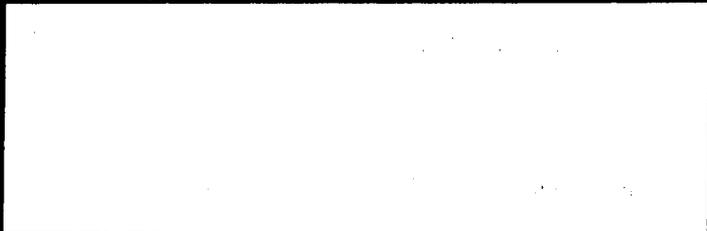
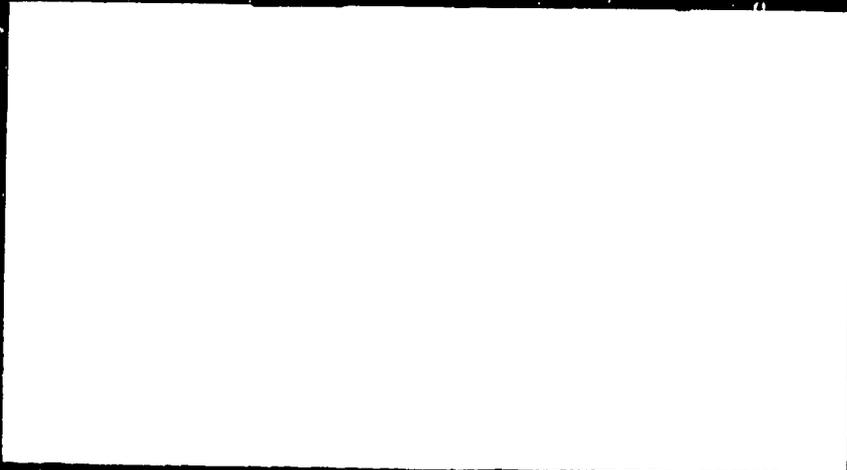


PW-ABG-978



PA-ABG-978

ISI 69732

**A STUDY OF COST RECOVERY OPTIONS  
FOR CHILD SURVIVAL PROGRAMS**

Country Profiles

## BENIN

### CURRENT A.I.D. HEALTH ACTIVITIES

Rural Water Project, now being renewed

### GOVERNMENT POLICIES

"Free" care/ User charges: Government appears fully committed to cost recovery schemes already being implemented.

Decentralization: Local retention of revenue has been authorized.

Pharmaceuticals: Cost recovery schemes based on sales of generic drugs. Benin is developing an essential drugs program.

### COST RECOVERY ACTIVITIES

Bamako Initiative: Following a successful PRICOR study in Pahou Commune, 36 non-governmental, bilateral and multilateral groups have attempted to replicate community-managed financing schemes, providing the best available model for the Bamako Initiative. Government also has replicated scheme in 300 of the country's 517 sub-districts. System is based on sale of generic drugs at about a 300% markup and is meant to cover all local primary health care costs. (Though shortfalls occur due to exemptions for the indigent and losses in the system, average recovery has been 250% of drug costs in last 2 years. 150% of drug cost goes for operating expenses.) Program emphasizes use of standardized treatment regimens to ensure quality of care.

District managers have been trained in planning, supervision, resource management, and evaluation. The president has authorized health service retention of community-generated revenues. Health workers receive small bonuses from community-generated funds based on the approval of community committees. Accumulation of unused funds has been a problem.

"The monitoring system has been collecting data on service utilization before and after the introduction of charges in February 1988. An examination of the average number of monthly visits per centre, based on data from 44 centres between 1987 and 1989, shows that overall utilization in 1988 doubled and increased a further 25 percent in 1989. Not only have curative visits increased, but so have pre-natal visits and the number of deliveries. This trend indicates that by revitalizing the system, with an emphasis on curative PHC, there appears to be an increase in the use of services for preventive care. . . Household surveys have been carried out in six areas covered by the EPI/PHC programme to determine levels of health care expenditures for different socio-economic groups and reasons for non-utilization of PHC services." (UNICEF, 1990)

System also monitors costs and revenues. "In 40 of the 44 centres (for the first six months of 1989), revenues have surpassed the levels needed for drug replenishment and local operating costs."

According to UNICEF (E/ICEF/1989/L.3), "Benin's experience in community financing is probably the most advanced to date, with a pricing system and the necessary mechanisms for the local management of drugs and finances securely in place."

## KEY INFORMANTS

Rudi Knippenberg

Lynne Miller-Franco (PRICOR)

## USEFUL LITERATURE

Alihonou E. 1987. "Report on Community Financing," PRICOR.

Alihonou. E. "L'utilisation du médicament essentiel comme base du financement communautaire - Une approche de la mise en oeuvre de la stratégie soins de santé primaires dans un pays à revenu faible."

Blakney, Richard B., Jennie I. Litvack, and Jonathan D. Quick, 1989. Financing Primary Health Care: Experiences in Pharmaceutical Cost Recovery, p. 25.

International Children's Centre, 1990. "The Bamako Initiative: Primary Health Care Experience", Special issue of Children in the Tropics.

Knippenberg, R. et al. 1987. "Implications of the Bamako Initiative - Community Financing for Sustainability of Primary Health Care in West Africa."

Knippenberg, R. et al. "Stratégies pour protéger la santé des groupes vulnérables dans des conditions de crise économique en Afrique de l'Ouest."

Mandi, Pierre-E., et al., 1988. Community Financing Experiences for Local Health Services in Africa. UNICEF Working Papers no. 2.

PRICOR, 1987. "Community Financing of PHC Services in the Pahou Health Development Project."

Projet Benino-Allemand des soins de santé primaire, 1988. "La Stratégie de l'Autofinancement des C.S.D."

"Reflexions sur l'Experience du Benin," Journal d'Information sur l'Initiative de Bamako, Vol. 1, No. 1.

United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)

## BURKINA-FASO

### CURRENT A.I.D. HEALTH ACTIVITIES

Save the Children: ORT, immunizations, growth monitoring, high risk birth management, malaria treatment, and vitamin A supplementation

New Family Health and Health Financing Project will include major sub-project for community pharmacies plus lab fees. Grant conditions include significant changes in government policies regarding local retention of revenue and legal status of pharmacies. See bibliography.

### GOVERNMENT POLICIES

"Free" care/ User charges: "Burkina Faso has a long history of experimentation with cost sharing at certain of its health facilities, via national legislation, the Tarification des Actes Medicaux. Fee for service experimentation began in the 1970s when hospitals, urban maternities, and medical centers began to charge for certain laboratory tests, consultations, and for hospitalization. . . . In a major revision, in 1984, a rather complicated system of personal exemptions from payment for services was outlined." (USAID) Recent decree calls for self-financing of two national hospitals and nine regional hospitals.

Private sector: Government regulations severely limit numbers, e.g., in Ougadougou, 9 doctor's clinics and 36 clinics run by nurses. Government regulates fees.

Decentralization: Revenues are not retained by the collecting facility but revert to treasury; treasury is then supposed to return most to MOH "caisse maladie." Boulgou study has received special exemption.

Pharmaceuticals: Burkina is developing an essential drugs program. No fixed prices for drugs sold at community level.

### COST RECOVERY ACTIVITIES

Bamako Initiative: Government has established management committee and undertaken preliminary studies on: drug consumption patterns, supply logistics, PHC financing in each province; and evaluation of existing community financing experience. UNICEF is supporting operations research on community financing mechanisms, including the management of community-generated funds; also helping to train depot managers in the management of funds; expects full-scale proposal by 1991.

USAID's Strengthening Health Planning Capacity Project in conjunction with the World Bank has conducted operations research on PHC financing in Boulgou Province since 1987. Study has established 10 community-managed revolving drug funds and instituted lab fees, and will be replicated in five provinces under new Family Health and Health Financing Project. (See bibliography for extended description.) All 10 have functioned for over 20 months with loss and wastage below 6%.

There are currently 65 community pharmacies in the five provinces of the new AID project, plus several hundred elsewhere. "Most were established during Burkina's Program Populaire de Developpement (early 1980s) and most are owned and operated

by either farmer cooperatives or the local politico-administrative structure (the High Commissioner, the Prefect, or the Comité de la Révolution). These pharmacies are entitled to purchase wholesale from officines at a 13% discount. Although some pharmacies have been able to generate enough revenue to cover the modest salaries of village pharmacists and to restock supplies, the majority have been severely decapitalized." (USAID)

"In addition to USAID and UNICEF/WHO, other donors have expressed interest in funding cost recovery activities: the Dutch government has expressed preliminary interest in undertaking cost recovery activities in Zoundweogo Province along the general lines of the Bamako Initiative; the United Nations Equipment Fund has discussed funding cost recovery activities in Bam Province; and the French aid and cooperation agency (FAC) and the African Development Bank are including cost recovery considerations in complementary projects to support the national hospital in Bobo-Dioulasso." (USAID) GTZ will also start cost recovery in 8 provinces.

