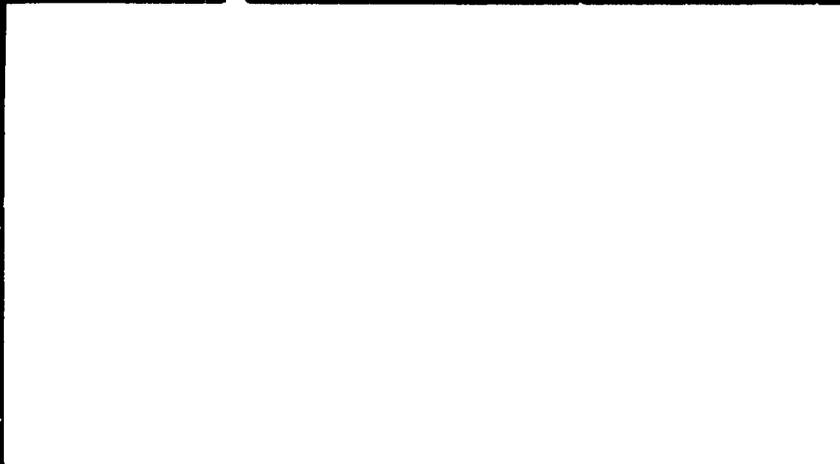


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**AskFINE**

**Financing Health Care in  
Developing Countries**

**A Knowledgebase**

**September 1990**

# **AskFINE**

**Financing Health Care  
in Developing Countries**

*A Knowledgebase*

## **How to use AskFINE**

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**Boston, September 1990**

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## System Requirements

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NOTEBOOK and the Ask FINE Knowledgebase can run on a IBM or compatible XT or AT personal computer with 640 kB of memory and at minimum two floppy disk drives or a floppy and a hard disk drive. A hard disk makes the use of AskFINE much more convenient (faster). Even though NOTEBOOK runs on a computer with less than 640 kB of memory some of the AskFINE records might be too large to be processed properly.

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## WHERE TO GET NOTEBOOK

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The NOTEBOOK program is not provided with the AskFINE knowledgebase. The AskFINE Knowledgebase should only be operated with a licensed copy of NOTEBOOK. A copy can be obtained through computer software dealers or directly from:

PRO/TEM Software, Inc.  
814 Tolman Drive  
Stanford, CA 94305  
(415)947-1024

# How to use AskFINE

## 1 INTRODUCTION

---

This document contains a brief description of AskFINE and instructions how to use the knowledgebase. The following functions are covered:

- Entering the knowledgebase.
- Screening the contents of records.
- Finding records with some specific contents.
- Viewing selected records.
- Printing records.
- Printing custom formatted reports.

It is assumed that the user has followed the instructions in the NOTEBOOK II<sup>TM</sup> user manual and installed the software as indicated. Otherwise see section three "Get started" on page 11 of this manual. This paper is specifically related to the use of the AskFINE knowledgebase. However, some of the frequently used NOTEBOOK II functions are summarized as well.

### 1.1 WHAT IS NOTEBOOK

Notebook is a text database program with an easy to use built-in word processor. Like in any database information is organized in fields and records. One record relates to a single item, a bibliographic abstract for example. Information concerning this item is partitioned into fields. Author name can be one field and journal or abstracts others. This is comparable to paper record in a filing cabinet, such a record usually refers to particulars about a single client or movements of a stock item. NOTEBOOK can handle text databases of up to a maximum of 50 fields,

where all fields together, which form one record, can hold up to 50,000 characters (an equivalent of 25 single spaced letter size pages of 2,000 characters each). There is no limit as to how much text can be fitted into a single field as long as the total per record is not exceeded. The number of records, i.e. each record being a journal abstract, is only limited by the capacity of the disk where the database is stored.

Figures entered into a NOTEBOOK database are treated as text. No calculations can be performed as in other database programs such as dBase or CLIPPER. The strongest points of NOTEBOOK are its sophisticated functions to find or replace text anywhere in a field or even within a record. It allows also to select a subset of records meeting a certain criterion such as a keyword or phrase. Printed output can be obtained in very different formats than the on screen display of records. Custom reports can be generated to any length abstracting only certain information from each or a subset of records.

While NOTEBOOK is well suited to create and maintain databases for libraries, client or medical records, etc. it will be used in the present context as a tool to retrieve specific information from a ready to use text database (which should not prevent the user to expand the database according to his needs). An earlier application to assist the development of small enterprises in developing countries had been created for U.S.A.I.D. [1]. The concept to present highly specialized information in a problem oriented manner provided a useful basis for AskFINE.

1 Charles Mann et al. The Askaries Knowledgebase. Harvard Institute for International Development, Cambridge 1989. Published by Kumarian Press, Inc. West Hartford, CT.

## 2 WHAT IS AskFINE

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AskFINE has been created as part of a strategy paper for A.I.D. Regional Economic Development Support Office sponsored child survival projects in West and Central Africa [2]. Increasing concern about the sustainability of family planning, child survival and AIDS control activities was at the origin of the paper. The projects concerned are especially interested in past experience of countries in the region with any form of revenue generation or other measures to sustain health care services traditionally provided free to the population. In the process of writing the strategy paper numerous articles, working papers or reports were reviewed. All of them make some contribution to the topic and all are about or from countries in West and Central Africa.

The strategy paper contains a synthesis of all papers reviewed. To enable A.I.D. officers and project personnel a fast and more detailed access to these papers without having to locate them first and then read them from cover to cover a summary and citations of all papers were entered in a text database. Because of its nature to represent knowledge in prose rather than figures the term "knowledgebase" is used. This specific knowledgebase is called "Financing Health Care in Developing Countries", abbreviated AskFINE. The user can retrieve relevant information fast and focuss on specific countries or problems of interest.

Apart from providing a mere synthesis of the document many contain additional remarks or critical comments related to the quality or the relevance of the paper as perceived by the analyst who reviewed it. Moreover, the central problem dealt with by some of the papers is highlighted specifically, as well as some of the most important solutions suggested.

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2 Kleinau EF, Shepard DS, Stinson W, Vogel R. Building Sustainable West African Health Projects. Measures to Enhance the Sustainability of A.I.D. Health Investments in West and Central Africa. University Research Corporation, Maryland, 1990.

## 2.1 THE AskFINE STRUCTURE

AskFINE uses 44 out of 50 available fields. A list of field names is displayed in the following table. Each field is explained in more detail in the first record of the AskFINE knowledgebase, which serves as an on-line help to the AskFINE user. The contents of this record is found in Appendix 1 of this paper.

Table Field names of the AskFINE knowledgebase.

KEYNAME	EXPERIENCE REPORTED	PROBLEM IDENTIFIED
DOCUMENT ID	SUMMARY	PROBLEM CAUSES
NUMBER OF RECORDS	SUMMARY SOURCE	IMPLICATIONS
LAST NAME	PROJECT SPONSOR	SUGGESTIONS
FIRST NAME	PROJECT CLIENTS	RELATED REFERENCES
OTHER AUTHORS	PROJECT STARTED	TRAINING IDEAS
TITLE	SERVICE PROVIDER	ANALYST COMMENTS
EDITOR(S)	PROVIDER TYPE	ANALYST
ARTICLE/CHAPTER	SERVICE CATEGORY	COPYRIGHT
JOURNAL/SOURCE	TYPES OF SERVICE	COMMENTS
VOLUME	FINANCING SERVICES	USER-DEFINED FIELD
ISSUE	PROVIDER LOCATION	USER-DEFINED FIELD
PUBLISHER	PROVIDER SIZE & AGE	USER-DEFINED FIELD
YEAR	AREA CHARACTERISTIC	USER-DEFINED FIELD
PAGES	MAIN PROBLEM CAT.	USER-DEFINED FIELD
LOCATION/CALL NO.	KEY PROBLEMS	USER-DEFINED FIELD
EXPERIENCE FRAME	PROBLEM SUBCATEGORY	

Most fields are self explanatory and comparable to those found in annotated bibliographies, such as author's name, title, etc. The concept and contents of some fields is, however, unique to the AskFINE knowledgebase. These are explained in the following.

## 2.2 FIELDS AND PROBLEM ORIENTED KEYWORDS IN AskFINE

The field EXPERIENCE FRAME gives a short description of the source which provided the information for the document reviewed. The following field, EXPERIENCE REPORTED, classifies the paper in one of 14 categories, referring to general methodology or analytical papers, to project report or to cost recovery and other specific topics. This field can be useful when searching for a particular type of document.

The SUMMARY itself is the central piece of the knowledgebase. It provides a summary of the document written either by the author or the analyst who reviewed the paper. Sometimes both sources are combined.

The PROJECT SPONSOR allows a quick identification of the main sponsors of a project. All U.S.A.I.D. funded projects can be selected easily.

The field PROVIDER LOCATION shows the country or countries where the experience in the document refers to. So far only countries in West and Central Africa are included in AskFINE. If the experience applies in general to several countries in the region, only "Africa" or "Sub-Saharan Africa" might be listed. For a few documents further details were available, such as the city or more general a distinction between urban and rural areas. The following specifies all countries included in the knowledgebase.

(A) Geographic area

- (1) Africa(S) (sub-Saharan Africa)

(B) Name of Country

- (1) Benin
- (2) Burkina Faso
- (3) Cameroon
- (4) Central African Republic
- (5) Chad
- (6) Congo
- (7) Gabon
- (8) Gambia
- (9) Ghana
- (10) Guinea
- (11) Guinea-Bissau
- (12) Ivory Coast
- (13) Liberia
- (14) Mali
- (15) Mauritania

- (16) Niger
- (17) Nigeria
- (18) Senegal
- (19) Sierra Leone
- (20) Togo
- (21) Zaire
- (22) Other, specify
- (C) Name of city, town, or village (where possible)
- (D) Location
  - (1) urban
  - (2) rural
  - (3) urban and rural
  - (4) community

The division into categories of letters and numbers does, for the moment, only serve the purpose to organize the information. They can not be used to search for information, only some records would be selected. To facilitate searches lengthy phrases do not to be typed, a single keyword or part of it is sufficient. Instead of searching for "Guinea-Bissau" one can use simply "Bissau".

A group of three fields also belongs to the core of AskFINE. These characterize the problem(s) addressed by the document, using a predefined number of keywords. Each field provides a more detailed level of the problem. The broadest classification into four main categories is found in the following field.

**MAIN PROBLEM CATEGORY:**

- (A) Policy
- (B) Cost recovery
- (C) Management
- (D) Communications

Each main problem category is further refined into subcategories, termed key problems. Almost all papers allow a description of the problem to this level of detail.

**KEY PROBLEMS:**

- (A1) Macroeconomic environment
- (A2) Microeconomic factors
- (A3) Health services
- (A4) Health policy issues
- (A5) Pharmaceutical policy and regulations
- (A6) Developing management capacity
- (A7) Research
- (A8) Women in development and health care
- (A9) Financial control: external auditing

- (B1) Describing financing schemes
- (B2) Service characteristics and resources
- (B3) Planning projects
- (B4) Designing projects
- (B5) Implementing projects
- (B6) Incorporating microeconomic factors
- (B7) Establishing accounting practices
- (B8) Monitoring and evaluation
- (B9) Types of services
- (B10) Operations research

- (C1) Managing human resources
- (C2) Managing funds
- (C3) Management by Objectives

- (D1) Managing information
- (D2) Linking with institutions
- (D3) Collaborating with other sectors

The most detailed level of a description of the problems addressed in the document is found in the field PROBLEM SUBCATEGORIES. Not all papers allow such specificity.

