the big brother role. The MOHP has always taken a major and leading role in implementing collaboration, for example, in providing almost all specialist medical care, training all registered nurses (and recently doctors) without any contribution from other providers, paying local staff salaries and wages in all CHAM health units and providing drugs, and providing in-service training to CHAM staff members and local authority staff members. The MOHP has provided this assistance every year, and at the same time, allowed these providers to charge fees for their services and keep the revenue. Sometimes the MOHP has had to do this when its own health units have been facing crippling recurrent cost problems. Some view this situation as unfair.

The implication of the big brother approach is that any part of the health sector facing problems has tended to look to the government to provide solutions. For example, whenever they face a funding shortfall, CHAM and local authorities look to the government for assistance. The result is that providers are not equal partners, with all the attendant problems of feeling left out of policy decisions and suspecting the government's motives when it takes a certain course of action. Despite the good intentions of all parties concerned, the big brother syndrome has not helped to strengthen collaboration.

To address this problem, the government has formed the Health Sector Coordinating Committee, which brings together all major health providers, the Ministry of Finance, and the Department of Personnel Management and Training. The committee has met several times, but its effectiveness is limited because the MOPH lacks a desk officer to follow up on issues raised. Similarly, CHAM and other providers have no specific officer to follow up on matters. The result is that what is discussed is rarely incorporated into policy changes.

Thus the type of collaboration that exists between health providers in Malawi is mainly with respect to the provision of services. Because health services in government health units are still free at the point of consumption, there is no collaboration in the setting of patient fees.

Future Collaboration

Based on the lessons learned, future collaboration needs to focus on the following:

- Collaboration in the provision of health services should be strengthened through
 - Providing a desk officer in the MOHP to act as a gateway into the MOHP for all other providers, including NGOs, and to provide planning officers responsible for planning in all major providers except the MOHP
 - Operationalizing the health delivery area concept to streamline the referral of patients and supervision of health services provision.
- Further collaboration among providers will always have limited success, particularly in the referral of patients, supervision, and quality improvement, as long as the MOHP continues to provide free medical services to most patients. The government has already worked out ways to introduce cost sharing, and is now working out the necessary mechanisms, such as the need to retain fees collected at the collecting units and how such funds should be used.
- Collaboration in health planning needs to be introduced. Gone are the days when health planning was merely planning civil works, such as hospitals and health centers. Planning needs to deal with resources in the sector and how best these can be allocated equitably to improve people's health

status. The need to collaborate in planning and developing human resources for the sector and the expansion of financial resources is particularly urgent.

- The 1980s witnessed growth in the number of NGOs involved in the provision of health services and of private practitioners. Thus to facilitate effective collaboration, the laws and regulations that govern the provision of health services need to be reviewed.

Conclusion

Collaboration is unavoidable in the health sector in Malawi; however, current collaborative relationships require improvement if Malawi is to achieve further progress in the provision of health services. While various significant achievements in collaboration have been accomplished, especially from 1964 to 1992, more work remains to be done. While consensus generally exists on the areas that require collaboration, all parties concerned should develop mutually agreed on and effective mechanisms for collaboration in the future.

Immediate attention should be paid to policy formulation. The present form of collaboration is limited to material and financial support and service provision; it does not come into play in analyzing problems that affect health provision. This is unfortunate considering that primary health care as a strategy adopted by the MOHP emphasizes the need for coordination and collaboration within the health sector, as well as between the health sector and other sectors. This recognizes that health as defined today cannot be provided by one type of provider alone or by the health sector alone. The MOHP needs to open its doors to allow other providers, including NGOs not affiliated with churches, to participate in policy analysis and formulation. Likewise, these other partners also need to open their doors for the MOHP to appreciate, for example, the amount of resources they bring into the sector. Without this transparency and involvement in policy analysis, plans and policies made for the sector will remain unrealistic. The MOHP is about to start preparing the new national health plan to cover the next ten years. This is an opportunity to begin collaboration in policy formulation.

For other areas of collaboration, such as referral of patients, the MOHP will have to establish preconditions, such as the introduction of cost sharing, for this type of collaboration to be effective. We note that the mere creation of health delivery areas will not help much. In conclusion, we believe much can be done to improve the approach to collaboration if future actions are based on what has gone before.

References

- MOHP (Ministry of Health and Population). 1996. "National Health Policy Framework." Lilongwe, Malawi.
- Ngalande-Banda, E. E. 1995. "Basic Social Services in Education and Health: The Case for Malawi." Lilongwe, Malawi.
- Ngalande-Banda, E. E., and H. P. M. Simukonda. 1993. "The Public/Private Mix in the Health Care System in Malawi." *Health Policy and Planning* 9(1):63-71.

14

Reprioritizing Public Health Resources Toward Primary Health Care in Mozambique

Ministry of Health, Mozambique

Mozambique's epidemiological pattern is pretransitional: morbidity and mortality are associated with infectious and parasitic diseases such as malaria, diarrhea, acute respiratory infections, measles, and tuberculosis. Poor hygiene and sanitation, a limited safe water supply, poor nutrition, high vulnerability to recurrent epidemics and natural disasters, and reduced access to health care are all important health status determinants that interact with each other in a complex manner. Of particular importance is the high prevalence of absolute poverty that affects nearly 60 percent of the population.

Available data suggest that the HIV seroprevalence rate is increasing, particularly in the central provinces of Manica, Sofala, Tete, and Zambézia. Some 2,900 AIDS cases have been reported to date, but experts believe that the actual number of AIDS cases might be as high as 25,000. An estimated 800,000 persons are HIV-infected. One certainty is that HIV infection will overburden the health system.

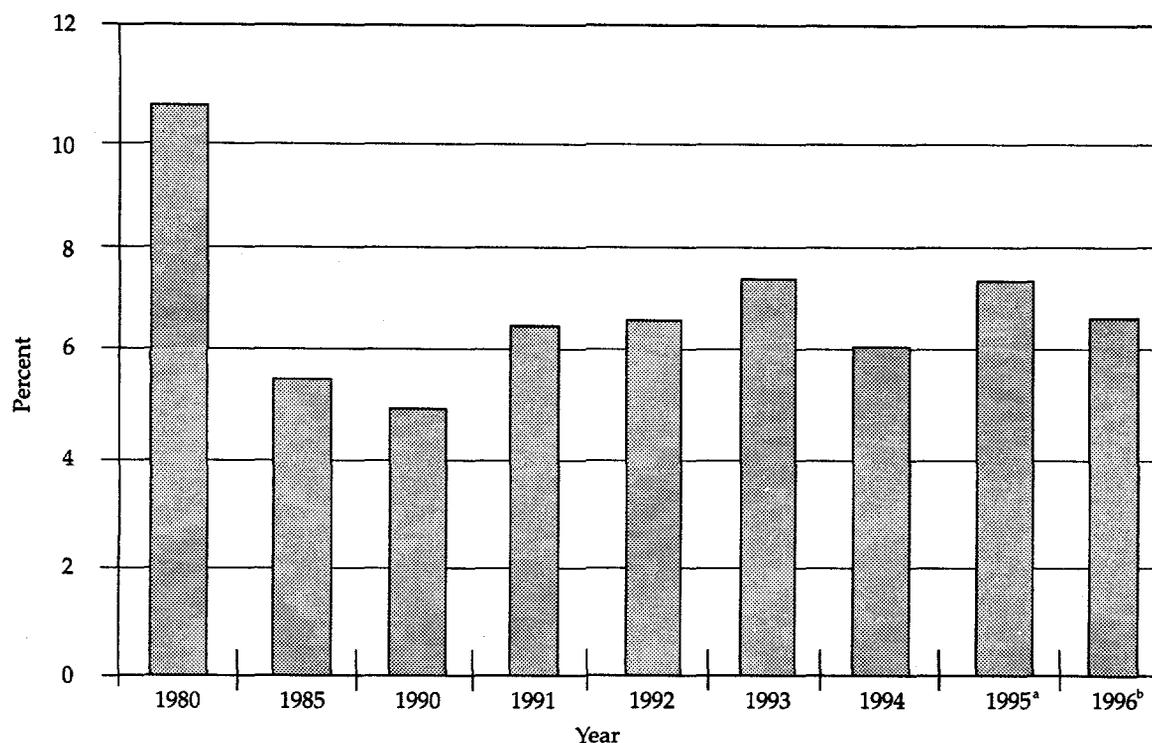
The country recently emerged from a 16-year war that had detrimental effects on the health sector and has virtually paralyzed the economy, particularly in the countryside. The resettlement of refugees and displaced persons and the improvement in access to rural areas are inducing a significant increase in the demand for health care, health needs, and community expectations.

Thus, at this juncture, the government adjusted its health policies to maximize the health benefits to the population from available resources. The strategy stresses the need to allocate resources for those activities proven most effective in improving the health status of the greatest number of people at relatively low cost, in contrast to those that are costly and benefit only individuals or relatively small groups of the population. The focus on allocative efficiency should not cause technical efficiency to be overlooked as a means of providing services of an acceptable standard at the lowest cost possible.

Health Financing

The main sources of funds for the National Health System are the state (public funds) and the international community (external funds). The Ministry of Planning and Finance allocates public funds for recurrent expenditures on an annual basis. Final allocations are agreed on through negotiations between the Ministry of Planning and Finance and the Ministry of Health (MOH), including the distribution of funds among

Figure 14.1. Recurrent Health Sector Expenditures as a Percentage of Total Recurrent Expenditures, Selected Years 1980–96



a. Estimated.

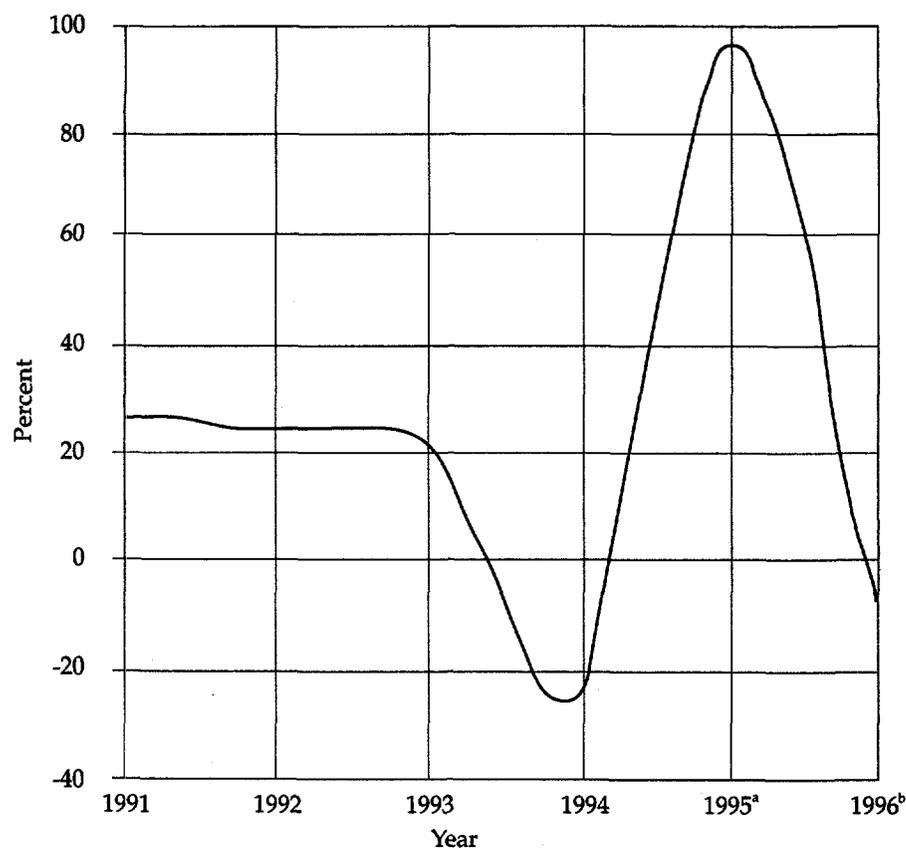
b. Projected.