### **KEY INFORMANTS**

Abraham Bekele

### **USEFUL LITERATURE**

Bekele, Abraham. "Gestion Financière."

Bekele, Abraham. "Organisation Communautaire: Participation pour le Recouvrement des Coûts."

Campagne, Pierre, 1989. "Technical Conference on Community Financing to Strengthen Local Health Services in Francophone Africa," Synthesis Report of Meeting Organized by UNICEF in Cooperation with the French Committee for UNICEF.

de Champeaux, Antoine, and Bruno-Jacques Martin, nd. "Comparative Cost-effectiveness Analysis of Two Vaccinal Strategies in Burkina Faso."

United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)

USAID, 1990. Project Paper for Burkina Faso Family Health and Health Financing Project.

## **CAMEROON**

### **CURRENT A.I.D. HEALTH ACTIVITIES**

Maternal Child Health/Child Survival: Harvard, Drew, AED, support ORT, immunizations, and nutrition in Adamaoua Province

### **GOVERNMENT POLICIES**

### **COST RECOVERY ACTIVITIES**

Overview: "Programmes supported by GTZ, USAID, the Government of Belgium, and NGOs have provided experience in cost recovery schemes." (UNICEF, 1990)

Bamako Initiative: "Activities in 1990 will concentrate on PHC policy development, including the analysis of current community-based services and an evaluation of the various experiences in community financing. Future analyses will need to focus on the development of a national essential drugs policy and a policy for decentralized management." (UNICEF, 1990)

### **KEY INFORMANTS**

Eckhard Kleinau, HIID

## **CENTRAL AFRICAN REPUBLIC**

### **CURRENT A.I.D. HEALTH ACTIVITIES**

CCCD (including health care financing component)

### **GOVERNMENT POLICIES**

"Free" care/ User charges: 1989 legislation authorized user fees for government health services.

Decentralization: Practitioners allowed to keep a part of fees but must share them with the state.

### **COST RECOVERY ACTIVITIES**

Overview: Financing discussions underway since 1986 culminated in fee policy of 1989. A multi-sectoral seminar on health care financing was held in February 1989 to move toward a national consensus. The MOH is being reorganized to include a financing unit, and the MOH has requested funds to train officers for planning implementation strategies.

Bamako Initiative: Planning has begun for Bamako Initiative.

### **KEY INFORMANTS**

### **USEFUL LITERATURE**

"Loi No. 89.003 Fixant les Principes Généraux Rélatifs à la Santé Publique en République Centrafricaine, 1989"

## CHAD

### CURRENT A.I.D. HEALTH ACTIVITIES

Child Survival Project in Moyen-Chari Province: ORT, vitamin A, high risk birth management

### GOVERNMENT POLICIES

"Free" care/ User charges: Decree n. 074/MSP of Feb. 25, 1989 set up committee to devise cost recovery system for Chad. "The Committee, which is chaired by the Director General of the Ministry of Public Health and whose rapporteur is the Director of Pharmacies and Medical Analysis Laboratories, has 16 members, including representatives of WHO, UNICEF, USAID, Médecins sans Frontières, and the Swiss Institute for Development." Tasks include:

- identification of the problems likely to be solved by setting up a system for recovery of health costs, and identification of priorities
- formulation of the aims of a system for recovery of health costs
- definition of strategies for the setting-up of the system
- proposal of a plan for implementation and monitoring of the system."

### COST RECOVERY ACTIVITIES

Government undertook pilot revolving drug fund in the town of Fianga, province of Mayo-Kebbi. (See Carrin reference below and summary in Blakney, p. 26.) Other efforts have occurred in Bokoro (Chari-Baguirm Division), Bol Rural (Lac), Moundou Rural (Logone), Oum Hadjer (Batha), Abeche Rural (Ouddai).

"(UNICEF's) country programme . . . proposes to develop an effective, efficient and sustainable PHC system, emphasizing the strengthening and extension of the PHC network and building on the logistical infrastructure created by UCI. Cost containment is to be achieved through improved management, community involvement and community financing to offset operating and essential drug expenses. Mechanisms for financing PHC are currently being field-tested in some area-based programmes." (UNICEF, 1990)

### USEFUL LITERATURE

Bamako Initiative Management Unit, UNICEF, 1990. Bamako Initiative Newsletter, March 1990.

Carrin, Guy, 1986. "Self-Financing of Drugs in Developing Countries - the Case of the Public Pharmacy in Fianga."

## CONGO

### **CURRENT A.I.D. HEALTH ACTIVITIES**

### **GOVERNMENT POLICIES**

### **COST RECOVERY ACTIVITIES**

Bamako Initiative: "Congo is assessing experiences from projects supported by the Governments of the Federal Republic of Germany and France as a basis for formulating a national plan for the Bamako Initiative." (E/ICEF/1989/L.3)

#### Brief descriptions

GTZ has supported project in Niari region.

## COTE D'IVOIRE

### CURRENT A.I.D. HEALTH ACTIVITIES

CCCD

### GOVERNMENT POLICIES

"Free" care/ User charges: 1960 circular set charges for hospital care. Two centres hospitalières universitaires and Public Health Pharmacy told to become self-sufficient (though, still heavily subsidized)

Private sector: Government promotes private sector and privatization. Most drug distribution is effectively through private sector.

Employment-based health care: Not clearly required (but see Overview below).

Decentralization: All revenue must be submitted to Ministry of Finance.

### COST RECOVERY ACTIVITIES

Overview: Official policy statements require nationwide cost recovery effort, but charges have so far been instituted in only 7 "public entities" plus anti-TB centers. Revenue in these places was 8.1% of costs; national total, 3.1% of MOH budget in 1986.

Insurance scheme (Caisse Nationale de la Prévoyance Sociale) covers formal labor market, provides care through 8 Medical Social Centres (unbedded dispensaries). Government employees and families may buy insurance from Mutuelle (which also has 1 dispensary) or from private insurers. (Private insurers covered approximately 1.4% of private health care spending in 1985. Côte d'Ivoire is the only one of Vogel's 4 countries to have private health insurance.) Many employers provide dispensaries or cover insurance costs.

Bamako Initiative: initial discussions underway

Protestant Hospital at Dabou has been charging fees since 1968 (Vogel, pp. 123ff) and has always covered 40-45% of costs (including local salaries).

Other hospitals with cost recovery include: Institut de Cardiologie d'Abidjan; Institut National de Santé Publique; Institut Raoul Fallereau; Service d'Aide Médical d'Urgence; Centre Hospitalière Universitaire de Cocody; Centre Hospitalière Universitaire de Treichville; Centres Anti-Tuberculeux (Vogel, pp. 109-111). Polyclinique Internationale Sainte Anne Marie (Vogel, pp. 120-123)

### KEY INFORMANTS

Paul LOA GAH: Economiste; Projet Santé; Banque Mondiale et Ministère de la Santé Publique et de la Population

Professeur K. MANLAN: Directeur de la Médecine Hospitalière; MSSP

Monsieur APETE: Directeur des Affaires Financières, MSSP

Monsieur B. KAMAGATE: Chargé des Investissements de Santé; Ministère du Budget

Mr. P. DEKENS, Economiste; Projet Sante; Banque Mondiale et MSSP

Mr. T.A. N'UETTA: Membre, Assemblée Nationale

### **USEFUL LITERATURE**

Vogel, Ronald J. 1988. Cost Recovery in the Health Sector: Selected Country Case Studies in West Africa, World Bank Technical Paper no. 82.

## THE GAMBIA

### CURRENT A.I.D. HEALTH ACTIVITIES

#### GOVERNMENT POLICIES

"Free" care/ User charges: Cost recovery introduced at village level in 1981 and at secondary and tertiary levels in 1988.

Decentralization: Funds collected by village development committee are kept and used at that level, while proceeds from secondary and tertiary levels are deposited into special account at the Central Bank.

Pharmaceuticals: has essential drugs program

#### COST RECOVERY ACTIVITIES

Overview: Notes from 1990 Panafrican Conference on Community Financing, Kinshasa: "Through the Village Development Committee (VDC), the village health worker is provided with supplies of 6-8 essential drugs, e.g., chloroquine, aspirin, penicillin V. These drugs are sold to the community at predetermined prices, based on cost-price plus a markup. There are no exemption categories at this level.

"Part of the proceeds are used to replenish supplies, while the profits are put into a special local development fund which is controlled by the VDC. This fund is used for development activities, such as construction of latrines. . . .

