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Health Financing: A.I.D. Policies, Strategies, and Program Responses

As governments in developing countries feel increasing pressure on their budgets because of often deteriorating economic conditions and as they seek relief from some of the burden of health costs, donor agencies have also put attention on the matter of financing. Many governments are confronting the need to cut expenditures drastically across the board, and for almost all there is a severe lack of resources to pay for the government's activities.

A.I.D. POLICIES AND CONCERNS ABOUT HEALTH FINANCING

A.I.D. has formulated both policies and strategies to assist host-country governments to deal with the situation in the health sector. It is A.I.D.'s intent to promote economically and financially viable health programs through the following general approaches.

- complementarity, rather than duplication of private sector services (including traditional providers), and public primary health care systems;
- development of payment systems for personal health services that are appropriate to the country setting;
- applied research on a range of topics concerning health financing;
- examination of country policies and practices that hinder the health system's viability.

The points that particularly need to be taken up in dialogue with governments are policies and practices that are obstacles to economic and financial viability. Some of these are difficult areas involving political decisions: stated commitments to free health care for the entire population, allocation of resources in the health sector to urban and rural populations relative to their health needs, expansion of the health sector at a rate and in a manner that outstrips the government's capacity in the long term with regard to financing and management, and equity considerations. A.I.D. also tries to promote the idea that financial planning for the health sector ought to consider both public and private providers and resources in order to achieve national health goals.

These elements of concern about financing need to be placed in the context of another important goal of A.I.D. A.I.D. is firmly committed to significantly reducing fertility and infant and child mortality, and A.I.D. has put large amounts of resources into efforts directed toward this goal. A.I.D. believes, along with other donors, that low technology, community-oriented selective primary health care services can be cost-effective means of achieving this goal. In addition to funding service delivery, A.I.D. is supporting research to determine the most cost-effective ways to deliver these selective interventions.

This point brings up a dilemma faced by A.I.D., namely, how to reconcile the goal of self-sufficiency in long-term financing of health systems with accelerated action programs for child survival in the poorest countries. The legislation that provides funds for A.I.D.'s programs stipulates that the monies be used for specified activities such as child survival; consequently, A.I.D. responds to these legislative directives by implementing such activities. There is no resolution yet within the Agency as to how concerns about financing fit into the design of action programs to reduce mortality among young children.

Despite this difficulty, A.I.D. is currently supporting a variety of projects that deal with different health financing questions, albeit not always in conjunction with program activities directed towards improving child survival. These projects are bilateral, centrally funded, or regional bureau programs.

Before making further comments on these projects and some of the lessons we have learned so far, several concerns should be mentioned. There is a need for ongoing dialogue among donor agencies on these issues and for coordination in the stances we take with governments on financing. A.I.D. recognizes that each organization has its particular strength; for A.I.D. it is implementing programs, for the Bank it is analyzing the health sector as a whole from an economic perspective, for WHO it is providing leadership and technical guidance in health. Donors need to take advantage of these various strengths by offering assistance to countries in a coordinated fashion. Some of the financing issues with which A.I.D. has relatively less experience could be addressed better by other donors here today. For example, the question of re-aligning the allocation of resources--from urban to rural, with its implicit shift in equity, is an area that is intertwined with macro analysis of the entire health sector and policy.

Another concern is the confusion that countries have shown in the face of the different approaches and expectations about health financing communicated to them by donor agencies. Perhaps there could be consensus among donors on a few basic principles related to financing health care that would guide project development and policy recommendations. For example, funding high-technology health institutions, which tend to be in urban areas, exacerbates the resource allocation problems already mentioned, and with which countries must wrestle. A.I.D. is interested in seeing dialogue continue and in supporting other ways donors could cooperate on health financing.

A.I.D. has identified three other unanswered questions that relate to health financing and the points brought up so far.

- To what extent should there be more attention to resource allocation? A.I.D. is re-examining the tendency to focus on cost-cutting and revenue generation up to this time.
- What are the long-run financial implications of the programs we are promoting in child survival? Will these programs increase countries' dependency on donors for funds? It may be that the incremental and recurrent costs to sustain these programs, which are now heavily supported by external funds, are too much for governments to take on in the long run, if current economic conditions and resource allocation patterns continue. A.I.D. and other donors have a responsibility to analyze this question and adapt child survival programs to this constraint. Very little analysis of this question is being carried out, with the notable exceptions of the CCCD project in Africa and a few small-scale projects looking at relative cost-effectiveness of different ORT delivery approaches.