Source: Government of Mozambique data.

provinces and subordinate institutions. Since 1992 the authorities have been conducting an allocation exercise with central-level staff and with donor participation at the provincial level that includes both public and external funds. At some point during the fiscal year, the Ministry of Planning and Finance usually provides some extra funds to compensate for inflation or unexpected expenditures. Public hospitals, including so-called special clinics, charge user fees, and drugs are dispensed at a subsidized price of 70 to 80 percent of their actual price. Currently the government recovers only 2.9 percent of its recurrent expenditure on health through these mechanisms. After a sharp decrease in the health sector's share of total government recurrent expenditure in the 1980s, a positive trend (above 6 percent) has been evident since 1991 (figure 14.1).

As a result of resources being released from the defense sector, the health budget grew by some 40 percent in real terms from 1994 to 1995, a figure well above the previous commitments agreed upon. Nevertheless, the prospects for financial sustainability in the health sector remain poor, because of the enormous gap between needs and available resources. Excluding salaries from this analysis, the annual growth in expenditures on goods and services in real terms between 1991 and 1993 was above 20 percent (figure 14.2). The dip in 1994 was due to extraordinary budget allocations for the peace process and for general elections.

Mozambique's dependence on international aid is overwhelming. In 1995 about 50 percent of recurrent expenditures were externally funded, and donors' share in capital and recurrent expenditures was approximately 70 percent. That same year per capita, internally funded recurrent expenditure was US\$1.25, while the externally funded component stood at US\$4.10 per capita. Although the increasing health needs have been widely recognized, the level of external assistance is decreasing, probably because of new emergencies elsewhere in the world.

Figure 14.2. Growth in Expenditures on Goods and Services in Real Terms, 1991–96

a. Estimated.

b. Projected.

Source: Government of Mozambique data.

Donors' funds, both in kind or in cash, enter the system in many ways: directly through government channels, indirectly through agencies, or as services delivered by nongovernmental organizations. In recent years, the authorities have developed strategies to track external resources and to integrate them into working plans and program budgets. The assumption is that transparency and accountability have improved, and probably efficiency as well. Nonetheless, coordination could still be improved.

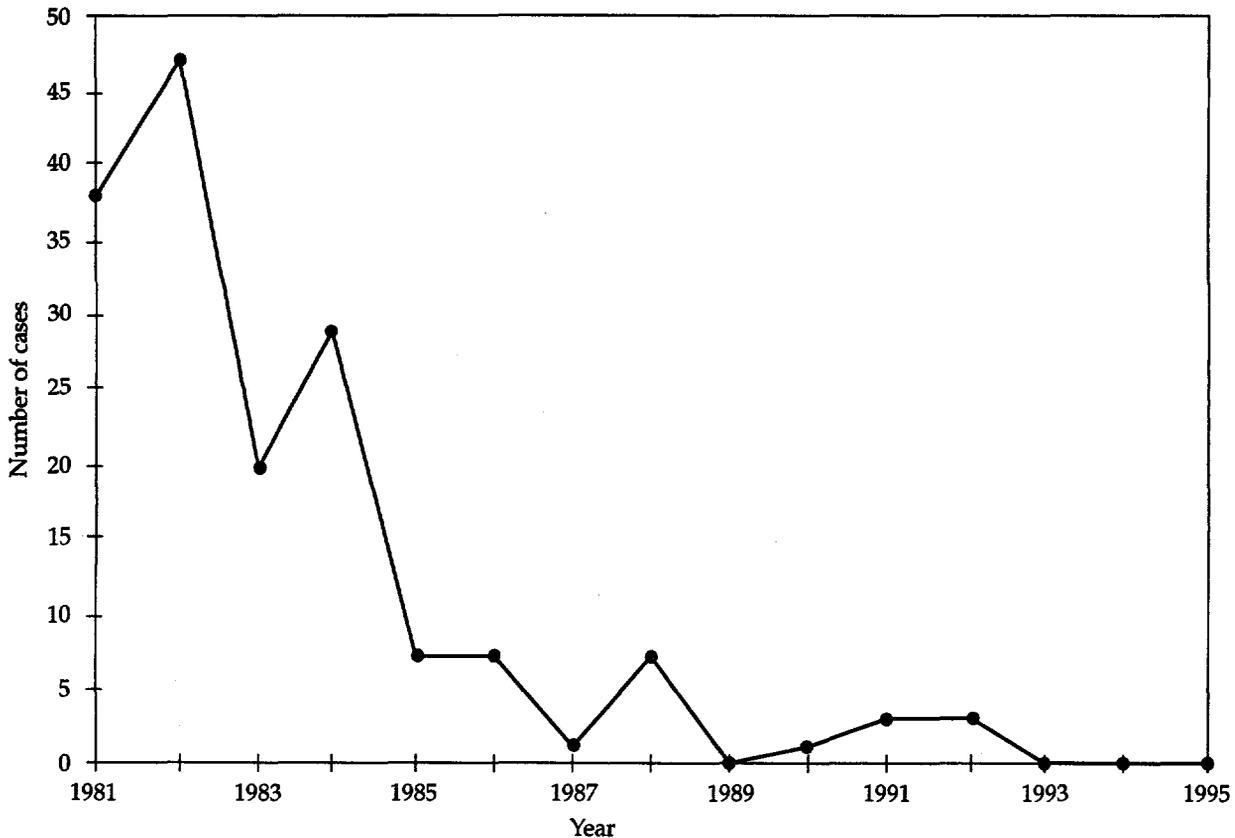
Estimates indicate that to reestablish the health network that was in place before 1981, some US\$500 million dollars are required over a five-year period. About half this amount would be spent on rebuilding and rehabilitating first-level facilities. Preliminary estimates indicate that the functional and physical rehabilitation of a health facility increases its running costs three- to fivefold.

Approaches and Options

Mozambique has accumulated experience in implementing primary health care (PHC) and essential drugs policies aimed at improving allocative efficiency. The government assumed that PHC interventions would yield large benefits to most citizens. Available data suggest that some PHC interventions have considerably reduced the incidence rates of poliomyelitis; neonatal tetanus; and, to a lesser extent, measles (figures 14.3 and 14.4).

The National Health System was organized to provide four levels of care, with PHC interventions mainly carried out at the first level (health posts and centers). A referral system was established to increase the

Figure 14.3. Reported Cases of Poliomyelitis, 1980–95



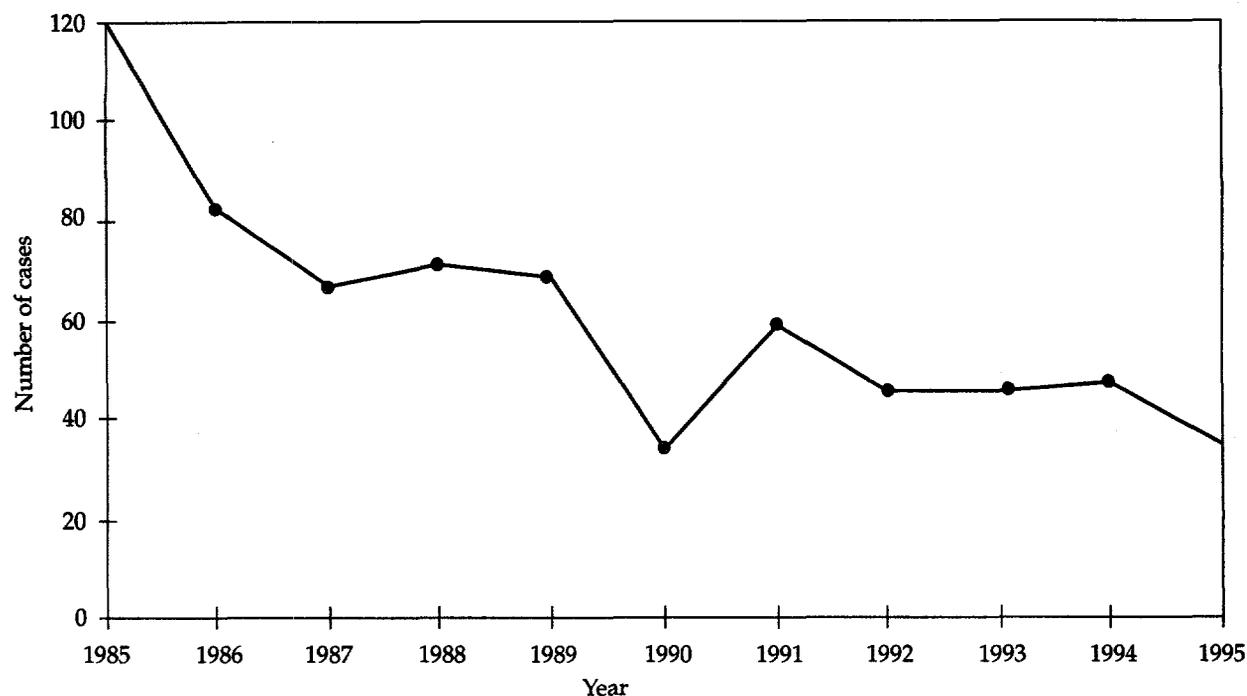
Source: Government of Mozambique data.

efficiency of the services, but was severely disrupted during the war, when the PHC network was virtually nonfunctioning, especially in rural areas. At that time, for security reasons, the government made no investments in those regions and the quality of care decreased significantly. Also the average distance from people's homes to health units increased and access decreased. Thus in its present state the referral system exists largely in theory only. In this context, the bias toward urban areas was reinforced. Partial data suggest that large cities absorb more than 60 percent of overall health expenditure. Moreover, the central and southern provinces are better endowed than others. These imbalances are also a legacy of the colonial era.

The national pattern is replicated within each province, that is, resources and consumption are concentrated in the capital city, leaving some rural areas underserved. Note that the systems for budgeting and monitoring spending prevent a precise determination of the proportion of spending on PHC.

Available data demonstrate that a major shift in resource allocation occurred during the 1980s (table 14.1). Spending on the primary and secondary levels decreased from 64 percent in 1982 to 42 percent by 1991. The same pattern was apparent in expenditures in the provinces from 1993 to 1995 (table 14.2). The proportion of public expenditure devoted to hospitals increased, while external funds covered spending on PHC. As mentioned earlier, the constraints associated with war and instability may have reduced health care activities, and hence resource allocation, particularly to rural areas. Health care activities, particularly in rural areas, likely decreased because of the war. Another factor was the migration to cities, which increased the urban demand for health care, and therefore increased resources requirements in the cities.

The exact number of PHC facilities is unknown because of the ongoing rehabilitation, the precarious functioning of some of them, and the lack of reliable data. Table 14.3 shows a conservative estimate of the number of health facilities as of March 1996.

Figure 14.4. Reported Cases of Neonatal Tetanus, 1985–95


Source: Government of Mozambique data.

