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GUIDELINES FOR IDENTIFYING AND IMPLEMENTING HEALTH CARE FINANCING ACTIVITIES

**Prepared as part of the Overview of Health Care Financing
in Latin America and the Caribbean 1982-1988 for
AID/LAC/DR/HN**

Resources for Child Health Project

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REACH



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FOREWORD

The Resources for Child Health (REACH) Project was initiated by the U.S. Agency for International Development (A.I.D.) to provide technical assistance to developing countries in the areas of immunization and health care financing (HCF). The overall goal of A.I.D. assistance in the health sector is to improve health status in developing countries through support of cost-effective interventions directed at the most needy populations -- poor mothers and children. A.I.D. health assistance is seen primarily as an investment in building developing countries' capacity to achieve and sustain improvements in health status. These gains are reflected by reductions in infant, child, and maternal mortality and morbidity.

Sustaining improvements in health status requires, in addition to direct program support, assistance for strengthening the national capacity to generate and manage resources more effectively. The provision of such support is the basis for A.I.D. involvement in health care financing, and its implementation, carried out by the Health Care Financing Group of John Snow, Inc., is a central focus of the REACH Project. The goal of this assistance is to increase the effective level of resources available for health in developing countries. To achieve this goal, A.I.D. implements, where appropriate, activities to increase the level and focus the direction of government commitment to health, mobilize increased revenues from users of health services and other non-governmental sources, and improve the efficiency with which available resources are utilized in both the public and the private sectors.

The difficult economic conditions faced by the region during this decade have made evident the need to review the health financing policies, and have given rise to an extensive policy dialogue among financing organizations, donors and host countries. These Guidelines provide a common framework of analysis for host countries as well as donors and international organizations, active in the field of health care financing in the region.

The Guidelines are designed to facilitate the identification of activities which could support the development of effective health care financing interventions. They start from the recognition that financing strategies do not represent objectives for the development process. Rather, they are vehicles for the achievement of development goals. In the health sector, financing initiatives need to be aimed at helping to improve health status by generating and influencing the use of resources in ways that promote the effectiveness of the health service delivery system.

The Guidelines describe the relationships that exist among the four major economic dimensions of the health system; resource mobilization, resource allocation, efficiency, and equity, and the various health care financing initiatives which might be considered to influence each of them. The presentation is designed to make the reader aware of the interactions among these dimensions and the positive and negative impacts associated with

each health care financing initiative. Recognizing the range of potential impacts associated with particular financing initiatives facilitates the identification of health care financing strategies which are most likely to reinforce improvements in the effectiveness of health services.

The Guidelines further suggest means for USAID Missions to identify developing health care financing initiatives in the country as well as other players influencing the health care financing environment. Knowing that every setting is unique, the goal of the Guidelines is to facilitate the implementation of health care financing activities in Missions where such efforts can contribute to a productive policy dialogue directed at enhancing the resource base for primary health services through improved health care financing.

The REACH Project invites comments on all of our publications and welcomes the opportunity to continue our collaboration with interested colleagues through the widest possible dissemination and discussion of REACH materials.

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INTRODUCTION

Public health and primary care have never been so well endowed as now with the technologies to save lives and strengthen the health of families. These include oral rehydration, therapy, immunization, essential (and effective) drugs, methods of family planning and extraordinarily rich knowledge about management, communications, and mobilization. Paradoxically, however, never have public health and primary care been so constrained by economic and political instability. As part of the effort to support the process of economic development, international donors - preeminently AID - are doing much to both advance these technologies and support their delivery to developing countries. Nevertheless, development is ultimately defined by the degree of self-sufficiency a country has to continue to provide adequate levels of standards of living for its population, that is sustainability.

Health care financing (HCF) is one of several spheres of work that can address the issue of sustainability (political will, constituency development, management, and training are among others) and comprises a large set of ideas, activities and strategies. Since addressing the issues of financing the provision of health services also requires dealing with institutional arrangements, political realities, organizational issues, and expectations, all substantial activities in HCF require policy dialogue and careful scientific analysis within a commonly understood framework.

This document, therefore, proposes such a framework - presented in the form of guidelines - to assist USAID Health, Population and Nutrition Officers in the process of identifying health care financing activities that have the potential to lead to a fruitful policy dialogue with host countries.

The guidelines are part of an overview of HCF in the Latin American and Caribbean (LAC) Region during the period 1982-1988. This overview was undertaken by the REACH project in response to a request from AID/LAC/DR/HN. Two previous documents were developed as components of the overview. The first presents an annotated compilation of HCF activities in the LAC

Region during the period under consideration, while the second contains three case descriptions of the AID experience in the field of HCF in Bolivia, Guatemala, and the Regional Development Office in the Caribbean (RDO/C).

The guidelines have been developed based on the experience gained during the completion of the first two components of the overview, as well as from worldwide REACH Project experience in HCF. The purpose of these guidelines is to provide a frame of reference for assessing HCF opportunities and to suggest areas for developing HCF activities within the LAC Region.

The guidelines are presented in the form of defined ordered elements to nourish the dialogue of health offices and to aid in the task of identifying potential HCF activities. The first chapter contains the goals of the guidelines, the second presents the linkages between the goals of development and HCF, the third is devoted to the goals of HCF interventions, the fourth presents the choices that countries can consider for HCF interventions, and finally the fifth chapter presents a proposal for selecting Missions' activities and developing an HCF policy agenda.

I. THE OBJECTIVES OF THE GUIDELINES

These Guidelines are designed to assist USAID Missions in the identification of HCF activities that can support a learning process and feed the policy dialogue **prior** to the implementation of policies. The lessons presented in these reduced cases are intended to highlight the **potential** negative results that are likely to occur when appropriate analysis is not undertaken prior to the implementation of a HCF intervention. These scenarios are not based on actual evaluations of AID supported projects, but have been developed merely for demonstration and discussion purposes.