What is the relationship between supply of and demand for health services? A.I.D.'s programmatic support has tended to be used for improving the supply of services--putting facilities and providers of various types in place in local communities. However, relatively less attention has been given to the demand side of the situation: are the services that have been installed what people "demand" or what they "want"? (Are people willing to make economic exchanges for services?) In the field A.I.D. has observed that government health services tend to be underutilized because they are of such low quality. The fact that perhaps half of health expenditures are in the private sector suggests that people are willing to pay for quality in health services and that even very poor people may be willing to spend money for some level of service acceptable to them.

Thus, it seems problematic to develop plans to collect revenues before looking at what people expect to obtain from health services and what they are spending money for. In setting prices for any health services, it is also necessary to take into account the fact that some people cannot pay, yet they should not be prevented from receiving services. A.I.D. believes that the question of quality of services in government health facilities needs to be addressed, also, and certainly management has a lot to do with improving quality. Until quality is brought to a certain minimal level, there is no logical reason to believe that people would pay to use services that they have formerly avoided when they were free.

A.I.D.'s HEALTH FINANCING ACTIVITIES

The next part of this paper describes the types of activities about financing that A.I.D. has undertaken in the last few years. These activities have been basically of seven types:

- in-service training of A.I.D. regional health officers;
- regional or country studies and assessments of financing issues in the health sector--from the entire system to demand and expenditure studies, cost studies, studies in the supply of health providers, and case studies;
- testing various alternative financing schemes in demonstration projects;
- studies of cost-effectiveness of intervention strategies;
- policy dialogue with host-country governments;
- providing advice and guidance from experts on the development of large-scale alternatives to government financing (e.g. health insurance, HMOs, prepayment schemes);
- assistance in financial management of the public health sector.

1. Inservice Training

In 1984 the Latin America and the Caribbean Regional Bureau of A.I.D. held a conference for field health officers on issues in financing and resource allocation. The Bureau had recognized that the concepts and approaches involved in financing were generally new subjects for health officers and that they needed to become conversant with the area in order to handle financing effectively in their work. The conference was a means to develop their familiarity with the issues, so that they could integrate them into their programming activities--engaging in policy dialogue and identifying potential projects and needs for expert assistance.

Since the Health Officers' Conference, many new initiatives have been started. The conference relied on technical presentations by experts in specific areas and unstructured discussions. Conclusions and recommendations included:

- policy dialogue among donors on issues of financing and resource allocation;
- health sector strategies to include attention to cost containment, particularly for hospital and prepayment schemes, and to the potential for expansion of private and/or quasi-public providers;
- expanded time frame for projects;
- expanded professional development for health officers on these technical areas via special training, workshops, seminars, and dissemination of technical information,
- funds for more studies on financing and resource allocation issues.

Following the example set by the Latin America/Caribbean Bureau, Health Officer Conferences this summer will include sessions on financing. These will be opportunities to familiarize field officers with the issues.

2. Studies

The second area where A.I.D. has been working is in assessments and studies of financing issues, either on a regional or national basis. Basic data collection on financing topics has been an important activity for A.I.D. Demand studies of expenditures on health and household-based expenditures and utilization have been noted in at least 13 Caribbean, Latin American, and African countries. A cost study is being developed for El Salvador.

Two examples of completed surveys may give some sense of the types of demand studies that A.I.D. is presently supporting.

A recently completed household expenditure study in Honduras as part of the PRICOR project produced estimates of costs to families for illness. Overall these illness-related costs were about 11% of monthly household expenditures and about half of the expense was for drugs. Analysis of other responses pointed out the community had the capacity and strongly desired to have managerial and financial responsibility for local health services. The study concluded that there was great potential for success if the government enabled the community to participate in the health care system in this way.

In Mali, a household expenditure survey has been developed and used in the field. Quick turnaround may be possible with this survey instrument, which may serve as a model to collect such data in other countries.

Another major topic for studies has been user fees and prepayment mechanisms. In the Latin American region, Jordan, Egypt, and the Dominican Republic, policy studies have explored the possibility of national (or regional) health insurance. User fees have been a focus of studies in Senegal and Niger (primary health care), and in Honduras (hospital fees).

Sometimes financing studies have been a part of country health sector assessments, such as recent assessments in Peru and Egypt. The Africa Bureau has performed a review of information in available studies on demand for health services, and particularly utilization patterns outside of the government facilities in African countries. The Latin America Bureau has funded region-wide reviews of a variety of financing issues, as well as region-wide reviews of social insurance/social security mechanisms for funding and delivery of services, and the development and operation of HMOs in the region.