The government launched the five-year Health Sector Recovery Program in 1996 to rehabilitate and upgrade the existing health network and laboratory facilities. The program's objective is to increase the number of small facilities, thereby making services more accessible and reducing the average distance between homes and health units. The plan is to build 600 new health posts and health centers and to rehabilitate other infrastructure. By 2002 Mozambique should have 1,450 first-level health units. At the same time, the authorities will address the current imbalance in the distribution of facilities (table 14.4). Finally, the government expects that the number of points for immunization delivery will double and that large health

Table 14.1. Total Public and Private Health Expenditure by Level of Care, Selected Years 1982–95

Level of care	1982	1989	1991	1993 ^a	1995 ^a
Levels 1 and 2	64	44	42	61	46
Levels 3 and 4	36	56	58	39	54
National Health System	100	100	100	100	100

a. Excluding Gaza, Sofala, and Manica.

Source: 1982 and 1989: World Bank (1992); 1991, 1993, 1995: government of Mozambique data.

Table 14.2. Public Health Expenditure by Level of Care in the Provinces, 1993 and 1995

Level of care	1993 ^a	1995 ^a
Levels 1 and 2	42	31
Levels 3 and 4	58	69
National Health System	100	100

a. Excluding Gaza, Sofala, and Manica.

Table 14.3. Health Facilities by Level, March 1996

<i>Level of care</i>	<i>Number of health units</i>
Level 1	700 health posts, 200 health centers
Level 2	24 rural and general hospitals
Level 3	7 provincial hospitals
Level 4	3 central hospitals, 2 specialized hospitals

Table 14.4. Ratio of Population Per First-Level Unit, 1996

<i>Category</i>	<i>National average 1996</i>	<i>Best ratio 1996</i>	<i>Worst ratio 1996</i>	<i>Year 2002 target ratio in high population density areas</i>	<i>Year 2002 target ratio in low population density areas</i>
Inhabitants per health post	25,700	10,500	37,900	20,000	10,000
Inhabitants per health center	90,100	48,300	126,400	60,000	40,000

Source: Government of Mozambique data.

centers will have clinical laboratories. Thus overall, the implementation of the Health Sector Recovery Plan should result in major improvements in the population's health.

Rural hospitals play a crucial role in the health care delivery system. In making critical services available outside cities, they provide referral and logistic support to the first level and enhance the system's effectiveness and credibility. The expected output of the Health Sector Recovery Program will be to provide the average rural hospital with 100 beds to deliver referral and backup services (distribution of drugs and vaccines, supervision, and so on) to a cluster of three to four districts serving a population of 300,000 to 500,000 people.

Private medicine has been playing a role since 1991, when it was reintroduced. While the number of for-profit providers experienced modest growth in Maputo, the capital, little growth was recorded among non-profit operators. Experts believe that this is because of the prohibitively high capital cost of setting up a private business, along with the small number of people able and willing to pay (who are located mainly in urban areas). There is also some skepticism about the quality of the services provided. Thus some transitional, and perhaps ambiguous, arrangements emerged. Large hospitals opened so-called special clinics, where they provide better logistic services at a higher fee, but still well below the real cost of services. A significant portion of the revenue collected is used to top up health workers', mostly doctors, salaries. In rural areas, churches are managing some facilities, but the state and donors cover most of the capital and recurrent costs. The churches' contribution is limited to appointing some health workers, often those in charge of the facility, and providing a marginal share of recurrent expenditure. The impact of the private sector and the special clinics in freeing resources for PHC is unknown. Data should be collected to evaluate this.

The public-private mix should evolve into a partnership, with clearly defined roles and responsibilities. In this respect, the public sector should be in charge of critical facilities and services, that is, referral hospitals and preventive services. Donors should fully support these core services. Nonprofit operators should be partners of the public sector in providing basic services to underserved populations at a reasonable cost. Neither donors nor the government should subsidize the operations of for-profit providers.

Investment Program and Resources for PHC Activities

The government has started an adjustment process to reduce the gaps in health care delivery that includes measures to reduce both consumption and the concentration of resources in the major cities. However, the

reconstruction exercise is being hampered by the poor infrastructure outside the health sector: poor roads, communications, and services; rudimentary banking systems; and the general lack of private sector development. The search for greater equity is sometimes at odds with economic priorities. Only a long-term political commitment, supported by the international community, can reverse the current situation.

Pharmaceuticals

Drug requirements are increasing steadily and currently amount to US\$50 million per year. Drug imports for 1996 amounted to an estimated US\$33 million. About 98 percent of expenditure on drugs is donor funded. In the last four years, Mozambique has obtained less than half its drug requirements. The situation is somber: drug stocks are low and shortages are registered nationwide. The government has made emergency funds available to stabilize the drug supply on an ad hoc basis.

In 1986 the authorities introduced an essential drug program for PHC. With annual imports worth some US\$4 to US\$5 million, about US\$500,000 will be needed yearly to accommodate the increase required by the growth of the health network. The program has been considered successful in securing basic drug supplies for the PHC network, as well as being relatively reliable and efficient. The government plans to strengthen this program.

Human Resources

The rapid growth in the number of health workers registered after independence consisted mainly of lower level personnel. Half the staff is ancillary, without any formal health training. Among skilled personnel, most received only elementary or basic training, and fewer than 10 percent have a university degree or mid-level certificate. In addition, few officials are trained to take on managerial positions.

In 1992 the MOH launched the Health Manpower Development Plan 1992–2002 to restructure the work force. In the medium run, the number of health workers should not increase significantly; however, the ratio of skilled to unskilled personnel will increase from the 1991 figure of 1:1 to 2:1 by 2002. The proportion of untrained workers will slowly decrease through attrition, and the MOH's hiring policy gives priority to university graduates and personnel with mid-level certificates. Of the skilled personnel, 33 percent are oriented toward PHC, and this proportion will increase to 40 percent by 2002. Training capacity is being reinforced, and recurrent expenditure allocations for training have increased. The training of medical technicians and medical staff will receive substantial inputs. These cadres are expected not only to provide curative care, but also to be in charge of health centers and to act as health team leaders. They will run facilities staffed by a balanced health team of maternal and child health, preventive medicine, in-patient, pharmacy, laboratory, and administrative personnel.

Patterns of personnel deployment have favored large hospitals and cities and southern and central provinces. The MOH is now addressing this imbalance by giving high priority to understaffed provinces when deploying new staff. In the last few years, staffing patterns have been improving (table 14.5).

Unfortunately, high-level professionals strongly resist hardship appointments. Incentives to attract health professionals to serve in rural areas should include housing, vehicles, hardship bonuses, and better career opportunities. Improved staffing patterns will not be restricted to the PHC network: mid-level nurses and midwives are being trained to strengthen hospital capacity, to cope with the expected increase in the work load, and to ensure better quality care. In addition, improved management at all levels should increase morale, productivity, equity, and quality of care.

Improved Managerial Capacity and Donor Coordination

Despite achievements in PHC delivery, the efficiency and quality of care are low. Factors correlated with this situation include low staff productivity, frequent wastage of resources (improper storage of drugs and

Table 14.5. Average Composition of Health Teams by Level of Education, 1990 and 1995

(number of staff)

Level of training	Health posts		Small health centers		Large health centers		Rural hospitals	
	1990	1995	1990	1995	1990	1995	1990	1995
University	0.0	0.0	0.0	0.1	0.0	0.4	0.5	2.4
Mid-level	0.0	0.1	0.1	0.5	0.4	2.2	3.2	6.1
Basic	0.4	0.4	2.1	2.3	9.2	8.7	27.5	20.8
Elementary	0.4	0.6	1.5	1.6	5.8	5.2	6.4	8.3
Average team	0.8	1.0	3.7	4.5	15.4	16.5	37.6	37.6

Source: Government of Mozambique data.

vaccines, pilferage, and loose control of stocks), and misuse and poor maintenance of equipment and vehicles. In a financially strained environment, improved system efficiency is essential. The existence of several separate projects weakens the system's already fragile institutional capacity, and the need for parallel administrative procedures acceptable to donors impairs institutional development. Effective coordination would reduce the number of projects and nongovernmental organizations, improve the accountability of all partners, facilitate project integration within a national framework, and help achieve a planning methodology that would link inputs to outputs. The government and donors should try to ensure that an effective coordinating mechanism is in place that can address global, geographic, and sector priorities. Such efforts should help ensure the equitable allocation, rational use, and proper monitoring of public health and external funds.

The public sector, including health, is moving toward decentralization. To this end, the government is creating municipalities, and some functions of the district health directorate will be transferred to local authorities. However, the government recognizes that districts and provinces are not yet ready to receive broader responsibilities. Therefore, decentralization in the health sector is currently primarily concerned with capacity building at all levels. To promote decentralization, donors' funds are now being channeled directly to recipient authorities. In the context of reform, discussions are underway about redefining the MOH's roles and functions, particularly at the central level.

The recovery program should not be limited to increasing coverage and service volumes. It should also improve the quality of care. Increased efficiency in using scarce resources is crucial. The reconstruction of the PHC network must be backed by greater financial allocations, a reasonable drug supply, and better management skills and systems. In addition, users should be active partners of the National Health System rather than simply passive beneficiaries.

The MOH foresees a modest increase in public expenditure from the present level of US\$1.25 per capita to about US\$1.48 per capita by the year 2002, of which US\$0.25 will be for capital expenditure. Various cost-recovery schemes (insurance, fees, drug sales) will add about US\$0.18 per capita. External financing is expected to increase marginally from US\$4.10 per capita in 1993 to US\$4.94 per capita in 2002. Table 14.6 compares per capita expenditures in 1993 with estimated per capita expenditures in 2002.

The cost-recovery system has been debated with respect to what share users should pay, different approaches, and a suitable time frame for implementation. Some political issues are involved in updating user fees and concerns about their possible negative impact on access, given the high levels of absolute poverty. People will not be able to afford to pay a significant share of health service costs for many years. Thus fees should be increased progressively, based on the rate of economic recovery and income levels. The MOH is examining the possibility of introducing a social insurance scheme and other community-based copayment schemes.

Cost recovery is important to maintain a progressive reduction in donor dependency. The National Health Scheme will rely on external support for many years to come, but internal funding (both public and

Table 14.6. Per Capita Expenditure, 1993 and 2002

(U.S. dollars)

Per capita expenditure	1993			2002		
	Internal	External	Total	Internal	External	Total
Investment	0.15	2.20	2.35	0.25	1.25	1.50
Recurrent	1.02	0.62	1.64	1.23	0.88	2.11
Drugs	0.00	1.28	1.28	0.00	2.81	2.81
Cost recovery	0.02	0.00	0.02	0.18	0.00	0.18
Total	1.19	4.10	5.29	1.66	4.94	6.60

Source: Government of Mozambique data.

private) is expected to expand. Even so, the donor share of recurrent expenditures will be substantial. A balanced situation, with internal resources covering most of the health services' costs, is not anticipated until well beyond the year 2000.

References

World Bank. 1992. *Public Expenditure Review*. Washington, D.C.

15

District Financing Issues and Implementation in Botswana

Ministry of Health, Botswana

At independence, Botswana's health care system was largely curative and based on the delivery of hospital care in urban areas and larger villages. The greatest concern at that time was to improve access to health care facilities for the rural population, thus the government undertook an infrastructure development program. It also decentralized the provision of social services, including basic health care, to district and town councils. The objectives of the decentralization process were to streamline financial allocation to these services, to increase responsiveness to local needs, to improve access to services, and to increase community participation.