"Serious constraints at this level include:

- poor financial, managerial, and administrative skills of the VDC
- pooling of profits to the fund, which may not ensure proportional benefits for direct health activities
- limited capacity in needs assessment and utilization of resources. . . .

"The cost recovery programme has also been evaluated, covering the whole country, from which a 50% cost recovery ability was observed."

Bamako Initiative: "Cost recovery was introduced into the health system in 1988 to improve the availability of funds for non-salary recurrent costs, and evaluation of this financing system will be a first step towards implementation of the Bamako Initiative." (UNICEF, 1990)

"The Gambia launched its national revolving drug fund in August (1988) with a credit agreement from the International Development Association (IDA) of the World Bank. This complements a community financing system that has been operating in rural areas since 1983 and is intended to enhance the financial resources available for recurrent costs other than salaries." (E/ICEF/1989/L.3)

### Brief descriptions

1988 cost recovery scheme includes visit fees, hospital charges, and annual fees for treatment of such chronic conditions as hypertension and diabetes. Cards are sold for MCH and EPI services. The following are exempt:

- the military (including families)
- children under 9
- those with certain diseases of "public interest," e.g., STDs
- pregnant and postpartum (up to 3 months) women
- those certified to be indigent.

### **USEFUL LITERATURE**

United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)

Bamako Initiative Management Unit, UNICEF, 1990. Bamako Initiative Newsletter, March 1990.

## GHANA

### CURRENT A.I.D. HEALTH ACTIVITIES

Major health sector project being developed.

### GOVERNMENT POLICIES

"Free" care/ User charges: Concept of user charges introduced in 1971 Hospital Fee Act (mainly to discourage frivolous use) but not enforced until 1985. Hospital Fee Regulations (described in Vogel, p. 134) now aim to cover 15% of costs, with full cost recovery for drugs. In 1987, MOH recovered 12% of recurrent costs through user payments.

Private sector: Private voluntary organizations, employer-based hospitals, and private clinics are all active.

Employment-based health care: Social Security for government employees and some private insurance - but neither covers health care. Efforts underway since 1985 to develop health coverage. (Latter might cover (a) 200,000-300,000 independent cocoa growers, (b) 2 million employees in other formal labor markets, and (c) 200,000 civil servants. Mines operate 7 hospitals.

Decentralization: Revenues split between collecting institution, Ministry of Health, and Ministry of Finance. "Health centers and clinics are encouraged to use retained income for the purchase of items such as stationery, cleansing agents, bed linen, electric bulbs, fuel and lubricants for vehicles and generating plants, as well as for the maintenance and repair of minor equipment and building (Blakney, p.69).

Pharmaceuticals: Ghana is developing an essential drugs program.

### COST RECOVERY ACTIVITIES

Overview: Cost recovery "off to a good start" (Vogel). Mandl says 35 of 69 health districts now involved in cost recovery activities. Revenue was 7.9% and 12.1% of costs in 1986 and 1987 respectively. Pharmaceuticals must be sold at full price and thus account for most revenue. System modeled on that of religious missions.

Notes from 1990 Panafrican Conference on Community Financing, Kinshasa: Hospital fee act exempts certain chronic patients (e.g., those with TB), prisoners, the military, destitutes and paupers. Certificate of indigence normally required but waived in emergencies, leading to alarming rise in number of delayed (hence emergency) cases.

"Funds are controlled through the use of tickets and receipts, then the monies are paid into a bank account. There is an annual audit. . . Funds are used to purchase drugs. They are also used for very basic repairs and renovations . . . Such funds are not used as salaries for health workers. . . . There are difficulties in the utilization of funds - too many instructions as to the use of the monies resulting in huge sums being accumulated in the accounts. "Recently a baseline survey has been conducted in five districts . . . Issues raised include people's average income levels . . . and the average cost of treatment for particular episodes, e.g., malaria."

Bamako Initiative: "Several steps have been taken to strengthen the district-level management of PHC in Ghana. Fees for treatment were introduced somewhat arbitrarily in 1987, and one study has shown that service utilization rates declined initially, mainly due to the lack of improvement in the services provided. Although attendance has risen again in urban areas, poor rural areas still lag behind. A comprehensive essential drugs policy is being formulated and the government is planning to provide drug kits on a regular basis to 350 health centres in low-income areas. It is expected that this will improve the quality of services. The Bamako Initiative in Ghana is incorporated within the national program to mitigate the social costs of structural adjustment, which is supported by the World Bank, the United Nations Development Programme (UNDP), the World Food Programme (WFP), the International Labour Organization (ILO), UNICEF and others." (UNICEF, 1990)

#### Brief descriptions

Ashanti-Akim District has most experience in cost recovery (see Blakney, et al., pp.6-7, and pp. 69-75; also Mandl, pp. 6-10).

1985 World Bank Health and Education Rehabilitation Project required MOH to undertake cost recovery for 15% of budget.

1985 MOH directive, Modalities for Collecting New Hospital Fees, details operational procedures for fee collection. 35 mission hospitals have long charged fees; all hospitals include a primary health care unit.

Church hospitals have created funds for the sick and poor which are used on the recommendation of the parish priest.

#### **KEY INFORMANTS**

Mr. Mohamed COFIE: Director of Planning, Ministry of Health

Dr. K. ADAMAFIO: Deputy Director, Medical Services, MOH

Dr. M. ADIBO: Director, Medical Services, MOH

Mr. Joseph AMENYAH, Consultant to MOH

#### **USEFUL LITERATURE**

Blakney, Richard B., Jennie I. Litvack, and Jonathan D. Quick, 1989. Financing Primary Health Care: Experiences in Pharmaceutical Cost Recovery, page 6 and Annex C.

Hogerzeil, Hans V. "Use of Essential Drugs in Rural Ghana," International Journal of Health Services, Vol. 16, No. 3, 1986.

Mandl, Pierre-E., et al., 1988. Community Financing Experiences for Local Health Services in Africa. UNICEF Working Papers no. 2.

United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)

Vogel, Ronald J. 1988. Cost Recovery in the Health Sector: Selected Country Case Studies in West Africa, World Bank Technical Paper no. 82.

Waddington, C. J. and K. A. Enyimayew. "A Price to Pay: the Impact of User Charges in Ashanti-Akim District, Ghana." International Journal of Health Planning and Management, 1989.

## GUINEA

### CURRENT A.I.D. HEALTH ACTIVITIES

CCCD, including health care financing component

### GOVERNMENT POLICIES

"Free" care/ User charges: Government aims to have beneficiaries pay all recurrent costs other than for salaries. 1987 decree authorized cost recovery.

Decentralization: For community financing (International Children's Centre): "The State Secretariat for Decentralization organized the community to play an active role in checking revenue, expenditure, and drug use. By official decree, the communities in Guinea are the owners of the drugs and finances in their community. Local revenue is under their direct control. The State Secretariat for Decentralization supervises and supports the communities, and in case of dispute, they can take disciplinary measures through the Ministry of Interior."

"According to the 1987 decree of the Ministry of the Economy and Finance/ Ministry of Health and Social Welfare, cost recovery allows for retention of all revenue . . . at the community level, including hospitals. Projects must complete quarterly reports of incoming revenue and expenditures." (Mandi) Government has established State Secretariat for Decentralization which apparently oversees many activities.

Pharmaceuticals: Guinea is developing an essential drugs program. New public/private company starting drug production. Standard treatment protocols have been developed. Great effort to standardize the prices of drugs sold at the community level.

### COST RECOVERY ACTIVITIES

Bamako Initiative: Government has established intersectoral committee for Bamako Initiative and has asked UNICEF for substantial funding. Activities underway in 97 of 300 health centers; 70 to be added in 1990.

"Cost recovery is well underway in many areas, including the initial districts of the Eastern Forest region which began operations in April 1988. Funds are already accumulating, and there are indications that cost recovery may exceed 200 percent in some locations. Community participation is especially well developed, and the health management committees are responsible for the funds generated. The cost of services includes treatment and a prescribed course of drugs, based on the diagnostic charts that cover the main health problems of the country. . . . Guinea is probably the country most advanced in implementing the Bamako Initiative, although the initial phase concentrates on establishing health centers at prefectural level. . . . At the subdistrict level in some parts of Guinea, over \$2000 in local currency has accumulated. These funds are under the control of local health development committees." (E/ICEF/1989/L.3) Report also notes that part of receipts are returned as incentive bonuses to workers. Cost recovery has averaged 90 percent of drug and local operating costs.

Policy being developed for cost recovery at hospitals.

Campagne reports that Guinea can measure progress toward community financing zone by zone.

