

PD-ABK-345

ISA 92815

**KENYA MINISTRY OF HEALTH
HEALTH CARE FINANCING
STRATEGIC PLANNING MISSION**

August 11 - September 10, 1990

LIMITED DISTRIBUTION

**Resources for
Child Health
Project**

REACH



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**Kenya Ministry of Health
Health Care Financing
Strategic Planning Mission**

August 11 - September 10, 1990

Mission Report

Prepared by the JSI Health Financing and Management Group as part of the Resources for Child Health (REACH) Project, USAID Contract No. DPE-5927-C-00-5068-00.

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USAID staff in Kenya, Botswana, Swaziland, and Mexico were extremely helpful, especially in putting REACH in contact with appropriate personnel at the respective Ministries of Health. The Ministries of Health of Botswana, Swaziland, Mexico, and Canada went out of their way to arrange useful meeting schedules for the group. Their willingness to welcome the group and discuss the structure and financing of health services in their countries was essential to the success of the study tour. In addition, we would like to thank the Ontario Ministry of Health, the Mexican Foundation for Health, and the many other health agencies and institutions that welcomed the group. We would like to acknowledge the assistance of the individuals who coordinated the visits in each country: the staff of the Planning Unit in Botswana, Mr. Paul Thompson in Swaziland, Dr. Antonio Hurtado and Lic. Ferdinan Recio Solano of the Mexican Hospital Association, Ms. Patricia Dunn Erickson in Ottawa, and Dr. Bruce Buchanan in Toronto.

The staff of the London School of Hygiene and Tropical Medicine provided a useful meeting for the group while they were in the United Kingdom. Our appreciation is extended to Dr. Anne Mills, Dr. Susan Foster, and Dr. Dyna Arhin.

Three individuals deserve special thanks for facilitating the final workshop in Boston and helping the Kenyans to apply their experiences to the development of a strategic plan for health financing in Kenya: Dr. David Dunlop of the Economic Development Institute at the World Bank, Mr. Robert Taylor of Taylor Associates, Inc., and Dr. Randall Ellis of Boston University.

Finally, we would like to thank the many JSI staff members who went above and beyond the call of duty to assist the study tour: Andra Sawyer for arranging all the logistics and accompanying the group to the ends of the earth, Stefani Olsen and Mary-beth Souza for handling hotels, airports, and visas, Allison Percy for background research and arranging programs in each country, and Leslie Richardson and the JSI/Boston staff for fulfilling innumerable last-minute requests.

ABBREVIATIONS

GOK	Government of Kenya
JSI	John Snow, Incorporated
MOH	Ministry of Health
NGO	Non-Governmental Organization
REACH	Resources for Child Health Project (JSI/USAID)
USAID	United States Agency for International Development

I. BACKGROUND

The Resources for Child Health (REACH) Project has been involved in health financing in Kenya since 1987 through a series of major studies of the financing and management of health services in that country. These studies have provided input to the Government of Kenya (GOK) Ministry of Health (MOH) for the definition of a policy reform agenda for the delivery and financing of health services. The GOK has already instituted cost sharing in public sector hospitals as a first step in this process. Plans are underway for strengthening the national health insurance system as well. To support and manage these reform efforts, it was decided that a strategic plan for the financing of health services in Kenya needed to be developed.

II. DESCRIPTION AND PURPOSE OF MISSION

Kenyan health officials wanted to have the opportunity to observe and discuss different types of public/private sector provision of health services. USAID/Nairobi and the Kenyan Ministry of Health asked REACH to conduct a study tour for senior policy makers as background and input for their preparation of the health sector financing strategy. The participants in the study tour were senior decision makers from the Ministries of Health and Finance and outside agencies.

The participants traveled to Botswana, Swaziland, the United Kingdom, Mexico, Canada, and the United States to examine different models of service delivery and financing. A final workshop was held in Boston, USA to take into account what the group observed and discussed during the tour with policy makers in other countries.

Each country on the tour was chosen for particular aspects of the organization and financing of its health system which were of interest to Kenyan decision-makers. Botswana was chosen in order to examine the relationship between the Ministry of Health (MOH) and non-governmental organizations (NGOs, for example church missions) in the planning, financing, and delivery of health services. Swaziland was included on the tour because of the Ministry of Health's experience with user fees for health services. The group stopped in London, U.K. to hold discussions with the faculty of the London School of Hygiene and Tropical Medicine because of their extensive experience with the British National Health Service and their knowledge of health financing systems in several countries the group was not able to visit (in particular, Ghana and the Republic of Korea).

In Mexico, the Social Security system was of particular interest to the group, especially its efforts to extend services to rural areas. The group examined the multiplicity of government service providers and the interaction between these providers. The tour also focused on the experience in cost recovery and its impact on equity. In addition, the participants were able to observe the health services in the Federal District, which are analogous to the services operated by the Nairobi City Commission.

The Canadian health system was examined by the group because of its universal, government-sponsored health insurance system. Both the national and provincial level ministries were visited due to the decentralized nature of the Canadian health system. Finally, the group heard a presentation during the Boston workshop on the health financing system in the United States as a point of comparison.

At the workshop in Boston organized at the end of the tour, the group discussed what it had observed on the tour and developed a comprehensive strategic plan for the financing of health services in Kenya. This plan is to serve as a guide for the development of policies and actions over the short, medium, and long terms. A copy of this plan is included as Appendix D.

**APPENDIX A:
PARTICIPANTS**

Government of Kenya

Mr. D.M. Mbiti, Permanent Secretary, Ministry of Health (MOH)¹
Mr. James Khachina, Christian Health Association of Kenya (CHAK)
Mr. George Kioko Wa Luka, Ministry of Finance
Mr. J.K. Mutai, Deputy Secretary, MOH
Mr. Francis Mworira, Chief Hospital Secretary, MOH
Mr. Njoroge, Chairman, HCF Implementation Committee, MOH
Mr. G.H. Olum, Chief Economist, MOH

USAID/Nairobi

Ms. Connie Johnson, Population and Health Office²

REACH Project

Dr. Gerald Rosenthal, Associate Director for Health Care Financing³
Dr. Catherine Overholt, Senior Health Economist⁴
Ms. Allison Percy, Technical Associate⁵
Ms. Andra Sawyer, Program Manager

London School of Hygiene and Tropical Medicine⁶

Dr. Anne Mills, Health Policy Unit
Dr. Susan Foster
Dr. Dyna Arhin

Other⁷

Dr. David Dunlop, Economic Development Institute, World Bank
Dr. Randall Ellis, Boston University
Mr. Robert Taylor, President, Taylor Associates, Inc.

¹U.S.A. portion only.

²Joined group in London and continued through end.

³Mexico portion only.

⁴U.K., Canada, and U.S.A. portions only.

⁵Canada and U.S.A. portions only.

⁶U.K. portion only.

⁷These individuals provided technical input and helped facilitate the final study tour workshop in Boston.