A narrative summary of the main problem follows in the field PROBLEM IDENTIFIED. Its CAUSES are explained, IMPLICATIONS, SUGGESTIONS, TRAINING IDEAS and ANALYST COMMENTS are also noted. The last five fields have not yet been used extensively.

### **2.3 AskFINE RECORDS**

AskFINE contains a total of 106 records, representing 80 documents. A few documents are spread out over three or four records because of more elaborate summaries. In these instances all records belonging to one document carry the same identification number, and most fields carry the same contents. However, the field NUMBER OF RECORDS will read 1 of 3, 2 of 4, etc. instead of 1. The summary is continued sequentially. As mentioned before, the first record in the knowledgebase describes all fields as an instant help to the user.

Another 21 records are country profiles. These are not based on one particular document, they rather provide an overview over the economic and health sector situation and of child survival activities in one country and a summary of experience related to sustainability. A list of references accompanies each profile.

### 3 GET STARTED

---

If a hard disk is available the following procedure provides the fastest way to install NOTEBOOK II and AskFINE.

Create a subdirectory, "notebook" or "askfine", on a hard disk. Copy the contents of the two NOTEBOOK II disks and of the AskFINE disk into that directory. Use the DOS command, for example if the diskettes are in drive A and the "askfine" subdirectory is on drive C:

```
> COPY A:*. * C:\ASKFINE.
```

Change the directory to "askfine" with the DOS command:

```
> CD \ASKFINE.
```

Now start NOTEBOOK by typing:

```
> NB and press the [ENTER] key.
```

The main menu of NOTEBOOK will appear. Select NAME from this menu and type "FINE\_001" (without quotation marks). This tells NOTEBOOK with which file (knowledgebase) to work.

There are several ways to select an option from any of the different NOTEBOOK menus.

1. Press the first letter of the option.
2. Press [Spacebar] to move the highlight and press enter once the right choice is highlighted.
3. Use the [Tab] key to move the highlight forward.
4. Use the [Shift]-[Tab] keys to move the highlight backward.

## 4 SCREEN THE CONTENTS OF ALL RECORDS AND QUIT NOTEBOOK

---

Selecting EDIT from the main NOTEBOOK menu lists the contents of record after record. The EDIT function would allow the user to modify the contents or the records, however, the contents of the knowledgebase should not be changed without the approval of the analysts who reviewed the document. Later on it will be described how the user can add his own comments to an existing record or how to add new records for additional documents reviewed.

The [PgDn] or [PgUp] keys move from record to record. Use the cursor keys or [Ctrl]-[PgDn] or [Ctrl]-[PgUp] keys to move within a record from letter to letter or between lines and paragraphs. The [F3] and [F4] keys move from field to field. All key functions used by NOTEBOOK can be viewed on screen by pressing the [F1] key. Press [Esc] to leave this help screen.

Press the [Esc] key to display a menu on the bottom of the screen. The options BEGINNING, END and GOTO take the user to the first, last or the specified record. Select QUIT to get back to the NOTEBOOK main menu. The option QUIT on the main menu exits NOTEBOOK and the user is back at the DOS level of the computer system.

## 5 FIND KEYWORDS OR PHRASES

---

The function most frequently used in a knowledgebase is to FIND a specific text. This option is available once EDIT has been selected from the NOTEBOOK main menu and the edit menu is displayed by pressing [Esc].

Now all field names are displayed. Move the highlight with the cursor keys to the field name which shall be searched for certain text. FIELD TO FIND: will display this field name. Use the [Tab] key to move to TEXT TO FIND: and enter the keyword or phrase to be found. It can be up to 20 characters long including spaces. No quotation marks should be used.

**Example:** If the field KEY PROBLEMS is chosen and one wants to find the text "service" (upper or lower case can be used), then all occurrences of:

- A,3 Health services
- B,2 Service characteristics and resources
- B,9 Types of services

will be found. If "services" instead of "service" is used B,2 will not be included.

LOCATION is usually set to "anywhere". This assures that words or parts of a word can be found anywhere in a field, even in lengthy summaries of several pages.

DIRECTION is usually set to "forward". No matter which option is selected, the entire knowledgebase is always searched, even records before the current record.

Once FIELD and TEXT are specified press [ENTER] and NOTEBOOK will stop at the first occurrence of the phrase. Press [Shift]-[F4] to find the next occurrence in the next record. Press [Shift]-[F3] to find the next occurrence in the same record.

The problem related fields are particularly useful for searches, because they use a standard set of keywords (listing in record number one). Fields with fewer text produce faster results than fields with lots of text such as the SUMMARY field. If it is not known where a phrase might be found, NOTEBOOK can be requested to search all fields in a record by selecting {RECORD} as a FIELD TO FIND. However, this requires more time to find the text.

## 6 SELECTING A SUBSET OF RECORDS, CREATING A VIEW

---

Many times one might be interested only in documents from one or two countries for example. It is a good way to limit the information accessible to just these countries. This is less distracting and makes searches faster. Chose the SELECT option from the EDIT menu. The difference between FIND and SELECT is that SELECT renders only a subset of records accessible (even though all records are still physically present in the knowledgebase, they are only invisible).

As for the FIND function before, highlight the FIELD: on which to select records. Use the [Tab] key to move to the conditions. Select among conditions by moving the highlight with the [Spacebar]. For text one usually would chose the options CONTAINS, EXCLUDES or BEGINS WITH. Use the [Tab] key again to the TEXT option and enter the keyword or phrase (without quotation marks).

**Example:** For the field PROVIDER LOCATION select if it CONTAINS the text "Mali", or, alternately, "b,14".

Press [ENTER] when all options are correct. Other conditions can be added in the same way, but this is optional. NOTEBOOK will ask the user to give a name to the view of up to eight characters. Now only documents referring to Mali will be visible. To find a specific phrase within these records use the FIND function as in the previous chapter.

The option VIEW from the EDIT menu allows a selection among different views previously created. To see all record again rather than selected ones in a view, select the option UTILITIES from the NOTEBOOK main menu (not from the EDIT menu). Select VIEW from the UTILITIES menu and chose VIEW ALL RECORDS. QUIT and select EDIT from the main menu to list all records.

## **7 ADD COMMENTS IN USER DEFINED FIELDS, ADD NEW RECORDS**

---

AskFINE provides the user with six unused fields, named USER-DEFINED FIELD, which can serve for comments. First rename the fields to be used by selecting the option HEADING from the EDIT menu. Move the highlight to the field and type in a new name. Press [Esc] and chose the SAVE option if the new field names are correct.

Now text can be entered by typing it to the right of the field name like in a word processor. Words are wrapped to a new line automatically at the end of each line. Press enter for new paragraphs only.

The space for some records is very limited, a number in the middle in the bottom of the screen displays the amount available in percent for the current record. For safe operations of NOTEBOOK leave at least 1% room in each record. Zero percent might cause problems and loss of information.

To add reviews of new documents simply go to the last record and press [PgDn]. An empty new record appears. Fill in text as available following the outline of AskFINE.

## 8 PRINT ALL FIELDS OR CUSTOM REPORTS

---

Selecting the option PRINT from the NOTEBOOK main menu when all records were displayed (no view selected), all records and all fields with their corresponding contents will be printed. Field names are always on the left, separated by a vertical line from the contents. If a view was selected only records in that view will be printed.

A more comprehensive printout is obtained by selecting a report format before printing. Select the option FORMAT from the PRINT menu and highlight the custom format provided with AskFINE or created by the user. AskFINE comes with three custom formats:

**SHORT:** Provides a summary list of the documents reviewed. Contains information about title, author, year of publication and few other problem related fields.

**LONG:** Provides more information by including the summary.

**BIBLIO:** Lists all documents reviewed by author, title, source, year published and document ID.

Depending on the type of printer and the paper size, some adjustments might have to be made through the OPTIONS in the PRINT menu. Trial and error will provide correct results. The page length should be set to 66 line for 11 inch paper or 72 lines for 12 inch paper on a matrix printer. A Hewlett Packard laser printer requires 60 lines for 11 inch and 66 lines for 12 inch paper. Other settings should not be changed initially. It might be easier to select a smaller character print on the printer control panel to obtain a satisfying output.

## APPENDIX: AskFINE SAMPLE RECORD AND FIELD DEFINITION

---

KEYNAME	FIRST RECORD: Sample Record of AskFINE Format,  FINancing hEalth care in developing countries.  This record describes the contents of each field.  Keyname: Author date  E.g., Koita 1989
DOCUMENT ID	Identifies a document in the FINE collection.  E.g., "89.001" refers to a document published in 1989  that was the first one to be added to the FINE  Collection. For documents without dates of  publication, "ND" is used.
NUMBER OF RECORDS	Used to indicate two things: (1) When a document is  annotated with only one record, a "1" is entered  because there is only 1 entry ("record") for this  document; and (2) when a document is annotated with a  long summary which exceeds the limit, then there are  multiple entries ("records") for one document. This  is indicated as follows: "1 of 4" means that the  user is looking at the first of four entries. Thus,  "3 of 5" means that the user is looking at the third  of five entries for that document.   Note: if you wanted to locate the first record  only (entry #1) for ONLY those documents that have  summaries of several records, then you would use the  "select" process to search for "1 of" not just "1".  If the word "of" is added in this select process, this  indicates that you want only those documents annotated  with MORE than just a summary.
LAST NAME	E.g., Koita
FIRST NAME	E.g., Amadou
OTHER AUTHORS	E.g., and Joseph Brunet-Jailly
TITLE	Title of paper. DO NOT put in quotation marks.  E.g., Recurrent Costs in the Health Sector
EDITOR(S)	Brian Abel-Smith and Andrew Creese
ARTICLE/CHAPTER	Titles of articles in journals or chapters in books.  DO NOT put in quotation marks.  E.g., Chapter 2, Mali
JOURNAL/SOURCE	Used for two purposes: (1) when the citation is an  article in a journal, the name of the journal is here;  and (2) when the citation is an unpublished paper,  the source is here, e.g., institutional affiliation or  conference name and date.
VOLUME	E.g., none
ISSUE	E.g., WHO/SHS/NHP/89.8
PUBLISHER	E.g., WHO/USAID

EAR AGES	E.g., 1989  Used for two purposes: (1) when the document is an entire separate book or paper, numbers and "pp." are used; e.g., 165 pp.; and (2) when the document is an article or chapter from an edited volume, only page numbers are used, including first and last page, without "pp". E.g., 45-92
LOCATION/CALL NO.	Indicates whether the document is in an institution such as the Harvard library system or in a personal collection of documents. Identify the following:  (1) Institutional or personal   E.g., institutional  (2) Name of institution or person keeping the document, city.   E.g., HIID, Boston   E.g., REDSO, Abidjan  (3) Library number or other identifier   E.g., none
EXPERIENCE FRAME	Short description of information:  E.g., Information collected: during 1983 to 1987   Information collected by: Institute National pour la Recherche en Sante Publique, Bamako, Mali   Source of funding: USAID   Coordination: WHO
EXPERIENCE REPORTED	(1) Methodology paper  (2) Project evaluation  (3) Analytical paper  (4) Management Case  (5) Household survey  (6) Demand and/or utilization analysis  (7) Cost recovery experience  (8) Cost analysis  (9) Financial analysis  (10) From presentation, conference proceedings  (11) Government policy statement  (12) Bibliography  (13) Directory of organizations  (14) "How-to" guide   "Project evaluation" includes not only official evaluations, but descriptions of projects with analyses of strengths and weaknesses. That is, any document including information about a specific project will receive this label. If the evaluation is USAID-related, this will be indicated in the field "Analyst Comments" with the statement: "This is a USAID-related paper."
SUMMARY	Presents the summary and conclusions of the document.
SUMMARY SOURCE	Identifies the source of the summary: the author, the analyst (initials and organization), or both. E.g., "EFK" or "Author" or "Author and EFK"
PROJECT SPONSOR	(A) Local government