SOME LESSONS FROM EXPERIENCE

Case 1. In Country X health indicators - and particularly those related to children - show wide disparity among regions. It is known that the Region Y has the worst health status and has an infant mortality rate two times higher than the national average. Thus, every international donor targets the provision of health services in this Region. A donor concerned with the financing of health services decides to start a pilot project in primary health care financed through a user fee system. Since its target population is Region Y, the project is located in this Region and is used as a demonstration experience.

When an evaluation was carried out, all involved realized that while the user fee scheme had been promoted among the poorest group of population, expensive hospital care was still provided free of charge in the capital city. Even though it was proven that poor populations had been able to pay, no increase in coverage of primary health care had been noticed. Coverage may have in fact decreased since many mothers who were in the process of acculturation to modern medicine went back with their children to the traditional health providers, who would charge a similar or lower price for a service with which they were familiar.

Case 2. Following the "common notion" that the private sector is more efficient than the public sector, this

Ministry of Health (MOH) decided to divest "a package" of support services (laundry, cleaning and food services) from public hospitals to the private sector. This measure required the dismissal of a number of public employees, some of whom were hired by the private company contracted to provide the services.

An ex-post evaluation showed that due to the characteristics of the services (scale and production process), the MOH was saving money in services A and B, while service C became more expensive when contracted out (as compared to the service being provided by hospital personnel). At the same time, the Ministry of Labor had to negotiate a compensation bonus with the personnel dismissed from their jobs.

Case 3. Concerned with the issue of equity (access to health services) and the reported inefficiencies of the social security system, a new government passed a law that entitled all of the uncovered population to receive health care from the social security system.

An economic assessment undertaken a year after the law had been passed showed that the social security system was not only unable to accommodate the new population but that it faced a number of operational problems in addressing the needs of the population already within the system. Those problems needed to be solved in order to make the social security self-financing before increasing coverage.

Improving health and the access to health services is a central component of the development process. For USAID, support for improved health has been a significant priority. However, focussing on service delivery has not addressed more fundamental problems of:

- o System Organization
- o Resource Allocation
- o Sustainability of Achievements in Improved Health

In order to address these issues, the financial and economic dimensions of the service delivery system need to be considered as part of the health effort. HCF activities are to be considered as tools which can support or limit the Missions' ability to sustainably improve child survival and the overall health status of a population.

As a result, USAID Missions are exploring the potential for developing health care financing activities to complement and support national plans and other Mission initiatives to improve health. These guidelines have been designed to help identify areas where HCF activities are possible and potentially useful, and the steps that might be taken to initiate such activities.

OBJECTIVES OF THESE GUIDELINES

To assist Missions to identify HCF activities that:

1. Support Mission goals for development
2. Are feasible within the country and Mission context
3. Could be implemented within Mission resources and areas of operation.

II. DEVELOPMENT GOALS AND HEALTH CARE FINANCING

A. Development = Growth + Equitable Distribution

The fundamental goal of all USAID activities is to provide support for a sustained process of development, demonstrated by:

1. Economic growth, and
2. Improved distribution of the benefits of economic growth.

Improving health is one element of this process, a proven means of moving from economic growth to economic development. Thus, activities in the health sector represent **investment** in both of these dimensions of policy: growth and distribution.

AID commitment to support improved access to health care services reflects a recognition that economic growth requires a healthy labor force and a population of children sufficiently nourished and free from illness to respond to education in ways that can ensure the continued development of the human resources necessary to sustain the development effort. This commitment to health also reflects a shared commitment to "health for all" which makes widespread access to care a measure of the benefits of development as well as an input into the process.

B. AID HEALTH DEVELOPMENT EMPHASIS

The health activities of AID within countries reflect three major **directions of action**:

1. Promotion of cost-effective interventions
2. Strengthening of country capacity to achieve and sustain the interventions, and

3. Promotion of political and community support for public health priorities.

USAID has focused its health activities within these directions of action, and has developed strategies for interventions under each of them (see box below).

AID STRATEGIES FOR IMPROVING HEALTH	
DIRECTION OF ACTION	STRATEGIES/AREAS
1. Emphasis on Cost-Effective Interventions	a) Child Survival b) Primary Health Care
2. Strengthening Country Capacity	a) Human Resources b) Institutional Development
3. Supporting Public Health Priorities	a) Policy Dialogue b) Resource Support c) Social Mobilization

C. THE ROLE OF HEALTH CARE FINANCING INTERVENTIONS

The severe economic pressures of the decade of the 1980's in the LAC Region have made improvements in health status more difficult to achieve and sustain. Thus, the growing emphasis on sustainable development has been accompanied by increasing interest in aspects of the financing of health care. This, in turn, has generated new challenges for the health activities of the Missions.

Under these circumstances, the role of HCF interventions is to:

1. Identify the major resource constraints to the achievement of selected health and development goals.

2. Identify activities which have the potential to address those constraints.

Health care financing activities are not to be considered as ends in themselves, but as tools to help achieve and sustain the benefits from development. Furthermore, we need to think of health care financing in the larger framework of **economic dimensions**. The next section sets the goals of HCF interventions within the framework of such dimensions.

III. THE GOALS OF HEALTH CARE FINANCING INTERVENTIONS

As noted in the Health Financing Guidelines issued by A.I.D. in July 1986, "appropriate health financing initiatives can **help** (emphasis added) to free otherwise committed resources, leverage new resources, and more efficiently allocate scarce existing resources toward support of cost-effective programs...that will lead to significant morbidity and mortality reductions." Thus, health care financing interventions are expected to:

1. Support health promotion and improvement, and
2. Foster a sustained development process, by making more resources **effectively available** to support health promoting activities.

A. THE ECONOMIC DIMENSIONS OF FINANCING INTERVENTIONS

Health care financing interventions include those designed to **generate** additional resources as well as those that **improve** the way new and existing resources are used. We may list these HCF initiatives under four economic dimensions of the health care delivery system:

1. Resource mobilization
2. Resource allocation
3. Efficiency of production
4. Equity of distribution of benefits

While not having sufficient resources is a fundamental problem, and one that is usually the main focus of development projects, simply increasing the resources devoted to health activities will not automatically improve the system or necessarily generate additional services; in fact it may exacerbate inefficiencies in

the system. Therefore, much of the framework presented here necessarily deals with the last three dimensions.