The Ministry of Health is responsible for general health policy and professional supervision of all health services in the country. It administers government-run primary services and district and referral hospitals. The Ministry of Local Government, Lands, and Housing, through the district and town councils, is responsible for providing basic health services. Regional health teams, created in 1972, provide technical supervision of local government services. Originally supervised by the Ministry of Health, the teams were later transferred to town and district councils and are now referred to as district health teams because their areas of operation correspond to district boundaries.

The government established a nationwide network of health facilities, and by 1991, 88 percent of the population lived within 15 kilometers of a health facility, while 81 percent were within 8 kilometers. However, accessibility remains a problem in some areas, mainly in the western areas of the country, because of the sparsely distributed population, the difficult terrain, and the long distances between settlements. Box 15.1 shows the hierarchy of the health system, table 15.1 presents national health indicators for 1981 and 1991, and table 15.2 shows the distribution of health facilities by type and district.

Despite the significant improvements in health status and geographical coverage, other challenges have emerged. These include the following:

- The rising expectations of consumers of health care regarding what the government can afford to provide, exacerbated by rapid population growth
- The shortage of trained manpower
- The need to improve the quality of services offered rather than increasing their quantity and to improve coverage in sparsely populated areas

Box 15.1. Hierarchy of Health Care Services

1. Referral hospitals in Gaborone and Francistown
2. District hospitals in major villages
3. Primary hospitals in villages with more than 10,000 people in certain remote areas
4. Clinics with maternity wards in villages with more than 1,000 people
5. Clinics without maternity wards in villages with more than 1,000 people
6. Health posts in rural areas with populations of 500 people
7. Mobile health services in remote areas with small, scattered populations

- The AIDS epidemic, which threatens to reverse gains made to date
- The need to establish a more equal partnership between providers and users of health services
- The need to explore alternative and more sustainable ways to finance modern health care and to improve the efficiency of health services.

Given the economic slowdown projected for the coming years, what is the way forward? How does one strike the right balance?

The Economy and Health Care Financing

The theme for the Eighth National Development Plan (1997–2002) is sustainable economic diversification. Slower economic growth is projected for the next few years, and therefore government expenditure must be restricted for the budget to remain sustainable. The objective of economic diversification is to broaden the country's economic base away from mining, particularly diamond mining. The health sector theme for the next five years is "sustainability, appropriateness, and quality in health care."

In the last few years the demand for health services has increased. People's expectations tend to be much higher than what the government can afford to provide and sustain. This led to the adoption of a national health policy in 1995 that provides health workers with guidelines on when to refer patients, when to use laboratory services, and so on. The policy also informs patients about the standard and range of services available to them. It therefore lays the basis for the choice and level of technologies to be used in public facilities. In addition, it will provide guidance on determining the right balance between primary, secondary, and tertiary levels of care. The hope is that a more explicit definition of guidelines for care will improve the current situation, whereby most of the population has access to basic services, while a few have access to highly sophisticated, expensive services.

The objective is thus to improve the quality of services offered at current cost levels, or better still, at lower costs. Some of the options open to the ministry include the following:

- Privatizing certain services
- Delineating a minimum package of care
- Exploring alternative and more sustainable ways to finance health care
- Involving consumers of health care in the financing of services.

Privatization

The current system frequently wastes resources. For example, drugs may be overprescribed and consumables used too readily; X-rays and laboratory investigations may be used excessively; and some nonclinical services, such as cleaning, maintenance, catering, and laundry services, may be inefficient. The government will attempt to contain costs and explore cost-effective methods of providing these services, including privatization.

Table 15.1. National Health Indicators, 1981 and 1991

Indicator	1981	1991
Infant mortality rate (per 1,000 live births)	71.0	37.0
Child mortality rate (per 1,000 children under five years old)	109.0	52.0
Life expectancy at birth (years)	55.9	60.2
Crude birth rate (per 1,000 population)	49.1	40.4
Crude death rate (per 1,000 population)	14.4	9.7

Source: Government of Botswana (1981, 1991).

Minimum Package of Care

To facilitate the optimal use of resources, a minimum package of care has to be defined. The absence of such a package results in the government subsidizing nonessential services even for those who can afford to pay for them. The package will therefore define the range and level of services to be offered and, in the process, also cut down on waste. It will also facilitate cost recovery for those services outside the package, especially from those who can afford to pay.

Table 15.2. Health Facilities by Type and District, 1996

District	GH	PH	CWM	CWOM	TC	HPWN	HPWON	THP	THF	MS
Maun	1	0	1	7	8	14	1	15	24	44
North East	0	0	5	1	6	26	0	26	32	18
Serowe	1	1	3	15	18	21	8	29	49	26
Bobirwa	0	2	3	5	8	9	3	12	22	16
Kweneng East	1	1	5	10	15	19	4	23	40	47
Southern	2	0	8	10	18	14	11	25	45	29
Gantsi	0	1	4	1	5	13	0	13	19	241
Mahalapye	1	1	6	7	13	20	6	26	41	15
Kgatleng	1	0	5	5	10	14	2	16	27	48
Kasane	0	1	2	0	2	10	0	10	13	3
Kgalagadi	0	1	4	1	5	11	1	12	18	21
Tutume	0	1	6	8	14	17	9	26	41	20
Boteti	1	2	1	6	7	11	0	11	21	50
Gumare	0	1	4	1	5	9	7	16	22	33
Gaborone	2	0	4	14	18	0	0	20	0	0
Francistown	1	0	2	11	13	5	0	5	19	1
South East	1	0	2	6	8	4	2	6	15	23
Lobatse	2	0	0	6	6	0	0	0	8	4
Selebi Phikwe	2	0	2	9	11	0	0	0	13	0
Kweneng West	0	1	3	5	8	10	1	11	20	28
Good Hope	0	1	4	5	9	9	14	23	33	17
Hukuntsi	0	0	2	0	2	9	0	9	11	3

KEY: GH General hospitals.
 PH Primary hospitals.
 CWM Clinic with maternity facilities.
 CWOM Clinic without maternity facilities.
 TC Total clinics (clinic with maternity facilities).
 HPWN Health post with nurse.
 HPWON Health post without nurse.
 THP Total health posts.
 THF Total health facilities.
 MS Mobile stops (facilities).

Source: Ministry of Health data.

Alternative and Sustainable Ways to Finance Health Care

Health care provided by the government and by mission facilities is essentially free, with only nominal fees paid for each curative contact. Fees were set in 1975 at 40 thebe (US\$0.13), and were only revised in 1993 to P 2 (US\$0.60). Several factors led to the adjustment of the fees, of which one of the most important was that the cost of collecting the fees had become higher than the amount collected. At the time of setting the fees in 1975 the fees collected accounted for almost 5 percent of the Ministry of Health's recurrent expenditure, but by 1993 this figure had fallen below 0.5 percent. Increasing the charge to P 2 probably resulted in fees accounting for about 1 percent of recurrent expenditure at most. The fees remain far below cost recovery levels. In addition, they go to the central revenue pool, which is a disincentive to active collection. There is a strong case for retaining a proportion of the fees at the facilities so as to improve services.

Several studies are planned for the next five years to explore alternative and more sustainable ways to finance health care in Botswana. Some of the areas to be covered include the following:

- Determining patterns of current spending on health by both the formal and informal sectors
- Comparing trends in government expenditure with trends in the private sector
- Examining the government's ability to sustain current expenditure trends
- Assessing affordability and ability and willingness to pay
- Investigating the feasibility of a national health insurance scheme.

The need for health expenditure data by level of facility and by unit costs within facilities cannot be overemphasized. Information on expenditures is currently aggregated. Facilities have no incentives to cut down on costs, and individual facilities probably have no idea about their costs or where waste occurs.

An exploration of potential new sources of revenue for local authorities is under way. Even at the macroeconomic level, the government will attempt to put in place appropriate cost recovery strategies to ensure that resources are used efficiently, and that the government's budget remains in balance.

Involving Consumers of Health Care

Consumers of health care need to participate more in the financing of services. Efforts will be directed toward educating the public about what goes into the provision of health services and how much they cost. Their expectations and demands have tended to be much higher than the government can afford, perhaps partly because of a lack of information. The spirit of self-reliance seems to have been eroded in the authorities' attempts to improve coverage and access to health care. One of the aims of the next five-year plan is therefore to revive the spirit of self-reliance. The national health policy, which identifies all stakeholders and their respective roles, will be widely publicized as a first step toward addressing the problem.

To facilitate improved quality of health services, health facilities, particularly referral hospitals, need to be given more authority to run their institutions, including managing funds and all other activities of their institutions. Currently, everything is centrally planned. However, the current share of the government budget devoted to health care must be maintained until other sources of financing can be identified. Table 15.3 shows recent trends in health expenditure.

Table 15.3. National Health Expenditure Trends, 1991/92–1996/97
(P thousands)

<i>Category</i>	<i>1991/92</i>	<i>1992/93</i>	<i>1993/94</i>	<i>1994/95</i>	<i>1995/96</i>	<i>1996/97^a</i>
Capital	29,475	31,726	40,135	51,794	38,749	57,881
Recurrent	102,169	132,426	174,330	197,499	197,576	279,798

a. Estimates.

Source: Government of Botswana data.

Implementation Strategies

Management skills must be in place before more authority can be handed over to individual facilities. One of the priorities identified in the five-year plan is the adoption of more innovative management systems. Information management systems will also be strengthened.

Another impediment to overcome concerns the increased financial accountability of local authorities. Whether local authorities can mobilize more resources is not certain. The government plans to continue examining ways to reduce local authorities' financial dependence on the central government. The reform of local authority finances has already begun through the new system of revenue support grants. Under this system, local authorities are expected to expand their revenue base through property taxes, service charges, higher cost recovery from utilities, and so on. A revenue-sharing formula that automatically allocates a specified share of designated national revenues to local authorities is set for each authority. For example, the formula could be 50 percent from own source revenue for a particular local authority and the other 50 percent from the central government. The onus would therefore be on the local authority to ensure that it did indeed raise the money, otherwise it would encounter shortfalls that would not be covered as was previously done through deficit grants. The annual grants from the central government to local authorities are therefore fixed according to this formula. Consultants are currently examining the development of local authority own source revenue.

Conclusion

Botswana does not have much experience to share, as most of the initiatives are still in their infancy. The reform process is motivated more by the need to be prepared for difficult times ahead rather than problems already at hand. The government believes that if a determined effort to influence health expenditure is not made now, it will run into serious problems in the future. It thus plans to undertake a number of studies to generate information that will enable policymakers to make informed decisions.

References

Government of Botswana. 1981, 1991. *National Census Report*. Gaborone.

16

Effective Coordination and Use of Donor Funding in Angola

Nkanga K. Guimarães, Central Technical Support Unit/Community Rehabilitation Programme/Miniplan, Angola; Sousa Diogo, Budget Technician, Planning Bureau, Ministry of Health, Angola; Joaquim Saweka, Advisor in International Cooperation and Health Policy, Ministry of Health, Angola; and Augusto Chipesse, General Secretary of the Council of Christian Churches of Angola

The Republic of Angola is the second largest country in Sub-Saharan Africa, covering an area of about 1.3 million square kilometers. The population is estimated at about 12 million inhabitants, of whom some 60 to 70 percent live in or around the main towns. As of 1994 as many as 1.25 million people had been displaced as a result of the war and some 280,000 Angolans had fled to neighboring countries.

Three decades of war along with a highly centralized economic system, the collapse of production in most nonoil sectors, and the government's efforts to maintain national consumption at an acceptable level have led to a permanent budget deficit and a lack of self-sufficiency. Hundreds of thousands of people were forced off their lands during this period.