	(B) USAID mission
	(C) AID central project
	(D) World Bank, WB
	(E) World Health Organization, WHO
	(F) UNICEF
	(G) Other, specify
PROJECT CLIENTS	Describes the characteristics of clients assisted by   the services or project(s) reviewed in the document:
	(A) Age group
	(1) Children under five years
	(2) Women in their reproductive age (15-44           years)
	(B) Rural or urban
	(C) Income
	(1) Poor
	(2) Self sufficient
	(3) Affluent
	(D) Income from
	(1) Modern sector
	(2) Informal sector
	(E) Main activity to earn income
	(1) Subsistence farming
	(2) Cash crop farming
	(3) Fishing or hunting
	(4) Wage earning
	(5) Trade or business
	(F) Other, specify
PROJECT STARTED	The year project activities were established.
SERVICE PROVIDER	Service organization which provided the data presented   in the document. Postal address, FAX, TELEX and   telephone, if available
	E.g., Ministry of Health, Bamako, Mali
PROVIDER TYPE	Used to classify a provider in terms of four   attributes; separate by comma and space:
	(A) Type
	(1) PVO
	(2) Government health services: entire sector           representing the total consumption
	(3) Legal organization
	(4) Development bank
	(5) Commercial bank
	(6) Cooperative
	(7) Association
	(8) Business institution or enterprise
	(B) Sector
	(1) Private
	(2) Public
	(3) Public and private
	(4) Parastatal
	(C) Scope
	(1) Local
	(2) Regional
	(3) National
	(4) International

	(D) Organization
	(1) Centralized
	(2) Decentralized
	(3) Gender specific: female or male
	E.g. A,2 B,3 C,3 D,1
	Government, public and private, national,
	centralized
SERVICE CATEGORY	Used to classify the focus of the provider:
	(A) Health service provider
	(B) Consultant
	(C) Training
	(D) Technical assistance
	(E) Research
	E.g. Health service provider
TYPES OF SERVICE	The main type of medical service(s) provided as
	discussed in the document.
	(A) Preventive care
	(B) Curative care
	(C) Special programs or clinics
FINANCING SERVICES	Indicates how the provider's services are financed.
	(A) Type
	(1) Government free care or semi-free care
	(2) Community based or operated
	(3) Not for profit
	(4) Private for profit
	(B) Subsidy
	(1) Fully subsidized
	(2) Partly recovering costs, subsidized
	(3) Fully self-sufficient, no subsidy
	(C) Adequacy of financing
	(1) Adequate
	(2) Insufficient, underfinanced
PROVIDER LOCATION	Indicates where provider's project(s) or activities
	are located.
	(A) Geographic area
	(1) Africa(S) (sub-Saharan Africa)
	(B) Name of Country
	(1) Benin
	(2) Burkina Faso
	(3) Cameroon
	(4) Central African Republic
	(5) Chad
	(6) Congo
	(7) Gabon
	(8) Gambia
	(9) Ghana
	(10) Guinea
	(11) Guinea-Bissau
	(12) Ivory Coast
	(13) Liberia
	(14) Mali
	(15) Mauritania

- | (16) Niger
- | (17) Nigeria
- | (18) Senegal
- | (19) Sierra Leone
- | (20) Togo
- | (21) Zaire
- | (22) Other, specify
- | (C) Name of city, town, or village (where possible)
- | (D) Location
  - | (1) urban
  - | (2) rural
  - | (3) urban and rural
  - | (4) community

| Word order is important when using the "SELECT"  
 | process. Searching for "rural and urban," will NOT  
 | find all of the category 3 entries. Using "D,3" will  
 | avoid this problem.

PROVIDER SIZE & AGE | Indicates the provider's type of institutions, number  
 | of institutions operated or supervised, average  
 | institution size, whether the institutions are new or  
 | existing.

- | (A) Type of institutions
  - | (1) Hospital
  - | (2) Health Center
  - | (3) Dispensary
  - | (4) Health Post
  - | (5) Nutrition Center
  - | (6) Special Clinic, Sanatorium
  - | (7) Pharmacy
  - | (8) Other, specify
- | (B) Number of institutions
  - | (1) 1
  - | (2) 2-5
  - | (3) 6-10
  - | (4) Over 10
- | (C) Average size of institution assisted
  - | (1) Curative services: inpatient beds
    - | (a) 0
    - | (b) 1 - 49
    - | (c) 50 - 199
    - | (d) 200+
- | (D) Start-ups (new institution) or existing health  
 | institutions;
  - | (1) Start-ups
  - | (2) Existing

AREA CHARACTERISTIC | Indicates additional information about area covered  
 | by the provider of services.

- | (A) Religion
  - | (1) Islam
  - | (2) Christianity
  - | (3) Judaism
  - | (4) Hinduism
  - | (5) Buddhism

	(6) Traditional beliefs
	(7) Other
	(B) Ethnic group
	(C) Other, specify
MAIN PROBLEM CAT.	This field and the following eight fields constitute the "analysis of key problems" section of the knowledge base. The three layers of categories go from general to specific, only certain categories follow from "Policy," and these are distinct from the categories that follow from "Cost recovery."
	(A) Policy
	(B) Cost recovery
	(C) Management
	(D) Communications
KEY PROBLEMS	(A1) Macroeconomic environment
	(A2) Microeconomic factors
	(A3) Health services
	(A4) Health policy issue
	(A5) Pharmaceutical policy and regulations
	(A6) Developing management capacity
	(A7) Research
	(A8) Women in development and health care
	(A9) Financial control: external auditing
	(B1) Describing financing schemes
	(B2) Service characteristics and resources
	(B3) Planning projects
	(B4) Designing projects
	(B5) Implementing projects
	(B6) Incorporating microeconomic factors
	(B7) Establishing accounting practices
	(B8) Monitoring and evaluation
	(B9) Types of services
	(B10) Operations research
	(C1) Managing human resources
	(C2) Managing funds
	(C3) Management by Objectives
	(D1) Managing information
	(D2) Linking with institutions
	(D3) Collaborating with other sectors
PROBLEM SUBCATEGORY	(A1) (a) Debt service
	(b) Economic crisis
	(A2) (a) Exemption policy for indigent care (persons)
	(b) Exemption policy for medical conditions
	(c) Budget shortage, underfinancing
	(d) Competitive environment
	(e) Equity
	(f) Sustainability: Creating autonomy, self-sufficiency
	(g) Mobilizing additional resources

- (h) Containing costs
  - (1) Reduce scope of services
- (A3) (a) Traditional medicine: collaboration with modern sector
- (b) Preventive services linked to curative care
  - (1) Immunization: routine vs. accelerated
  - (2) Oral rehydration therapy: integration
  - (3) Maternal and child health: reinforce
  - (4) Family planning: political acceptance
  - (5) Malaria control: prophylaxis & resistance
  - (6) Nutrition: supplement vs. behavioral change
  - (7) HIV infection, AIDS: counseling
  - (8) Other, specify
- (c) Curative services: distribution of resources
- (d) Geographic distribution of services
- (e) Scope of services: comprehensive vs. selective
- (f) Changing the structure of the health sector
  - (1) Degree of privatization
- (A4) (a) Free care policy vs. user fees
- (b) Retention of fees at provider level
- (c) Low cost, efficient purchasing and distribution of essential drugs
- (d) Role of the private sector to contribute to the common good
- (e) Government subsidies to the private sector
- (f) Decentralization vs. centralization
- (g) Employment based health care and health financing
- (h) Foreign exchange requirements
- (i) Foreign support, technical assistance
- (j) Detecting resistance or acceptance
- (k) Developing political support
- (A6) (a) Strategic goals
- (b) Medium term planning
- (c) Pilot projects
- (d) Institutional capacity building
- (e) Becoming efficient
  - (1) Identify managerial constraints
  - (2) Improve efficiency of services
  - (3) Provide staffing and support
  - (4) Identify the level of know-how
- (B1) (a) Government budget or taxes
- (b) Structural adjustment
- (c) Budget reallocations
- (d) Privatization
- (e) Health insurance
  - (1) Reduce adverse selection
  - (2) Prevent moral hazards
  - (3) Be aware of anti-selection
- (f) Prepayment plans
- (g) Fee for service
- (h) Price discrimination: amenity wards,

- | population subgroups, geography
- | (i) Revolving drug funds
- | (j) Pricing of services: cross-subsidizing services and essential drugs
- | (k) Manufacture essential drugs nationally
- | (l) Production based prepayment: cooperatives
- | (m) Other forms of community participation: labor donation, volunteerism
- | (n) Ad hoc fund raising
- | (o) Donor financing
- | (p) Other, specify
- | (B2) (a) Select type of services covered
- | (b) Pricing of services: set fee structure
- | (c) Collection of financial data
- | (d) Fee collection procedures
- | (e) Incentives for fee collection
- | (f) Revenue management
- | (g) Use of revenues
- | (h) Assess wealth of target population
- | (i) Identify provider characteristics
- | (j) Identify payor characteristics
- | (k) Identify sources of revenues
- | (l) Calculate cost and expenditures
- | (m) Calculate costs recovered
- | (n) Predict and monitor main effects
- | (B3) (a) Prioritizing projects
- | (1) Assessing the need
- | (2) Knowing the demographic environment
- | (3) Knowing the socioeconomic environment
- | (4) Assess the epidemiologic environment
- | (5) Analysing the organization: public/private
- | (6) Considering feasibility
- | (7) Targeting populations
- | (c) Objectives, activities, indicators
- | (d) Estimat required resources: capital costs, recurrent costs, personnel
- | (e) Identifying sources of funding
- | (f) Identify key players
- | (g) Select appropriate technical assistance
- | (B4) (a) Sequencing of activities
- | (b) IEC, KAP surveys and research
- | (c) Sollicit participation
- | (d) Client selection, minimize fraud
- | (e) Integrate cost recovery into project proposals and ongoing projects
- | (f) Short term budgeting
- | (g) Medium/long term financial planning
- | (B6) (a) Assessing demand for care
- | (b) Determining price elasticity for care
- | (B8) (a) Establish management information systems
- | (b) Assess quality of services
- | (c) Assess coverage
- | (d) Provide field support and supervision

- (B9)(a) Simple curative services
  - (1) Hospitalization
  - (2) Ambulatory care
- (b) Preventive services
  - (1) Immunization
  - (2) Oral rehydration therapy
  - (3) Maternal and child health
  - (4) Family planning
  - (5) Malaria control
  - (6) Nutrition
  - (7) AIDS prevention and control
  - (8) Essential drug supply
  - (9) Other, specify
- (B10)(a) Cost-minimization analysis
- (b) Cost-effectiveness analysis
- (c) Cost-benefit analysis
- (d) Cost-utility analysis
- (e) Utilization of services
- (f) Predicting trends
- (C1)(a) Dealing with personnel:
  - government/private
- (b) Hiring staff
- (c) Dealing with disciplin
- (d) Training staff
- (e) Motivating staff
- (f) Coordinating personnel
- (C2)(a) Assisting communities in
  - financial management
- (b) Developing institutional capacity
- (D1)(a) Learning from feedback
- (b) Evaluating programs
- (D2)(a) Networking with other resource
  - institutions of similar type
- (b) The role of Public Health Schools
- (c) Public relations and publicity campaign
- (d) Communicating between government and
  - private sector
- (e) Linkages with governments and
  - international donors
- (D3)(a) Collaborate with sectors public works
  - or mines and power for water supply
  - and sanitation
- (b) With agriculture for nutrition

This field helps to locate documents addressing key specific problems. The format is as follows: The "higher" level (Letters A through I) is always entered, and the "lower" or more detailed level (i.e. numbers 1 through 10 or small letters a to e) may or may not be entered. "Letter" levels are separated from "number" levels by a comma. Thus, the user can use the "select" process to explore the data base at

any level of detail. Do not include quotes:  
 E.g. "Microeconomic factors, Fee collection  
 procedures"  
 or to save typing: "Fee collection" or "B,2"

**PROBLEM IDENTIFIED** | Presents a substantive, concise discussion of the  
 | targeted problem. If the situation involved a  
 | successful outcome, this is noted at the beginning of  
 | the field with the following word: "(Success)." If  
 | the situation had a negative outcome, this is noted at  
 | the beginning of the field with the word: "(Failure)".