**APPENDIX B:
ITINERARY**

August 11:	Depart Kenya
August 11-15:	Gabarone, Botswana
August 15-18:	Mbabane, Swaziland
August 19-21:	London, United Kingdom
August 21-27:	Mexico City, Mexico
August 27-30:	Ottawa, Canada
August 30-September 1:	Toronto, Canada
September 1-9:	Boston, U.S.A.
September 6-8:	Washington, D.C., U.S.A. (Mbiti, Johnson, Overholt only)
September 10:	Arrive Kenya

**APPENDIX C:
PROGRAMS FOR COUNTRY VISITS**

**TENTATIVE ITINERARY FOR KENYAN STRATEGIC PLANNING MISSION
MINISTRY OF HEALTH
REPUBLIC OF BOTSWANA**

August 8, 1990:

- 8:00am - Deputy Permanent Secretary
- 8:30am - Assistant Director/Technical Support Services
- 9:00am - Assistant Director/Primary Health Care
- 9:30am - Assistant Director/Hospital Services
- 10:00am - Planning Unit
- 11:00am - Botswana Medical and Insurance Scheme (Mrs. Ntebela)
- 12:00 - Botswana Public Officers Medical Aid Scheme (Provisional)
- 1:00pm - Lunch
- 2:00pm - Courtesy call on Permanent Secretary

August 14, 1990:

- 10:00am - Good Hope Health Centre
- 2:00pm - Athlone Hospital

August 15, 1990:

- 8:30am - Wrap-up meeting with Permanent Secretary

Kenya Ministry of Health
Health Care Financing
Strategic Planning Mission

Program
Swaziland Country Visit

August 15-18, 1990

- August 15: Arrival
 Meeting with Principle Secretary, Mr. Chris Mkhonza
- August 16: Visit to rural health centers, government hospital, and NGO
 facilities:
 Mbabane Referral Hospital
 Good Shepherd Mission Hospital
 Lamahasha Clinic
 Siteni Public Health Unit
- August 17: Meetings at Ministry of Health, including:
 Principle Secretary, Mr. Chris Mkhonza
 Undersecretary, Ephraim Hlophe
 Paul Thompson, Finance Controller
- August 18: Departure

PROGRAMA

LUGAR: MEXICO, D. F.

FECHA: 21 - 26 AGOSTO 1990

COORDINADOR: DR. ANTONIO HURTADO B.

MARTES 21

LLEGADA AL AEROPUERTO

TRASLADO AL HOTEL KRYSTAL ZONA ROSA

MIERCOLES 22

09:00 ENTREVISTA CON EL DR. JESUS KUMATE
SECRETARIO DE SALUD DE LA
SECRETARIA DE SALUD

11:00 ENTREVISTA CON EL DR. GUILLERMO SOBERON
PRESIDENTE DE LA FUNDACION MEXICANA PARA LA SALUD
FUNDACION MEXICANA PARA LA SALUD

12:30 ENTREVISTA CON EL DR. JOSE LUIS BOBADILLA
DIRECTOR DEL CENTRO DE INVESTIGACIONES EN SALUD PUBLICA
ESCUELA DE SALUD PUBLICA DE MEXICO

LUNCH

8

13:00 a 15:00 ESTRUCTURA DEL SISTEMA NACIONAL DE SALUD EN MEXICO (PRESENTACION)
DR. ANTONIO HURTADO BELENDEZ
ESCUELA DE SALUD PUBLICA DE MEXICO

15:00 COMIDA

17:00 a 18:00 RECEPCION EN LA EMBAJADA DE LOS ESTADOS UNIDOS DE NORTEAMERICA CON EL SR. GERARD BOWERS REPRESENTANTE DE LA A.I.D.

JUEVES 23

09:30 a 09:40 ENTREVISTA CON EL DR. JOSE ANTONIO VAZQUEZ SAAVEDRA, DIRECTOR GENERAL DE SERVICIOS MEDICOS DEL DEPARTAMENTO DEL DISTRITO FEDERAL DIRECCION GENERAL

09:40 a 10:00 PRESENTACION SOBRE ESTRUCTURA DE LOS SERVICIOS MEDICOS DEL DEPARTAMENTO DEL DISTRITO FEDERAL

10:00 a 10:30 TRASLADO AL HOSPITAL GENERAL DE BALBUENA

10:30 a 12:00 PRESENTACION Y VISITA A LAS INSTALACIONES

12:00 a 12:30 LUNCH

12:30 a 12:45 TRASLADO AL HOSPITAL PEDIATRICO TACUBAYA

12:45 a 14:00 PRESENTACION Y VISITA A LAS INSTALACIONES

14:00 a 14:30

VISITA A LAS UNIDADES DE ATENCION MEDICA (HOSPITAL GENERAL DE XOCO Y PEDIATRICO DE COYOACAN)

LUNCH

16:30 a 18:00

HOSPITAL ABC
PRESENTACION SOBRE LA ORGANIZACION DE INSTITUCIONES DE ASISTENCIA PRIVADA Y VISITA A LAS INSTALACIONES.

VIERNES 24

08:30

VISITA I.M.S.S.-SOLIDARIDAD EDO DE PUEBLA
SALIDA HOTEL
(EXPOSICION SOBRE LA ORGANIZACION DEL PROGRAMA DURANTE EL TRASLADO).

11:00 a 13:00

VISITA AL HOSPITAL RURAL I.M.S.S. SOLIDARIDAD

10:30

LLEGADA A LA POBLACION DE IXMIQUILPAN

13:00 a 14:00

ENTREVISTA CON LA COMUNIDAD

COMIDA

16:00

REGRESO A LA CIUDAD DE MEXICO

SABADO 25

VISITA INSTITUTO NACIONAL DE SALUD
PUBLICA DE MEXICO.

09:00 SALIDA DEL HOTEL A CUERNAVACA, MORELOS

10:30 a 11:00 ENTREVISTA CON LOS DOCTORES:
JOSE LUIS BOBADILLA FERNANDEZ
DIRECTOR DEL CENTRO DE INVESTIGACION EN
SALUD PUBLICA
ERNESTO CALDERON JAIMES
DIRECTOR DEL CENTRO DE INVESTIGACIONES
SOBRE ENFERMEDADES INFECCIOSAS

11:00 a 11:30 PRESENTACION DE LA ESTRUCTURA DEL
INSTITUTO NACIONAL DE SALUD PUBLICA.
(VIDEO)

11:30 a 12:30 VISITA A LAS INSTALACIONES

12:30 a 13:00 ENTREVISTA CON LA TITULAR DE LA
SECRETARIA DE SALUD DEL ESTADO DE
MORELOS.

13:00 SALIDA A JOJUTLA, MORELOS

14:00 a 15:00 VISITA AL HOSPITAL RURAL

15:00 COMIDA EN LA HACIENDA SAN JOSE,
VISTA HERMOSA.

18:00 REGRESO A LA CIUDAD DE MEXICO

DOMINGO 26

09:00	VISITA A LA ZONA ARQUEOLOGICA DE TEOTIHUACAN. SALIDA DE HOTEL
10:00 a 13:00	VISITA A LA ZONA ARQUEOLOGICA
14:30	COMIDA TIPICA MEXICANA C L A U S U R A



Health and Welfare
Canada

Santé et Bien-être social
Canada

Intergovernmental
and International
Affairs

Affaires
intergouvernementales
et internationales

Proposed Program

Kenya

August 27 to September 1, 1990

Visitors:

Government of Kenya:

Mr. Mbiti
Ministry of Health
Permanent Secretary
Mr. G.H. Olum
Chief Economist
Dr. J. Maneno
Chairman
HCF Advisory Committee
Mr. Njoroge
Representative from the
Ministry of Health

Mr. J.K. Mutai
Deputy Secretary
Ministry of Health
Mr. F. Mworio
Chief Hospital Secretary
Mr. Kioko Wa Luka
Representative from the
Ministry of Finance
Mr. Khachina
Christian Health Association
of Kenya (CHAK)

U.S. Agency for International Development

Ms. Connie Johnson
Health, Population, and Nutrition Officer
USAID/Nairobi

REACH Project

Dr. Cathy Overholt
Health Economist
Ms. Andra Sawyer
Program Manager

Ms. Allison Percy
Technical Associate

Interests: to observe the organization and financing of
health services.