As a result of this combination of problems, Angola has experienced a continuous rise in malnutrition, an inability to provide safe drinking water, and disrupted sanitation schemes. Morbidity and mortality rates have soared because of the increased prevalence of malaria, acute diarrheal diseases, tuberculosis, and measles. The population's declining health status has been further aggravated by the destruction, looting, or abandonment of basic health infrastructure and the lack of essential drugs.

Coordination and Management of Donor Funds

To help Angola weather this crisis, many donors and nongovernmental organizations (NGOs) provided emergency programs, while many more are expected to help with the rehabilitation and development program (table 16.1). International aid is provided either through multilateral or bilateral cooperation. Most donor funds are channeled through NGOs, although some NGOs use their own funds. France, Italy, Portugal, Spain, Sweden, and the United Kingdom are the principal bilateral donors, while United Nations agencies such as the Food and Agriculture Organization of the United Nations, the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Fund for Population Activities (UNFPA), the World Food Programme, and the World Health Organization (WHO) along with the African Development Bank (AfDB), the European Community, and the World Bank have provided substantial multilateral assistance.

Table 16.1. Aid Per Donor, 1993

Donor	Amount (US\$ thousands)	Percentage of total aid
European Union	49,186	22.7
Italy	35,701	16.5
Sweden	33,373	15.4
World Bank/International Development Association	20,377	9.4
France	18,474	8.5
Portugal	16,152	7.5
United States	12,419	5.7
Germany	8,366	3.8
United Kingdom	3,660	1.7
UNDP	3,585	1.6
Food and Agriculture Organization	2,858	1.3
Switzerland	2,761	1.3
Netherlands	2,435	1.1
Australia	1,832	0.8
Spain	1,738	0.8
UNICEF	866	0.4
German Agro A.	713	0.3
World Food Programme	681	0.3
Austria	511	0.2
Canada	203	0.1
ACRD	168	0.1
Others	235	1.1
TOTAL	216, 290	100.0

Source: United Nations Development Programme data files, Angola, 1993.

In 1993, 42 national and 45 foreign NGOs were operating in Angola. Table 16.2 shows the contributions of different groups of donors, table 16.3 presents the main types of assistance received, and table 16.4 sets out contributions by sector to show contributions to the health sector in relation to contributions to other sectors.

Like many other African countries, in the search for sustainability, Angola faces the challenge of obtaining the best value from donor funding. In the past, many donors and NGOs arrived in the country without any knowledge of Angola's two decades of efforts to build a national health system and to educate and train its people. They failed to inform themselves about local institutions and human resources in their area of interest. Sometimes they also failed to contact government bodies, choosing to by-pass them and to work predominantly with alternative entities. This tendency may force the government to mold national health strategies around available donor funding rather than to develop sound national health policies and strategies to make the best use of external assistance. It has had the further result of fragmenting the health care delivery system and undermining national capacities in health policy analysis and planning.

International aid is critical for health care financing. It is the main source of funds for rehabilitating infrastructure; purchasing medical equipment; and supporting various health programs, such as essential drugs, the Expanded Program of Immunization, health education, family planning, and AIDS prevention.

In the transition from emergency to development programs, the Ministry of Health, under the general supervision of the Ministry of Planning (which coordinates all international cooperation), is bringing together the main donor agencies to work with Angolan national experts to define a direction for health policy reform and to build national capacities for health sector sustainability over the long term. The cooperation between donor agencies and the Ministry of Health aims to eliminate a long-standing problem in the coordination of donor funding. As box 16.1 shows, donors tend to address the health issues they themselves are most interested in rather than those that are most prevalent in the country. For example, although malaria is the greatest killer in Angola, only two agencies support malaria prevention and control

Table 16.2. Aid by Type of Donor, 1990

<i>Donor group</i>	<i>Amount (US\$ thousands)</i>	<i>Percentage of total</i>
Bilateral aid	95,300	48.6
Multilateral aid	88,105	44.9
NGOs (self-funded)	12,721	6.5
Total	196,126	100.0

Source: CREDES/OTH International (1992).

Table 16.3. Types of External Aid, 1993

<i>Type of assistance</i>	<i>Amount (US\$ thousands)</i>	<i>Percentage of total</i>
Technical cooperation	75,348	34.8
Investment projects	61,666	28.5
Emergency technical assistance	29,928	13.8
Food	22,165	10.2
Technical cooperation linked to investments	19,624	9.1
Other	7,558	3.1
Total	216,289	99.5

Source: United Nations Development Programme data files, Angola (1993).

Table 16.4. Aid by Sector, 1993

<i>Sector</i>	<i>Amount (US\$ thousands)</i>	<i>Percentage of total</i>
Emergency assistance	58,197	26.9
Social development	26,642	12.3
Health	24,433	11.3
Agriculture, forestry, fisheries	21,651	10.0
Natural resources	20,092	9.3
Human resources	19,321	8.9
Regional development	19,029	8.8
Home affairs, trading	5,900	2.7
Communications	5,354	2.5
Development management	5,162	2.4
Energy	4,141	1.9
Economic management	2,872	1.3
Disaster prevention	2,252	1.1
Transport	887	0.4
Industry	359	0.2
Total	216,292	100.0

Source: United Nations Development Programme data files, Angola (1993).

activities, whereas HIV/AIDS, which is not yet a major cause of morbidity and mortality in Angola, attracts many more donors. The same is true as concerns the spread of donors across the country. Again, donors tend to concentrate their efforts in accessible and convenient areas, which are not always the areas of greatest need.

Until the beginning of the 1990s, the Ministry of Social Affairs was almost the only government entity responsible for emergency-related activities, with some subsidiary support from religious institutions. However, since that time the number of foreign NGOs involved in such activities has been increasing steadily,

Box 16.1. International Organization and NGO Support to Health Programs, 1993

DPC–Malaria	WHO, SIDA
MCH/FP	UNICEF, UNFPA, WHO, SIDA, European Union, MSF
Expanded Programme on Immunization	UNICEF, WHO, SIDA, European Union, MSF
CDD–Diarrheal diseases	UNICEF, WHO, SIDA, European Union, MSF
NUT–Nutrition	UNICEF, WHO, SIDA, European Union, World Bank, MSF
CWS–Water and sanitation	UNICEF, WHO, SIDA, FRANCE, World Bank
HRH–Human Resource	UNICEF, UNFPA, WHO, SIDA, Portugal
Information, education, communication	WHO, Italy
GPD–Development program	WHO, France, World Bank
Infrastructure	UNICEF, SIDA, European Union, World Bank, Italy, France, Spain
Essential drugs	UNICEF, UNFPA, WHO, SIDA, AfDB, OCDE, Italy, France
Institutional re.	UNICEF, UNFPA, WHO, SIDA, AfDB, Italy, France
Laboratories	WHO, SIDA
Statistical information	WHO
Emergency assistance	UNICEF, WHO
AIDS	WHO, SIDA, European Union, World Bank, MSF, AALSIDA, Italy, France

Source: WHO (1993).

and foreign NGOs have taken over most of the government's humanitarian activities. More recently, emerging national NGOs are sharing the task and gradually spreading around the country.

Improving Coordination and Management of Donor Funds

As already noted, to foster sustainable development Angola faces the challenge of managing donor support efficiently. This section discusses the government's efforts to this end in general, and the efforts in the health sector in particular.

Government Efforts

Since 1992, with UNDP technical support, a Ministry of Planning team of national consultants has been working on a project entitled "Macroeconomic Management and Aid Coordination." The project has developed a proposal for a strategy for managing technical assistance and coordinating donors.

Meanwhile, following the signing of the Lusaka Protocol in November 1994, the prime minister established the Interministerial Aid Coordination Committee, a multisectoral board composed of representatives of the Ministry of Planning, the Ministry of Economy and Finance, the National Bank of Angola, the State Secretariat for Cooperation, and the Ministry of Territorial Administration. A technical support unit has been attached to the committee and is composed of representatives from each of the ministries and a representative from the cabinet. One of the committee's main objectives is to coordinate donors and to ensure the best use of funds coming from the international community. At the same time, within the framework of the Community Rehabilitation and National Reconciliation Program, the government, with UNDP technical assistance, is setting up a structure for managing and coordinating donor funds to ensure a transparent and efficient program management cycle.

A multilevel committee is being established at both the central and provincial levels and includes representatives of the government, donor countries, the UNDP, NGOs, community associations, and churches. The prime minister chairs the overarching central committee, while provincial committees are chaired by provincial governors. Technical support units help the central and provincial committees define priorities

and select strategies, and they also maintain a dialogue with donors and help match donors' interests with program goals.

The government has defined three phases in the country's development process: the emergency phase, the transition period, and the return to sustainable socioeconomic development. The Ministry of Social Reinsertion is responsible for emergency and demobilization programs, while the Ministry of Planning is responsible for coordinating the transition phase through the Community Rehabilitation and National Reconciliation Program. The program is essentially funded by donor countries, with government participation limited to 15 percent of the total budget. The total amount received from donor countries for the program to date is US\$533,379 million of the US\$879,150 million pledged.

The Community Rehabilitation and National Reconciliation Program is based on four subprograms as follows:

- Restoring production capacity in agriculture, microenterprises, and small enterprises
- Rehabilitating the social sectors, that is, health, education, and social assistance, to vulnerable groups
- Rehabilitating basic infrastructure, namely, secondary roads, bridges, mine clearance, water and sanitation, energy and electricity generation, and basic housing construction for vulnerable groups among displaced populations and demobilized soldiers
- Reactivating and strengthening the management capacities of local administrations and the program's executing agencies (NGOs, churches, community associations, the private sector, and other organizations).

As noted earlier, donor countries are most interested in health, education, infrastructure, and agriculture and focus on some provinces at the expense of neglecting others. This has not only led to an imbalance of funding among Angola's 18 provinces, but surplus funding in some provinces in relation to the budget estimates for the Community Rehabilitation and National Reconciliation Program by province. Furthermore, it has also increased the risk of duplication in covering the different components of the subprograms in each province.

The funding mechanisms being used to channel donor contributions to the program are the UNDP Trust Fund, the government's Fundo de Apoio Social, and bilateral and multilateral mechanisms. As far as the latter two mechanisms are concerned, in most cases donor funding will be channeled through the executing agencies.

The following are the main challenges that lie ahead:

- Determining the real capacity of executing agencies to manage rehabilitation projects when most NGOs in Angola, both international and national, have focused on emergency activities
- Achieving a balanced absorption capacity in all 18 provinces
- Matching donors' geographical interests with the need to ensure balanced coverage of the country
- Developing a partnership between the government, which is responsible for coordinating the process, and the implementing agencies, specifically the NGOs.

Health Sector Efforts

The health sector has been making a continuous effort at health system reform since the Southern Africa Workshop on Health Sector Reform and Strengthening of Local/District Health Systems held in Livingstone, Zambia, in 1994. The Ministry of Health has created task force groups to tackle issues related to identifying health needs, revising health strategies, and defining health policies in areas such as essential drugs and human resources, including capacity building and partnership.

Some donors are supporting the health initiative through institutions like WHO, the World Bank, and the European Union. This will lead to the formulation of a national health policy, and subsequently a national plan of action, a framework that will elaborate the health initiatives needed and the required resources. At

the same time, the national plan of action along with provincial plans will facilitate more effective coordination and efficient use of national resources for health, including donor funds.

The Ministry of Health intends to reinstate the International Cooperation Office, which will mobilize and coordinate funds within the Ministry of Health. The authorities recognize, however, that the prerequisites for success are the existence in the ministry of a functioning health planning office, improved community participation in health financing, and the formulation of a realistic national plan of action based on what Angola can afford.