1. Resource Mobilization:

The growing attention to the development of social areas has clearly demonstrated that existing resources are insufficient to respond to the target population's needs. Yet considerable differences exist among countries, even among poor countries, in the absolute and relative amounts of resources currently devoted to the production and delivery of health care.

While there is no correct amount, or per capita expenditure level, health care expenditures compete with all other areas of resource use in both the public and the private settings. Initiatives to increase total resources for health are usually directed at improving the success of health in this general competition.

2. Resource Allocation:

Resources in the health sector are directed toward a wide range of services. In terms of impact on health, not all of these services are equally productive. Many countries devote the largest portion of their (public and private) health resources to costly forms of curative care that may not advance health status overall, nor be accessible to the majority of the population.

Changing the allocation of resources toward greater commitment to child health and primary and preventive services -- the most cost-effective interventions -- is a goal of USAID health policy.

3. Efficiency of Production:

Poor operating efficiency in the health sector is a problem in almost every developing country. In this regard, three points should be highlighted when designing HCF interventions:

- a. Adding resources to an inefficient system without improving the process of production offers little promise for significantly improving health.
- b. Imbalances in the composition of resources leads to a level of output that is constrained by the most limited resources (e.g. supplies and drugs). As a consequence, the relatively less limited resources remain underutilized (e.g. x-ray equipment with no film).
- c. Although many political and personal incentives exist within the system to perpetuate poor use of resources, HCF arrangements can help modify these incentives to influence the use of resources and improve efficiency.

4. Equity of Distribution:

Many countries in the LAC region suffer from significant problems of income maldistribution that manifest themselves, as well, in the maldistribution of access to health services. Some health care financing initiatives are designed to generate improvements in equity by:

- a. providing alternatives for financing service delivery for those without access,
- b. transferring part of the financial burden for provision of health services to those more able to pay,
- c. supporting preventive and primary care priorities for the service delivery system.

B. ASSESSING HEALTH CARE FINANCING INTERVENTIONS

The experience of the three years since the **AID Health Financing Guidelines** were issued has validated the importance of these four economic dimensions in influencing the performance of the health care delivery system. HCF activities undertaken by USAID have the potential to influence these characteristics. Missions can help countries to shape a HCF strategy that takes into account the expected results of each financing initiative and considers the dilemmas and trade-offs they present (for example resource mobilization vs. equity). Through activities like baseline studies, research, direct technical support and demonstration or pilot projects. USAID Missions can help the governments coordinate their HCF initiatives so that they form a coherent strategy rather than a series of interventions that may have conflicting results.

The next section specifies the **possible** initiatives within each of the economic dimensions. The selection of an **appropriate** set of initiatives will depend on the particular environment within which they will be implemented. A more extensive discussion of these issues is presented in section V.

IV. CHOICES FOR HEALTH CARE FINANCING INITIATIVES

The ultimate goal of HCF initiatives is to identify and support the implementation of interventions which:

1. Promote resource mobilization
2. Improve resource allocation
3. Foster efficiency of production
4. Facilitate equity in access to health services

AREAS FOR HEALTH CARE FINANCING INTERVENTIONS	
AREA	GOAL
RESOURCE MOBILIZATION	Increasing the total resources devoted to the production and delivery of health services.
RESOURCE ALLOCATION	increasing the proportion of health resources devoted to primary and preventive health services.
EFFICIENCY OF PRODUCTION	Increasing the amount of services produced from resources devoted to the production and delivery of health services.
EQUITY OF DISTRIBUTION	Reducing the difference among population groups in access to and utilization of health services.

Within each HCF dimension we divide the initiatives among those that are to be developed inside the public sector and those that are to be undertaken in collaboration with the private sector.

A. RESOURCE MOBILIZATION

The starting point for much of the current discussion of health care financing is the recognition that **existing resources are not sufficient** to achieve health care goals.

1. PUBLIC SECTOR INITIATIVES

Initiatives to increase health resources in the public sector focus on one of three sources of revenue:

- a. General taxes
- b. Social security/earmarked taxes, and
- c. nontax from user fees.

a. General Taxes

For most AID assisted countries, **increasing the share of general tax revenues devoted to health** is a difficult task and cannot be addressed outside of the general macroeconomic conditions of the country.

b. Social Security/Earmarked Taxes

The declining employment levels and real wages in the LAC Region may limit the ability to expand **social security/national insurance schemes** at the current time, but there is growing activity in the region and the potential of this area needs to be considered. In particular, the cost effectiveness of the addition of benefits for dependants and provision of child survival and family planning interventions should be analyzed.

The move toward **decentralization** of the allocative decisions regarding funding for public health services also has the potential for increasing resources for health as health services may receive a higher priority at the community level.

c. Nontax User Fees

The most important initiative for expanding public sector resources for health is the institution of **user fees** by public providers. It is possible to generate significant additional revenues from user fees; however, the net result will depend on how such an effort is implemented and the alternatives for services that exist. Two issues that need to be considered when designing user fees initiatives are the following:

- o Simply initiating fees without making changes in the quality of services may not generate significant additional revenue.
- o Recent experience in the LAC region demonstrates that initiating user fees without addressing the management and incentive issues may seriously limit the effectiveness of the program.

d. Revolving Drug Funds

Although a form of user fee initiative, revolving drug funds have certain additional characteristics:

- o A revolving drug fund essentially sets up a community based drug distribution effort which provides and/or receives resources to purchase an initial stock of drugs. Community members purchase drugs from this stock and the user fees are utilized to replenish the supply.
- o The advantages of this financing mechanism are that it permits bulk purchasing and it may provide opportunities for serving equity goals through some cross-subsidization within the community.