**PROBLEM CAUSES** | Presents a substantive exploration of problem causes.  
**IMPLICATIONS** | Discusses the implications of the targeted problem for  
 | either provider or clients; also may include the  
 | broader implications for small-scale initiatives.

**SUGGESTIONS** | Discusses recommendations put forth by the author(s).  
**RELATED REFERENCES** | List references provided in the document related to  
 | topic of interest.

**TRAINING IDEAS** | Presents specific training ideas and methods included  
 | in the document.

**ANALYST COMMENTS** | Presents the responses and/or additional knowledge of  
 | the analyst. Also used to cross reference entries,  
 | and to give other citations containing pertinent  
 | information.  
 | If the document pertains to a USAID project, or to  
 | USAID's role in a program, the record will include the  
 | statement: "This is a USAID-related paper."  
**ANALYST** | E.g., EFK refers to Eckhard F.Kleinau, specify  
 | Institution and Project as applicable. Names of all  
 | analysts can be found in the AskFINE handbook.

**COPYRIGHT** | Copyright of this summary:  
**COMMENTS** | Can be treated as a USER-DEFINED FIELD  
**USER-DEFINED FIELD** | [USER CAN RENAME HEADINGS CALLED "USER DEFINED  
 | FIELD", THUS ALLOWING INFORMATION FROM OTHER SOURCES  
 | TO BE ADDED TO A RECORD.]

**USER-DEFINED FIELD** |  
**USER-DEFINED FIELD** |  
**USER-DEFINED FIELD** |  
**USER-DEFINED FIELD** |  
**USER-DEFINED FIELD** |

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## **APPENDIX: LIST OF DOCUMENTS REVIEWED AND COUNTRY PROFILES**

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# **AskFINE**

**Financing Health Care  
in Developing Countries**  
*A Knowledgebase*

## **Bibliography**

**Eckhard Kleinau  
Donald Shepard  
Wayne Stinson  
Ronald Vogel**

**Boston, September 1990**



AUTHOR: Chelemu WC  
TITLE : Essential Drugs Programme and the Bamako Initiative  
SOURCE:  
EXPERIENCE REPORTED: 15 Strategy paper  
PROVIDER LOCATION :  
MAIN PROBLEM CATEGORY: policy  
KEY PROBLEMS :

DOCUMENT ID: 90.009 YEAR PUBLISHED: 1990  
AUTHOR: Knippenberg Rudolph  
TITLE : The Bamako Initiative: Primary Health Care Experience  
SOURCE: Children in the Tropics  
EXPERIENCE REPORTED: 7 cost recovery experience  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin B,10 Guinea  
MAIN PROBLEM CATEGORY: A policy B cost recovery C management  
KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services  
A,4 Health policy issues A,6 Developing management capacity B,1  
Describing financing schemes B,2 Service characteristics and resources  
B,8 Monitoring and evaluation B,9 Types of services C,2 Managing funds

DOCUMENT ID: 88.010 YEAR PUBLISHED: 1988  
AUTHOR: Mandl Pierre E  
TITLE : Community Financing Experiences for Local Health Services in  
Africa  
SOURCE: UNICEF Staff Working Paper No.2  
EXPERIENCE REPORTED: 7 cost recovery experience  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin B,9 Ghana B,21  
Zaire  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications  
KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services  
A,4 Health policy issues B,1 Describing financing schemes B,2 Service  
characteristics and resources D,3 Collaborating with other sectors

DOCUMENT ID: 88.011 YEAR PUBLISHED: 1988  
AUTHOR: Mandl Pierre E  
TITLE :  
SOURCE: UNICEF, Staff working Paper No.3  
EXPERIENCE REPORTED: 12 Bibliography  
PROVIDER LOCATION : A,1 Sub-Saharan Africa  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery C Management D  
Communications  
KEY PROBLEMS :

DOCUMENT ID: 90.012 YEAR PUBLISHED: 1990  
AUTHOR: UNICEF  
TITLE : Revitalizing Primary Health Care / Maternal and Child Health:  
The Bamako Initiative, Progress Report  
SOURCE: United Nations Children's Fund, Executive Board

EXPERIENCE REPORTED: 16 Progress report  
PROVIDER LOCATION : A,1 Sub-Saharan Africa Nigeria, Benin, Guinea,  
Sierra Leone, Ghana  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 89.013 YEAR PUBLISHED: 1989  
AUTHOR: UNICEF  
TITLE : Recommendations to the Executive Board for Program Cooperation  
within the Framework of the Bamako Initiative  
SOURCE: United Nations Children's Fund, Programme Committee  
EXPERIENCE REPORTED: 15 Strategy paper  
PROVIDER LOCATION : A,1 Sub-Saharan Africa  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 89.014 YEAR PUBLISHED: 1989  
AUTHOR: UNICEF, HAI, OXFAM  
TITLE : Report on the International Conference on Community Financing  
in Primary Health Care  
SOURCE:  
EXPERIENCE REPORTED: 10 Conference proceedings  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin B,9 Ghana B,11  
Guinea-Bissau B,19 Sierra Leone  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications  
KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services  
A,4 Health policy issues A,6 Developing management capacity B,1  
Describing financing schemes B,2 Service characteristics and resources  
D,3 Collaborating with other sectors

DOCUMENT ID: 90.015 YEAR PUBLISHED: 1990  
AUTHOR: Fabricant Stephen J  
TITLE : Community Health Financing in Sierra Leone: Initial Results of  
an Operations Research Study  
SOURCE:  
EXPERIENCE REPORTED: 5 Household survey  
PROVIDER LOCATION : A,1 Sub-Saharan Africa  
MAIN PROBLEM CATEGORY: B Cost recovery  
KEY PROBLEMS : B,10 Operations research

DOCUMENT ID: 89.016 YEAR PUBLISHED: 1989  
AUTHOR: Campagne Pierre  
TITLE : Technical Conference on Community Financing to Strengthen  
Local Health Services in Francophone Africa  
SOURCE:  
EXPERIENCE REPORTED: 10 Conference proceedings Synthesis Report of  
meeting organized by UNICEF in cooperation with the French Committee  
for UNICEF

PROVIDER LOCATION : A,1 Sub-Saharan Africa Senegal, Mauritania, Congo, Togo, Burkina Faso, Zaire  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications  
KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services A,4 Health policy issues A,6 Developing management capacity B,1 Describing financing schemes B,2 Service characteristics and resources D,3 Collaborating with other sectors

DOCUMENT ID: 88.018

YEAR PUBLISHED: 1988

AUTHOR: REACH

TITLE : Proceedings from the Resources for Child Health (REACH) Project Workshop in Health Care Financing

SOURCE:

EXPERIENCE REPORTED: 10 Conference proceedings

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,4 Central African Republic B,6 Congo B,8 Gambia B,10 Guinea B,12 Ivory Coast B,13 Liberia B,17 Nigeria B,20 Togo B,21 Zaire

MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services A,4 Health policy issues A,6 Developing management capacity B,1 Describing financing schemes B,2 Service characteristics and resources D,3 Collaborating with other sectors

DOCUMENT ID: 88.019

YEAR PUBLISHED: 1988

AUTHOR: Dunlop David W

TITLE : A Comparative Analysis of CCCD Project Health Care Financing Activities

SOURCE: REACH Project

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,4 Central African Republic B,6 Congo B,8 Gambia B,10 Guinea B,12 Ivory Coast B,13 Liberia B,17 Nigeria B,20 Togo B,21 Zaire

MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

KEY PROBLEMS : A,1 Macroeconomic environment A,2 Microeconomic factors A,3 Health services A,4 Health policy issues A,6 Developing management capacity B,1 Describing financing schemes B,2 Service characteristics and resources B,8 Monitoring and evaluation B,9 Types of services D,3 Collaborating with other sectors

DOCUMENT ID: 87.020

YEAR PUBLISHED: 1987

AUTHOR: Brenzel Logan E

TITLE : Planning the Financing of Primary Health Care: Assessing Alternative Methods

SOURCE: REACH Project

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,21 Zaire

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services A,4 Health policy issues A,6 Developing management capacity B,1

Describing financing schemes B,2 Service characteristics and resources  
B,6 Incorporating microeconomic factors B,8 Monitoring and evaluation

DOCUMENT ID: 85.021 YEAR PUBLISHED: 1985  
AUTHOR: Stevens Carl M.  
TITLE : Cost Recovery by Government Hospitals in LCDs: A Key Element  
in Startegy to Increase the Commitment of Resources to Primary Health  
Care (PHC)  
SOURCE: REACH project  
EXPERIENCE REPORTED: 15 Strategy paper  
PROVIDER LOCATION : A,1 Sub-Saharan Africa  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS :

DOCUMENT ID: 88.022 YEAR PUBLISHED: 1988  
AUTHOR: Bitran Ricardo A  
TITLE : Health Care Demand Studies in Developing Countries  
SOURCE: REACH project  
EXPERIENCE REPORTED: 6 Demand analysis  
PROVIDER LOCATION :  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 88.023 YEAR PUBLISHED: 1988  
AUTHOR: Lewis Maureen A  
TITLE : The Private Sector and Health Care Delivery in Developing  
Countries: Definition, Experience, and Potential  
SOURCE: REACH project  
EXPERIENCE REPORTED: 7 Cost recovery experience  
PROVIDER LOCATION : A,1 Sub-Saharan Africa  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services  
A,6 Developing management capacity B,1 Describing financing schemes  
B,8 Monitoring and evaluation

DOCUMENT ID: ND.024 YEAR PUBLISHED: ND  
AUTHOR: Birch and Davis  
TITLE : Evaluating Health Care Financing and Privatization  
Alternatives  
SOURCE: Birch and Davis International Inc.  
EXPERIENCE REPORTED: 15 Strategy paper  
PROVIDER LOCATION :  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,3 Health services A,6 Developing management  
capacity B,1 Describing financing schemes

DOCUMENT ID: 90.025 YEAR PUBLISHED: 1990

54'

AUTHOR: UNICEF  
TITLE : The State of the World's Children  
SOURCE: UNICEF  
EXPERIENCE REPORTED: 16 Progress report  
PROVIDER LOCATION :  
MAIN PROBLEM CATEGORY: A Policy  
KEY PROBLEMS : A,1 Macroeconomic environment A,2 Microeconomic factors A,3 Health services A,4 Health policy issue

DOCUMENT ID: 89.026 YEAR PUBLISHED: 1989  
AUTHOR: McGuire Judith S  
TITLE : Beyond Survival: Children's Growth for national Development  
SOURCE: Assignment Children, UNICEF  
EXPERIENCE REPORTED: 15 Strategy paper  
PROVIDER LOCATION :  
MAIN PROBLEM CATEGORY: A Policy  
KEY PROBLEMS : A,3 Health services