### Brief descriptions

CCCD project has helped install cost recovery system in Kindia and Telimele. Revenues from the sale of vaccination cards, ORS packets, and chloroquine tablets will be used for local recurrent costs.

### **USEFUL LITERATURE**

Bamako Initiative Management Unit, UNICEF, 1990. Bamako Initiative Newsletter, March 1990.

Campagne, Pierre, 1989. "Technical Conference on Community Financing to Strengthen Local Health Services in Francophone Africa," Synthesis Report of Meeting Organized by UNICEF in Cooperation with the French Committee for UNICEF.

International Children's Centre, 1990. "The Bamako Initiative: Primary Health Care Experience", Special issue of Children in the Tropics.

Makinen, Marty and Steven Block, 1986. "Pricing for Cost Recovery in Guinea."

Médicins sans Frontières, 1987. "Rapport d'Activités dans les Centres de Santé Périphériques."

Ministre de la Santé et des Affaires Sociales, Ministre de l'Economie et des Finances, Conakry. "Arrête Conjoint no. 6460/MSAS/CAR/87".

United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)

## GUINEA-BISSAU

### CURRENT A.I.D. HEALTH ACTIVITIES

#### GOVERNMENT POLICIES

essential drugs program

#### COST RECOVERY ACTIVITIES

Overview: "The country has considerable experience in local pre-payment mechanisms (the abota system) which could be the basis for appropriate community financing schemes and PHC management." (UNICEF, 1990)

Bamako Initiative: ". . . limited cost recovery scheme is in place and plans are underway to bring the essential drugs program, supported by UNICEF and the Government of Italy, into line with the Bamako Initiative." (E/ICEF/1989/L.3)

#### Brief descriptions

From UNICEF, et al., 1989: "Community (i.e., village) financing for drugs started in 1980 as part of the general village health scheme. In this scheme, drugs are given free of charge to the village for an initial period of six months. Thereafter, the village, consisting of between 200-500 people, is collectively responsible for raising money to buy their drugs at district or regional level. . .

"The 'Abota Scheme,' . . . a voluntary levy paid once a year by the villagers, is a positive example of a pre-payment financing scheme. To ensure that a majority of the population participates, a system was devised whereby only one payment is made for any level of health care needed.

"Important characteristics of the implementation of this scheme are:

1. The relative simplicity of its administration system. Once a year only, a collectively decided amount of money is gathered by the villagers themselves, thus avoiding the problem that drugs run out in the rainy season.
2. The clear handing over of responsibility to the villagers in deciding the amount of money they want to pay for their drugs and their way of collecting it."

#### KEY INFORMANTS

#### USEFUL LITERATURE

UNICEF, Health Action International, OXFAM, 1989. Report on the International Study Conference on Community Financing in Primary Health Care, pages 27-28.

## LIBERIA

### CURRENT A.I.D. HEALTH ACTIVITIES

CCCD, including revolving drug fund  
Private Health Care Improvement

### GOVERNMENT POLICIES

"Free" care/ User charges: Small visit fee authorized but drugs and medical supplies were to be free.

Decentralization: "Liberia's 1987 proposal to UNICEF for a revolving drug fund indicates that funds collected by drug sales will be held and managed by a village committee. It will be the role of the county management to implement and operate the separate fee-for-service policy. As soon as decentralized financial management systems are established at the county level, fee-for-service revenues will remain there for use in county health programs." (Mandl)

Pharmaceuticals: National Medical Supply Depot prices drugs at replacement cost (even though many are donated). Government is trying to establish community, hospital, and national revolving drug funds. Liberia is developing an essential drugs program.

### COST RECOVERY ACTIVITIES

Overview: With donor support, revolving drug funds have been established in 10 of 13 counties. Two counties participate in scheme operated by National Medical Supply Depot.

#### Brief descriptions

"Currently all health facilities in Liberia charge a fee for service or registration fee before services are rendered. Although promulgated by the Ministry of Health and Social Welfare as a uniform fee structure, there is great variation from county to county in the fee structure, both at the hospital level and health center and health post level. Under the policy of decentralization, all fees generated are retained at the county or community level. As yet, there is no standardized financial management reporting system."

"The National Drug Service has recently (September 1989) established a three person revolving drug fund unit. The unit is charged with training, implementation, monitoring and evaluating RDFs throughout the country. The three individuals recruited to staff the unit have accounting, financial management, and public administration backgrounds." (McFarland)

Blakney (pp. 12-13 and Annex E) describes revolving drug funds in Grand Geddah and Sinoe Counties. "The mechanism used to maintain the community's motivation was to have the community raise funds for the seed stock . . . ; thus, the money collected and the stock belong to the community. The policy is that there are no exemptions except in the event of genuine emergencies, and then that the family or community is responsible for payment."

The CCCD-supported revolving drug fund is functioning well in most counties. The absence of foreign exchange to restock the National Drug Service has been identified as the major constraint to a sustainable system.

PRICOR describes community-managed revolving drug fund in Kolahun District.

## **USEFUL LITERATURE**

Blakney, Richard B., Jennie I. Litvack, and Jonathan D. Quick, 1989. Financing Primary Health Care: Experiences in Pharmaceutical Cost Recovery, p. 12 and Annex E.

McFarland, Deborah A., 1990. "A Review of Health Financing Systems in Liberia."

Ministry of Health and Social Welfare, 1986. "Revolving Drug Fund Manual - Health Center/ Health Post."

Ministry of Health and Social Welfare, 1986. "Revolving Drug Fund Manual - Hospital."

Ministry of Health and Social Welfare/ Liberia, 1989. Report on Revolving Drug Fund assessments of Eight Clinics in Sinoe and Gedeh Counties.

National Drug Service - Ministry of Health and Social Welfare, 1987. "National revolving drug fund proposal to UNICEF."

PRICOR, 1987. "Planning and Evaluating Community Financing in Kolahun District."

## MALI

### CURRENT A.I.D. HEALTH ACTIVITIES

Mali is a Child Survival Emphasis country.

Integrated Family Health Services: MCH/FP services in 15 health centers in Bamako and Koulikoro

Dioro Child Survival: Africare project in 31 villages of Segou Region

PRITECH representative for ORT

CARE supports the Macina Child Health project in central Mali for immunizations and ORT

Foster Parents Plan provides immunization and ORT services to Banamba

Save the Children in four regions of Kolondieba, immunizations, maternal health, ORT, health education

World Vision Relief and Development supports MCH in six districts of the Koutiala Region, including ORT, chloroquine distribution, weaning foods and growth monitoring, nutrition, health education

also short-term technical assistance for AIDS (WHO and AIDSTECH), malaria, ARI, immunizations

### GOVERNMENT POLICIES

"Free" care/ User charges: 1983 decree required hospital cost recovery. Ministry of Health wants 3 national hospitals to be fully self-financing for recurrent costs.

Private sector: Bulk of private health practice is by MOH personnel working clandestinely. The private sector was legalized in 1985, but under stringent price controls; only 12 professionals were officially in private practice as of 1989.

Employment-based health care: Social Security Institute (INPS) has 60,000 members and serves 250,000 persons. See description in Vogel (pp.83-84).

Decentralization: MOH received only temporary authorization for hospitals to retain fees. Almost all revenue goes to Ministry of Finance. Government recently centralized taxation policies.

Pharmaceutical supplies: "People's Pharmacy" has had complete monopoly since 1960's on importation and (minor) local production, but is very poorly managed (Vogel, pp. 62-65). PPM costs about four times as high as competitive tender for generic drugs; turnover accounts for over half the recurrent costs of the health system (Abel-Smith, p. 61). Koita (p. 78) argues for privatization of drug procurement to reduce costs.

"Following a 1988 evaluation of the pharmaceutical sector, in May 1989 the Council of Ministers approved a contract with the Central Pharmacy Company giving them the exclusive right to import and sell drugs, on the understanding that prices would be

competitive and that 60 essential drugs would be continuously available." (UNICEF, 1990)

Mali is developing an essential drugs program, and a list of 60 essential items has been developed.

## **COST RECOVERY ACTIVITIES**

Overview: According to Blakney (p. 14), "Though the majority of the country's eight regions remain in infant stages of cost recovery efforts, two donor-sponsored projects have inspired more advanced implementation of user charges. In 1985, the World Bank sponsored three Circles sub-regions within the Kayes region (Vogel, 1988), and the Belgian organization *Médecins sans Frontières* initiated the Health Stores Project in the Gao and Tombouctou Regions."

Cost recovery started with three hospitals (Gabriel Toure, Point G, Kati) in 1984 and is still mainly focused on hospitals. Total revenue in 1985 budget was only about 1.3% of MOH budget (including foreign aid). Cost recovery efforts inhibited by perceptions of poor quality, due to drug unavailability (and inefficiencies of People's Pharmacy). According to Koita (p. 73), "The sums recovered at national hospitals would allow them to increase slightly the volume of pharmaceuticals and other medical supplies and to do some maintenance of the buildings, but they represent only 21 to 53% of operating costs, excluding salaries."