Visit Coordinator:

Patricia Dunn Erickson
International Visits
Tel: (613) 957-7288
Fax: (613) 952-7417

Ottawa, Canada
K1A 0K9

Canada

13

August 27 - Monday

20:28 Arrival in Ottawa
 (Air Canada 464)

August 28 - Tuesday

10:00 **Minister's boardroom**
Coffee 21st Floor boardroom
available Jeanne Mance Building
 Tunney's Pasture

Mr. Norbert Préfontaine
Assistant Deputy Minister
Intergovernmental and International
Affairs Branch
Tel: (613) 957-7280
Fax: (613) 952-7417

- Viewing of Health and Welfare in Canada video

10:30 **Mr. Jake Vellinga**
 A/Director
 Health Insurance Directorate
 Health Services and Promotion Branch
Tel: (613) 954-8679
Fax: (613) 952-8542

Issue: - Health Care delivery and financing in
 Canada

12:00 **Buffet Lunch - served in same room**

13:30 **Minister's boardroom**
 21st floor boardroom
 Jeanne Mance Building
 Tunney's Pasture

Dr. David Bray
Director
Canadian Centre for Health Information
Statistics Canada, Ottawa.
Tel: (613) 951-8571
Fax: (613) 951-0792

Issue: - Management of National Health Information

August 28 - Tuesday (continued)

14:30 **Ms. Barbara Ouellet**
Director
Programs Division
Health Services and Promotion Branch
Tel: (613) 957-7799
Fax: (613) 957-7097

Issue: - Health Promotion in Canada

15:30 **Dr. Jean Dupont**
Director
Human Resources
Health Services and Promotion Branch
Tel: (613) 954-8671
Fax: (613) 957-1406

Issue: - Health Manpower in Canada

August 29 - Wednesday

10:00 **Ms. Margaret Hilson**
Assistant Executive Director
International Health Secretariat
Canadian Public Health Association
1565 Carling Avenue, Suite 400
Tel: (613) 725-3769
Fax: (613) 725-9826

Issue: - Impact of NGOs on Canadian Health
 Care System
 - Role of CPHA

12:00 **Lunch - to be hosted by CPHA**

14:00 **Mr. Léo-Paul Landry**
Secretary General
Canadian Medical Association
1867 Alta Vista Drive
Ottawa, Ontario
Tel: (613) 731-9331
Fax: (613) 731-9013

Issue: - Role of health professionals in the
 Canadian health system

August 30 - Thursday

10:15 Depart for Toronto
 (Air Canada 449)

11:12 Arrival in Toronto
 (Air Canada 449)

August 31 - Friday

Program will be prepared by the Ontario Ministry of Health.

September 1 - Saturday

13:15 Depart for Boston
 (U.S. Air 038)

14:48 Arrival in Boston
 (U.S. Air 038)

Ontario Ministry of Health

VISIT OF

KENYAN STRATEGIC PLANNING MISSION

Friday, August 31, 1990

Assistant Deputy Ministers' Boardroom
Ninth Floor, Hepburn Block, Queen's Park
Toronto, Ontario

Provisional Program:

- 9:30 a.m. - Introduction and role of government
10¹⁵ → coffee
 . Dr. Bruce Buchanan, Senior Consultant,
 Intergovernmental Affairs
- 10:15 am. - Mechanisms for financing health;
 . Mr. Ron LeNeveu, Assistant Deputy Minister,
 Corporate Affairs
- 11:00 am. - Client/consumer services: access, eligibility;
 . Mr. Charlie Bigenwald, Executive Director,
 Consumer Services
- 12 NOON - LUNCH (ADMs Boardroom)
- 1:00 p.m. - Health system planning
 . Mr. Michael McEwen, Director,
 Health Planning Branch
- 1:45 pm. - Professional roles and responsibilities;
 . Ms. Linda Bohnan, Counsel,
 Professional Relations Branch
- 2:15 pm. - Human Resource Planning;
 . Ms. Pat Baranek, Manager,
 Health Manpower Planning
2¹⁵ → coffee.
- 3:00 pm. - Community Health Programs;
 Mr. James Shea, Program Development Officer,
 Health Service Organizations, etc.
- 3:30 pm. - Public Health Programs;
 Dr. Helen McKilligin, Coordinator,
 Healthy Growth & Development
- 4:00 pm. - Adjournment

APPENDIX D:
STRATEGIC PLAN FOR FINANCING HEALTH SERVICES IN KENYA
(Including Annex with Country Reports)

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CONCEPT PAPER
STRATEGIC PLAN FOR FINANCING HEALTH SERVICES
IN KENYA

- The overall objective in financing health services is to provide health for all.
- The strategy for financing health services consists of objectives and implementation activities in three fundamental areas:
 - 1) Revenue Generation/Mobilization of Financial Resources
 - 2) Organization and Structure of Health Sector
 - 3) Efficiency, Effectiveness, and Equity in Use of Health Sector Resources

I. REVENUE GENERATION/MOBILIZING FINANCIAL RESOURCES

The present level of government funding, even though keeping pace with inflation, is not adequate. The gap in funding of health services has recently been documented in a survey of expenditures on maintenance, transport, drugs, and personnel for preventive services. Although increases in the current national allocation to the health sector may be desirable and can be justified based on analyses from these studies, the share of national financial resources is unlikely to rise in the near future due to the economic circumstances which the country faces. Total expenditures on health as percentage of GNP are too low and should rise over this decade. Revenues for health will be provided through cost sharing, insurance, and government funding. The strategic orientation for each of these revenue sources is as follows.

A. Cost Sharing (Health Improvement Fees)

- Fees will remain a permanent feature of financing health services for the foreseeable future; consumers need to take responsibility for their health care as an individual service.
- Fees in place as of December, 1989, shall be increased over time.
- Over time the fee base will be broadened; an operational strategy needs to be identified to move towards charges for drugs at full recovery of drug cost.
- Fees presently are expected to account for around 5% of total recurrent costs of government service; this should increase to 20% by the end of the decade.

Implementation of this strategy requires a strategy for promoting acceptability of fees. The concept of acceptability encompasses:

- an aggressive type of public education for consumers, communities, and politicians which focuses on the idea that health is a consumer responsibility (to include mass media, schools, church leaders public meetings -- at districts with DHNBs and in communities -- and traditional health education means)
- decentralization of responsibility for fee implementation to local level -- Health Centre Committees composed of local leaders, Executive Expenditure Committee
- visible changes in improvement of services at facilities
- strategy to ensure access of those who cannot pay for services

B. Insurance

1. National Health Insurance Fund (NHIF)

NHIF as a public insurance mechanism should move towards covering 90% of health care costs of its membership over this decade and should act as a source of funding for the health sector; it should remain a not-for-profit enterprise. Specific objectives are:

- broaden its membership -- one approach to be pursued aggressively is to investigate the mechanisms for including cooperatives whose members are not contributors to NHIF; NHIF should recruit agents for expanding membership
- increase its premiums in the long run and adjust benefits accordingly
- include employer as contributor to premiums with the employers eventually contributing on a 50/50 basis with employees
- allow for alternative benefit packages (a basic coverage plus additional coverage)
- allow a higher maximum claim for MOH facilities -- billing rate should be higher than the user fee charges so as to reduce the government subsidy to this higher income group
- MOH facilities need to efficiently manage billings and claims to NHIF; MOH hospitals should also make claims under car insurance for treatment of road accidents
- encourage shift to use of government facilities by NHIF membership -- move from 4% to a higher target rate by end of decade

- maximize returns to financial surpluses
- Use financial surpluses to improve quality of government services; study the feasibility and appropriateness of alternative mechanisms -- such as prospective payment -- to control the money in the fund to the benefit of improvements in government health services.
- Outpatient services will not be included in the benefit package in the near term. The addition of these services to the package will be studied for its fiscal impact on the financial viability of the NHIF.

2. Private Insurance

Private insurance is to be encouraged. Implementation of this strategy requires:

- legal changes for NHIF
- more information regarding employer coverage for health services and utilization patterns

Insurance schemes are complicated and need to include study of marketing and legislative requirements. Recommendations for policy and direction in the insurance area need to be based on further careful study.

C. Government Funding

- Budget allocation should increase at a positive real rate -- net of domestic inflation and local currency devaluation; the MOH recognizes that this would represent a new but desirable approach not presently used by Treasury.
- The priority status of the MOH for access to foreign exchange needs to be maintained.
- MOH recognizes that general taxes are already high and therefore difficult to increase; however, the taxable group is small and should be expanded.
- MOH should make a representation to government discussions on general taxation policies. Earmarked taxes can provide source of funds for health sector. Taxes to consider include:
 - cigarettes
 - alcohol
 - car insurance
 - other commodities (based on income elasticity criterion)

The underfunding gap for health services is estimated very roughly at 1.4B Ksh. Insurance can be expected to contribute approximately 400M Ksh;

cost sharing can contribute 100M Ksh; an increase in the MOH budget allocation can provide 100M Ksh; new or increases in excise taxes have potential to contribute 200M to 400M Ksh; cost savings from efficiency improvements 400M Ksh.