DOCUMENT ID: 89.027 YEAR PUBLISHED: 1989  
AUTHOR: Jiggins Janice  
TITLE : How Poor Women Earn Income in Sub-Saharan Africa and What Works Against Them  
SOURCE: World Development  
EXPERIENCE REPORTED: 3 Analytical paper  
PROVIDER LOCATION : A,1 Sub-Saharan Africa  
MAIN PROBLEM CATEGORY: A Policy  
KEY PROBLEMS : A,8 Women in development and health care

DOCUMENT ID: 88.028 YEAR PUBLISHED: 1988  
AUTHOR: WHO  
TITLE : Guideline for the Implementation of the Bamako Initiative  
SOURCE: WHO, Regional Office for Africa  
EXPERIENCE REPORTED: 15 Strategy paper  
PROVIDER LOCATION : A,1 Sub-Saharan Africa  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services B,1 Describing financing schemes

DOCUMENT ID: 86.029 YEAR PUBLISHED: 1986  
AUTHOR: Lieberman Joseph  
TITLE : Draft Report Health Sustainability in Africa: An Evaluation of the Factors of Sustainability in the Lesotho Rural Health Development Project  
SOURCE: USAID  
EXPERIENCE REPORTED: 2 Project evaluation  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,22 Lesotho  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications  
KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services

A,4 Health policy issues A,6 Developing management capacity B,3  
Planning projects D,2 Linking with institutions

DOCUMENT ID: 86.030 YEAR PUBLISHED: 1986  
AUTHOR: Bekele Abraham  
TITLE : Financing Health Care in the Sudan: Some Recent Experiments in  
the Central Region  
SOURCE: Social Science in Medicine  
EXPERIENCE REPORTED: 7 Cost recovery experience  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,22 Sudan  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,2 Microeconomic factors A,6 Developing  
management capacity B,1 Describing financing schemes

DOCUMENT ID: 87.031 YEAR PUBLISHED: 1987  
AUTHOR: Alihonou E  
TITLE : Community Financing in the Pahou Primary Health Care Project  
SOURCE: PRICOR  
EXPERIENCE REPORTED: 7 Cost recovery experience  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,4 Health policy issues B,1 Describing  
financing schemes B,2 Service characteristics and resources

DOCUMENT ID: ND.032 YEAR PUBLISHED: ND  
AUTHOR: NN  
TITLE : Projet de Developpement Sanitaire Pahou: Rapport de la  
Recherche Operationelle  
SOURCE: Pahou project  
EXPERIENCE REPORTED: 5 Household survey 7 Cost recovery experience  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin  
MAIN PROBLEM CATEGORY: B Cost recovery  
KEY PROBLEMS : B,1 Describing financing schemes B,2 Service  
characteristics and resources B,10 Operations research

DOCUMENT ID: 90.033 YEAR PUBLISHED: 1990  
AUTHOR: GREDONOU Placide D  
TITLE : L'INITIATIVE DE BAMAKO DANS LE CADRE DU PROGRAMME ELARGI DE  
VACCINATION INTEGRE AUX SSP AU BENIN  
SOURCE: UNICEF  
EXPERIENCE REPORTED: 7 Cost recovery experience  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin  
MAIN PROBLEM CATEGORY: B Cost recovery  
KEY PROBLEMS : B,1 Describing financing schemes B,2 Service  
characteristics and resources B,9 Types of services B,10 Operations  
research

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DOCUMENT ID: 88.034 YEAR PUBLISHED: 1988  
AUTHOR: TRAORE Abdoulaye  
TITLE : RESUME DE L'ETUDE DE LA CONSOMMATION DE MEDICAMENTS AU  
BURKINA-FASO  
SOURCE: UNICEF  
EXPERIENCE REPORTED: 6 Utilization analysis  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,2 Burkina Faso  
MAIN PROBLEM CATEGORY: B Cost recovery  
KEY PROBLEMS : B,1 Describing financing schemes B,2 Service  
characteristics and resources B,10 Operations research

DOCUMENT ID: 88.035 YEAR PUBLISHED: 1988  
AUTHOR: SONDO Blaise  
TITLE : PARTICIPATION COMMUNAUTAIRE DANS L'ORGANISATION DES SOINS  
PREVENTIFS DANS LA PROVINCE DU HOUEY.  
SOURCE: MOH Burkina-Faso  
EXPERIENCE REPORTED: 2 Project evaluation  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,2 Burkina Faso  
MAIN PROBLEM CATEGORY: B Cost recovery  
KEY PROBLEMS : B,1 Describing financing schemes B,2 Service  
characteristics and resources B,10 Operations research

DOCUMENT ID: 89.036 YEAR PUBLISHED: 1989  
AUTHOR: DES ROCHERS Gilles  
TITLE : COST RECOVERY IN THE PHC SERVICES OF CAMEROON  
SOURCE: USAID  
EXPERIENCE REPORTED: 7 Cost recovery experience  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,3 Cameroon  
MAIN PROBLEM CATEGORY: B Cost recovery  
KEY PROBLEMS : B,1 Describing financing schemes B,2 Service  
characteristics and resources B,10 Operations research

DOCUMENT ID: 89.037 YEAR PUBLISHED: 1989  
AUTHOR: WADDINGTON C.J.  
TITLE : A PRICE TO PAY: THE IMPACT OF USER CHARGES IN ASHANTI-AKIM  
DISTRICT GHANA  
SOURCE: International Journal of Health Planning and Management  
EXPERIENCE REPORTED: 7 Cost recovery experience  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,9 Ghana  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,2 Microeconomic factors A,6 Developing  
management capacity B,1 Describing financing schemes B,2 Service  
characteristics and resources B,10 Operations research

DOCUMENT ID: ND.038 YEAR PUBLISHED: ND  
AUTHOR: ISSAKA-TINORGAR Abdulai  
TITLE : ENCOURAGING EFFICIENCY THROUGH PROGRAMME AND FUNCTIONAL  
BUDGETING - LESSONS FROM EXPERIENCE IN GHANA AND THE GAMBIA.

## SOURCE:

EXPERIENCE REPORTED: 9 Financial analysis  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,8 Gambia B,9 Ghana  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,6 Developing management capacity B,1  
Describing financing schemes B,2 Service characteristics and resources  
B,3 Planning projects

DOCUMENT ID: 87.039

YEAR PUBLISHED: 1987

AUTHOR: BRUDON-JAKOBOWICZ Pascale  
TITLE : RAPPORT D'UNE MISSION OMS - Conakry  
SOURCE: WHO

EXPERIENCE REPORTED: 16 Progress report  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,10 Guinea  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy  
issus A,6 Developing management capacity B,1 Describing financing  
schemes B,2 Service characteristics and resources B,10 Operations  
research

DOCUMENT ID: 89.040

YEAR PUBLISHED: 1989

AUTHOR: UNICEF  
TITLE : PROGRAMME DE RELANCE DES SSP/INITIATIVE DE BAMAKO (YH 801) ET  
PROGRAMME D'APPUI A LA NUTRITION (ZN 804)  
SOURCE: UNICEF

EXPERIENCE REPORTED: 15 Strategy paper, project proposal  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy  
issus B,1 Describing financing schemes B,2 Service characteristics and  
resources B,9 Types of services

DOCUMENT ID: 89.041

YEAR PUBLISHED: 1989

AUTHOR: BRUNET-JAILLY J.  
TITLE : LE FINANCEMENT DE LA SANTE DANS LES PAYS PAUVRES : RECOUVRER  
LES COUTS OU LES REDUIRE

SOURCE: African Health Policy Paper, World Bank  
EXPERIENCE REPORTED: 9 Financial analysis  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,1 Macroeconomic environment A,2  
Microeconomic factors A,3 Health services A,4 Health policy issus A,6  
Developing management capacity B,1 Describing financing schemes B,2  
Service characteristics and resources B,8 Monitoring and evaluation  
B,9 Types of services

DOCUMENT ID: 87.042

YEAR PUBLISHED: 1987

AUTHOR: OMS

TITLE : LA PROBLEMATIQUE DU RECOUVREMENT DES COUTS DES SERVICES DE SANTE (MALI).

SOURCE: WHO-UNICEF

EXPERIENCE REPORTED: 7 Cost recovery experience 15 Strategy paper

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy  
issus A,6 Developing management capacity B,1 Describing financing  
schemes B,2 Service characteristics and resources

DOCUMENT ID: 87.043

YEAR PUBLISHED: 1987

AUTHOR: De Vos Leo

TITLE : FACT SHEET - COST RECOVERY

SOURCE: UNICEF-Mali

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy  
issus A,6 Developing management capacity B,1 Describing financing  
schemes B,2 Service characteristics and resources

DOCUMENT ID: 90.044

YEAR PUBLISHED: 1990

AUTHOR: Ministere de la Sante

TITLE : EVALUATION DES SYSTEMES DE GESTION DES SERVICES DE SANTE EN SEME REGION.

SOURCE: MINSANTE

EXPERIENCE REPORTED: 2 project evaluation 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy  
issus A,6 Developing management capacity B,1 Describing financing  
schemes B,2 Service characteristics and resources

DOCUMENT ID: 89.045

YEAR PUBLISHED: 1989

AUTHOR: UNICEF

TITLE : CONFERENCE TECHNIQUE SUR LE FINANCEMENT COMMUNAUTAIRE ET RECOUVREMENT DES COUTS.

SOURCE: UNICEF, New York, Paris

EXPERIENCE REPORTED: 10 Conference proceedings

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,15 Mauritania

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy  
issus A,6 Developing management capacity B,1 Describing financing  
schemes B,2 Service characteristics and resources

DOCUMENT ID: 87.046

YEAR PUBLISHED: 1987

AUTHOR: TAYLOR HASSOUNA MARY

TITLE : FAMILY PLANNING/MANAGEMENT TRAINING PROJECT

SOURCE: Management Science for Health/MOH  
EXPERIENCE REPORTED: 10 Conference proceedings  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,17 Nigeria  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,3 Health services B,3 Planning projects B,4  
Designing projects B,9 Types of services

DOCUMENT ID: 87.047

YEAR PUBLISHED: 1987

AUTHOR: WHO

TITLE : DRUG FINANCING EXPERIENCES IN NIGERIA Readings from Workshops,  
State Experiences, and Teaching Hospital Experiences

SOURCE: Ministry of Health, WHO

EXPERIENCE REPORTED: 7 Cost recovery experience 10 Conference  
proceedings

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,17 Nigeria

MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services

A,4 Health policy issues A,6 Developing management capacity B,1

Describing financing schemes B,2 Service characteristics and resources  
D,3 Collaborating with other sectors

DOCUMENT ID: 88.049

YEAR PUBLISHED: 1988

AUTHOR: Jeannee Emile

TITLE : PROJET PIKINE - PARTICIPATION ET DEVELOPPEMENT SANITAIRE EN  
KILISU URBAIN AFRICAIN

SOURCE: Cooperation Belge

EXPERIENCE REPORTED: 16 Progress report

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,18 Senegal

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy

issues A,6 Developing management capacity B,1 Describing financing  
schemes B,10 Operations research

DOCUMENT ID: 88.060

YEAR PUBLISHED: 1988

AUTHOR: MILLER Lynne

TITLE : RAPPORT DE LA MISSION SUR LA POSSIBILITE DE MISE EN PLACE  
POLITIQUE DE L'INITIATIVE DE BAMAKO AU TOGO

SOURCE: UNICEF-Togo

EXPERIENCE REPORTED: 2 Project evaluation 7 Cost recovery experience  
15 Strategy paper

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,20 Togo

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy

issues A,6 Developing management capacity B,1 Describing financing  
schemes B,10 Operations research