- o To date, most revolving drug funds focus on generating replacement costs, with other sponsors of the program subsidizing elements such as central purchasing and distribution costs, foreign exchange requirements, and training of management personnel.
- o Revolving drug funds focus on quality drugs, those truly essential and thus incorporate significant components of training, health education and evaluation.
- o The emphasis on drugs reflects both their importance in the overall costs of care, particularly ambulatory care, and the evidence that many families already pay significant amounts of income to purchase drugs.

2. PRIVATE SECTOR INITIATIVES

The major emphases of private sector development is on **increasing incentives for efficiency and mobilizing additional resources** for health while placing less direct pressure on public resources.

Efforts to encourage the development of **private sector expansion of services** into under-served areas and new capital formation have the potential to stimulate the flow of resources into the sector by drawing on users' resources more effectively.

The development of **private insurance/prepayment mechanisms** can also facilitate the mobilization of resources for health. By providing an alternative vehicle for "saving for health" and spreading risks, insurance mechanisms have the potential to increase the overall resources for delivering health services.

B. RESOURCE ALLOCATION

A primary goal of resource allocation in the health system is the expansion of coverage for the most cost-effective services, particularly primary health and preventive services.

Given existing resource constraints, the most cost-effective strategy for meeting health goals is in emphasizing services for high-risk populations where interventions produce the greatest improvement in health status. Nevertheless, most USAID Missions confront health care delivery systems in which the greatest part of all resources, public and private, are spent on curative, hospital-based services.

Strengthening public support for primary and preventive services may require, at the same time, initiatives to expand the resource base of hospitals, coupled with initiatives to assure the appropriate reallocation of the "freed" resources.

1. PUBLIC SECTOR INITIATIVES

Public sector initiatives to improve resource allocation need to be directed toward two goals:

- a. Reducing the hospital's claim on public resources, and
- b. Increasing the priority given to primary and preventive services in the public resource allocation process.

Without addressing the fundamental issue of the hospital's claim to the public health budget, no real reallocation of country resources is likely to be achieved. Initiatives in this area take one of three forms:

- a. Improvements in hospital efficiency,
- b. Separation of the hospital from the public health budget, and
- c. Generation of new sources of non-public revenue.

The target is the development of alternative sources of revenue which can substitute for public funds, rather than providing additional resources to be absorbed.

In regard to redirection of public funds, **user fees** can influence a more appropriate allocation of resources by generating **alternative revenue sources** for the hospital/curative services and modifying **patterns of utilization** through changes in the relative prices to the users of different kinds of services.

To be effective, the imposition of user fees must be connected with a strategy that:

- a. Reallocates resources currently directed at hospital services toward non-hospital services, and
- b. Limits the hospital's continuing claim on general revenue resources.

User fees have the ability to modify patterns of utilization. The desire, in many countries, to limit the application of user fees to ambulatory services, may result in a misallocation of resources. This limitation provides a price structure that makes it more costly to the user to receive services outside of the hospital and therefore encourages greater use of free hospitals which are the more costly components of the health system.

2. PRIVATE SECTOR INITIATIVES

The interest in resource allocation is directed at increasing the share of public resources devoted to primary and preventive services. The accomplishment of this goal will depend on the ability to transfer a greater responsibility for curative services to the private sector. Major initiatives in this area focus on:

- a. Creating incentives for the expansion of private insurance and prepayment structures, and
- b. Changes in rules to allow greater public/private collaboration in provision of health services.

From the user's standpoint, the expansion of insurance and prepayment mechanisms provides a basis for reducing the financial uncertainty often associated with the purchase of private health care services.

For the providers, insurance and prepayment mechanisms serve to strengthen demand and to assure a potential market for services. As a result, increases in private investment in health services are stimulated.

Private insurance programs can offer a wider set of choices for covered services and a wider variety of risk-sharing alternatives. By stabilizing the financial risks, dependency on public provision and/or charity for serious illnesses can be reduced for many users.

C. EFFICIENCY OF PRODUCTION

Efficiency refers to the effectiveness with which resources are converted into output. A more efficient producer would use fewer resources to produce the same output or would produce more output from the same resources.

While efficiency **per se** is not a goal for the health care system, it is a necessary condition for the achievement of the goals of improved health status and child survival and is central to a process of sustained development. No effort to improve health care financing can have a significant impact if it does not directly address the efficiency with which health services are produced and distributed.

1. PUBLIC SECTOR INITIATIVES

In general, all efficiency improving initiatives focus on at least one of two major goals:

- a. Creating the incentives for efficient production, and
- b. Strengthening the management capacity to achieve improved efficiency

For public providers, there is little linkage between operating performance and the budgetary resources available to produce health services. This reality serves to obscure the link between efficiency and other operating goals. In addition, decision-makers are constrained in their ability to improve efficiency by public sector budget procedures, chronically inadequate or sporadically available resources, and public employment regulations which restrict the ability to utilize human resources effectively.

2. PRIVATE SECTOR INITIATIVES

In the private sector, the continued operation of health providers is more closely linked to economic performance. For profit-making private providers, incentives for efficiency are already operational. For other private providers (e.g. charitable organizations or NGO's), equity and resource allocation often present higher priorities, with efficiency concerns sometimes limited only to the requirements for economic survival.

Divestiture may be part of a set of health care financing initiatives designed to shift the form of public responsibility from provision of services to payment for services. Under such arrangements, private firms take on the responsibility for delivering support services formerly produced within the public institutions.

The goal of divesting or “contracting out” support services is to produce them more efficiently **and** to have some of the cost savings accrue to the providing public institution.

D. EQUITY

Extension of the distribution of the benefits of economic growth, as expressed by adequate access of the entire population to services devoted to meeting basic human needs, is the attribute that transforms a process of economic growth into one of economic development. Health is a key component of the set of services that helps improve the standards of living of the more vulnerable groups: mothers, children, and the poor. Primary health care services have been proven to be the ones that produce the most significant improvements in health status within a given resource constraint. Thus, these interventions are recognized as the most cost-effective.