Some of the challenges the Ministry of Health faces include the following:

- The need for consensus building among health personnel and within Angolan society on key health issues, including increasing community participation in health financing, increasing the health budget, and funding private health initiatives
- The health sector's capacity to absorb technical and financial assistance during a complex period of many changes related to the peace process, democracy, decentralization, and the replacement of a centralized economy by a market economy
- The effects of macroeconomic collapse on civil servants, who are paid extremely low salaries, which is likely responsible for their lack of motivation.

References

- CREDES/OTH International. 1992. "Health Sector Preinvestment Study." Final report. Luanda.
- WHO (World Health Organization). 1993. "Angola Health Country Profile."

17

Effective Coordination and Use of Donor Funding in Zambia

*Katele Kalumba, Minister of Health, Zambia, and V. Musowe, Chief Health Planner,
Ministry of Health, Zambia*

Donors will continue to play a pivotal role in supplementing the government's efforts to realize its health objectives. To get the most from these efforts, the Ministry of Health has effectively coordinated various donor contributions. This process has been aided by the ministry's ability to make its priorities clear, thereby avoiding duplication of efforts.

In the Zambian context, the phrase donor coordination is a misnomer. In the past the Ministry of Health attempted to coordinate donors, did not succeed, and later realized that this was not possible. From this experience it concluded that donors cannot effectively be coordinated, because they are development agencies of sovereign countries with their own cultures, hidden agendas, and biases. Accordingly, the ministry has stopped coordinating donors as such, but successfully coordinates programs and activities through its health sector support policy. Figure 17.1 shows estimates of the extent and sources of donor funding relative to other sources of funding in Zambia.

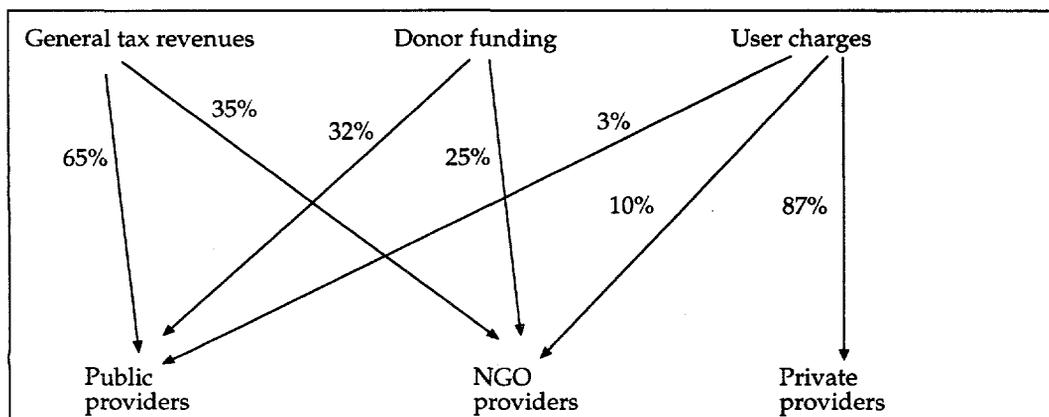
Conceptual Framework for Health Reforms

Zambia's health system has been likened to a Cadillac maintained for years by a relatively wealthy family. The family's economic situation has changed, and it can no longer afford to maintain this expensive vehicle without seeking assistance from cousins and relatives to help fuel, repair, and maintain the gas-guzzling vehicle. The alternative is to design and construct a more efficient vehicle that can meet the family's changing health care needs given its limited means.

The Ministry of Health has initiated the process of redesigning the car, but more remains to be done. It is trying out parts and road testing them, but the vision of the whole new Zambian health vehicle must be a product of societal consensus, a product of collective effort that will go beyond the government's own interests (Kalumba and others 1994).

The health reforms represent a major initiative to improve the equity, accessibility, quality, and cost-effectiveness of health services in the country. The authorities have developed a national health policy document that lays out clearly their health vision, goals, objectives, priorities, and targets. The mission statement is "to provide Zambians with equity of access to cost-effective quality health care as close to the family as

Figure 17.1. Health Sector Financing in Zambia



Source: Ministry of Health.

possible." The national health strategic plan describes how Zambia will achieve the aspirations of its national health policies and strategies.

Underlying these reforms is the desire to build effective leadership, accountability, and partnership. These principles are an integral part of the health reform process, which continues to be one of national analysis and debate to identify solutions instead of scapegoats. The outcomes of this process are expected to be better quality care and improved use of existing resources in infrastructure, personnel, equipment, drugs, and information.

Zambia's vision of its new health care system was fleshed out by answering the questions What do we want? What do we have? What do we need? What can we afford? A step-by-step process guided planners to

- Undertake a critical self-assessment of health needs; financial, physical, human, and academic resources; and stakeholders in the reform process
- Propose a set of standards for the new health system based on an agreed upon set of principles (equity, affordability) and on what the various levels of health care could reasonably be expected to provide
- Develop an essential minimum health care package.

The government cannot afford to continue to finance all possible health care services indiscriminately. If infant, child, and maternal mortality are to be reduced and life expectancy increased, then government health care services must concentrate on efficient, effective, interventions that reduce the leading causes of morbidity and mortality. The essential package will exclude costly services that are not expected to have a significant impact upon health status given Zambia's morbidity and mortality patterns. Some of the services identified in the essential package will be provided through health centers and hospitals. Others will be provided at the household or community level, in which case districts will be responsible for ensuring that households and communities receive the necessary support. This does not necessarily mean that services outside the essential package will not be provided; however, resources for funding these services have to be sought elsewhere, for example, from private sources.

Donor Coordination in the Health Sector

According to SIDA (1996):

Development assistance has all too often been fragmented and delivered in the form of multiple projects. The institutions in the recipient countries have not been able to cope with the diverse

modes of assistance and the multitude of donors. Evaluations of international development cooperation often conclude that the best way of ensuring efficient and effective use of external resources is broader and better coordinated sector programmes. Some multilateral and bilateral development agencies have subsequently started to review their forms of assistance accordingly.

The bottom line for effective coordination and use of donor funding is that cooperating partners move away from supporting multiple programs and projects to providing integrated health sector support. The main reasons for this include

- Encouraging the recipient government to take the leadership role and to use the foreign exchange provided in accordance with its own priorities
- Securing a realistic and constructive donor-government dialogue
- Contributing to better donor coordination
- Achieving a better connection between the financing of sectoral development and macroeconomic objectives
- Making resource use in a sector more transparent and subject to dialogue
- Facilitating long-term financial sustainability.

Health Sector Support Concept

Based on Zambia's experience, the prerequisites for successful health sector support are a clear and well-articulated national health policy and a clear, well-articulated, and costed national health strategic plan/health investment plan.

The main inputs into the strategic investment plan and associated activities are

- Human resource development
- Medical supplies and drugs
- Medical equipment
- Financial, administrative, and management systems
- Partnership between the government and donors
- Physical infrastructure
- Financial resources to cover fixed and recurrent costs and a health care financing policy
- Ministry of Health restructuring and reorganization, from neighborhood committees to health centers, district health/hospital boards, central health board, and the ministry's headquarters.

Integrated Common Basket Funding

The purpose of the integrated common basket funding strategy is to encourage cooperating partners to support the Ministry of Health with financial assistance rather than technical assistance. A long-term aim is both to streamline and rationalize financial and administrative procedures and to facilitate the channeling of all financial donor support to the health sector in a simple and efficient way. The provision of this kind of untied financial support to the ministry budget (or, in the interim, the district grant and/or provincial grant components of the budget) has become known as basketing. When the Financial, Administrative, and Management System (FAMS) forms, procedures, and guideline are all in place, the government envisages that the Ministry of Health and the various donors to the health sector can move closer toward fully basketing their funds. This implies that donors will support the health sector by financing a single, agreed upon budget administered by the permanent secretary of the Ministry of Health.

A uniform system of disbursement of funds, procurement, reporting, and auditing would be in place. The proposed disbursement procedures are as follows:

- Donors will be asked to visit the Ministry of Health quarterly. The contribution to district basket funding from each donor will depend on the donor's commitment to the total budget.

- The Ministry of Finance will make disbursements to the Ministry of Health account on a monthly basis.
- Each month money will be disbursed to the district boards' basket and to provincial officers or other units according to recommendations or funding approvals. The boards or units approved for funding will receive a check from the Ministry of Health's Accounts Unit.
- Receiving entities will keep accounts and make financial and progress reports.

As concerns reporting procedures, donors will receive the following reports from the ministry, submitted not later than three months after the end of each quarter:

- Monthly bank statements on the individual donor accounts (currently some donors maintain separate accounts at the Ministry of Health)
- Bank reconciliation statement on the individual donor accounts
- Monthly bank statements on all accounts
- Bank reconciliation statement on all accounts
- Quarterly reports on the disbursement of funds to the various districts, hospital boards, or units showing each contributor's share of the total disbursement
- Consolidated report on expenditure for the quarter ended three months earlier
- Consolidated report on district, hospital, or unit performance based on progress reporting and performance audits.

The Budget Steering Committee will be responsible for approving the reports before forwarding them to donors.

Monitoring and Evaluation

The development of monitoring and evaluation indicators is based on institutional, as opposed to individual cooperating partners' vertical program or project, indicators. The goal is to establish a self-sustaining monitoring and evaluation system that improves decisionmaking at all levels of the system through the use of timely, valid, and appropriate information required to increase the effective utilization of quality health services.

The major parameters to be monitored and evaluated include

- Coverage of the essential package of health services
- Provider and client perceptions of the quality of health services
- Management and development of human resources
- Availability of drugs and supplies
- Status of infrastructure, equipment, and logistics
- Morbidity and mortality rates
- Equity, including gender issues
- Financial information (costs and expenditures)
- Health reforms process.

The Effectiveness of Coordination

The Ministry of Health has achieved donor coordination in support of health reform in a number of ways. To begin with, the government's strategic plan now serves as the framework for all donor contributions to the sector, and all donor support should fit within it. This strategic plan will be discussed and updated regularly with all interested donors. Based on the agreed strategic plan, the government has developed a five-year rolling investment program and an annual budget for recurrent costs and grants that it discusses with donors and that fully reflect all donor support. The investment program and the recurrent budget represent a consolidation of the programs of all district, hospital, and parastatal boards. As concerns the

recurrent budget, all donor support is channeled to districts using a single set of planning, budgeting, disbursement, accounting, and auditing mechanisms. However, some donors have not fully committed themselves to the common basket funding process.

The Ministry of Health holds annual consultations with donor agencies. In an effort to enhance donor coordination and partnership with the Ministry of Health, the 1994 consultative meeting proposed that the Ministry of Health organize two consultative meetings annually. Thus the first meeting takes place in April each year to review activities and accomplishments under the health reform process, and the second takes place in October each year to plan implementation and budgets and to review commitments for the following year.

The April review meeting extracts the lessons learned by

- Examining evidence that the previous year's budgeted investment and recurrent expenditures took place as envisaged
- Assessing district-level capacity in financial management using audited reports
- Evaluating progress in meeting agreed targets in districts
- Assessing progress in the number of health centers and other facilities offering the basic package of services
- Summarizing beneficiary assessments and other external reviews for the previous year along with actions proposed and taken to correct any problems found
- Assessing progress in implementing revised policies and logistics systems in human resources, drugs and supplies, urban primary health care, family planning, and nutrition
- Examining draft audit reports for the boards that received support during the preceding year.