II. ORGANIZATION AND STRUCTURE

Kenya's ability to achieve its objectives in improving the level of financial support for its health care system, and to improve its efficiency and effectiveness in managing these resources, is dependent on how the components of the system are organized and structured. The non-governmental health sector in Kenya is composed of KCS, CHAK, and other NGOs, private hospitals, private physicians and pharmacies, private insurance plans, and industry sponsored health services. Of hospital beds in the country, approximately 69% are in MOH institutions (8% in Kenyatta National Hospital), 21% in "mission" hospitals and health centers, and 9% in private institutions. In comparison, about 71% of all health facilities are in the MOH, 17% in mission organizations, and 12% in private organizations. While these figures are approximate and need to be verified, it is apparent that non-governmental organizations make a significant contribution to health care in Kenya -- in the range of 30 to 40% of all health services in the country.

A. Non-Governmental Sector

The following principles should be considered in establishing a policy regarding the non-governmental health sector:

- As a continuation of its present policy, the government of Kenya does not wish to assume responsibility for operating non-governmental health facilities, nor increase financial assistance above the level now targeted.
- As a last resort, the MOH may step in to assist a NGO or mission facility that is mismanaged or is having financial difficulty, especially where that unit is considered important in maintaining the level of health services available in that area.
- The subsidy provided to non-governmental health facilities should continue to be targeted at about 30% of total operating costs, even though this level of funding has not been possible during these last few years.
- Non-governmental health facilities are located primarily in rural areas and are considered both supplemental and complementary to services provided by governmental units.
- Non-governmental facilities are supported financially from three primary sources: from external sources (ranging from a low of 20% up to 50%), up to 30% from governmental subsidies, and the balance from user fees.

- As external sources continue to diminish, non-governmental facilities should be encouraged to increase support from user fees rather than from increased governmental subsidies. Non-governmental facilities do not face the same restrictions on collecting user fees as do governmental facilities.
- Mission and other NGO facilities should be encouraged to expand their services in coordination with MOH priorities. NGO facilities should be included in the MOH annual planning process and coordinated at the central level, possibly through the re-activation of the Central Health Board.
- The role and utilization of private physicians and clinics should be quantified.

B. Governmental Sector -- Decentralization

Under the umbrella of Kenya's decentralization initiatives implemented in 1984, the MOH introduced a decentralization plan about one year ago. The plan aims to place more responsibility and authority for planning, budgeting, financial management, and program monitoring at the district and division levels. Responsibilities have been assigned to each level of the organization as described in the chart on the following page. This decentralized organization is intended to carry the MOH into the next decade.

- The decentralized system, as it applies to health financing, is new and should be monitored during the next few years so that refinements can be introduced.
- The District Health Management Board, under the broad direction of the District Development Committee, has responsibility for setting priorities, managing district funds (both those collected from fees and others), setting standards, and handling consumer complaints. It meets about every three months during the year.
- The District Health Management Team is responsible for professional and technical issues and meets every week.
- Each facility has an Executive Expenditure Committee to oversee the expenditure of funds collected from user fees -- within the limits approved at the district level.
- The needs and plans of NGOs and other non-governmental facilities will be coordinated primarily at the central MOH headquarters.

23'

Decentralized Organization of Ministry of Health

	MOH Headquarters	Provincial Level	District Level	Facility
Planning:	Review & Approval	<<<<<<<< >>>>>>>>	Review Prioritize	<<<>>> Identify Needs & Priorities
Budgeting:	Recommend to MOF		Consolidate	Develop Needs
Revenue Generation:	Set Guidelines		Receive Proceeds	Collect Fees
Expenditures:	Set Guidelines		Retain 25% for PHC at District Approve 75% for Health Facilities	Set Priorities
Personnel:	Approval Set Salary Scales & approve complement Discipline E level and above		Recommend	Identify Needs Discipline & Hire B level
Facilities/Equip:	Approve construction or purchase		Recommend Maintain	Identify Needs Operate & Maintain
Supplies/Drugs:	Procure Central Store & Distrib.		Recommend Distribute	Identify Needs Use Local purchase of food and perishables

C. Guidelines and Standards

Certain incentives and controls need to be maintained in order to assure that the health services system moves in the desired direction of decentralization. Some of those incentives and controls include:

- The responsibilities and authorities assigned to each level of the organization, as described in item B, above, have been clearly delineated.
- The facility's ability to use 75% of collected revenues to address local priorities motivates the facility to improve collections and increases the acceptability of fees among users.
- Assigning increased responsibility and authority at the district and local levels is expected to increase commitment and improve performance.
- Outstanding performance at the local level should be recognized and the ideas generated should be shared with other local managers as a learning experience.

III. EFFICIENCY, EFFECTIVENESS, AND EQUITY

A. Management Systems

1. Budget Allocations

a. Allocations Between Preventive and Curative Services

Definitional problems regarding what expenditures are considered as preventive and what are curative have hampered accurate assessment of the proportion of the budget spent on each. The definition needs to be broadened. Estimates have been difficult to make and imprecise. It is recognized that expenditure on preventive services can reduce or contain costs of curative services. It is also recognized that improvements on the prevention side must include coordination and cooperation with other ministries.

The policy of the last 10 years has put an emphasis on preventive and promotive services. However, budget allocations have not always been consistent with that policy, although the above mentioned definitional problem makes it difficult to determine the exact allocations to each area. Preventive services are to be a priority area for new financial resources that come into the system through government budget increases or cost sharing revenues. The following recommendations are geared toward achieving that objective.

Curative services will continue to be an important focus of the health care system.

- Preventive services have a priority for new resources.
- Preventive services which reduce the need for curative services will be particularly emphasized.
- Specific areas of preventive services will be identified and targeted to maximize effectiveness (for example, the eradication of certain vectors).
- Creating public awareness for use of preventive services is an essential feature of the financing strategy.

b. Allocations Between Personnel and Nonpersonnel Expenditures

It is recognized that expenditures on personnel are a large proportion of overall MOH expenditures. These expenditures are difficult to adjust in the short term because salaries and staffing levels are fixed. The problem is compounded by overstaffing in some facilities or areas and serious personnel shortages in other places. In addition, salary levels are considerably higher in the private sector, which attracts health personnel away from the public sector, further aggravating personnel shortages. The imbalance between personnel and nonpersonnel expenditures contributes to low productivity because of inadequate supplies and equipment. The following represent the means to improve this situation.

- Human resource (manpower) planning is essential; accurate and reliable data based on information collected from both public and private sectors is necessary to make informed decisions on labor supply and demand.
- Staffing norms need to be reviewed, revised, and then used in the public sector.
- Human resource projections need to be developed with particular attention to replacement and growth needs.
- Less expensive cadres of staff should be substituted for more expensive cadres whenever appropriate.
- Nonpersonnel expenditures will be given priority for new resources as a means of reducing the imbalance between personnel and nonpersonnel expenditures, which will subsequently lead to an increase in productivity.
- Training and specialization of staff should be examined to avoid any duplication of operational functions.

c. Allocations Across Districts

Up-to-date, reliable information is required to allocate the recurrent budget to district areas. This information should also be used more fully. A workable formula for MOH allocations should be developed, taking into account the following variables:

- population
- access indicators (# beds, hospitals, health centers; travel time to facilities)
- health status indicators (e.g., disease prevalence, infant mortality rates)
- income indicators

2. Information to Increase Efficiency, Effectiveness, and Access

High quality information is needed in order to make effective management decisions.