Equity considerations are crucial for a health system that aims to help achieve a sustained process of development. Every HCF initiative has equity impacts. The equity implications must be properly considered in the assessment of every health care financing initiative and should feed back into the design of HCF strategies in order to ensure that resources devoted to providing health services are equitably distributed within the target population.

V. SELECTING MISSION HCF ACTIVITIES

The following section describes in detail some of the HCF initiatives that can be discussed with host governments and the activities that Missions may undertake in order to support the implementation of those initiatives. These activities are meant to support policy dialogue in the design of an HCF strategy.

A. ASSESSING THE ENVIRONMENT

The issue of financing the provision of health care has become a concern of every international donor and financial organization. Thus, in almost every country there is an ongoing dialogue where governments' priorities and donors' views and proposals are assessed. HCF strategies will be shaped by this dialogue. It is important that USAID Missions get involved at an early stage in order to ensure that strategies are the outcome of a collaborative effort where each of the participants' views are considered; where all of the trade-offs, in terms of potential for achieving health and financial goals, are properly scrutinized; and the efforts and philosophies of the several donors are coordinated.

Overall, the choice of an appropriate activity should reflect:

1. Specific Mission priorities,
2. Country receptivity (both within the MOH and in other ministries),
3. Other actors and initiatives in the policy setting, particularly other financing or service delivery initiatives.

1. Specific Mission Priorities

Due to their extensive in-country involvement in the health sector, USAID Missions have the potential to play a role as catalytic agent in the process of setting common priorities and designing strategies. Nevertheless, policy decisions are often made outside the boundaries of the health sector. Thus each Mission needs to assess within its priorities the prospect of raising the subject of HCF at levels where macroeconomic decisions and policies that will affect the health sector are discussed and designed.

The USAID Mission's knowledge about the macroeconomic and political environment that surrounds and constrains access to health services is a valuable input in discussions about HCF strategies and initiatives to implement them. It is important to reiterate that all of these activities need to be integrated into the ongoing policy dialogue efforts of the Mission.

2. Country Receptivity

In considering the receptivity of country officials to USAID proposals, it is important to identify the appropriate decision-makers. In the area of health care financing, many of the critical players in effecting any change in policy are outside of the Ministry of Health and, often, outside of the usual contacts for Mission HPN personnel. Because health care financing issues are often linked to more general macroeconomic issues, activities in this area will often best be integrated with the Mission's overall structural adjustment efforts, and the locus of policy dialogue needs to involve decision-makers with responsibilities in these areas.

Although each country is different, health care financing initiatives will typically link to some or all of the following components of government:

- a. Ministry of Finance
- b. Directorate for Social Security
- c. Ministry of Planning
- d. Secretariat for Social Affairs
- e. Treasury
- f. Tax Authorities
- g. Central Bank
- h. Ministry of Interior

The general process of screening potential health care financing initiatives will identify the appropriate participants in the policy dialogue.

3. Other Actors and Initiatives

USAID Missions in most countries already coordinate well with the donors which provide support for the direct provision of health services such as PAHO, UNICEF and PVOs, and international organizations involved in the field of HCF such as the World Bank, the Inter-American Development Bank and the European Economic Community. Field missions from these organizations often visit USAID offices; it is suggested that Missions follow up on their proposals and develop more systematic knowledge about their aide memoires, reports, and bases for negotiations with the host governments.

B. SELECTING AND DEVELOPING HCF ACTIVITIES AT THE MISSION LEVEL

- 1. Linking Initiatives to Goals.** Identifying financing initiatives which have the potential to support health improving activities by generating the "right" incentives and opportunities for the creation and redirection of financial resources in the health sector. This step is addressed in sections III and IV.

- 2. Choosing the Target Initiatives.** Determining which of these initiatives are the most promising for implementation in the country and supportive of USAID goals for balanced development. The discussion in section IV should allow the reader to identify a few possible target initiatives. While in some instances Missions may find that target initiatives are recommended or chosen before the earlier steps in this process have been completed, it is important to consider Mission priorities, assess country receptivity, identify other players and initiatives in HCF, and link initiatives to USAID goals before choosing target initiatives in order to avoid making inappropriate choices.

- 3. Identifying Specific Activities.** Specification of health care financing activities which can be implemented by the Mission and which support the development of the target initiative(s).

It is important to reassess the potential for new health care financing initiatives periodically. The changing economic environment offers new opportunities for policy dialogue within which HCF interventions can be initiated and in support of which Missions' activities can be developed.

C. SCREENING ACTIVITIES TO SUPPORT HCF INITIATIVES

This section has two objectives. The first is to facilitate the process of screening HCF interventions that are most commonly considered for implementation at the country level (step 2 above). The second objective is to assist USAID health officers in identifying and selecting the HCF activities that can be undertaken and sponsored by USAID Missions in order to support the implementation of interventions that may be identified as appropriate for the country (step 3 above).

The proposed screening process includes five components:

1. Identifying the **primary** economic dimensions which the initiative addresses (i.e. generating revenues or improving resource allocation).
2. Linking the initiative to other, secondary dimensions. For example, if the initiative primarily addresses revenue mobilization, what is its potential impact on efficiency or equity?
3. Identifying implementation issues which need to be considered or addressed to enhance the probability of success.
4. Specifying a set of activities for the Mission which correspond to the implementation issues identified in the preceding step.

5. Identifying complementary initiatives which will maximize the impact and sustainability of the initiative under consideration.

We chose four HCF initiatives as illustrations of the screening process: user fees for hospital care, divesting hospital support services, revolving drug funds and social security interventions. For each intervention we briefly assess the principal economic dimension being addressed and its likely impact on other dimensions. Then we list the issues to be considered in implementation of the initiative. Next we suggest typical activities that can be undertaken to support the initiative, with particular emphasis on analysis, documentation, design and demonstration. Where applicable, we note other initiatives which may complement those being undertaken.

INITIATIVE 1: USER FEES FOR HOSPITAL CARE

A. Primary Dimensions Addressed:

Resource Mobilization/Resource Allocation

The initiative of starting user fees for hospital care is expected to: a) generate increased revenues, b) release public funds presently committed to secondary care, and, c) reduce future demand on public funds. In turn, these resources can be reallocated toward more cost-effective health interventions in PHC.