The October planning and review meeting includes discussion of

- Future policy direction and steps in decentralization
- Basic program targets and goals
- Areas for further strengthening of district-level capacity, that is, next steps in personnel and human resource development
- Training commitments
- Technical assistance foreseen
- New issues for operations research
- Areas for study and evaluation.

The ultimate goal of FAMS is to ensure transparent, accountable, effective, and efficient use of funds in the health sector. To achieve this, the authorities use a single, simple, comprehensive, timely, and reliable system for planning, budgeting, accounting, stocking of supplies, and financial and progress reporting for all levels of the health system. FAMS is intended to streamline and rationalize the cycle of planning, implementation, and assessment within the Ministry of Health. The system facilitates analysis following traditional accounting lines (cost lines) as well as analysis following health programs (cost centers). It is also intended to enable donors to contribute to the health sector by meeting their requirements for disbursement, accounting, and reporting without overburdening the health sector with extra procedures.

FAMS was introduced in 1991 and since then has undergone a number of refinements. To date it has concentrated on the district level. The following are being developed under FAMS:

- A uniform system for planning, budgeting, and management
- A uniform system for inventory control and pharmaceutical procedures
- A means for accounting and financial reporting
- A method of progress reporting and performance auditing
- A system for carrying out audits and for internal control.

The following criteria must be met to widen donor commitment to providing financial support to a single Ministry of Health budget:

- Funds are used on agreed-upon purposes at all levels.
- Management of funds meets international standards of accounting and reporting.
- A budget steering committee is put in place, operates with a strong monitoring capacity, and is responsible for approving and authorizing all Ministry of Health expenditures and disbursements and approving consolidated financial and progress reports.
- A strong monitoring and internal audit unit is operational within the Ministry of Health.
- Reliable external audits are conducted according to international standards.

To facilitate the use of funds according to agreement, the planning procedures must be clear, both within the Ministry of Health and between the ministry and donors. The yearly planning process ends in signing "contracts" with districts that contain conditions, for example, districts health boards may spend a maximum of 20 percent on allowances, or at least 50 percent of the district budget must be spent at the levels of health centers and the community. Equally, donors and the Ministry of Health make a mutual commitment to funding and the spending of funds, that is, they agree upon a sufficiently detailed budget from which only specified percentage deviations between line items is allowed. This is important to ensure that districts do not spend all their money on one line item.

The Budget Steering Committee has been established within the reorganized Ministry of Health. The committee may delegate tasks to subcommittees or units within the ministry or central board of health. Currently the tasks of approving disbursements and consolidating reports are delegated to two different subcommittees. External audits are conducted by the auditor general.

Zambia resists and discourages the culture of establishing large donor project implementation offices with many technical support experts. It has no place within the sector support concept.

In addition to the two Ministry of Health/cooperating partners annual review meetings described earlier, in an effort to enhance transparency, accountability, and dialogue, the ministry has established the following committees with clear terms of reference:

- *Budget Committee*. Internal Ministry of Health Committee chaired by the permanent secretary to monitor both government and donor fund expenditures on a monthly basis.
- *Basket Steering Committee*. Donor membership is restricted to donors who are supporting the Basket. The purpose of the committee is to disburse funding on a quarterly basis applying agreed criteria.
- *Ministry of Health/Donor Steering Committee*. This committee includes all collaborating partners and meets on a quarterly basis to improve dialogue, transparency, and accountability.

Obstacles Overcome and Remaining Obstacles

The following obstacles have been overcome:

- Arriving at a shared vision of the health sector
- Improving dialogue, accountability, and transparency
- Reducing mistrust
- Agreeing on a uniform reporting, disbursement, and auditing system
- Improving Ministry of Health assertiveness.

The following obstacles remain:

- The current bilateral agreements
- The lack of a logical planning framework, which most donor agencies use to develop project documents
- The culture of some donors who support vertical programs and projects
- The supervisory missions from individual donors
- The country's political turbulence.

Conclusion

In conclusion, effective coordination and use of donor funding is contingent upon cooperating partners and the Ministry of Health moving away from project and program support to health sector support. Prerequisites for a successful health sector support include the following:

- Having a clear, well-articulated national policy with a clear mission statement, objectives, goals, priorities, and so on
- Preparing a clear, well-articulated (and costed) strategic plan
- Harmonizing all major cooperating partners as regards formats for disbursement, procurement, reporting, annual monitoring of progress, and auditing
- Implementing common basket funding, both at the district level, and ideally at the national level
- Encouraging support that focuses on the entire sector rather than on vertical programs or discrete projects
- Developing monitoring and evaluation indicators based on institutional indicators as opposed to individual cooperating partners in vertical programs or projects
- Discouraging donors from establishing project implementation offices in the country
- Installing transparency and dialogue mechanisms.

Health sector support is a long-term and negotiated learning process between cooperating partners and the Ministry of Health. Zambia has taken the first of many steps, and already the outcome has been effective coordination and use of donor funds. Donor resources are channeled to country-specific priorities. Duplication of efforts and donors' hidden agendas and biases have been checked. An open partnership between donors and the Ministry of Health has led to constructive dialogue, accountability, and transparency.

References

- Kalumba, K., E. Nangawe, V. Mosowe, L. M. Muuka-Kalumba, and others. 1994. "Looking Forward: Zambia's Health System Reform Agenda into the Next Century." In World Health Organization, ed., *Experiences with Primary Health Care in Zambia*. Geneva: World Health Organization.
- Ministry of Health. 1994. "National Health Strategic Plan (Investment Plan)." Lusaka, Zambia.
- SIDA (Swedish International Development Cooperation Agency). 1996. "Sector Program Support. Background Document to SIDA Policy." Sweden.

Appendixes

Appendix 1

Final List of Participants

*Economic Development Institute (EDI) of The World Bank, Center for Health Policy
of Witwatersrand University of South Africa
— World Health Organization (WHO) —*

Seminar on Sustainable Health Care Financing Johannesburg, South Africa June 23–28, 1996

Angola

Rev. Augusto Chipesse
General Secretary
General Secretariat
Council of Christian Churches
Luanda, Angola
Fax: (244-2) 393 746

Dr. Sousa Diogo
Economist
Planning Bureau
Ministry of Health
Luanda, Angola
Fax: (244-2) 39 35 79

Mr. Nkanga-A-Kiama Guimarães
National Consultant
Central Technical Support Unite - CRP
Community Rehabilitation and National
Reconciliation Programme
Ministerio do Planeamento
UNDP-Luanda
Luanda, Angola
Fax: (244-2) 33 56 09 (UNDP) / 39 06 22 (Ministry)

Dr. Joaquim Saweka
Advisor for Health Policy & International
Cooperation
Ministry of Health
Luanda, Angola
Fax: (244-2) 39 35 79

Botswana

Dr. Edward T. Maganu
Permanent Secretary
Ministry of Health
Gaborone, Botswana
Fax: (267) 353 100

Mr. Bareng Moahi
Hospital Administrator
Kanye, Botswana
Fax: (267) 340 224

Ms. Gillian Madirwa Moalisi
Projects Coordinator
National Health Planning
Ministry of Health
Gaborone, Botswana
Fax: (267) 353 100

Mrs. Monica Aleseng Tselayakgosi
Principal Planning Officer
Planning Unit
Ministry of Health
Gaborone, Botswana
Fax: (267) 353 100

Lesotho

Mrs. Majoel M. Makhakhe
Director
Department of Health Planning and Statistics
Ministry of Health and Social Welfare
Maseru, Lesotho 100

Mrs. Grace Peiso Nchee
Executive Secretary
Coordination Office for Mission Hospitals
Private Health Association of Lesotho (PHAL)
Maseru, Lesotho 100
Fax: (266) 310 314

Mrs. Malika Nkuebe
Deputy Principal Secretary
Administration Department
Ministry of Health and Social Welfare
Maseru, Lesotho 100
Fax: (266) 323 010 / 310 213

Ms. Cecilia Sedibe Tsepe
Senior Budget Officer
Ministry of Finance
Maseru, Lesotho
Fax: (266) 310 157

Malawi

Mr. Regent Lither Mataka Gondwe
Executive Secretary
Christian Health Association of Malawi (CHAM)
Lilongwe 3, Malawi

Dr. Wiston Byson Mukiwa
Secretary for Health and Population
Ministry of Health and Population
Lilongwe 3, Malawi
Fax: (265) 783 109

Mr. Frank R. Mwambagahi
Principal Health Planner
Planning Unit
Ministry of Health and Population
Lilongwe, Malawi
Fax: (265) 783 109-33

Dr. Ellias E. Ngalande-Banda
Secretary to Treasury
Ministry of Finance
Lilongwe 3, Malawi
Fax: (265) 781 679

Mozambique

Dr. Humberto Albino Pedro Cossa
National Director
Directorate of Planning and Cooperation
Ministry of Health
Maputo, Mozambique
Fax: (258-1) 32 103

Mr. Joaquim Durão
Advisor to the Minister of Health
Ministry of Health
Maputo, Mozambique
Fax: (258-1) 32 103

Mrs. Ernestina Jorge Jama
Health Officer
National Health Department
Mozambican Red Cross
Maputo, Mozambique
Fax: (258-1) 429 545

Mr. Domingos Juliao Lambo
Investment and Development Planning Officer
Ministry of Planning and Finance
Maputo, Mozambique
Fax: (258-1) 492 70

H. E. Dr. Abdul Razak Noormahomed
Deputy Minister of Health
Ministry of Health
Maputo, Mozambique
Fax: (258-1) 427 133

South Africa

Mr. Jonathan Broomberg
Monitor Company
South Africa

Mr. Andrew Donaldson
Department of Public Finance
Johannesburg, South Africa

Mr. Fezile Makiwane
Director, Health Finance and Economics
Department of Health
Pretoria, South Africa
Fax: (27-12) 328 6117

Mr. Patrick Masobe
Director, Policy and Planning
Department of Health
Pretoria, South Africa
Fax: (27-12) 328 6117

Dr. Malcolm Segall
European Union Consultant to Directorate General
Department of Health
Pretoria 0001, South Africa
Fax: (27-12) 312 0711

Dr. Olive Shisana
Director General
Department of Health
Pretoria, South Africa
Fax: (27-12) 323 0093

Swaziland

Mr. Dumsane E. Masilela
Under Secretary
Budget and Economic Affairs Department
Ministry of Finance
Mbabane, Swaziland
Fax: (268) 43187

Ms. Ncane Rejoice Masuku
Senior Accountant
Accounts Department
Ministry of Health and Social Welfare
Mbabane, Swaziland
Fax: (268) 42092

Mr. Sandilie Mdziniso
Under Secretary
Ministry of Health and Social Welfare
Mbabane, Swaziland
Fax: (268) 43187

Mr. Roger Mswati Mpapane
Executive Secretary
Swaziland Nazarene Health Institutions
Nazarene Mission-Manzini
Manzini, Swaziland 09268
Fax: (268) 55077

Mr. Thulani Matsebula
Health Planner
Planning Unit
Ministry of Health and Social Welfare
Mbabane, Swaziland, 1110
Fax: (268) 45092

Tanzania

Prof. Philip R. Hiza
Coordinator
Health Programs
Christian Social Services Council
Dar es Salaam, Tanzania
Fax: (255-51) 448 66

Mr. Raynald A. Mrope
Principal Secretary
Administration Dept.
Ministry of Health
Dar es Salaam, Tanzania
Fax: (255-51) 399 51