National Social Welfare Institute covers 55,000 employees in formal labor market (described in Vogel, p. 83, and Koita, p. 73) and provides care directly through industrial medical centers and dispensaries. In 1985, 5.7% of health spending was by the NSWI. No private health insurance.

In 1985, 56.8% of health spending was from private sources; including 38.2% (of all spending) for traditional practitioners, 16.7% for purchases from the Peoples' Pharmacy of Mali, and 1.7% for private modern providers.

Bamako Initiative: Government has established intersectoral committee. UNICEF supports pilot project in Djerine District, Mopti Region. Official drug procurement has been assessed, and UNICEF hopes that it will be able to use it for Bamako Initiative. UNICEF helping to "strengthen existing activities in the regions of Timbuktu (health warehouses project, supported by the European Economic Community and managed by *Médecins sans Frontières*), Mopti (District Health Planning Unit supported by UNICEF), and Kolikoro." (E/ICEF/1989/P/L.26)

Campagne reports that Mali is creating Health Development Fund to receive some of the profits from drug sales. "These Funds would permit a redistribution between the regions, based on economic resources, . . . external aid, and actual health budgetary resources."

### Other Descriptions

Cost recovery started in three national hospitals (Gabriel Touré, Point G, Kati) after 1983 decree (discussed in Vogel, pp. 65-67).

World Bank Health Development Project supported system strengthening and cost recovery efforts in Kita, Bafoulabe, and Kenieba Circles (Kayes Region) starting in 1985

(described in Vogel, pp. 68-76 and Blakney, pp. 110-111). Efforts stymied by unreliable and high cost drug supply. Kita is approaching profitability.

Médecins sans Frontières in Timbuctu and Dire (see Vogel, pp. 76-79 and Blakney, pp. 109-117) procure drugs from UNICEF or preferred suppliers and then sell through Magasins-Santé. Patients pay service fees, covering consultation and medication for 7 days. Vogel shows detailed plan for reducing costs and increasing revenue. Have excellent computerized data base. According to UNICEF (E/ICEF/1989/L.3), revolving drug fund has accumulated \$60,000 indicating lack of planning for appropriate use.

"Free enterprise" (but government-sponsored) drug depots around country sell basic medications at 15% markup (see Vogel, p.76). According to Koita (p. 63), most use donated drugs and are completely decapitalized within 2 years.

Campagne reports that community solidarity funds will be created to support health care for the poor. Funds will derive from 30% retention of drug profits.

### **KEY INFORMANTS**

M. Brehima S. DIALLO, Direction Planification Sanitaire, Ministère de la Santé Publique et des Affaires Sociales (MSPAS)

Dr. M. KANTE, MSPAS

M. A. K. TRAORE, MSPAS

### **USEFUL LITERATURE**

Abel-Smith, B. and Creese, A. (eds.). Program and Policy Options in Three Countries. World Health Organization and USAID, 1989.

Ainsworth, M., Orivel, F., Chuhan P. (1987). "Cost Recovery for Health and Water Projects in Rural Mali: Household Ability to Pay and Organizational Capacity of Villages." World Bank PHN Technical Note.

Bamako Initiative Management Unit, UNICEF, 1990. Bamako Initiative Newsletter, March 1990.

Blakney, Richard B., Jennie I. Litvack, and Jonathan D. Quick, 1989. Financing Primary Health Care: Experiences in Pharmaceutical Cost Recovery, page 14 and Annex F.

J. Brunet-Jailly, "Les dépenses de santé dans l'économie familiale rurale," 1988.

Campagne, Pierre, 1989. "Technical Conference on Community Financing to Strengthen Local Health Services in Francophone Africa," Synthesis Report of meeting organized by UNICEF in cooperation with the French Committee for UNICEF.

Carrin, Guy, 1988. "Autofinancement par la population des coûts des médicaments au centre de santé de Kita - Limites actuelles et prospectives."

Claudine Coppel, Ministère de la Santé et des Affaires Sociales; UNICEF/Bamako, 1984. "Etude sur les charges récurrentes de santé."

- Leo De Vos, UNICEF/Bamako. "Fact Sheet - Cost recovery," 1988.
- Direction regionale de la santé publique de la région de Gao, 1987. "Troisieme seminaire regional "Magasins-santé", Vlle Region."
- Koita, Amadou. "Le Financement des Coûts Recurrents de la Santé au Mali." Mali: Institut National de Recherches en Santé Publique, 1988.
- Koita, Amadou and Joseph Brunet-Jailly, "Mali," in Abel-Smith, Brian and Andrew Creese, editors, 1989. Recurrent Costs in the Health Sector.
- Medicins sans Frontières. "Rapport d'Activites 1987." Mali: Ministère de la Santé Publique et des Affaires Sociales, 1987.
- Ministère de la Santé et des Affaires Sociales, Bamako. "Analyse de la Situation Financière des Magasins-Santé du cercle de Tombouctou suivant les registres," 1987.
- Ministère de la Santé Publique et des Affaires Sociales. "Rapport d'Activites 1986.
- Medicins sans Frontières, 1988. "Projet Magasins-santé: situation au 31/12/1987, critiques et évolutions sur la periode 1988-1990.
- Ministère de la Santé Publique et des Affaires Sociales, Bamako, 1987. "Evaluation permanente de la santé en VIe Région du Mali: Etude des registres de consultation."
- Ministère de la Santé Publique et des Affaires Sociales, Mali, 1987. "Gestion financière et recouvrement des coûts en VIe region - Rapport de mission."
- Ministère de la Santé Publique et des Affaires Sociales, Mali, 1987. "Point sur le systeme de recouvrement des couts dans la zone du projet de developpement sanitaire."
- Ministère de la Santé Publique et des Affaires Sociales; Médecins sans Frontières, 1986. "Projet de rehabilitation medico-nutritionelle en VIe et VIIe régions de Mali - Rapport d'activités."
- Ministère de la Santé Publique et des Affaires Sociales, 1986. "Le systeme de recouvrement des coûts dans le cadre des Magasins-santé: VIe et VIIe regions du Mali."
- Plan de Réelance et de Réhabilitation CEE-Mali, 1986. "Système d'évaluation permanente." Rapport trimestriel No. 1.
- Troisieme réunion annuelle directeurs regionaux OMS/UNICEF, 1987. "La problematique du recouvrement des coûts des services de santé."
- Traoré, Mamadou Namory, 1987. "Community Financing of Primary Health Care in Peripheral Areas of Mali," PRICOR Study Report.
- UNICEF, Bamako, 1987. "Analyse de la Situation des Femmes et des enfants au Mali en 1987."
- United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)

Vogel, Ronald J. 1988. Cost Recovery in the Health Sector: Selected Country Case Studies in West Africa, World Bank Technical Paper no. 82.

## MAURITANIA

### CURRENT A.I.D. HEALTH ACTIVITIES

- Vitamin A grant to World Vision

### GOVERNMENT POLICIES

"Free" care/ User charges:

Decentralization: "In March 1989, a national decentralization policy was initiated in the health sector, leading to the creation of regional health action departments with autonomous responsibility for managing human and material resources. The national coordinating committee for PHC and for implementing the Bamako Initiative . . . elaborated a guide for community PHC management committees, allowing for their autonomy in financial management. A portion of the funds generated will be sent to the central level to guarantee the supply of essential drugs." (UNICEF, 1990)

Pharmaceuticals: lack of essential drugs policy or national drug formulary. No fixed prices for drugs sold at the community level.

### COST RECOVERY ACTIVITIES

Bamako Initiative: Strong political commitment, with intersectoral committee established, but health infrastructure is extremely weak. World Bank and ADB are active. Government trying to create two demonstration areas (population 70,000). UNICEF helping to plan for community financing. "A monitoring system and a programme for operational research have been designed, including household surveys, to assess families' expenditures on health and the potential for community financing." (UNICEF, 1990)

Mauritania plans to create single national agency to help community financing schemes through supervision, monitoring, evaluation, and training.

#### Other Descriptions

"Since 1980, the Trarza region has accumulated experience in community financing of health services, and other regions have also initiated similar experiments." (E/ICEF/1989/P/L.26)

### USEFUL LITERATURE

Campagne, Pierre, 1989. "Technical Conference on Community Financing to Strengthen Local Health Services in Francophone Africa," Synthesis Report of meeting organized by UNICEF in cooperation with the French Committee for UNICEF.