Through the PRITECH project, S&T/Health has supported the development of financing guidelines to aid in planning and reviewing oral rehydration therapy programs. The guidelines identify a set of economic and financing questions and suggested approaches for answering them.

3. Testing Financing Alternatives

In many countries both small-scale and large-scale projects have been supported to test various alternative financing mechanisms to direct payment by the government. The PRICOR project currently has nine such small-scale projects in all regions of the world.

In Benin and Zaire the approach of a fee-for-illness episode is being tested in PRICOR projects. In Zaire, this fee approach will also be compared against fee for visit, fixed fee for consultation, and variable fees for drugs. Revolving drug funds are being studied in Thailand and Dominica, as is an experiment with drug sales through small community-operated pharmacies in the Philippines. Alternative ways to compensate community health workers are being explored in Haiti. Mixed alternative financing schemes are being tested in Liberia, Bolivia, and Brazil. The Sine-Saloum project, which covers a region of Senegal, has been developed along the lines of charging user fees for services, which have been mostly curative in nature until recently. In Niger and Mauritania the rural health systems are heavily dependent on community health workers whom the government trains and then returns to the village. Rather than working for the government, they are supported by the villagers, who pay fees for services. These workers also sell and restock the drugs they use.

The Philippines Primary Health Care Financing Project takes a fairly comprehensive approach to health financing. This project, which has been in operation for more than a year, now includes provisions to test a variety of health financing schemes to be developed by a diverse group of public and private institutions, as well as background studies on health financing policy. The alternative financing schemes will address ways to rely more on the community and the private health sector to organize and manage primary health care services. Sustainability of these schemes will be a key element in their design and evaluation. The results of these trials will suggest ways that recurrent costs can be shared.

4. Testing Cost-Effectiveness of Interventions

A few studies are looking at the cost-effectiveness of intervention strategies. This is an area that might be strengthened in A.I.D.'s future programming.

One of the components of The Philippines Primary Health Care Financing Project is to study the cost-effectiveness of the current Ministry of Health programs. These operations research and background studies will help to refine the technical advice and managerial decisions about training of village-level health workers, supply of equipment and supplies to these workers, guidance to village pharmacies, and public communications campaigns about primary health care services. These studies, plus those mentioned earlier, are intended to feed into the process of redesign of the system for health services and future investments of public funds in health.

The CCCD project in Africa should probably be mentioned at this point because it deals with high-priority health goals and attempts to validate the costs and ultimately the cost-effectiveness of its programs.

One of the project's objectives is to design the country projects within the government's capacity to handle definite proportions of the recurrent costs of the project. The government's ability to assume these costs is explicitly assessed and taken into account in designing the scope of the project, and future additional and recurrent costs are forecast. A schedule for the government to assume an increasing proportion of the recurrent costs annually is built into the agreement. Yearly reviews of the recurrent cost situation are made, and if the government cannot handle the scheduled increase in the recurrent cost burden, the project activities are scaled back to be within the government's reach. In order to keep the projects within a size that governments can provide for, they are designed within the existing personnel and facility constraints to minimize cost. CCCD is presently working in twelve countries.

Another aspect of the CCCD projects is the expectation that the governments commit themselves to explore alternative financing mechanisms to support the projects. There has been dialogue with the governments on this subject, and CCCD is increasing its technical assistance on this subject.

5. Policy Dialogue and the Private Sector

Dialogue about health financing and policies that affect it occur primarily between USAID missions and host-country governments. In some cases, a government request for a specific type of assistance (e.g. information about HMOs or health insurance planning) is being viewed as a vehicle to engage in considerations of a larger range of financing issues and the implications of various strategies. Such is the case in several countries in the Near East. It is in these kinds of discussions that resource allocation, the private sector in health, and cost recovery through revenues, for example, come up. In Honduras there is an ongoing dialogue between the government and A.I.D. on the implications of new hospital construction for the continued ability of the Ministry of Health to support primary health care services.

Many countries are recognizing the significant role of the private sector and the potential for increasing its involvement in providing and paying for health care. In some cases, as for instance, Morocco, there have been directives from the highest level of government to reduce the government's burden in all ministries and to find ways to cooperate with the private sector, including financing options. In Egypt, also, the government is trying to find ways to promote the development of private financing of health. What forms this shift will take in Egypt are not yet clear.