Mr. Rogatian Mshabaa Shirima
Project Manager
Ministry of Health
Dar es Salaam, Tanzania
Fax: (255-51) 399 51

Mr. John Lesley Zayumba
Director
Social Services
Planning Commission
Dar es Salaam, Tanzania
Fax: (255-51) 347 23

Zambia

Dr. Banda
Secretary General
Churches Medical Association of Zambia (CMAZ)
Lusaka, Zambia

Mr. Vincent Musowe
Chief Health Planner
Ministry of Health
Lusaka, Zambia
Fax: (260) 223 435

Zimbabwe

Mr. MacDonald Tatenda (Mac) Chaora
General Manager
Medical Aid
CIMAS (Medical Aid Society)
Harare, Zimbabwe
Fax: (263-4) 753 567

Mr. George Anthony Chigora
Director
Public Sector Expenditure
Ministry of Finance
Harare, Zimbabwe
Fax: (263-4) 792 750

Mr. Obert Matshalaga
 Director
 Domestic and International Finance
 Ministry of Finance
 Harare, Zimbabwe
 Fax: 792 750

Mr. Thomas Arnold Zigora
 Deputy Secretary
 Administration and Finance Department
 Ministry of Health and Child Welfare
 Harare, Zimbabwe
 Fax: (263-4) 727 406

Center for Health Policy

Mr. Vishal Brijlal
 Research Intern
 Center for Health Policy
 Witwatersrand University
 Johannesburg 2000, South Africa

Mrs. Tanja Bruce
 Administrative Officer
 Center for Health Policy
 Witwatersrand University
 Johannesburg 2000, South Africa

Dr. Jane Doherty
 Leader of Health Economics Financing Group
 Center for Health Policy
 Witwatersrand University
 Johannesburg 2000, South Africa
 Fax: (2711) 489 9900

Ms. Lucy Gilson
 Senior Research Officer
 Center for Health Policy
 Witwatersrand University
 Johannesburg 2000, South Africa

Mr. Solani Khosa
 Junior Researcher
 Center for Health Policy
 Witwatersrand University
 Johannesburg 2000, South Africa

Mr. Droby Matsimani
 Administrative Assistant
 Center for Health Policy
 Witwatersrand University
 Johannesburg 2000, South Africa

Mr. Enoch Peprah
 Senior Research Officer
 Center for Health Policy
 Witwatersrand University
 Johannesburg 2000, South Africa

Dr. Neil Soderlund
 Senior Research Officer
 Center for Health Policy
 Witwatersrand University
 Johannesburg 2000, South Africa

Mr. Alex van den Heever
 Senior Research Officer
 Center for Health Policy
 Witwatersrand University
 Johannesburg 2000, South Africa

World Health Organization

Dr. L. A. Arevshatian
 WHO Representative, Zimbabwe
 Harare, Zimbabwe
 Fax: (263-4) 728 998

Dr. N. Chuwa
 WHO Representative, Malawi
 Lilongwe-3, Malawi
 Fax: (265) 782 350

Dr. J. A. Kalilani
 WHO Representative, Lesotho
 Maseru, Lesotho
 Fax: (266) 31 21 22

Dr. Joseph Kutzin
 Health Economist
 Division of Analysis, Research and Assessment
 WHO
 1211 CH-Geneva 27, Switzerland
 Fax: (4122) 791 0746

Dr. E. Lambo
 Health Economist
 WHO AFRO
 Brazzaville, Congo
 Fax: (242) 839 400

Dr. A. P. Maruping
 WHO Representative, Swaziland
 Mbabane, Swaziland
 Fax: (268) 44 566

Dr. Welile Shasha
WHO Representative, South Africa
Civitas Building 19th floor, Corner of
Pretoria 002, South Africa
Fax: (27-12) 312 0847

Dr. Carlos Tiny
WHO Representative, Mozambique
Maputo, Mozambique
Fax: (258-1) 491 990

Dr. D. Tembo
WHO Representative, South Africa
WHO
Pretoria 002, South Africa
Fax: (27-12) 312 0847

Dr. D. W. Warning
WHO Representative, Tanzania
WHO
Dar es Salaam, Tanzania
Fax: (255-51) 113 180

World Bank

Mr. Keith Hansen
Economist
Southern Africa Dept., Human Resources
The World Bank
1818 H Street, N. W.
Washington, D.C. 20433
Fax: (202) 473-8239

Mr. Cornelis P. Kostermans
Public Health Specialist
Southern Africa Dept., Human Resources
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433
Fax: (202) 473-8239

Ms. Julie McLaughlin
Public Health Specialist
Southern Africa Dept., Human Resources
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433
Fax: (202) 473-8239

Mr. Montserrat Meiro-Lorenzo
Public Health Specialist
Southern Africa Dept., Human Resources
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433
Fax: (202) 473-8239

Ms. Helena Ribe
Principal Poverty/Human Resources Operations
Economist
Southern Africa Dept., Human Resources
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433
Fax: (202) 473-8239

Ms. Hadia N. Samaha
Research Assistant
Economic Development Institute (EDI)
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433
Fax: (202) 676-0961

Mr. R. Paul Shaw
Principal Human Resource Economist
Economic Development Institute (EDI)
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433
Fax: (202) 676-0961

Mr. Vincent Turbat
Health Economist
Economic Development Institute (EDI)
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433

Resource Persons

Dr. Abraham Bekele
Senior Health, Economic and Finance Advisor
United States Agency for International
Development
Arlington, VA 22209-0089
Fax: (703) 235 4466

Dr. Di McIntyre
Health Economics Unit
Department of Community Health
Medical School, Anzio Road
Observatory 7925, South Africa
Fax: (27-21) 406 6559

Prof. William Pick
Head, Department of Community Health
Witwatersrand University
Johannesburg, South Africa

Observers

Dr. Charlotte Leighton
Partnership for Health Reform
Abt. Associates Inc.
Bethesda, MD 20814
Fax: (301) 652 3916

Dr. Vincent Orinda
Chief of Health and Nutrition Section
UNICEF
Pretoria, South Africa
Fax: (27-12) 320 4085

Dr. Ferko Ory
Regional Health Advisor
Royal Netherlands Embassy
Harare, Zimbabwe
Fax: (263-4) 776-700

Mr. Oscar F. Picazo
Regional Health Finance Advisor
USAID/REDSO/ESA
United States Agency for International
Development
Nairobi, Kenya
Fax: (254-2) 743 204

Ms. Mary Pat Selvaggio
Health, Population and Nutrition Officer
USAID Mission in Zimbabwe
United States Agency for International
Development
Harare, Zimbabwe
Fax: (263-4) 722 418

Appendix 2
Seminar Agenda
Senior Policy Seminar on Sustainable Health Care Financing
Johannesburg, South Africa
June 23–28, 1996

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<i>Sessions</i>	<i>Sunday June 23</i>	<i>Monday June 24</i>	<i>Tuesday June 25</i>	<i>Wednesday June 26</i>	<i>Thursday June 27</i>	<i>Friday June 28</i>
Session 1–2 08:30–12:30		Introduction of Seminar Keynote Address: "A Strategic Framework on Health Care Financing" by A. Bekele Coffee Break Module 1: <i>User Fees</i> - Overview Paper: L. Gilson - Swaziland Country Presentations	Module 3: <i>Health Insurance Mechanisms</i> - Overview Paper: J. Kutzin - Zimbabwe Country Presentation: T. A. Zigora Coffee Break - Break-Away Discussions - Plenary Report-Back and Discussion	Module 5: <i>Control & Accountability of District Financing</i> - Botswana Country Presentation Coffee Break - Break-Away Group Discussions - Plenary Report-Back and Discussion	Module 7: <i>Public-Private Collaboration</i> - Overview Paper: E. Banda - Malawi & Lesotho Country Presentations Coffee Break - Break-Away Groups - Plenary Report-Back and Discussion	Module 8: <i>Effective Use of Donor Funding</i> - Angola Country Presentation: J. Saweka & N. Guimarães - Zambia Country Presentation: V. Musowe Coffee Break Special Invitation to Discuss Future Technical and Financial Needs with Donor Representatives - Questions & Answers
12:30–14:00		Lunch	Lunch	Lunch	Lunch	Closing Lunch

Appendix 2, continued

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<p>Session 3-4 14:00-17:30</p>		<p>Module 1: User Fees (cont.) - Plenary Report-Back and Discussion</p> <p>Module 2: Prepayment Schemes - Overview paper: E. Lambo - Tanzania Country Presentation: R. Shirima</p> <p><i>Coffee Break</i></p> <p>- Presentations and Panel Discussion</p>	<p>Module 4: Reprioritizing Public Health Resources Towards PHC - Mozambique Country Presentation: H. Cossa</p> <p>- Comments by Panel Members</p> <p><i>Coffee Break</i></p> <p>- Plenary Session - Evaluation of the Progress of the seminar</p>	<p>Module 6: Hospital Efficiency - Overview Paper: J. Broomberg</p> <p><i>Coffee Break</i></p> <p>- Break-Away Groups - Plenary Discussion</p>	<p><i>Introduction to the Private Sector in South Africa: A. Kinghorn</i></p> <p>Special Panel Session on Private-Public Collaboration in South Africa: Opportunities and Threats</p> <p>- Presentation by Panel Members - Open Discussion</p> <p>Field Visit</p>	<p>Departure</p>
<p>20:00-</p>	<p>Reception</p>	<p>Barbecue</p>			<p>Dinner at the Waterfront</p>	

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Micro Industries Development
Assistance Society (MIDAS)
House 5, Road 16
Dhanmondi IV Area
Dhaka 1209
Tel: (880 2) 326427
Fax: (880 2) 811188

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Jean De Lanroy
Av. du Roi 202
1060 Brussels
Tel: (32 2) 538-5169
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Apartado Aéreo 34270
Santafé de Bogotá, D.C.
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Fax: (57 1) 285-2798

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Center d'Edition et de Diffusion Africaines
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Abidjan 04
Tel: (225) 24 6510; 24 6511
Fax: (225) 25 0567

CYPRUS

Center for Applied Research
Cyprus College
6, Diogenes Street, Engomi
P.O. Box 2006
Nicosia
Tel: (357 2) 44-1730
Fax: (357 2) 46-2051

CZECH REPUBLIC

USIS, MIS Prodejna
Havelskova 22
130 00 Prague 3
Tel: (420 2) 2423 1486
Fax: (420 2) 2423 1114

DENMARK

Samfundslitteratur
Rosenøens Allé 11
DK-1970 Frederiksberg C
Tel: (45 31) 351942
Fax: (45 31) 357822

ECUADOR

Libri Mundi
Libreria Internacional
P.O. Box 17-01-3029
Juan Leon Mera 851
Quito
Tel: (593 2) 521-606; (593 2) 544-185
Fax: (593 2) 504-209
E-mail: librimundi@librimundi.com.ec

CODELUX

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Quito
Tel/Fax: (593 2) 507-383; 253-091
E-mail: codeu@impsat.net.ec

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Al Galaa Street
Cairo
Tel: (20 2) 578-6083
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41, Sherif Street
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Fax: (20 2) 393-9732

FINLAND

Akateeminen Kirjakauppa
P.O. Box 128
FIN-00101 Helsinki
Tel: (358 0) 121 4418
Fax: (358 0) 121-4435
E-mail: akatilaus@stockmann.fi

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75116 Paris
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GREECE

Papasotiropu S.A.
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106 82 Athens
Tel: (30 1) 364-1826
Fax: (30 1) 364-8254

HAITI

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