United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)

## **NIGER**

### **CURRENT A.I.D. HEALTH ACTIVITIES**

Niger is a Child Survival Emphasis country.

Health Sector Support Grant, including cost recovery activities (Tulane team includes an Abt Associates economist).

Family planning project managed by University Research Corporation.

PRICOR manages operations research and other activities to strengthen the financing and quality of care provided through the village health worker program. Financing options currently being investigated.

Africare Child Support provides ORT, nutrition counselling and growth monitoring, in Diffa and Dosso

CARE supports growth monitoring and ORT in two districts of Zinder

Helen Keller International supports operations research to find best way to distribute vitamin A capsules

PRITECH has resident advisor

Peace Corps works in health as well as other areas

### **GOVERNMENT POLICIES**

"Free" care/ User charges: Principle of cost recovery has long been accepted, but AID and Abt Associates have worked for two years to change practices.

Decentralization: very little at present

Pharmaceuticals: ONPPC imports most drugs and appears to be very inefficient. World Bank is supposed to conduct systems analysis. Niger is developing an essential drugs program.

### **COST RECOVERY ACTIVITIES**

Overview: Great attention being given to cost recovery issues, especially to longterm policy change and development of mechanisms.

USAID Health Sector Grant: \$15 million for five years, disbursed in "tranches" as Niger government achieves specified conditions precedent. Three of its five objectives are:

- to increase cost recovery of the health care system
- to contain health care costs
- to increase the equity of financial resource allocation.

Project contractor is Tulane University (Ian Sliney, chief resident advisor), with a subcontract to Abt Associates for financing work. Activities until recently emphasized cost recovery and financial management at Niamey Hospital (see Holly Wong citation in bibliography), but with increasing attention to rural health services.

Five day workshop for senior government officials in November 1989 reviewed principles and practices of cost recovery and selected three alternatives for testing over the next two years:

- obligatory tax (200 CFA per year per taxable person) plus co-payment per episode
- straight fee for service
- voluntary pre-payment plus co-payment per episode.

In a recent decision, the government has chosen to implement one or more of these schemes without testing, and to include financing of the village health worker within the scope of the system to be financed. It is not yet clear exactly what will be done, however, nor how it will be managed. Niamey Hospital has separate fee structure for private payers and for government employees, but Wong study showed that potential fees were often not collected; only about 16% of hospital costs were recovered in 1986-87 budget year.

PRICOR is assisting the Ministry of Health to develop new financing methods for the now practically defunct village health worker program, emphasizing arrondissement level taxation and community activities. Preliminary research shows: (1) extreme underfunding of current program design; but also (2) seven (of 39) arrondissements using head tax to augment centrally allocated resources; (3) strong community interest and willingness to actively support an effective program; and (4) considerable potential for cost reduction. A multi-donor strategy for technical assistance, operations research, and information dissemination is now being developed. Additional information may be obtained from the PRICOR references in the bibliography below.

Male securistes and female matrones are not currently paid, but matrones in particular may occasionally receive gratuities. Secouristes sell chloroquine, aspirin, ORS, and perhaps a few other "tablets" at cost and then restock them; one issue raised at a June 1989 workshop on VHWS concerned the need for a "marge beneficiare" to at least cover transport and associated restocking costs. PRICOR systems analysis found special restocking problems along the Nigerian border where villagers had paid for chloroquine with Naira, but the latter had lost its value.

Belgian experiment in Dosso was effort to standardize treatment regimens and drug dosages so that they could be accurately costed, with fees then set to cover both drug and non-drug treatment costs. Designers set episode fees of 200 francs per adult and 100 francs per child; fee was to cover consultation, drugs, and any followup for seven days. TB patients and the indigent (with authorization of Chef de Poste) were exempted. The system took effect on March 1, 1989.

## KEY INFORMANTS

Ministry of Health: Mme. Gadot, Directrice de la Division d'Etudes et Planification; Mme. Alou in same division

Donors: H. Vogel, Dutch Aid

Susan Farnsworth, CARE International

Project personnel: Tisna Veldhuyzen van Zanten, PRICOR

Ian Sliney, Health Sector Development Project

## **USEFUL LITERATURE**

Hatsell, Theresa, 1990. "Conclusions from the Study on Community Support of the Village Health Worker Program of Niger," PRICOR study report (draft).

Qualls, Noreen and Ibrahim Abou, 1990. "A Cost Analysis of the Village Health Worker Program in the Republic of Niger," Abt Associates consultancy report (draft).

République du Niger, Ministère de la Santé Publique, Direction des Etudes et de la Programmation, 1989. "Quelques Eléments sur la Situation Financière du Secteur Sanitaire au Niger."

République du Niger, Ministère de la Santé Publique. Cooperation Médicale Belge, Octobre 1989. "Recherche operationelle sur la participation des populations aux frais de santé, Experience de Tibiri (dep. de Dosso)".

Wong, Holly (Abt Associates), December 1988. "Cost Analysis of Niamey Hospital (Draft)":

"Seminaire/Atelier sur le Recouvrement des Coûts dans le Secteur Sanitaire," November 1989.

## NIGERIA

### CURRENT A.I.D. HEALTH ACTIVITIES

Nigeria is a Child Survival Emphasis country.

\$67 million PHC loan

CCCD supports immunization program, with assistance from Rotary International

Adventist Development Relief Agency works in six states, on immunizations, ORT, nutrition and breastfeeding, family planning, water, sanitation, hygiene, malaria control, vitamin A deficiency and supplementation, health education

Africare supports the Imo State's Ministry of Health in Isiala Ngwa and Aniazu-Mbaise

Rotary International Polio Plus Program emphasizes voluntary activities

World Vision Relief and Development promotes immunizations, ORT, growth monitoring and nutritional counseling, birth spacing and malaria prevention in Ogbomoso South in Oyo State

### GOVERNMENT POLICIES

"Free" care/ User charges: Many institutions have charged, at least for drugs, since the 1970s or earlier.

Employment-based health care: no insurance for general public but some big private sector employers provide free health care

Decentralization: deliberate policy to decentralize to Local Government Associations. LGAs participating in Bamako Initiative have been authorized to establish autonomous accounts outside the government system.

Pharmaceuticals: Nigeria is developing an essential drugs program. Standard treatment protocols have been developed.

### COST RECOVERY ACTIVITIES

Overview: PHC clinics and dispensaries charge, except for the indigent, EPI, and ORT.

Bamako Initiative: Strong political commitment to Bamako Initiative, led by intersectoral committee. "Nigeria has been one of the most active participants in the Bamako Initiative, and the government views it as a strategic opportunity for strengthening community-based health care. Activities have been initiated in four of 306 LGAs." (UNICEF, 1990.) "A cost analysis of the feasibility of community- financed PHC activities has found this to be within the reach of the majority of households . . . The cost recovery system has been proposed as the best option for strengthening and expanding PHC/MCH service." (E/ICEF/1989/L.3).

Number of LGAs may now be 8: Jahun (Kano State), Central Ife (Oyo), Oyun (Kwara), Idah (Benue), Issiala Mbanjo (Imo), Ifo (Ogun), Kaura Namoda (Sokoto), Barikin-Ladi (Plateau).

### Brief descriptions

Blakney et al. (pp. 18-19 and Annex F) examined revolving drug funds operated by:

three parastatal Health Management Boards (Bendel, Niger, and Imo Hospital)

three university teaching hospitals (University of Benin and Ibadan, and Ahmadu Bello University), and

one PVO (the Christian Health Association of Nigeria).

World Bank project in Sokoto (assisted by Abt Associates) is studying health care costs and financing. See bibliography.

### **KEY INFORMANTS**

Marty Makinen, Abt Associates

Ron Vogel, University of Arizona

### **USEFUL LITERATURE**

Abt Associates, Inc., May 1989. "Health Care Financing, Cost, and Utilization Study, sponsored by the Sokoto Health Project for the State Ministry of Health".

Bamako Initiative Management Unit, UNICEF, 1990. Bamako Initiative Newsletter, March 1990.

Blakney, Richard B., Jennie I. Litvack, and Jonathan D. Quick, 1989. Financing Primary Health Care: Experiences in Pharmaceutical Cost Recovery.

Greenberg, Donald. Assessment of Drug Revolving Fund Experiences in Nigeria. PRITECH report (1988).

Igun, U.A. 1987. "Why We Seek treatment Here - Retail Pharmacy and Clinical Practice in Maiduguri, Nigeria." Social Science and Medicine, Vol. 24, No. 8.

United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)

## SENEGAL

### CURRENT A.I.D. HEALTH ACTIVITIES

Senegal is a Child Survival Emphasis country.

Project with significant financing elements being developed.