B. Linkage to Other Dimensions:

Equity

As long as the final outcome is an increase in resources for the provision of PHC in urban and rural areas, this intervention will contribute to equity. This intervention will be highly recommended in settings where hospital care is provided free of charge, where hospital facilities are concentrated in urban areas, and where there are population groups not adequately covered by PHC.

Efficiency

A user fee schedule, as such, will not contribute towards an improvement in efficiency. However, the initiation of a cost recovery scheme may reinforce the need to plan and manage better. Efficiency may be influenced by the rules which specify where the captured funds are distributed.

C. Implementation Issues:

Like most HCF initiatives, user fees will have an impact on the financing side of the system as well as on the population's access to health care. To the degree that user fees decrease access, particularly among those most in need, basic measures need to be taken to ensure that the benefits of a cost recovery system are not outweighed by increasing inequities.

Some of the issues that need to be addressed are:

1. What are the prices to be charged?
 - Should the target be total cost or variable cost?
 - Should the patient pay for the current inefficiencies in the delivery of services? Or should prices be lower than observed cost in order to squeeze out the inefficiency component?
2. What is the expected impact on utilization of health services?
 - Is the hospital system presently being overutilized with activities that could be better and less expensively provided in health centers?
 - Or is the hospital underutilized because
 - 1) it was built over capacity, or
 - 2) it is not properly supplied and maintained (including personnel, supplies and drugs, and equipment)?
 - What is the "ability to pay" of present users of the system? (family income of patients)
3. What incentives will be built in to:
 - encourage efficient production of services?
 - encourage collection of fees?
 - transfer newly mobilized resources to PHC?
4. How will the system be monitored and evaluated?

5. What is the expected impact of the initiative on the poor? What measures can be taken to protect them?
 - Do the poor have access to hospital care at present?
 - Would a sliding scale system protect them?
 - Is there a "basic" hospital care package that should be granted to the poor?
6. What are the criteria to define and identify the poor?
 - Should this be done within the health sector?
 - Is it possible to use a common screening system to target every social program?

D. Activities that can be undertaken

1. Costing of hospital services
2. Analysis of present utilization of hospital services
3. A community health services survey to analyze the potential impact on utilization of health services
4. Strengthening of the managerial and financial capability of hospital administrators (training, management support systems)
5. Design of a monitoring and evaluation system
6. Development of a proposal about fee collection and resources management (operational aspects of fee collection and decision-making on expenditure of those resources)
7. Behavioral studies about peoples' attitudes to fees, hospital services versus primary care services, and other determinants of patterns of utilization

8. Promotion of an integrated initiative to identify poor families
9. Design a waiver system
10. Pilot/Demonstration project (e.g. finance setting up a user fees scheme in one selected hospital)

E. Complementary Initiatives

1. Promotion of insurance and prepayment systems to cover hospital care
2. Divesting hospital support services
3. Transferring specialty hospitals to the private sector
4. Decentralization of provision of health services by public providers. Decentralization of management and decision making include creation of hospital boards with decision making independent of the Ministry of Health
5. Expansion of employer responsibility/support for employee health care
6. Introduce policies/procedures for cost containment

INITIATIVE 2: DIVESTING HOSPITAL SUPPORT SERVICES

A. Primary Dimension Addressed:

Efficiency

By contracting support services from the private sector, it may be possible to reduce costs and improve service quality, and thus to use existing resources more efficiently. Divestiture initiatives can be considered for support services such as laundry, housekeeping, and food services.

When properly implemented, this type of initiative has a straightforward positive impact on efficiency by creating a financial incentive to produce the service at the lowest cost. The impact on the achievement of other goals will depend on the actual use of released resources. In the event that those funds are kept within the hospital system, the initiative would have an impact on the efficiency goal only.

B. Linkage to Other Dimensions:

Resource Allocation:

When released funds are reallocated to the provision of PHC, the initiative has a positive impact on the economic dimension of resource allocation. Otherwise the impact is neutral.

C. Implementation Issues:

The main issue of concern when implementing this initiative is related to the identification of an appropriate private firm that can provide the volume of services according to the specified quality. Another issue that is not technical but highly political is that divesting to the private sector creates unemployment for public employees previously performing these activities. In periods of economic crisis this problem may not be simply marginal and financial arrangements to compensate the unemployed need to be defined as part of the divestiture program.

Thus, some of the issues that need to be addressed are as follows:

1. Which services might feasibly be divested?
(technically and financially)
2. What is the expected savings in hospital recurrent costs if support services are divested?
3. Where are the geographical areas with a private sector that could potentially respond to a request?
The initiative could involve only those areas and may not be country-wide.
4. Is there any legislative constraint to divestiture?
5. Is this feasible from the viewpoint of labor legislation?
6. What would be an appropriate workers' compensation scheme that would keep the initiative profitable?
7. Is there any other public institution that should be involved in this initiative?

D. Activities that can be undertaken

1. Feasibility study on divestiture of support services to the private sector. Such a study would need to assess the potential value of divesting each of the services through an independent cost/benefit analysis. The purpose of a study of this kind is to identify the services that are financially and technically convenient to buy from private suppliers rather than to produce within the hospitals.
2. Assessment of private sector's capability to produce support services in different geographical areas (probably the main cities). The purpose of this assessment would be to identify the geographical areas in which the private sector would be prepared to respond to a request for proposal.

3. Identify the administrative reforms required to implement a divestiture process, particularly in reference to budget development and management of resources. The objective is to assess whether the present administrative procedure for handling the budget and financial resources will be appropriate to respond to the cash flow identified in the feasibility study.
4. Develop a proposal for a compensation system for workers dismissed as a consequence of the divestiture process. This should include the package of benefits and the mechanism for financing it.