In some countries the private sector is a more viable provider of the services than the government. In Zaire, for example, A.I.D. is working with private mission hospitals to test alternative financing schemes in the PRICOR project mentioned earlier.

For its part, A.I.D. has also tried to promote consideration by governments that both the public and private parts of the health sector could be considered together in planning for health and that both have aspects that could help or hinder the achievement of national health goals. In the Latin America region one form this concern has taken is conferences with high-level policy-makers in Jamaica and LDCs of the Eastern Caribbean. In Bolivia, cooperatives are being considered as an alternative to public sector delivery of health services. Alternative financing schemes will be tested there in urban and rural cooperatives in a PRICOR project.

For the Near East, private sector representatives, A.I.D., and government officials met in Burgenstock, Switzerland last year to discuss cooperation in health. Many good ideas emerged for public-private sector cooperation. A.I.D. is putting some money into this process as a way to encourage private sector organizations and other donors to contribute in order to establish an organization that would engage policy makers in health financing discussions and initiate feasibility studies of particular public-private ventures. Production of supplies and equipment for health needs and financing, including HMOs, were some of the areas that were identified for possible projects.

6. Large-scale Financing Alternatives

A number of governments have expressed interest in mechanisms like HMOs and other prepayment capitation systems. This is one area of financing where the private sector receives more attention in the discussions. Plans to provide such information are being made for Morocco, the Philippines, Yemen, Tunisia, Turkey, Haiti, and several other countries in the Latin America and Caribbean region.

7. Financial Management

Two other financing areas that have received attention in A.I.D.'s work with countries are cost containment and fiscal management. The Latin America Bureau reports that in Costa Rica the government is receiving support from A.I.D. to introduce financial management procedures to collect revenues from employers and reduce inefficiencies. Hospital cost containment is the focus of technical assistance and projects in Dominica, Haiti, and Honduras.

CONCLUSIONS

In our dealings with LDC governments, A.I.D. has come to two realizations: one, that they are rather more interested in financing than many had thought, and two, that developing and implementing the financing alternatives that seem called for are turning out to be more difficult than we had originally believed. There are still serious gaps in our knowledge of the effects of various financing options on different segments of the population, how much governments and private sector are spending and for what in health, and so on.

Furthermore, in trying to respond to the interest shown by governments, A.I.D. is confronted with some other constraints that have to do more with our own organization. For example, the Health Officers Conference mentioned earlier addressed the fact that most of our health officers have limited knowledge and/or experience with health financing issues. This factor becomes a constraint on the extent to which they can have dialogue with government officials on these issues and on their ability to develop program activities in this area. At times, it may even be difficult for them to articulate what type of technical assistance may be needed due to this knowledge gap. In Washington also there is a relative dearth of expertise within the Agency that limits our ability to develop a comprehensive, coordinated approach to financing.

Nevertheless, it is clear from the examples that have been given that A.I.D. has gone ahead with numerous projects that deal with health financing issues throughout the world. Many of these projects have focused on cost recovery, rather than resource allocation in the health system as a whole or transfers of resources from curative to preventive services, which ironically, are our major programmatic thrust. Other support is going to research on financing and resource allocation issues, to case studies of financing mechanisms and to technical assistance for the purpose of informing governments about the issues and options. As A.I.D. learns more about health financing from all of these experiences, there will be opportunity to provide countries with increasingly more focused advice and sector support.

Some Current Activities in Health Financing Supported by A.I.D.

<u>Health Financing Concern/Strategy</u>	<u>PRICOR</u>	<u>Regional Bureaus (bilateral programs)</u>
Health expenditures and care-seeking behavior, utilization--surveys	Bolivia	Antigua St. Lucia Dominica St. Kitts Ecuador Jamaica Mali Peru Panama (demand & utilization)
Fiscal Management/Cost Containment		Costa Rica Dominica (hospital cost containment) Haiti Honduras (cost containment)
Analysis of Financing Issues, Sector Assessments	Senegal (Sine Saloum) Honduras Mali	Philippines (variety of studies) El Salvador (recurrent costs alternatives) Africa Bureau (review) Latin America & Caribbean (review) Morocco (HMOs) Colombia (case study) Peru (sector assessment) Egypt (sector assessment) Guyana (community financing)
User fees (fee-for-service, fee for illness, registration/inscription fees)	Benin Zaire	Senegal (Sine Saloum) CCCD Eastern Caribbean countries Honduras (hospital fees)
Revolving funds	Dominica (drugs) Thailand (drugs, mixed funds--drugs, PHC, nutrition, sanitation)	Haiti (drugs)
Drug Sales	Philippines	Senegal (Sine Saloum) Eastern Caribbean (regional drug project)