Rural Health Delivery Services II project supports preventive health and Child Survival services in Kaolack and Fatick: health education, ORT, malaria, nutrition

Family Health and Population: nationwide MCH/Child Survival program

World Vision Relief and Development supports immunizations, nutrition, ORT, and health education in Louga

PRICOR helping to improve cost-effectiveness of PHC supervision systems

Rural Health Care/Child Survival project now being developed "will help the MOH decentralize . . . , expand community participation in health care financing via limited user fees, collaborate with the private sector in health care delivery . . . ;" may provide opportunity for broader health sector reform

### GOVERNMENT POLICIES

"Free" care/User charges: Hospital price list published in 1968 but poorly enforced (Vogel, pp. 43). 1980 "Red Book" (Participation des populations a l'effort de sante publique: Principes et directives methodologiques) sets cost recovery goals and policies. Also, suggests prices.

Private sector: unrestricted since independence

Employment-based health care: 1975 law required firms with over 100 employees to create their own insurance funds and smaller ones to join a group (Vogel, pp. 51-52).

Decentralization: 1980 "Red Book" emphasizes decentralization to local Health Committees and Associations pour la Santé (see Vogel for details); indicates that localities should set fee levels. All revenue, nevertheless, goes to Ministry of Finance except for fees collected from the "not so poor" in one experimental area.

Pharmaceuticals: Senegal is developing an essential drugs program.

### COST RECOVERY ACTIVITIES

Overview: User charges began at health post and health center level in late 1970s (Pikine and Sine Saloum) and only recently reached hospitals. 1980 "Red Book" encouraged experimentation. In 1985, local health committees collected equivalent of 4.7% of MOH budget; Vogel estimates that cost recovery could yield 18.8% if "leakage" were stopped and prices were adjusted for inflation.

1975 law established Social Security System (I.P.M.), but system was poorly designed and has incurred many failures. No private health insurance.

Bamako Initiative: discussions underway

### Brief descriptions

Pikine (Dakar suburb) started cost recovery in 1975 with Belgian assistance (see Vogel pp. 37-43 for description). Government said to be evaluating experience for possible replication under Bamako Initiative (E/ICEF/1989/L.3).

Sine Saloum Rural Health Project started in 1977, based on "self-financing" health huts. Financing mechanisms have included service fees, drug payments, cash or in-kind contributions for health hut construction or worker compensation, and local taxes. According to Blakney (p. 25), "One problem identified early in the project was competition between the health huts where charges had been instituted and other facilities at higher levels . . . that were continuing to provide services and drugs free; this created a disincentive for villagers to seek care at the health posts, and was corrected by the Ministry instituting user fees at all levels. Financial viability has also been a problem, particularly early on when village health workers were collecting charges; since then village health committees have taken on the responsibility of collecting and managing funds, and the national government has agreed that all revenue will stay at the village level." See additional description in Vogel, pp. 38-39.

Private Hôpital Principal in Dakar features strong financial management.

Private hospitals Hôpital St. Jean de Dieu in Thiès also collects large sums in user fees.

Kaolack Hospital

Ndioum Hospital

Ourossogui Hospital

Fann Hospital

Thiès Hospital

St. Louis Hospital started in 1987 (described in Vogel, pp. 46-47).

### **KEY INFORMANTS**

Mary Ann Micka, A.I.D. Health and Population Officer

Dr. Emile JEANNEE, Médecin-chef du Projet Pikine, Dakar

M. M.G. LO: Projet Santé Rurale, Ministère de la Santé Publique

Mme. Ndeye Coumba Guissé DRAME, MSP

Mme. Bineta Ba DIAGNE, MSP

M. Alassane DIAWARA, MSP

M. Souleymane CISSE, MSP

## **USEFUL LITERATURE**

El-Hadj Birama N'Diaye (President, Association pour la Promotion de la Santé, Pikine), April 1989. "Discours"

Blakney, Richard B., Jennie I. Litvack, and Jonathan D. Quick, 1989. Financing Primary Health Care: Experiences in Pharmaceutical Cost Recovery, p. 25.

Salif Guindo. "Projet Pikine: soins de santé primaire en milieu urbain."

Jancloes, M. "Financing Urban primary health Services." Tropical Doctor, Vol. 15, No. 2.

Pape Marcel Serie, 1986. "Community Financing in Senegal", World Health.

USAID. Prospects for Primary Health Care in Africa: Another Look at the Sine Saloum Rural Health Project in Senegal. Washington, D. C.: USAID Evaluation Special Study No. 20 (1984).

Vogel, Ronald J. 1988. Cost Recovery in the Health Sector: Selected Country Case Studies in West Africa, World Bank Technical Paper no. 82.

## SIERRA LEONE

### GOVERNMENT POLICIES

"Free" care/ User charges: Cost recovery started with pilot projects in 1986.

Decentralization: drug distribution has been decentralized

Pharmaceuticals: has essential drugs program

### COST RECOVERY ACTIVITIES

Bamako Initiative: "During 1989, the implementation of the Bamako Initiative began in two of 12 districts in the Western Area, including Freetown, the capital. The population in these three areas accounts for 31 percent of the total population. PHC is financed locally through treatment fees and drug sales. . . . Some district bank accounts have already been opened, and during 1990 such accounts will be opened in all 12 districts. . . . Operational research activities were initiated in late 1989 to assess the equity aspects of community financing, to evaluate the role of traditional care providers, and to measure the impact of increased community financing on the utilization of health services." (UNICEF, 1990).

"The essential drugs program came into prominence in mid-1986 when the Government initiated reimbursable procurement of essential drugs from UNICEF in six districts and the western region. Support for other districts in the country from the World Bank and GTZ led to an effort to provide essential drugs on a national scale. A national drug policy evolved simultaneously, founded on a country-wide cost recovery system which started in Bombali District in 1986, with technical assistance from AFRICARE and drug supplies from UNICEF.

"Sierra Leone is planning to allocate 10 percent of the targeted 100 percent markup for operations at the central medical store, 20 percent for the district medical store and 10 percent for peripheral health units. An additional 10 percent will be used to benefit indigent patients, and the remaining 50 percent will constitute a development fund for extending PHC services." (E/ICEF/1989/L.3) Cost recovery said to average 61 to 86 percent.

#### Brief descriptions

UNICEF report describes experiences in Bo, Pujehun, Bonthe, Koinadugu, Bombali, Port Loko, Tonkolili, and Western areas (including Freetown). Major points:

90% cost recovery in Bo and Port Loko

Problems occur because drugs are resupplied as full kits rather than individually. Fast-moving items have to be restocked from unofficial sources. Private sector competition (including from village health workers told not to sell drugs) undermines program.

GTZ assists activities in Bo/Pujehun.

Economic situation makes it difficult for people to be completely honest.

## **USEFUL LITERATURE**

United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)

UNICEF, Health Action International, OXFAM, 1989. Report on the International Study Conference on Community Financing in Primary Health Care, pages 43 - 48.

## TOGO

### CURRENT A.I.D. HEALTH ACTIVITIES

#### CCCD

Mission developing Child Survival project focussed on sustainability (including financial components); may provide scope for broader health sector reform

### GOVERNMENT POLICIES

Free Care/User charges: Individuals pay for drugs and other supplies at both public and private health facilities; also for total cost of service at private clinics and most of cost at religious hospitals. Admission fee and other types of fees at public hospitals.

Pharmaceuticals: Togo is developing an essential drugs program.

### COST RECOVERY ACTIVITIES

Bamako Initiative: Government has established intersectoral Bamako Initiative committee and spent most of 1989 preparing. "Several major studies have been undertaken to assess the availability of and access to health care, the various existing mechanisms of community management, and the supply and distribution of essential drugs." (UNICEF, 1990) About 21 pilot villages will be assessed (one in each Prefecture).

"If it is successfully implemented, the Bamako Initiative Program can help the government raise revenue not only at hospitals but also at primary health care facilities. Given that patients usually do not have resistance to paying for drugs, the Bamako Initiative cost recovery program can be effective. However, it has too narrow a base -- only the sale of essential drugs -- and also raises some fundamental equity economic efficiency issues. An ideal system would include other cost recovery mechanisms such as fees for service and price, to the extent possible, of each category of service at its true cost." (Bossert, Foltz et al, 1990).

#### Brief Descriptions

GTZ has made it clear that they will provide technical assistance but not finance recurrent costs. In the Central Region PHC project, it is providing money to buy a first stock of drugs to be sold and provide surplus to pay for a village health agent salary. At Maternité de Be a fee is charged per delivery; also fees for laboratory analyses and other specific services. Revenue collected is returned to the Treasury for its management and spending.

#### KEY INFORMANTS

Thomas J. Bossert, Ph.D.

#### USEFUL LITERATURE

Baas, Belen. Financial Aspects of the Togolese Health Sector. September 1986.