DOCUMENT ID: 87.061

YEAR PUBLISHED: 1987

AUTHOR: MILLER Lynne  
TITLE : LES POSSIBILITES D'AUTONOMIE FINANCIERE DE LA ZONE DE SANTE AU  
ZAIRE  
SOURCE: UNICEF  
EXPERIENCE REPORTED: 7 Cost recovery experience  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B.21 Zaire  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications  
KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services  
A,4 Health policy issues A,6 Developing management capacity B,1  
Describing financing schemes B,2 Service characteristics and resources  
D,3 Collaborating with other sectors

DOCUMENT ID: 90.062 YEAR PUBLISHED: 1990  
AUTHOR: Bamako Initiative Management Unit  
TITLE : Economic Crisis, Adjustment, and the Bamako Initiative:  
Health Care Financing in the Economic Context of Sub-Saharan  
Africa EDITOR(S):  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Sub-Saharan Africa  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 89.063 YEAR PUBLISHED: 1989  
AUTHOR: Blakney Richard B.  
TITLE : Financing Primary Health Care: Experiences in Pharmaceutical  
Cost Recovery.  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Ghana, Liberia, Mali, Nigeria, Zaire  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 89.064 YEAR PUBLISHED: 1989  
AUTHOR: Evlo Kodjo  
TITLE : Health Financing in Africa: Tracking the AID Experience in  
the Child Survival Emphasis Countries.  
SOURCE: REACH  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Mali, Niger, Zaire, Nigeria, and Senegal  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 88.065 YEAR PUBLISHED: 1988  
AUTHOR: Vogel Ronald J.  
TITLE : Cost Recovery in the Health Sector: Selected Country Case  
Studies in West Africa  
SOURCE: World Bank Technical Paper

## EXPERIENCE REPORTED:

PROVIDER LOCATION : Ivory Coast, Mali, Ghana, Senegal

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

DOCUMENT ID: ND.066

YEAR PUBLISHED:

AUTHOR:

TITLE : Reflexions sur l'Experience du Benin

SOURCE: Journal d'Information sur l'Initiative de Bamako

EXPERIENCE REPORTED:

PROVIDER LOCATION : Benin

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

DOCUMENT ID: ND.067

YEAR PUBLISHED: 1989

AUTHOR:

TITLE : Loi No. 89.003 Fixant les Principes Gn raux Relatifs la Sant Publique en Rpublique Centrafricaine, 1989"

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Central African Republic

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

DOCUMENT ID: 89.068

YEAR PUBLISHED: 1989

AUTHOR: Republique du Niger, Ministere de la Sante Publique  
Direction des Etudes et de la Programmation

TITLE : Quelques Elements sur la Situation Financiere du Secteur Sanitaire au Niger

SOURCE:

EXPERIENCE REPORTED: Document summarizes three donor-supported studies of health sector financing.

PROVIDER LOCATION : Niger

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

DOCUMENT ID: 89.069

YEAR PUBLISHED: Octobre

1989

AUTHOR: Republique du Niger Ministere de la Sante Publique

TITLE : Recherche operationelle sur la participation des populations aux frais de sante, Experience de Tibiri (dep. de Dosso)

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Niger

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

DOCUMENT ID: 88.070 YEAR PUBLISHED: 1988  
AUTHOR: Wong Holly  
TITLE : Cost Analysis of Niamey Hospital (Draft)  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Niger  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 89.071 YEAR PUBLISHED: 1989  
AUTHOR: %OTHER AUTHORS:  
TITLE : Seminaire/Atelier sur le Recouvrement des Coûts dans le  
Secteur Sanitaire  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Niger  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 89.072 YEAR PUBLISHED: 1989  
AUTHOR: Abt Associates, Inc. %OTHER AUTHORS:  
TITLE : Health Care Financing, Cost, and Utilization Study  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Nigeria  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 89.073 YEAR PUBLISHED: 1989  
AUTHOR: El-Hadj Birama N'Diaye  
TITLE : Discours  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Senegal  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 89.074 YEAR PUBLISHED: 1989  
AUTHOR: Munkatu Mpese  
TITLE : Organisation et performance du systeme de financement des  
zones de sant au Zaire  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Zaire  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.075 YEAR PUBLISHED: 1990  
AUTHOR: Shepard Donald S.  
TITLE : Health Insurance in Zaire (draft)  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Zaire  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.076 YEAR PUBLISHED: 1990  
AUTHOR: Alihonou E.  
TITLE : Community Financing of Health Services for the Improvement  
of Primary Health Care  
SOURCE: Panafrican Conference on Community Financing  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Benin, Guinea  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.077 YEAR PUBLISHED: 1990  
AUTHOR: UNICEF Bamako Initiative Management Unit  
TITLE : %EDITOR(S):  
SOURCE: Bamako Initiative Newsletter  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Sub-Saharan Africa  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.078 YEAR PUBLISHED: 1990  
AUTHOR: UNICEF Bamako Initiative Management Unit  
TITLE : Operations Research Issues Related to Community Financing of  
PHC Development  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Sub-Saharan Africa  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 86.079 YEAR PUBLISHED: 1986  
AUTHOR: Departement de la Sante Publique du Zaire  
TITLE : Health Zone Financing Study, Zaire: Final Report  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Zaire  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.080, french in 90,009 YEAR  
PUBLISHED: 1990  
AUTHOR: International Children's Centre  
TITLE : The Bamako Initiative: Primary Health Care Experience  
SOURCE: Special issue of Children in the Tropics.  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Benin, Guinea  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 88.081 YEAR PUBLISHED: 1988  
AUTHOR: UNICEF  
TITLE : Problems and Priorities regarding Recurrent Costs.  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Sub-Saharan Africa  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 87.082 YEAR PUBLISHED: 1987  
AUTHOR: Vian Taryn  
TITLE : Financial Management Information Systems in Four Zairian  
Health Zones  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,21 Zaire  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.083 YEAR PUBLISHED: 1990  
AUTHOR: Bossert Thomas J.  
TITLE : Can They Get Along Without Us? Sustainability of  
Donor-Supported Health Projects in Central America and Africa  
SOURCE: Social Science and Medicine  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Zaire, Senegal  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.084 YEAR PUBLISHED: 1990  
AUTHOR: Hatsell Theresa  
TITLE : Conclusions from the Study on Community Support of the  
Village Health Worker Program of Niger  
SOURCE: PRICOR study report  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Niger  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :



PROVIDER LOCATION : Liberia  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: ND.091 YEAR PUBLISHED: n.d.  
AUTHOR: Stewart Kathryn J.  
TITLE : Cost Effectiveness of Child Survival Initiatives: a  
Literature Review  
SOURCE: background paper for the Fourth Report to Congress on Child  
Survival  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Sub-Saharan Africa  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 88.091 YEAR PUBLISHED: 1988  
AUTHOR: University Research Corporation  
TITLE : ACSI-CCCD Sustainability Strategy (Draft)  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Sub-Saharan Africa  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.092 YEAR PUBLISHED: 1990  
AUTHOR: USAID  
TITLE : Project Paper for Burkina Faso Family Health and Health  
Financing Project  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Burkina Faso  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 89.093 YEAR PUBLISHED: 1989  
AUTHOR: Vogel Ronald J.  
TITLE : Cost Recovery in the Health Care Sector in Sub-Saharan  
Africa  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Sub-Saharan Africa  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.101 YEAR PUBLISHED: 1990  
AUTHOR: Alihonou E  
TITLE : Community Financing of Health Services for the Improvement of

Primary Health Care." Panafrican Conference on Community Financing  
SOURCE:

EXPERIENCE REPORTED:  
PROVIDER LOCATION :  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 88.102 YEAR PUBLISHED: 1988  
AUTHOR: Carria Guy  
TITLE : Community Financing of Health Care  
SOURCE: World Health Forum  
EXPERIENCE REPORTED:  
PROVIDER LOCATION :  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.103 YEAR PUBLISHED:  
AUTHOR: COUNTRY PROFILE  
TITLE :  
SOURCE: COUNTRY PROFILE  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.104 YEAR PUBLISHED: 1990  
AUTHOR: COUNTRY PROFILE  
TITLE :  
SOURCE: COUNTRY PROFILE  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,11 Guinea-Bissau  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.105 YEAR PUBLISHED: 1990  
AUTHOR: COUNTRY PROFILE  
TITLE :  
SOURCE: COUNTRY PROFILE  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,2 Burkina Faso  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.106 YEAR PUBLISHED: 1990  
AUTHOR: COUNTRY PROFILE  
TITLE :  
SOURCE: COUNTRY PROFILE 1990

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,3 Cameroon

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

DOCUMENT ID: 90.107

YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,4 Central African Republic (CAR)

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

DOCUMENT ID: 90.108

YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,5 Chad

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

DOCUMENT ID: 90.109

YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,6 Congo

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

DOCUMENT ID: 90.110

YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,8 Gambia

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

DOCUMENT ID: 90.111

YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

149

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,9 Ghana  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :

DOCUMENT ID: 90.112 YEAR PUBLISHED: 1990  
 AUTHOR: COUNTRY PROFILE  
 TITLE :  
 SOURCE: COUNTRY PROFILE  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,10 Guinea  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :

DOCUMENT ID: 90.113 YEAR PUBLISHED: 1990  
 AUTHOR: COUNTRY PROFILE  
 TITLE :  
 SOURCE: COUNTRY PROFILE  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,12 Ivory Coast  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :

DOCUMENT ID: 90.114 YEAR PUBLISHED: 1990  
 AUTHOR: COUNTRY PROFILE  
 TITLE :  
 SOURCE: COUNTRY PROFILE  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,13 Liberia  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :

DOCUMENT ID: 90.115 YEAR PUBLISHED: 1990  
 AUTHOR: COUNTRY PROFILE  
 TITLE :  
 SOURCE: COUNTRY PROFILE  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :

DOCUMENT ID: 90.116 YEAR PUBLISHED: 1990  
 AUTHOR: COUNTRY PROFILE  
 TITLE :  
 SOURCE: COUNTRY PROFILE  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,15 Mauretania  
 MAIN PROBLEM CATEGORY:

KEY PROBLEMS

DOCUMENT ID: 90.117 YEAR PUBLISHED: 1990  
AUTHOR: COUNTRY PROFILE  
TITLE :  
SOURCE: COUNTRY PROFILE  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,16 Niger  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.118 YEAR PUBLISHED: 1990  
AUTHOR: COUNTRY PROFILE  
TITLE :  
SOURCE: COUNTRY PROFILE  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,17 Nigeria  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.119 YEAR PUBLISHED: 1990  
AUTHOR: COUNTRY PROFILE  
TITLE :  
SOURCE: COUNTRY PROFILE  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,18 Senegal  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.120 YEAR PUBLISHED: 1990  
AUTHOR: COUNTRY PROFILE  
TITLE :  
SOURCE: COUNTRY PROFILE  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,19 Sierra Leone  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :

DOCUMENT ID: 90.121 YEAR PUBLISHED: 1990  
AUTHOR: COUNTRY PROFILE  
TITLE :  
SOURCE: COUNTRY PROFILE  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,20 Togo  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :



Koita Amadou. Joseph Brunet-Jailly, Seydou Coulibaly, Kafin Diarra  
Recurrent Costs in the Health Sector.

SOURCE: Brian Abel-Smith and Andrew Creese , WHO/SHS/NHP/89.8,  
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Community Financing of Primary Health Care: The PRICOR Experience. A  
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SOURCE: Children in the Tropics , 184/185 , page(s) 96 .  
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SOURCE: UNICEF Staff Working Paper No.2 , , page(s) 24 . UNICEF  
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SOURCE: UNICEF, Staff working Paper No.3 , , page(s) 60 . UNICEF  
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Bamako Initiative, Progress Report .