- Information must be brought up to date for planning and monitoring purposes.
- Timeliness and availability of information is to be improved at HQ, districts and facility levels.
- Trained analysts are required for data analysis. An epidemiologist should be hired to assist with the analysis of utilization information.
- Data collection efforts should be reviewed and revised to ensure that only data required for a useful purpose are collected.
- Efforts of committee in setting and achieving targets in reducing average length of stay need to include the clinic officer and an experienced medical officer from the field.
- Cost analysis capacity needs to be developed in-house at HQ and at district level; this requires technical assistance inputs.
- A study should be undertaken of the unit cost for each health service offered (e.g. inpatient day, outpatient visit), taking into account all inputs going into treatment.

3. Drug Management System

The components of a drug management system are:

- procurement
- distribution
- record keeping
- accountability

Different parts of the system have worked better than others in Kenya. A useful distinction may be to look at procurement issues separately from distribution, record keeping, and accountability. Regarding procurement, the following should be considered:

- Members of the procurement committee should not be permanent, should not know in advance the period of service, and should be well acquainted with on-the-job drug supply needs.
- A drug policy on what and how much to procure needs to be formulated.
- Outsiders should be involved in the procurement process.
- An external technical evaluation committee should be established.
- A study should be instituted immediately to develop a sustainable drug procurement system.

4. Computer Management

Management of computer resources is required for efficient information management.

- Purchase and servicing of computers should be standardized and centralized.
- The ability to service computers should be assured at the time they are acquired.
- Trained personnel are needed to use computers effectively.

B. Access

At the moment, clear and specific guidelines for ensuring access to services are contained in Chapter 4 of the Cost Sharing Instructions. These guidelines have been in place for less than a year. These guidelines must be monitored and a review, evaluation, and revision conducted by June/July next year.

ANNEX:
COUNTRY REPORTS

BOTSWANA HEALTH SERVICES

Botswana is a Republic which became independent in 1965. It has a population of 1.3 million people distributed in arable parts of the country. The total area is 582 square kilometers. The infant mortality rate is 37 per 1000 population. The common causes of ill health are: tuberculosis, pneumonia, cardiovascular diseases, diarrhoeal diseases, scabies, and intestinal worms.

The country has fifteen hospitals which include 2 referral hospitals which provide tertiary care; 9 general hospitals, one of which is a psychiatric hospital; 3 nongovernmental hospitals and three mine hospitals which are self-financing. In addition, the country has thirteen (13) health centers with a capacity of 30-50 beds providing a wide range of curative and preventive services. The hospital services are administered by the Ministry of Health. On the other hand, the Ministry of Local Government administers basic health services in health centers, clinics (dispensaries) and mobile (stops) health service. In the recent past, the country introduced community based health care (CBHC) activities using the services of the Voluntary Health workers who are paid salaries like other cadres of health personnel.

Within the constraints posed by lack of financial and manpower resources, the Government operates on the basis of "Five Year Development Plan". The chapter of the plan on health outlines the Government policy and states the objectives to be accomplished during the plan period. The priority during the ongoing plan period is to consolidate the existing health system and to develop the manpower required for effective provision of services. Presently, the country has one hundred ninety-nine (199) physicians providing a physician population ratio of 1:8000. The nation has no medical school but has a National Institute of Public Health which trains nurses and health personnel supplementary to medicine. In recognition of the need to address manpower issues, the MOH has established a Division to deal with manpower development, indeed a step in the right direction.

Great advances have taken place in the development of Botswana since the early 1980's. This is largely due to remarkable growth in the economy. The Government is the main source of funds appropriated for financing of curative and primary health care services. In addition to exchequer finance, the entire health delivery system -- Government and NGOs -- has a system of "user charges" and indeed the principle of cost sharing in the health services is fully accepted by the Government and users as an essential tool in the management of services. The level of fees are the same in both Government, church and all health facilities. Subsequently, a user fee is levied for inpatient and outpatient services. The exchequer allocates 4% of the total Government budget to finance health services. An interesting feature of the Botswana Health Service is that NGOs are regarded as partners in health provision and are allocated the total recurrent funds they require to manage services under their jurisdiction. The mine hospitals do not obtain Government grants since they are able to financially sustain their services and are supported by the mining industry.

A number of studies focusing attention on issues of health care financing and management have been undertaken in Botswana with an objective of assessing potential for alternative sources of finance. Health insurance as a means of providing additional financial resources has not been fully developed because of difficulties presented by lack of formal earnings. However, two medical schemes, namely Medical Aids scheme for Public Employees and Botswana Aid Society for private employees are in operation. The two are voluntary associations to which the employee and the employer contribute funds on a 50-50 basis. Under the schemes the contributors are entitled to benefits for both himself/herself, spouse, and children to whom 90% of the expenses are refunded on presentation of a medical bill. It is anticipated that the two medical aid schemes will be consolidated into a health insurance scheme for presentation to Parliament.

Besides the macro level health financing efforts already in operation, the health sector in Botswana has made considerable effort to strengthen planning and management of health services. While the MOH takes direct responsibility for the secondary and tertiary care, the operative responsibility for primary and preventive services has been decentralized to the district level. In an effort to achieve "Health for All" by the turn of the century, the EPI (Expanded Programme of Immunisation), the control of diarrhoeal diseases and the control and management of respiratory diseases have been given a high priority in planning and management. A health manpower plan has been completed and a Manpower Planning Unit set up in headquarters. In each district, a DHMT (District Health Management Team) has been set up consisting of the key multi-profession people. The teams have been given the duty and responsibility of planning and management of services at the decentralized level.

Finally, field trips to three institutions -- namely a hospital, health center, and a clinic -- demonstrated a concerned effort to improve health care in rural areas, strengthen the District Hospitals as referral units for the PHC activities, and provide additional resources for financing health services. However, the effort to improve coverage is seriously constrained by the shortage of health personnel. While health facilities are well constructed, equipped and maintained, it was evident that the system lacks effective coordination under the decentralized system. Botswana has the financial resources but requires to give priority to the training and development of manpower and to adopt an integrated approach to health care delivery.

SWAZILAND HEALTH SERVICES

Swaziland is a small country located in southern Africa and it is bordered by the Republic of South Africa and Mozambique. It has a population of approximately 800,000, 85% of whom live in rural areas. The annual rate of population growth is estimated to be 3.6% and life expectancy stands at 54 years. The infant mortality rate is very high with an average of 110 but increasing to 150 per 1000 in some rural parts of the country. The main causes of morbidity and mortality are : respiratory infections including tuberculosis; diarrhoeal conditions; malaria; bilharzia; accidents; STDs; and psychiatric ailments. The country has a diversity of topography and socioeconomic variables hence the varied morbidity patterns.

By the standard of many African countries, Swaziland has a relatively developed health infrastructure. The sector is divided into the Government sector providing 45% of health services, the private sector providing 15%, and the Mission facilities which provide the balance of 40% of services. The private sector, in general, comprises general practitioners (GPs) and industrial hospitals initially established to treat employees of the respective industries. Mbabane Hospital is the referral center. Other levels of hospitals, health centers, public health units and clinics (equivalent to a dispensary) have been developed to serve in different capacities.

A visit to four health institutions, namely Mbabane referral hospital, Good Shepherd Mission Hospital, Lamahasha Clinic, and Siteni Public Health Unit demonstrated a high incidence of communicable diseases and ill conditions caused by nutrition and poor environmental sanitation. The illnesses mainly affected mothers and children. It was evident that there exists a disproportionate emphasis on the provision of hospital based services. Hospitals spend 76% of the total health budget leaving 24% of funds to be shared between preventive and administrative services. However of late, the Government has made a decision to correct the existing imbalance by reorienting the system towards preventive and promotive care and further decentralizing health services to the regional level. This will facilitate integration and remove competition and duplication of effort between the church and the Government health services.