E. Complementary Initiatives

1. Divesting lab services, emergency care and other departments involved in the direct provision of health services to the private sector.
2. Strengthen small businesses which are in the service industry sector.
3. Improve management and administrative operations in primary health care programs.

INITIATIVE 3: REVOLVING DRUG FUND

A. Primary Dimension Addressed:

Resource Mobilization

Revolving funds for the provision of drugs are seen as an intervention **par excellence** to achieve the goal of resource mobilization. In fact, such funds are extremely useful when the public sector does not have the flow of monies to cover free provision of medicines, or when there is no private sector willing to supply drugs. Through this mechanism, either the community or the regional health office is given an initial stock of medicines that can be sold to patients. The money collected is used to pay for replacements. In rural areas this may be the only source of drugs, while in urban areas the revolving fund may be an alternative to obtain medicines at a price lower than that charged by private pharmacies.

B. Linkage to Other Dimensions:

Resource Allocation

This initiative is not expected to have an important impact on the allocation of resources toward PHC. While some have argued that drug "sales" can make a profit which can support other community health services, revolving funds are generally initiated to fill a real current gap in the provision of drugs. To date, such programs have not generally released resources that would be reallocated towards PHC. Thus, such an initiative will be neutral with respect to the goal of resource allocation.

Efficiency

Efficiency is related to the process of production of health services. In general terms, the issue is to deliver the maximum of quality services at the minimum cost. Drugs are an important input

in the provision of effective health services; a lack of them makes the provision of health services quite ineffective. Thus, by making drugs available, revolving drug funds can have a significant impact in the economic dimension of efficiency.

Equity

The issue of equity has two dimensions of importance: equity with respect to other settings and equity within the group/ population served by the fund.

Although the initiative in itself can be neutral with regard to the achievement of equity, the outcome must be assessed in relation to alternative financing schemes within the system. In fact, revolving funds are generally directed towards rural populations that do not have access to drugs from the public sector. Requesting rural populations to pay for drugs through a revolving fund may reduce equity as long as urban populations with higher incomes receive drugs for free. On the other hand, the fund may contribute to filling the gap in the provision of drugs to rural areas. Such a fund may yield general improvement in equity.

Within the group served by the fund, however, the requirements for payment may generate inequities which need to be assessed and responded to in the implementation of the fund.

C. Implementation Issues:

The concerns about the implementation of revolving drug funds are usually related to administrative aspects and the questions to be solved are mainly operational.

Some of the questions are:

1. Which drugs will be purchased and who will decide?
2. Which is the most suitable organization to manage the fund?
3. Is it necessary to set up a new organization to administer the fund?

4. How can the problem of physical accessibility be handled?
5. How can managers cope with the scarcity of foreign exchange in the country? How can managers obtain the amount required to pay for replacement of drugs on an ongoing basis?
6. What administrative procedures need to be created in order to secure a proper supply of drugs?
7. How are misfeasance and malfeasance prevented?
8. What prices are to be charged to allow for replacement of medicines?
9. Is the population's ability to pay sufficient to generate the monies required to make the fund financially feasible?
10. How to respond to inability to pay?

D. Activities that can be undertaken:

1. Assessment of unsatisfied demand for drugs. Identification of a basic list that would have medicines that are not expensive but of good perceived quality, and medically effective. These drugs would be included in a revolving fund (based on frequency of prescription, price, and absence of less expensive alternative medicines).
2. Technical and financial feasibility study to set up a revolving drug fund. The study should include the following elements:

- o Identification of beneficiary population.
 - o Assessment of population's ability to pay.
 - o Estimation of administrative costs.
 - o Definition of administrative procedures in the implementation of the fund.
 - o Pricing policy, and sensitivity analysis for a range of different prices.
 - o Assessment of community organization capability to manage the fund.
3. Identification of PVO's or other community-based organizations most suitable to manage a revolving drug fund.
 4. Proposal to begin a pilot/demonstration project. The proposed location should be chosen based on the results of the feasibility study. Administrative and financial aspects need to be carefully designed.
 5. Provide financing to set up a pilot/demonstration project.

E. Complementary Initiatives

1. User fees for hospital care
2. User fees for drugs at urban public facilities
3. Implement drug treatment therapy protocols for most common outpatient and inpatient conditions

INITIATIVE 4: SOCIAL SECURITY INTERVENTIONS

A. Primary Dimension Addressed:

Resource mobilization/Resource allocation

A number of studies of social security in the LAC region have documented the belief that while the social security system in most countries is underfinanced, the cost-effectiveness ratio of the provision of health services could be greatly improved. Thus, several reforms have been suggested in the financial structure, administration, and the level of coverage. Initiatives in the area of social security can be complementary. Although it is not necessary to implement all the initiatives simultaneously, a good level of coordination is required in order to ensure that the system is moved in the desired direction.

Some of these interventions are as follows:

- o Improve the efficiency of the delivery of health services (such as divesting support services from hospitals to the private sector or improving the management of hospital resources).
- o Coordinate the provision of health services with the MOH.
- o Separate the management of income maintenance funds from the management of health services funds.
- o Change structure of financing (worker, employer, government)
- o Increase social security coverage. Give access to self-employed workers; increase the level of benefits to dependents.

B. Linkage to Other Dimensions:

Efficiency

This set of initiatives may have a significant positive impact on the level of efficiency in the social security system. Coordination with the MOH for the provision of health services has the potential to contribute greatly to the efficient use of resources. This initiative makes it possible to use public and social security facilities at higher capacity, thus reducing investment requirements. It can also reduce the unit cost per patient by spreading the fixed costs of each facility among a higher number of patients.

Equity

Initiatives aimed at increasing coverage may produce a more equitable distribution of health benefits. This requires that the target population for increasing coverage be carefully selected.

Reorganization in the management of funds, whereby resources devoted to income maintenance are separated from those devoted to the provision of health care, is seen as significant from the viewpoint of equity. In this way, the administration of funds may become more transparent and tracking of funds can be more accurate.

Changes in the structure of financing and expansion of coverage will also generate new equity impacts which need to be assessed as part of the implementation process.