SOURCE: United Nations Children's Fund, Executive Board ,  
E/ICEF/1990/L.3 , page(s) 31 . UNICEF 1990 . 90.012

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SOURCE: United Nations Children's Fund, Programme Committee ,  
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SOURCE: , , page(s) 59 . UNCEF, HAI, OXFAM 1989 . 89.014

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Community Health Financing in Serra Leone: Initial Results of an  
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Strategy to Increase the Commitment of Resources to Primary Health  
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## 21 COUNTRY PROFILES:

- (1) Benin
- (2) Burkina Faso
- (3) Cameroon
- (4) Central African Republic
- (5) Chad
- (6) Congo
- (7) Gabon
- (8) Gambia
- (9) Ghana
- (10) Guinea
- (11) Guinea-Bissau
- (12) Ivory Coast
- (13) Liberia
- (14) Mali
- (15) Mauritania
- (16) Niger
- (17) Nigeria
- (18) Senegal
- (19) Sierra Leone
- (20) Togo
- (21) Zaire

# **AskFINE**

**Financing Health Care  
in Developing Countries**

*A Knowledgebase*

## **Document summaries**

**Eckhard Kleinau  
Donald Shepard  
Wayne Stinson  
Ronald Vogel**

**Boston, September 1990**

DOCUMENT ID: 89.001 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: Koita Amadou

TITLE : Recurrent Costs in the Health Sector

SOURCE:

EXPERIENCE REPORTED: 4 Management case

PROVIDER LOCATION : A,4 Sub-Saharan Africa

B Mali

D Urban and rural

MAIN PROBLEM CATEGORY: A Strategic

B Technical

C Administrative

KEY PROBLEMS : A,2 Equity

A,4 Efficiency

A,7 Additional resources

B,1 Financing schemes

C,1 Funds

SUMMARY:

The document describes the results of a study carried out to assess expenditures for care between 1983 and 1987, identify areas of financial shortages, assess the feasibility of alternative financing and strategies to promote equity and efficiency of primary health care.

Mali has a very low per capita GDP of US\$180 for 1986. The infant mortality rate with 150 per 1,000 live births is high. The standard of living has deteriorated since the mid 1970s. Health services are organized hierarchically from the lowest, community, level with health posts to the highest, tertiary, level with national hospitals. Intermediate categories comprise maternities, dispensaries, health centers and hospitals. Private medical practice is rare.

Financing of health services. Total expenditure for health services, including traditional medicine, was about 4.3% of the gross national product. About two thirds of the costs is covered by direct payments from private households. Public subsidies to the health sector stem mainly from general taxation. Social security plays only a minor role in covering expenses for health care. Due to a small number of members and inefficient management administrative costs are high and benefits low.

Total recurrent costs of health services. Mali was not able to provide a recurrent budget to provide health services at an acceptable standard. A main problem was the negligence of building maintenance, leading to services insufficient in quantity as well as poor in quality. Waste of resources, indicated by excessive length of stay in some hospitals, might have increased costs.

The use of services. A striking difference of utilization of services between provinces suggests that availability of drugs, as well as prices, have a substantial effect on the utilization of medical care. A very poor infrastructure and the lack of transportation poses another severe restriction on the use of services, which is very low as compared to other countries.

Average costs per patient. Average monthly income per capita was about Francs CFA (FCFA) 5,000. An inpatient day in a tertiary medical facility was already FCFA 1,500 per day. Total costs for an episode of care and additional payment for drugs would easily exceed the monthly salary. This situation is prohibitive for an increase of user fees beyond a minimum of 20% of recurrent costs. On village level average costs per consultation amounted up to FCFA 110, costs for drugs were above FCFA 300 per consultation. These costs moved up at intermediate services levels to about FCFA 700 to 1,000.

Funding options. In general the document proposes the introduction of user charges up to the full costs of care are to remedy severe underfinancing of services. People should be offered to opt for coverage by insurance or prepayment scheme. The poor should generally be exempted from payments. In Mali there would be a market for private for profit insurance only for a small number of people in higher income groups in urban areas. Compulsory insurance for the employed would protect only a minority of less than 10% of the population, because of a very low employment level in the formal sector.

Recommendations. In order to maintain equitable and affordable medical care the authors propose several other measures. Decentralization could improve efficiency of services and allow a better monitoring of quality and quantity of care provided. This is recommended for the national social security system as well. Revenues from user fees should be retained at the provider of care level. Purchase of essential drugs by international tender would be more efficient. Potential savings were estimated to permit a raise by 50% of salaries of medical personnel.

Chapter examines both costs and financing, in their current condition and (through simulations) their potential. Particular emphasis is given to cost reduction through improved drug procurement and increased cost recovery through decentralization and reduced exemptions. Some excerpts: "The Ministerial Decree of 1983 fixed a scale of charges and defined the extensive conditions for free care. The regulations which were introduced a few months later were a masterpiece of ambiguity. They excluded health centers . . . but stated that they could introduce "forms of participation" not exceeding the rates in the Decree. This has led to total anarchy. With the exception of the World Bank project, no one knows in Bamako which health centers have established what forms of cost recovery, at what rates, with what results or for what uses." (p. 72) "If one wanted to raise more money, there are three possibilities. First, the rates could be raised: we know that the rates charged outside Bamako do not meet with opposition. Secondly, the categories entitled to free care could be reduced. They include pupils, students, health personnel and their families, and civil servants, all of whom are already privileged in their access to care. . . Thirdly, the rates could be enforced. . . . Granting free care is clearly a source of private remuneration to health service staff." (p. 73) "The presence of free medicines (subject to availability), alongside medicines which are paid for within the public sector, undoubtedly causes profiteering

by taking stock from the first category and transferring it to the other." (p. 76) "The problem lies not so much in legislation, but in the arrangement by which the whole control of hospital expenditure and revenue form part of the national budget. Similarly, the recent reform of local taxes imposes central control of the money, thus destroying local initiative which should instead have been boldly encouraged by decentralization." (p. 81) "The key to solving the problem lies in the purchasing of generic drugs by international tender. These drugs can be sold at lower prices than at present, while still accumulating a substantial surplus. The additional revenue can be used to give incentives to staff and generally improve the quality of services, particularly by ensuring that supplies of drugs are continuously available throughout the country. This, coupled with the decentralization of control of local services and the local retention of the revenue from user charges, can re-establish wards, promote effective work, prevent pilferage and secure a substantial increase in the utilization of services." (p. 92).

DOCUMENT ID: 87.002 RECORDS: 1 YEAR PUBLISHED: 1937  
 AUTHOR: Lieberon Joseph  
 TITLE : An evaluation of the factors of sustainability in the Gambia mass media and health practices project  
 SOURCE: USAID Evaluation Special Study No.51  
 EXPERIENCE REPORTED: 2, project evaluation  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,8 Gambia  
 MAIN PROBLEM CATEGORY: A B C D policy, cost recovery, management, communication  
 KEY PROBLEMS : A,2 B,4 B,5 B,9 B,10 C,3 D,2 microeconomic factors, designing projects, implementing projects, types of services, operations research, management by objectives, linking with institutions  
 SUMMARY:

This document addresses crucial factors of project sustainability and presents these clearly related to four main areas: economic, project implementation, management and political issues. The summary provided by the authors on pages X - XIV follows below:

#### FACTORS IMPORTANT TO THE SUSTAINABILITY OF THE GAMBIA MASS MEDIA AND HEALTH PRACTICES PROJECT

This evaluation identified a number of factors that were important in influencing the sustainability of the Mass Media and Health Practices (MMHP) project in the Gambia. These have been grouped under four categories : (1) economic and financial factors; (2) project design and implementation factors; (3) the organization and management structure of the project; and (4) the political and sociocultural context in which the project will operate.

The influence and importance of each factor on the sustainability of the Gambia MMHP project varied. While some critical factors were present, many others were not. As a result, the project was not sustained. The findings relating to the sustainability factors identified by the evaluation team are given below. Most have general

applicability to other health projects and should offer useful guidance to those trying to design more sustainable health projects.

#### "Economic and Financial Factors.

1. The research and development phase of a project incurs high costs. Once a methodology is developed and found to be effective, it can be maintained at relatively low cost. Estimates indicate that a "bare-bones" annual budget of \$ 36,000 (in 1985 dollars) could have treated 30 to 50 percent of diarrhea cases, compared with a 56 percent coverage rate at a cost of \$ 124,000 during the A.I.D. period. (pp. 9-10)
2. A project may be successful and cost-effective, and yet a country that is facing severe fiscal pressures may not be able to finance even a minimal program. The Gambia's deteriorating economic situation affected project sustainability. The financial crisis made domestic support of project activities difficult if not impossible. Considering the substantial A.I.D. investment, limited postproject support by A.I.D. would have been cost-effective. (pp. 10-12)
3. The sophistication and scope of project design determine a project's costs and benefits. For a very poor country, design efforts should focus on simple, low-cost projects. The design of the MMHP project matched Gambia capabilities. The project effectively used an existing health care system, along with simpler and inexpensive home based treatment and low cost mass media education methods. (pp. 12-15)
4. An unplanned or abrupt end to donor funding may be too great a shock for a developing institution. An adequate time horizon is needed not only to transfer project management responsibility to counterpart staff, but also to allow time for resource planning. The sudden end of MMHP project funding created a resource void in the Health Education Unit, which went from an intensive, resource-rich campaign effort to dependence on a limited host government budget. The government lacked adequate finances and trained staff to continue the effort.
5. An understanding of recurrent or operational costs is required at the beginning of the project. A realistic plan for a phased financial takeover by the host government also needs to be agreed on early in the project. No provisions were made for gradual phase-over in the Gambia project. (pp. 15-18)

#### Project Design and Implementations Factors

1. When designing a project in a developing country with low per capita income and limited institutional capacities, both the technology and its dissemination must be simple, precise, and cheap. The technology and teaching methods of the MMHP project were sustainable. Water, sugar, and salt were available in most rural homes. Existing health workers spread the message using simple pictorial posters, supported by radio messages. (pp.12-14)

2. Time is one of the most important constraints to institutionalization. A 2- or 3-year time period is too short. A.I.D.'s experience shows that at least 5 and often more years may be required to implement a project and permit the successful transfer of project management responsibility to counterpart staff. The 3-year time period of the Gambian MMHP project was too short to ensure institutionalization. The 2-year experiment worked, but even with the 1-year extension, the project's 3-year time frame was far too short to develop the technical expertise needed for successful institutionalization. (pp. 14-17)

3. A mass media project must be able to continuously revise its messages until it is clear that the target audience fully understands the desired message. There is a difference between a "product launch" and the maintenance of demand. It is the ability to maintain demand that influences sustainability. After the initial launching of promotional messages on the use of oral rehydration solution, revisions were required to clarify user misconceptions. It appears that unfulfilled expectations may have led to abandonment of treatment in some cases. (pp. 17-18)

#### Organization and Management Factors

1. A major requirement for sustainability is the institutionalization of skills. maintaining a flow of benefits requires a longer time frame and an emphasis on training and skills development. Despite final-year efforts in the Gambia project, the short time frame and emphasis on immediate behavior changes resulted in weak institutional development. (pp. 18-19)

2. The more a project depends on advanced technical skills, the greater the commitment that must be made to long-term participant training. The Gambia project chose to rely on in-service training and on-the-job training. This evaluation concluded that some formal training and/or additional time was required to develop the complex and varied skills required to sustain the health education strategy of the project. (pp. 19-21)