On 14, October, 1984, the Ministry of Health introduced a reform measure for health services that are provided by the Government and Mission institutions. The reform measure involved a new user charge which standardized the fee structure for all health institutions, that is, fees charged in Government and Mission hospitals were equalized. Prior to the introduction of this measure, Mission health facilities charged higher fees than the Government institutions. Mission services were considered by the public to be of a higher quality because facilities had a clean environment, serviceable equipment, and ready availability of drugs and personnel. The policy reform was designed to provide a uniform health service in terms of ambulatory care, referral, and supervision of the decentralized health system. Additionally, it had the advantage of making health care accessible and affordable by the majority of the people, and it drastically reduced queues commonly observed, particularly in public institutions.

The equalization of the fee structures, decentralization, and integration of Government and Mission health systems meant the church institutions had to be compensated by the Government for the loss of revenue essential for running their services. The Government introduced grants to the church health facilities amounting to 75% of their total recurrent expenditures. The balance of 25% needs to be generated through the cost sharing programme already agreed upon. The user charges that were introduced covered all types of medical care, both curative and preventive. It should be noted that the overall effect of the new system caused an overall 17% decline in utilization of health services. The Government subsidy that was introduced excluded capital funding and did not affect the ownership of the investment which still remains in the hands of the church.

The collaboration of the church and the Government and the standardization of fees is an interesting phenomenon which warrants further study, particularly in view of its inherent advantages in terms of greater utilization and decentralization of planning and administration of services.

The revenue generated through cost sharing drastically increased the amount of money available for effecting improvements in health services. It is noted that the hospitals were able to raise more money than the RHCs, possibly because the level of charges are the same. The Mission hospitals were able to raise a substantial amount of money, later used to directly improve services in the institution which raise such funds. The public services are disadvantaged because their revenue collection goes to the exchequer and consequently the collection of user fees, by comparison, is unsatisfactory. Nevertheless, the principle of cost sharing has been fully accepted both politically and by the health professionals, thus paving the way for contributory health care.

In conclusion, the Swaziland health delivery system has its good and weak points. The system was noted to have adequate supplies of drugs and equipment. However, they have acute shortages of well qualified staff to run RHCs, hospitals and health clinics. Mbabane, as a referral and specialized teaching hospital, is in many ways inadequate in terms of physical facilities, equipment, and personnel. Within the constraints described herein, the information available appears to suggest that the measures undertaken are insufficient to address issues of health development in the country. Subsequently, it is necessary to consider new strategies in planning and more elaborate financing mechanisms to ensure sustained growth to meet the future health needs of the people.

MEXICAN HEALTH SERVICES

Introduction

The Kenya team on health care financing strategic planning mission visited Mexico from 21st to 26th August, 1990 with a view of studying health care financing system of the country. The group was privileged to have official overview welcome address by the Minister for Health Dr. Jesus Kumate and thereafter held discussion with various senior officials in-charge of running health care system in the country.

Overview

Mexico has a total land area of 2 million square kilometers with the latest estimated population of 81 million people distributed in 31 federal states and 1 federal district of Mexico. Life expectancy at birth is 70 years with a differential of 9 years in some parts of the states. Rate of population growth has gone down from 3.5 percent in 1970's to 2.0 percent and it is expected that it will go down to 1.5 percent in 5-10 years time. Infant mortality is 25 per 1000 live births while crude birth rate is 27 per 1000 population. Crude death rate is 5.9 per 1000 population. The annual per capita income is US \$3000.

In order to reduce high infant mortality rates in the rural areas, the government has embarked extensively on EPI, CDD, and MCH care programmes. In areas where there are shortages of health personnel, promoters in rural areas are deployed. To reduce fertility rates 70 percent of women between the ages of 15-49 years use contraceptives. However, males are reluctant in using contraceptive methods as can be evidenced by the fact that for every 2000 women who accept contraceptives only one male does. The influenced of church is also an inhibiting factor.

Health Care System

National health care system in Mexico is complex and has gone through various reform measures, the latest of which introduced decentralization of decision making and resource allocation to the states. Out of 31 states, 14 have taken control over their health system activities. The process of decentralization is gradual to enable smooth handing over without interfering with quality of services. Health care systems can be summarized as follows.

(i) Social Security System

About 54 percent of the population have access to health care through social security organizations, the largest of which is the IMSS (Instituto Mexicano de Seguro Social). Its financial scheme is based on employee, employer, and/or government contributions. However, it was noted that government contribution has gone down considerably. The IMSS has solidarity programmes which cover population which cannot afford to contribute both in urban and rural areas. The scheme has, however, not succeeded in covering

everybody because of lack of human resources in the rural areas coupled with inaccessibility of some parts of the country. The quality of health care provided to non-contributors might not be as good as the one given to contributors. The use of health promoters or volunteers is a step forward in providing primary health care education to the community.

The second largest social security organization which covers state employees is the ISSTE. It is financed by contributions from the employees through check-off system.

(ii) Government Sector

Ministry of Health acts as the overall coordinator of health care system in Mexico. The Ministry and Welfare (SSA) provides health care to population not covered by any of social security organizations or private insurance schemes. As coordinator and policy makers in health activities, the Ministry takes a leading role in preventive and promotive health care activities. Ideally, the Ministry should provide health services to the entire population, but because of lack of financial resources and personnel, the quality and coverage of health services provided is inadequate. Nevertheless, the provision of health care to the population regardless of their socio-economic status is the responsibility of Ministry of Health based on the principle of universal coverage.

The Ministry receives its funding from budgeted allocations from Ministry of Finance.

(iii) Private Sector

About 10 percent of the population receives their health care in private institutions based on the criteria of ability to pay though government regulates their activities. However, some specialized private institutions such as ABC provide limited health care to the uninsured population living around the facility.

It should be noted that financing of ABC as a specialized institution is done by charity organizations, companies, and philanthropists.

Financial Resources

Generally it can be said that financial resources are insufficient and unequally allocated to providers, e.g. budget for MOH compared to others. Details of sources of funding are covered in sections dealing with specific providers.

Human Resources

Looking at the supply and demand of manpower, it was noted that Mexico is faced with the problem of unemployment and underemployed general practitioners

who are reluctant to work in rural areas. There has been poor planning of manpower and as a result 8000 graduate every year and only 2000 can be absorbed in various health services. Nurses, on the other hand, are in short supply.

Distribution of physicians is another major problem with over 80 percent concentrated in big urban centers. Secondly, over 50 percent of the total physicians and nurses work in social security organizations.

It was also noted that Mexican physicians overseas are not willing to take up jobs in Mexico because of low salaries. A new institute has been formed to work into, among other areas, qualified Mexican physicians overseas.

As a result of shortage of health personnel in rural areas, health promoters and volunteers are used for primary health care activities, particularly as educators to the community.

Access to Health Facilities

Distribution of health facilities is another area of concern. Most of them are concentrated in the urban counties whereas some areas in the rural areas have no facilities. In other words, the number of primary health care facilities and the number of secondary and tertiary-level units are not balanced in the country.

Summary of Cost Recovery Mechanisms

Federal District Health Services

The Federal District (D.F.), like a state, has independent health services. Although the general goal for decentralized states is 10% cost recovery, very little is currently recovered in the D.F.

All primary care, family planning, emergency, and preventive care is free. There is a fee schedule for other services which is not based on costs. There is a system of reduced or no fees based on family income measured against the official minimum wage (in D.F. now approximately \$3.50 - \$4.00).

If family income is:

> 3	times	the	minimum	wage	-	pay	fee	
2-3	"	"	"	"	-	pay	lower	fee
1-2	"	"	"	"	-	minimum	fee	
< 1	"	"	"	"	-	no	payment	

Using this system, approximately 70% of the population pays nothing for health services.

Funds from fees go to the Treasury, but this makes up less than one

26

percent of Treasury receipts. Thus there is no impact on the institution's or the Ministry's budget or resources.

State of Morales Health Services

The State of Morelos is a decentralized state which receives funds from the Federal and State Governments. Fees are set at a modest level -- a middle level fee is set to recover direct medical costs, with a higher fee set to include food costs as well. There is a lower token payment for some other patients.

Services are provided before payment is received. Patients' socio-economic status is evaluated (although there are no set income criteria), and patients are given a bill if appropriate. The bill is paid afterwards at the state finance office.