C. Implementation Issues:

In the LAC Region changes in the social security systems are probably the most difficult reforms to implement. They tend to be highly sensitive politically, with the small proportion of population that is usually covered by social security regarding these benefits as "rights" that cannot be changed. Thus, the first issue becomes not a technical issue but one of reforms to be handled politically.

A number of technical issues also need to be addressed in order to prepare a proposal for social security reform. Thus, several assessments must be done to cover each one of the areas of concern:

1. What measures can be taken in order to improve efficiency in the delivery of health services?
2. In which geographical areas is it feasible to coordinate the provision of health services with the MOH?
 - o In small cities, is it more effective to have facilities owned and run by the social security system rather than to buy the services from the public or private sector?
 - o What are the prices that make these proposals financially feasible?
 - o Is there enough idle capacity in the public sector to cover the social security demand?
 - o How much is the social security currently spending in the provision of these services?
3. What would be an equitable structure of financing for the health fund and what would it be for income maintenance funds?
4. What would be the cost of increasing coverage,
 - o If increasing the size of population covered?
 - o If increasing the number of services provided to dependents?

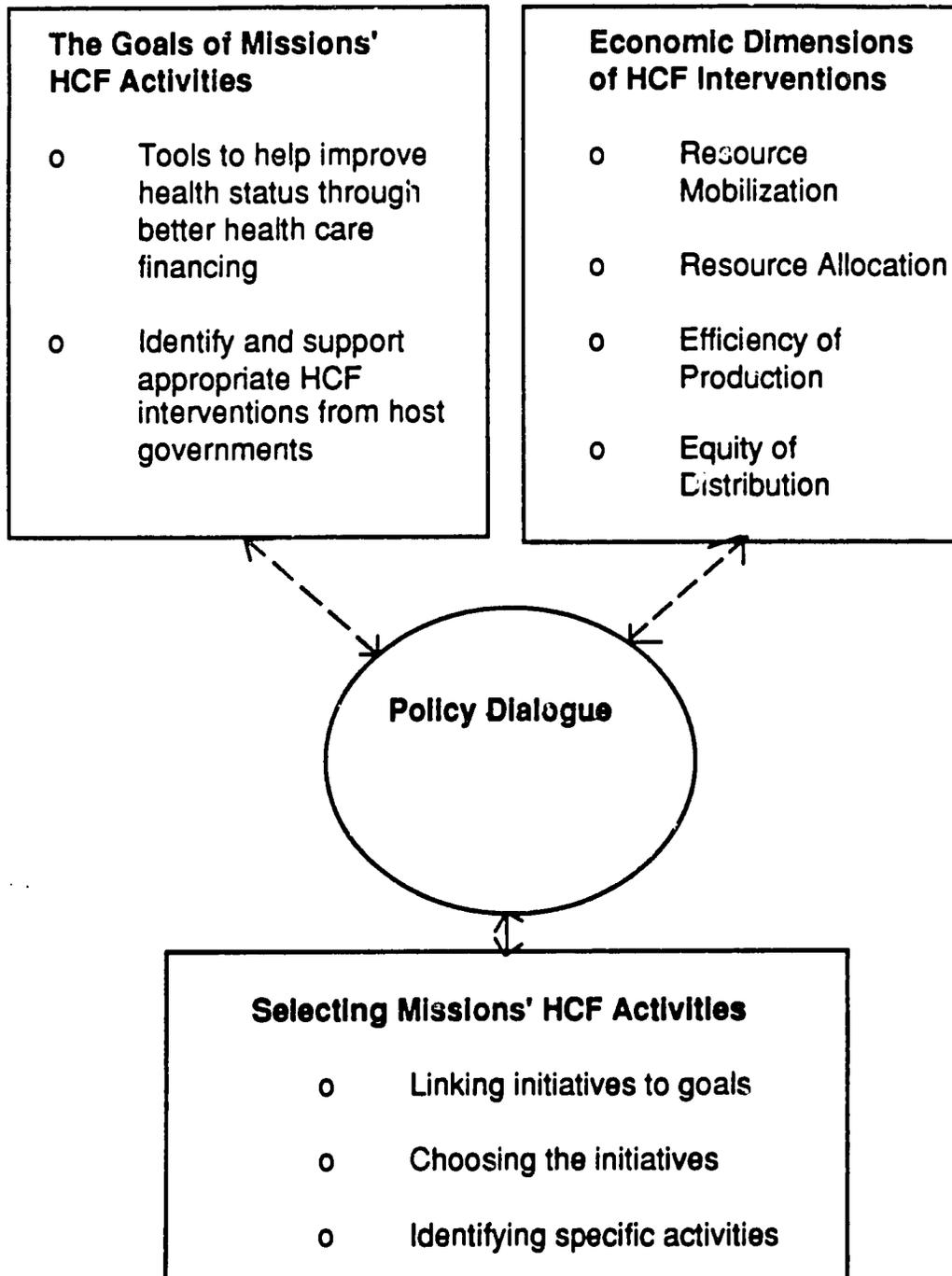
D. Activities that can be undertaken

1. Cost study on the provision of health services by the social security and by the MOH.
 - o Inpatient care
 - o Outpatient care
2. Assessment of public sector capacity to meet social security demand, and capacity of social security to meet public sector demand. This kind of study would shed light on the geographical areas and services in which it is sound to develop a program to coordinate activities with the MOH.
3. Feasibility study for increasing coverage.
 - o Design a proposal for increasing coverage that includes services to be provided, characteristics of dependents involved in the proposal, and criteria for selecting geographic areas if the proposal is not country-wide.
 - o Analysis of alternatives to increase coverage
 - o Cost estimation of the proposal.
 - o Alternatives to finance the proposal.

E. Complementary Initiatives

1. Promote participation of private sector insurance in the health sector
2. Decentralization of public provision of health services
3. Expand employer support for health insurance

**COMPONENTS IN THE IDENTIFICATION OF HCF ACTIVITIES
AT THE MISSION LEVEL**



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