Banque Mondiale. Aide Mémoire: Mission de Pré-Evaluation du Project Santé et Population en République Togolaise. December 1989.

Bossert, Thomas, et al. Health Sector Analysis/Togo. University Research Corporation, 1990.

Evlo, Kodjo. Inventaire des Activités de Survie de l'Enfant au Togo. (Unité de Planification et de Coördination.) Fevrier 1990.

Sherwin, Walter, et al. Evaluation of Health Sector Support for Child Survival Project: Togo. University Research Corporation, 1989.

United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)

Banque Mondiale. Aide Mémoire: Mission de Pré-Evaluation du Project Santé et Population en République Togolaise. December 1989.

Bossert, Thomas, et al. Health Sector Analysis/Togo. University Research Corporation, 1990.

Evlo, Kodjo. Inventaire des Activités de Survie de l'Enfant au Togo. (Unité de Planification et de Coordination.) Fevrier 1990.

Sherwin, Walter, et al. Evaluation of Health Sector Support for Child Survival Project: Togo. University Research Corporation, 1989.

United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L3)

## **ZAIRE**

### **CURRENT A.I.D. HEALTH ACTIVITIES**

Zaire is a Child Survival Emphasis country.

CCCD project

Basic Rural Health II, administered by l'Eglise du Christ, works in 90 health zones, emphasizes financial sustainability and Child Survival services

Development of School of Public Health with assistance from Tulane

Area Nutrition Improvement supports local production of weaning foods and distribution of corn and soy flour mix to nutrition rehabilitation centers (Kinshasa)

Family Planning Services in 52 zones, includes contraceptive social marketing

Shaba Refugee Health Project through United Methodist Church constructs hospitals and renovates health centers

Shaba Refugee Water Supply

Kimbanguist Hospital Assistance Project (Kinshasa) provides medical equipment and supplies as well as management assistance

Cooperating agencies include HEALTHCOM, Improvement of Maternal/Infant Diet, Peace Corps, PRICOR, WHO/GPA, AIDSTECH, Project Support, REACH, WASH

### **GOVERNMENT POLICIES**

"Free" care/ User charges: Government decentralization in 1982 essentially required health zones to sink or swim.

Private sector: fully legitimate. Private pharmacists compete with, and threaten viability of, public health centers.

Employment-based health care: Code de Travail requires employers to provide or pay for health care. Government does not do so for its own employees, however.

Decentralization: 306 health zones have very independent authority and responsibility.

Pharmaceuticals: Imported by over 100, largely unregulated, private importers. Misuse of drugs is common.

### **COST RECOVERY ACTIVITIES**

Overview: As of 1988, about 150 of 306 health zones were fully operational, with the rest expected to be underway by 1991. Ten zones studied by REACH in 1986 were recovering 79% of operating costs.

According to Shepard et al., "The most common form of health care financing is user fees. . . Nine of ten zones visited (during the Health Zone Financing Study) had fee per episode of illness systems, where followup consultations were provided for no additional charge. In three of these nine zones, drugs and laboratory tests were also included in the episode price.

"In most health zones, the price of inpatient care is calculated according to the number and types of services provided (drugs, procedures, bed days, etc.) . . . Two health zones in the Kivu Region, Kasongo and Kindu, have a system of pricing per episode of ambulatory care. It permits the patient to receive all services required, from the initial ambulatory consultation to eventual hospitalization. . . .

"Several zones have also initiated prepayment systems using health cards. Area residents are allowed to purchase the health card at a set price which entitles the bearer to a certain number of curative care visits. . . .

"Finally, laws in Zaire require that employers pay for health care services for their employees and employees' dependents. Firm employees and their dependents represent about 18 to 27% of the country's 31 million population. . . . Some large enterprises own and run their own health facilities, where they provide services to employees and dependents at no charge. Other firms contract with health zones or other private providers to treat employees."

Campagne reports that government comptrollers are available to assist communities in financial management. The Fond National Médico-sanitaire (FONAMES) is responsible for supervision, evaluation, and monitoring.

Bamako Initiative: Government has established Bamako Initiative committee but little has been done to date.

#### Other Descriptions

The health zone of Bwamanda in Equateur Region operates an insurance plan which covers hospitalizations (including deliveries), dental extractions, and ambulatory surgery, as well as treatment of chronic illnesses at health centers or posts. Shepard et al. provide an extensive description.

"The rural health zone of Bokoro, located in the Bandundu region of Zaire, . . . was created in 1981. Services at health center and hospital levels are coordinated by a central office . . . The zone recovers a substantial part of its recurrent costs (over 80% in 1988) through fees for services. . . . The reference hospital Bokoro recovers over 60% of its costs through fees for service." (Shepard, et al.)

Beginning in 1987, the St. Alphonse health center (Matete Health Zone) has offered health insurance covering ambulatory curative care. (Shepard et al.)

The Caisse de Solidarité Ouvrière et Paysanne (CASOP), Kinshasa, offers insurance covering ambulatory curative care. The health insurance plan is only one of the many social services provided by the CASOP, which operates nationwide. (Shepard, et al.)

Réseau Médecins de Familles (REMEF), Kinshasa, is a direct insurance plan which functions like a staff model HMO. Its focus is maternal and children health. (Shepard, et al.)

The Rural Health Zone of Masisi is located in the Kivu Region, covering a population of 214,240. Only recently started, the health zone . . . has a 142-bed reference hospital and 19 health centers or health posts. To increase economic access to health services, the zone began offering a health insurance plan in 1988." (Shepard, et al.)

Other insurance plans studied were:

- Mutuelle "Union et Prévoyance" (UPM), Kinshasa
- Mutualité de Solidarité Chrétienne, Kinshasa
- MUZAS, Kinshasa
- LETISSA, Kinshasa
- Sona Bata Health Zone
- SNHR Employee Cooperative in Rutshuru.

See also Blakney, pp. 23-25 and Annex J; Département de la Santé Publique du Zaïre, Executive Summary; as well as other citations below.

#### **KEY INFORMANTS**

Ricardo Bitran

Rhonda Smith

Don Shepard

Eckhard Kleinau

Taryn Vian

Munkatu Mpepe

#### **USEFUL LITERATURE**

Blakney, Richard B., Jennie I. Litvack, and Jonathan D. Quick, 1989. Financing Primary Health Care: Experiences in Pharmaceutical Cost Recovery.

Campagne, Pierre, 1989. "Technical Conference on Community Financing to Strengthen Local Health Services in Francophone Africa," Synthesis Report of Meeting Organized by UNICEF in Cooperation with the French Committee for UNICEF.

De Bethune, X., et al., 1989. "The Influence of an Abrupt Price Increase on Health Service Utilization: Evidence from Zaïre," Health Policy and Planning. Vol. 4: 1.

Département de la Santé Publique du Zaïre, SANRU, REACH, 1986. "Health Zone Financing Study, Zaïre: Final Report."

- Dikassa, Lusamba, 1986. "Community Financing of Primary Health Care in the Republic of Zaire," PRICOR Study Report.
- Greenberger, Lauren, 1986. "A Cost Analysis of the Introduction of Primary Health Care to Selected Health Centers in Zaire."
- Kasongo Project Team, 1984. "Primary Health Care for Less than a Dollar a year," World Health Forum, Vol. 5, No. 3.
- Litvack, Jennie I. "Summary Report of Health Zone Visits of Kisantu (Bas-Zaire), Lubumbasi (Shaba), Goma (Kivu) and Kisangani (Haute Zaire)," 1988.
- Makinen, Marty, 1987. "Sustainability of Vaccination Programs."
- Mandl, Pierre-E., et al., 1988. Community Financing Experiences for Local Health Services in Africa. UNICEF Working Papers no. 2.
- Miller, Lynne. "Les possibilités d'autonomie financière de la zone de santé au Zaire." Kinshasa. Prepared for UNICEF (1987).
- Munkatu Mpese, 1989. "Organisation et performance du système de financement des zones de santé au Zaire"
- Sarr, Robert. "Note por la réunion sur l'initiative de Bamako." UNICEF (1988).
- Sarr, Robert, 1987. "Rapport de fin de mission au Zaire."
- Shepard, Donald, Taryn Vian, and Eckhard F. Kleinau, 1990. "Health Insurance in Zaire." The World Bank.
- United Nations Children's Fund, 1989. "Revitalizing Primary Health Care/ Maternal and Children Health: the Bamako Initiative," (E/ICEF/1989/L.3)
- Vian, Taryn, Munkatu Mpese, Manunga Mapele, and Miaka-mia-Bilenge, 1987. "Financial Management Information Systems in Four Zairian Health Zones," Resources for Child Health Project.