Funds collected are accumulated and transferred monthly to an account of the Secretary for Health. It can be freely used for small purchases outside of budget. The actual amounts are relatively small, but the state health ministry keeps all of the money.

CANADIAN HEALTH SYSTEM

Overview of the System

According to the Canadian Constitution, the responsibility for health care rests with the provincial and territorial governments. This means that the national health system is a set of interlocking health plans operated by Canada's ten provinces and two territories. The Federal Government exercises influence over health through its financial contributions to the provincial and territorial health systems. The Canada Health Act is the Federal health insurance legislation which establishes national criteria that provinces and territories must meet to qualify for their full share of the federal payments for health care services. These criteria are the cornerstones of Canada's health care system and represent the national policies shaping the provincial and territorial health care systems. These criteria are:

- reasonable access to insured services without impediment by way of user charges and extra billing;
- comprehensiveness of insured services covered;
- universality of population covered;
- portability of benefits;
- public administration on a not-for-profit basis.

The Federal Legislation is designed to ensure that all residents of Canada have access to medically necessary hospital and physician services on an insured basis. The Provincial Ministries of Health become, in effect, the insurers. Access and payment for medical and hospital services are guaranteed by the Provincial MOH.

In 1988, Canada spent \$50.4 billion (Canadian) on health, or about \$1,945 per capita. As a proportion of GNP, health spending is 8.7 percent. Total health expenditures have been increasing at about 7 percent per year.

Strategy of Financing

There are three principal sources of health financing in Canada:

- the federal government;
- provincial and local government;
- private organizations and the consumer.

Provincial government spending is the principle source of funding, accounting for approximately 42% of total health expenditures; the Federal government is second with 30%; local governments account for only 1% of expenditures. The consumer and private organizations account for around 25% of expenditures.

Public sector spending is almost entirely financed through general tax revenues. Federal expenditures are financed from the Consolidated Revenue Fund -- personal and corporate income taxes, excise taxes, import duties, etc. Federal funds are transferred to provincial governments under Established Programs Financing (EPF) according to specific per capita formulas. Provincial governments have autonomy in deciding how these funds are spent.

Provincial health expenditures are financed by Federal contributions and by general tax revenues such as income tax and sales taxes raised at the provincial level. In addition, two provinces levy health premiums on employers and employees which account for between 5 and 20% of provincial health spending. Earmarked taxes, such as a special health payroll tax, are still levied in some provinces. Additional payments by consumers for provincial health services (e.g. user charges or extra billing) are specifically prohibited.

Health Services Financed through Provincial MOH

Hospital and related institutions services are the largest component of the health sector, accounting for more than 50% of the total health care budget. Hospitals are financed by the Provincial MOH on a global budget basis. Budgets are negotiated with the each facility before the beginning of each fiscal year. This method of financing allows hospital administrators flexibility in allocating the human and other resources at their disposal. Many Provinces have introduced cost savings programs to encourage administrators to improve operational efficiency.

All hospital facilities are not-for-profit institutions. Each is operated under the authority of a Board of Directors. While many hospitals do fund raising, particularly for refurbishing and rebuilding, their major source of funding is the provincial MOH. (St. Michael's in Ontario, for example, raised \$25 million Canadian in fundraising for renovation; the Ontario MOH provided \$63 million.)

Physician services are funded by the MOH on a fee-for-service basis. This means that the vast majority of the approximately 57,000 doctors in Canada are private entrepreneurs. They provide outpatient medical services to the provincial population in their private offices and bill the government according to the fee schedule which is negotiated between the provincial MOH and the provincial Medical Association. Medical services that doctors provide to patients in hospitals are similarly billed to the government. Only a very small proportion of doctors are employees; most of these work for universities or in administrative positions for the MOH.

Human Resources

Physicians are in very adequate supply in Canada; some say there is an "oversupply" of physicians (the physician to population ratio is more than 1:500). Distribution of physicians, however, is a problem: the number of physicians in remote rural regions and poor inner city areas is inadequate. Some provinces have created financial incentives for physician payments so as

to encourage movement to underserved areas. For example, fees paid for services may be less in urban areas and higher in remote areas. Other benefits such as continuing education and housing have also been provided. Although some of these programs have been successful, few physicians remain in remote areas for long.

Legislation regarding payment mechanisms and licensing have kept certain health professions from practicing in Canada. Only physicians are reimbursed by provincial health plans on a fee-for-service basis. Other health professionals (e.g. nurses) can only receive payment in the form of a salary at a hospital or other health facility. Some health professions which are important providers of health care in other countries (e.g. midwives) have not obtained the right to practice in Canada. Medical associations in Canada have lobbied against allowing other health professions to be licensed or to be reimbursed by provincial health plans for their services.

Efficiency and Cost Control

The characteristics of the Canadian system in terms of efficiency and cost control can be summarized as follows:

- waiting lists at hospitals
- slow technology proliferation
- non-optimal use of resources through incentives for use of more expensive personnel -- physicians vs. less sophisticated providers
- emphasis on ambulatory care, prevention/promotion, quality and appropriateness
- checks and balances for abuse of system

Equity

Equity in health care is a primary concern of the Canadian system. Because all medically necessary hospital and physician services are paid in full by the provincial health plans, no real financial barriers exist to access to health care.

As noted earlier, the difficulty in ensuring an adequate distribution of medical care providers in remote rural areas and the poor inner cities. This raises equity concerns, which the government has tried to address through financial incentives for doctors and provision and/or payment of patient transportation from remote areas to health facilities.

The Provincial Perspective: Ontario

See attached document: "Ontario's Health Care System: Some Facts and Figures."

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THE UNITED STATES HEALTH CARE SYSTEM

Both the private sector and government (federal, state and local) are involved in the health care system, though the private sector has historically and continues to dominate. Following is a very simplified summary of government and private sector involvement.

GOVERNMENT

- Provides health insurance for certain segments of the population. For the most part, under these insurance programs, services are delivered by the private sector and reimbursed on a fee-for-service basis.

Medicare provides insurance coverage for both hospital and physician services for people over 65 and certain classes of disabled individuals. Medicare is administered by the federal government. Approximately 12% of the population is covered by Medicare.

Medicaid provides insurance coverage for the very poor (predominantly single mothers with children). Medicaid is a federal/state partnership and States have considerable discretion in determining who is eligible for and what services are covered under Medicaid. Approximately 10% of the population is covered by Medicaid.

Both Medicare and Medicaid were enacted in the mid-1960's during a period of heightened support of social and health programs in this country.

- Funds research and technology development through the National Institutes of Health.

- Provides for the monitoring and promotion of Public Health through the Centers of Disease Control and state and local health departments.

- Provides some services directly. For example,

The **Indian Health Service** provides health care services for Native Americans.

The **Veterans Administration** supports a network of hospitals and clinics for veterans of the uniformed services.

Public health departments and clinics provide some direct services including prevention services, maternal and child health services, and immunizations.

Some state and local governments support **municipal hospitals**.

A national network of **Community Health Centers** supported with federal and local funds provide primary care to the poor and

others without access to health care.

- Supports training of health care providers in a limited way through the National Health Service Corps (a program which provides scholarships and loans in exchange for service in an underserved area). This program has been dormant for the last several years but is being revived. The government also supports advanced medical training for professionals in short supply.

- Develops and administers regulation of the health care industry.

PRIVATE SECTOR

- Is the biggest source of health insurance. Approximately 70% of the US population has some form of private health insurance, although this insurance may be limited and is usually focused on hospital care. A significant portion of people on Medicare also have private insurance. Estimates of people uninsured are between 12%-17%.

- Provides most hospital, nursing home, and physician services either on a not-for-profit or for-profit basis.

- Conducts most professional education.

- Develops and produces most pharmaceuticals, equipment and facilities.