<u>Health Financing Concern/Strategy</u>	<u>PRICOR</u>	<u>Regional Bureaus</u> <u>(bilateral programs)</u>
Staff compensation	Haiti (analysis)	Senegal Niger (self-supporting VHWs) Mauritania (self-supporting VHWs) Lesotho Guatemala (analysis)
Private-sector focus		Zaire Jamaica Morocco Honduras Egypt Latin America/Caribbean Region Peru Burgenstock Initiative (Near East)
Mixed Financing Schemes	Liberia Bolivia Brazil	Dominican Republic Philippines
Prepayment capitation		Eastern Caribbean countries Haiti (operations research)
Health Insurance-private		Ecuador (through coops) Jamaica
Regional, national health insurance-studies		Jordan Dominican Republic Egypt Latin America/Caribbean Region
HMCs (interest in)		Philippines Morocco Turkey Tunisia Yemen Latin America/Caribbean Region
Reallocation (dialogue)		Honduras Peru

Summary of PRICOR*
Community Financing Projects

<u>Country</u>	<u>Types of Project Focus</u>
1. Benin	Testing fee-for-illness episode in a district with a demonstration PHC project. This scheme was chosen by community leaders as way to finance drug costs and CHW remuneration.
2. Bolivia	Self-financing of PHC - rural and urban cooperatives. First phase of data collection on health problems, services, needs, and expenditures has been done.
3. Brazil	Test financing scheme for PHC- urban slums. Community leaders, MOH officials, representatives of CPAIMC (a community service organization), and providers decided together on combinations of services in 9 alternative packages now being tested. Survey done in first phase of project also informed these decisions. Varying fees for the health services will be charged.
4. Dominica	Revolving drug fund to deal with drug availability and financing PHC- drugs purchased from district funds and later consumer cost-sharing. Restructured central procurement, storage, and distribution, and improved accounting and inventory control. Peripheral units will purchase from central unit and plan to charge consumers; revenues will be directed toward resupply.
5. Haiti	Structure of PHC services and fees to cover recurrent costs-rural areas. Allocation of work to volunteer CHWs, cost, mix of reward mechanisms with focus on MCH impact. Task allocation, cost, resources.

* PRICOR (Primary Health Care Operations Research) is funded by the Office of Health, AID/Washington and is being implemented by the Center for Human Services, University Research Corporation, Chevy Chase, Md.

6. Honduras Health expenditures, case studies of ongoing financing schemes, testing of financing schemes; through Ministry of Public Health and Social Assistance. Household survey on illness, care-seeking behavior, and health expenditures found willingness of people to assume at least some health costs and management of health services. Testing four alternatives now: set fees for service, payment for drugs, labor contributions for construction and maintenance, and community revolving fund run by a health committee.
7. India Case studies of health cooperatives.
8. Liberia Partial or complete community financing of PHC services, with attention to ability and willingness to pay, and testing of a financing alternative. Household baseline survey done in three villages. Community leaders in one village have chosen mix of drug sales, production-based prepayment, ad hoc assessments, and community labor (villagers will work on CHW's farm as part of CHW's salary payment by the village); an assessment of families will be used for initial capitalization.
9. Mali Develop alternatives for financing priority PHC services for government decision; analysis of cost data.
10. Philippines Communities identified their own various health needs and chose to finance local pharmacies and generating revenues from local sales taxes, primarily to capitalize project. Although village boticas have been operating successfully, community has not been receptive to idea of using profits from drug sales for preventive and promotive health activities. Project staff are now trying to develop separate village-based fund-raising for these health services.
11. Senegal Reviewed Sine-Saloum community financing for PHC focusing on operational problems associated with financing.
12. Thailand Revolving funds, community-financed, in villages focusing on nutrition surveillance, supplemental feeding, and household sanitation; will examine equity effects. Study of revolving funds found an astonishing number of small village-based funds. Some handled mostly drugs, while others were more diversified in assistance provided. Now testing various types of revolving funds.

13. Zaire

Service costs, health-seeking behavior, recovered costs, utilization of PHC services of community financing schemes. Baseline household health costs and health seeking behavior have been studied. Three alternative finance strategies will be tested: fee-for-illness episode, fee for visit, fixed fee for consultation with variable fee for drugs.

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