MAJOR ISSUES IN US HEALTH CARE

- Increasing efforts to reduce and manage the costs of health care, focusing on controlling admissions to and length of stay in hospitals and using approaches to paying for services other than fee-for-service. Efforts at cost-containment have been lead by the government but private industry is becoming increasingly involved as their expenses for employee insurance escalate.

- Introduction of "alternatives" to the traditional hospital/acute care system, encouraging more out-patient, nursing home and home care services.

- Concern about the distribution of health services both geographically and by type of health care provider. Rural areas and poor urban areas do not have equal access to care. There are not enough of some types of health care providers (particularly primary care physicians and nurses) while we have ample and even over supply of some specialists in some geographic areas.

- An increasing recognition of the significant number of people in this country who are uninsured and underinsured and how services can be equally assured given severe financial constraints on the federal and state budgets.

ONTARIO'S HEALTH CARE SYSTEM

Some facts and figures

April 1989

Ministry of Health
 **Ontario**
Elinor Caplan, Minister

42

ONTARIO'S HEALTH CARE SYSTEM

Did you know...?

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The Ministry of Health supports:

- 223 public hospitals
 - 17 private hospitals
 - 17 children's and adult rehabilitation centres
 - 10 provincial psychiatric hospitals
 - 5 university medical teaching centres
-

It funds:

- More than 29,000 licensed nursing home beds
 - More than 37,000 acute care hospital beds
 - More than 14,000 chronic care and rehabilitation hospital beds
 - 177 ambulance services
 - 43 public health units
-

The health care people:

- 200,000 people working in health care
 - Over 17,000 are physicians
 - Over 80,000 are nurses
 - More than 25 professional groups including physicians, nurses, nursing assistants, dentists, optometrists, physiotherapists, audiologists, speech pathologists, chiropractors, denturists, psychologists, opticians, and others.
-

The 1988-89 budget of \$12.6 billion is allocated as follows:

• Institutions	52%
• OHIP expenditures (mostly doctors' fees)	32%
• Emergency & special services	6%
• Mental health	5%
• Community-based care	4%
• Administration	1%

Services have grown and expanded in almost every area of health care delivery: hospitals, OHIP, nursing homes, mental health, public health, home care, ambulance services, assistive devices, laboratory services, and drug programs. At the same time, health care spending in Ontario has steadily and dramatically increased in the last 10 years.

Here are some facts and figures that may interest you.

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Spending has risen rapidly

- Canada's spending on health care is the highest per capita of any country with a national health care system, and Ontario's per capita spending is one of the highest amongst the provinces.
- In the last 10 years, the cost of health care in Ontario has risen by 63.4%, while the provincial economy has grown by only 42.7%.
- One in every three tax dollars in Ontario goes to health care, up from one in every four a decade ago.
- Ministry of Health spending more than tripled in 10 years – from just under \$4 billion in 1978 to \$12.6 billion in 1988.
- Institutional health care plus doctors' and other practitioners' fees together account for about 85% of the total health care budget; leaving less than 15% for community-based care programs, ambulance services, public health, women's health, and health promotion, etc.
- The Ontario Drug Benefit Plan costs have been growing by more than 20% per year. The plan, covering the cost of prescription drugs for those over 65, social service recipients, and a number of other eligible recipients, is now costing nearly \$600 million per year.

Increasing needs of the elderly

- People over 65 make up 11% of Ontario's population; and about 45% of total spending goes to care for them.
- Statistics Canada projects that this group will grow to 20% of the population within the next 30 years.
- Many elderly people now face waiting lists for nursing home care.
- Chronic care patients often cannot find appropriate care and therefore must occupy costly acute care beds when their needs could be better met in other settings.
- If we continue to deliver services in the present manner and health care spending continues to escalate at its current rate, experts estimate provincial health care spending will increase from 8.6% of gross domestic product to more than 14% of GDP by the year 2000.

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How the funding works

- When the national hospital insurance and medicare programs were established, government took over as the principal funder of the system.
- Taxpayers pay for health services through provincial and federal taxes, and OHIP (Ontario Hospital Insurance Plan) premiums.
- OHIP premiums cover less than one fifth of total health care costs, federal contributions have been dropping, and the balance of about half comes from Ontario taxes.
- The government pays the people and institutions that provide health care but does not itself provide the majority of services.

How doctors are paid

- Most doctors are paid on a fee-for-service basis which means they receive a fee from OHIP for every treatment provided. A small number of doctors work on salary in community health clinics and other settings.
- Doctors' (OHIP) fees are set following negotiations between the government and the Ontario Medical Association (OMA). Once the overall annual increase has been agreed upon, the OMA decides how the increase will be spread out over the entire OHIP fee schedule.
- The total amount the government pays to physicians each year depends on the number of services they provide to patients. Total OHIP expenditures for physicians' and other practitioners' fees was about \$4 billion in 1988-89.
- Since physicians control the number and type of services they prescribe, the Ministry cannot predict its annual expenditure in advance. (For example, in 1987, the 4% increase in the fee schedule translated into a 12% increase in total amount paid to physicians by the end of the year).

How hospitals are run and paid

- Most hospitals are privately-run, publicly-funded, non-profit corporations run by appointed boards. The boards are composed of the administrative director of the hospital, members of the community (including business), and usually members of the hospital staff.
- Public hospitals receive annual budgets from the Ministry of Health to run the hospitals and provide patient services. In 1988-89, total hospital operating costs were about \$5.5 billion.
- A hospital's board of directors, in conjunction with its administrators and senior staff, decide how the budget will be allocated to various programs and services, including nursing services. Hospitals are responsible for managing within their budgets.
- Hospitals apply to the Ministry of Health for capital funds to rebuild, renovate, or expand existing facilities. To receive capital funding, projects must satisfy the Ministry's criteria and meet regional needs. Usually the hospital and its community raise one-third of the funds.

The evolution of OHIP

Ontario entitles 100% of its residents to insured health services through enrolment in OHIP. People are protected for a full range of hospital and medical services, regardless of age, income or state of health.

The insured services are listed as they have been introduced.

Hospital Services

- 1959
 - standard ward accommodation
 - necessary nursing services in hospital
 - diagnostic procedures
 - drugs prescribed in the hospital
 - use of operating rooms, delivery rooms, anaesthetic, surgical and medical supplies
 - services rendered by persons paid by the hospital
 - emergency out-patient treatment

- 1964
 - out-patient treatment of fractures
 - radiation treatment for cancer
 - physiotherapy – in hospitals and private clinics
 - occupational therapy
 - ambulance services
 - radiation treatment for non-cancerous conditions
 - kidney dialysis
 - dental work in hospitals
 - temporary prostheses

Medical Services

- 1969
 - all medically necessary services provided by a physician, general practitioner or specialist
 - specified dental procedures
 - specified optometric services

- 1970
 - health examinations for school children
 - family planning
 - cancer detection units
 - specified services provided by chiropractors, osteopaths, chiropodists
 - laboratory services and clinical pathology, when ordered by and performed under the direction of a physician

Related Health Services

- 1969
 - children's mental health centres
 - home kidney dialysis
 - special feeding arrangements at home for patients unable to feed normally

- 1972
 - extended health care services in nursing homes and homes for the aged
 - home care services including: nursing care, homemaker services, speech therapy, physiotherapy, occupational therapy
 - elimination of OHIP premiums for senior citizens and their dependents

- 1974
 - prescription drugs for senior citizens
 - medically necessary air ambulance trips

- 1976
 - helicopter ambulance services

- 1978
 - chronic home care pilot projects

- 1980
 - province-wide chronic home care services
 - expanded air ambulance services for Northern Ontario

- 1985
 - northern travel grant program
 - began expansion of assistive devices program including prosthetics, hearing aids, wheelchairs, and respiratory equipment

- 1986
 - dental services for children with cleft lip and palate
 - major expansion of community mental health and addiction programs

- 1987
 - dental care for children in need
 - began establishment of women's health centres
 - major treatment and education for AIDS patients

- 1988
 - provision of drugs for patients with cystic fibrosis and thalasemia
 - establishment of native, francophone, and multicultural community health centres