3. Retraining is as important for sustainability as is initial training. The newer the concept, the more likely that reinforcement through retraining will be necessary. Training during the initial stage of the MMHP project was excellent. The erosion of project achievements can be traced to the lack of follow-up training. The concept of oral rehydration therapy and the skills required for its use were new. Therefore, reinforcement through retraining was critical to the continued success of the project. (p. 21)

4. While spread effects and spin-offs are encouraging signs of sustainability, care must be taken that the demand for newly learned technologies or services does not outpace host government capacity to deliver them. Demand for the MMHP project's mass media technology in The Gambia spread so quickly that the small Health Education Unit was unable to keep pace. (pp. 21-23)

5. Limited, but focused postproject maintenance support is necessary to preserve project achievements. Given demonstrated success, other donors and regional/central A.I.D. programs may want to help sustain postproject activities, as the Technology for Primary Health Care project (PRITECH), the United Nations Development Program (UNDP), and the World Bank did in the Gambia. (pp. 23-25)
6. Vertical programs are usually very difficult to integrate into horizontal delivery systems. The more existing cadres are used in projects and the simpler the technology, the easier will be the integration. The promotion of water-sugar-salt solution in The Gambia appears to have been integrated into the regular rural health care delivery system. (pp. 25-27)
7. A management information system helps project managers determine how well their project is performing and which methods work most effectively. Managers need a continuing flow of information so that program approaches and dissemination techniques can be reevaluated and redesigned as the project unfolds. Because the MMHP project was marketing a new health practice, managers needed to know how effectively the message was being received and what actions the "customers" were taking. During the period of A.I.D. funding, the feedback system worked well. After funding ended, these capabilities were seriously reduced. (pp. 287-29)
8. While volunteers can provide low-cost extension or program outreach, it is unlikely that a system based on volunteers will be viable in the long run. In The Gambia, when compensation (either financial or in-kind) or remotivation ended, volunteers tended to drop out. The "red-flag" mothers were effectively used during the campaign phase of the project, but some did not understand their temporary role. Those that did not enter the system as health workers (village health workers or traditional birth attendants) ceased to provide services. (pp 30-31)
9. Parallel health services delivery systems can be effective, but they must be integrated at some point into an ongoing system if they are to be sustained. (pp. 30-31)

#### Political and Sociocultural Context

1. Projects that include social marketing require knowledge of village-level needs and attitudes. Such projects cannot be run from the capital city. They require the full support of the government and the recipients and should only be considered when objectives are shared. The MMHP project had the full support and cooperation of the Gambian Government, which permitted detailed village surveys that were necessary to determine use and acceptance of the rehydration therapy. (pp. 31-32)
2. Different players in a development project have different objectives. These objectives need to be understood and should be as mutually supportive as possible. For example, attainment of A.I.D. project objectives may not always be viewed as a success by the host

government. Conflicting A.I.D./Washington and field Mission agendas stifled successful maintenance of this effective project. (pp. 32-34)

3. Research and development projects may show success in small USAID Missions, but in the face of other program priorities, project extensions are not always ensured. The Gambia Mission is very small, with limited staff, and thus must limit its program initiatives. Given constricting USAID Mission portfolios, mechanisms are needed to allow highly successful projects to be maintained without placing an excessive management burden on smaller USAID Missions. (pp. 34-35)"

DOCUMENT ID: 87.003 RECORDS: 1 of 4 YEAR PUBLISHED: March 1987  
AUTHOR: Stinson Wayne  
TITLE : Community Financing of Primary Health Care: The PRICOR Experience. A Comparative Analysis.

SOURCE: PRICOR, U.S.A.I.D.  
EXPERIENCE REPORTED: 4 management design process

PROVIDER LOCATION : A,1 Africa, Sub-Saharan Africa B,1,13,14,18,21  
Benin, Liberia, Mali, Senegal, Zaire  
MAIN PROBLEM CATEGORY: A,B,C policy, cost recovery, management

KEY PROBLEMS : A,2 microeconomic factors B,1 financing schemes  
B,2 service characteristics and resources B,3 planning projects B,4  
designing projects B,5 implementing projects

#### SUMMARY:

Studies concerned with financing policy sought both to provide new information and to suggest specific reforms. Principal investigators believed that policy makers needed information on : (1) Current private expenditures, what they are for, and who makes them; (2) Evidence that user charges are politically acceptable, both to health care providers and to influential leadership and population groups; and (3) Guidance on how to operationalize new financing policies. With a few exceptions, most studies found that user charges were politically acceptable and that some users may prefer to pay official fees if they replace variable and perhaps excessive unofficial fees (Zaire). Users may also be quite willing to pay if new revenue pays for more accessible or higher quality services (Brazil). Most studies also demonstrated the operational feasibility of community financing, as described throughout this paper.

Participants in a conference of prior researches concluded that :

- . Support on high level decisionmakers is a facilitating factor, possibly an essential factor in the implementation of financing schemes. This is much more difficult to achieve in an unstable political environment where there are many changes in key decisionmakers.

- . It is essential to understand the values of the decisionmakers at

all levels - policy makers, managers, community members - in addition to existing practices. For example, in Honduras it was acceptable to the Ministry of Health to charge for special services but not for basic care.

. Government policies that allow regional or local managers to try out new ideas encourage community financing, whether decision making is completely decentralized, as in Benin, or there is just an unofficial, laissez faire attitude from the central Ministry of Health, as in Zaire. Depending on centralized, bureaucratic systems greatly slows and restricts the development of community financing.

. Researchers need to recognize the time it takes to develop support among decision makers and to develop the financial and accounting systems necessary to sustain financing. Studies which tried to implement incremental phased-in changes, as in Dominica, received support from the central ministry. This allowed time for the development of needed central systems and also allowed for attitudinal changes that often take some time to occur.

. In several countries, including Honduras, Somalia and Brazil, it was the key decisionmakers, not the communities, who were opposed to cost sharing by users. Documentation of the substantial health expenditures households were making and their expressed willingness to pay for services were used in an attempt to change decisionmakers' basic perception of the necessity of free care for all.

. Economic crisis or the fear that external funding will be reduced can stimulate interest in community financing both by governments and by users. Where providers and communities believe that outside funding is certain, it is very difficult to mobilize community resources for health care.

DOCUMENT ID: 87.003 RECORDS: 2 of 4 YEAR PUBLISHED: March 1987

AUTHOR: Stinson Wayne

TITLE : Community Financing of Primary Health Care: The PRICOR Experience. A Comparative Analysis.

SOURCE: PRICOR, U.S.A.I.D.

EXPERIENCE REPORTED: 4 management design process

PROVIDER LOCATION : A,1 Africa, Sub-Saharan Africa B,1,13,14,18,21 Benin, Liberia, Mali, Senegal, Zaire

MAIN PROBLEM CATEGORY: A,B,C policy, cost recovery, management

KEY PROBLEMS : A,2 microeconomic factors B,1 financing schemes B,2 service characteristics and resources B,3 planning projects B,4 designing projects B,5 implementing projects

SUMMARY:

DEMAND FOR HEALTH CARE : COMMUNITY INTERESTS AND RESOURCES

## INTRODUCTION

Demand is the relationship between the amount of something that a consumer will purchase and those factors that determine that amount such as income, travel costs, price, and perceived need. Demand is not a number but a relationship. Demand is often confused with need, but they are not the same. Someone may need medical care (because it would improve a particular health condition such as tuberculosis) but not know that they are sick or not believe that a treatment is efficacious and therefore not seek out medical care.

Demand is not directly observable, but utilization is. Utilization is the amount of health care that equates demand and supply. Bartlett identified five categories of factors that affect the demand for health care services : demographic, biologic, cultural, service-related, and economic. Measuring demand is further complicated by the context of the analysis including seasonality, inflation, and external factors affecting utilization such as natural disasters, disruption of services, and education.

None of the PRICOR-supported studies completed complex demand models as the primary purpose of their studies. Rather, descriptive data about service utilization and service preference were collected in a number of the studies in order to solve a specific operational problem in a community financing system. The results are descriptive and apply to specific community situations.

This chapter discusses ability and willingness to pay viewed prospectively as a policy development and scheme design issued. Chapter 10 again discusses these topics but viewed retrospectively as community financing activities were implemented.

## HOW DEMAND WAS STUDIED

PRICOR-supported researchers used the following techniques to study the public's ability and willingness to pay for health care :

- . National household expenditure surveys in Honduras, Somalia and Mali
- . Local or district household surveys in Liberia, Brazil/Lassner and the Philippines
- . Surveys in health providers in specific service areas in Brazil/Lassner, Swaziland and Thailand
- . A survey of pharmacists in Mexico
- . Observation of families in Honduras and Bolivia/Miller
- . Case studies of health care providers in Honduras, Bolivia/Miller and Thailand

- . Meetings with an expert group in Brazil/Lassner
- . Studies of what people liked and disliked about health care sources in Liberia, India and Bolivia/Gonzalez
- . Direct discussions with community leaders in Benin, Bolivia, Brazil/Lassner, Swaziland, Somalia, Liberia, the Philippines, Mali
- . Review of existing reports in Brazil/Baker and Bolivia/Miller.

The PRICOR studies which collected information about demand can be divided into two categories : those intended to influence policy decisions and those measuring community resources for the purpose of developing a particular community financing scheme.

### MALI

A survey of 1.800 family and household heads in two districts was conducted to obtain information about health needs, current and suggested methods of paying for health care, methods of paying CHWs and TBAs, household economic data and attitudes towards PHC programs.

Community financing of health care in a Malian village is complicated by the economic structure of the family unit, and by the family unit, and by the fact that many farming families are only able to farm at subsistence levels, leaving little or no disposable income for other necessities. The priority expenditures of a typical family unit were food, health and taxes in order of magnitude.

Eighty percent of the respondents in the Koro District said that they consume all of what they grow, largely a result of the continuing drought conditions in that part of the country. They are severely limited in their ability to pay for health care. In Kita, on the other hand, farmers grow peanuts as a cash crop, and only 4 % live at subsistence levels. Family members usually work collectively, but individual health-related expenditures are most often paid for by the family head (70 %). Most of the respondents complained of this system, and expressed interest in a more flexible method which leaves the individuals more free to seek health care.

### LIBERIA

The PRICOR-supported liberian study examined ways communities could use to generate funds to finance some or all of their PHC services. Researchers collected data for their study using a household survey of three rural villages and a series of meetings with village leaders.

Seventy percent of households surveyed reported an annual income of less than \$ 200 and 41 % reported incomes of less than \$ 100 a year, substantially less than national average of \$ 280. Though these data were not formally incorporated into the development of alternatives, the survey itself proved to be an effective entree into the communities and generated support for the project.

In each village the town council and other village leaders met to consider four issues : what health care services would be provided, who the health care provider would be, who would participate, and how much the services should cost. Further, the leaders discussed eight alternative financing schemes for generating PHC funds within the community. Each of the three study villages constructed a preference matrix and, on each, the same four schemes ranked the highest, although in different order : drug sales, production-based prepayment, community and individual labor, and donations and ad hoc assessments.

## BENIN

All the demand data collected in the Benin study came from meetings with commune leaders and projections of health service utilization based on estimated morbidity patterns. The researchers contacted commune leaders directly in order to identify which services and goods the communities would be willing to pay for.

Leaders agreed that villages would support the costs of drug supplies and VHW remuneration providing the government paid health center salaries and infrastructure costs and foreign donors covered investment costs.

In Benin, investigators asked villagers in communal meetings about what health care services they would support. Villagers indicated that they were willing to support CHWs and drug costs. Curative services were chosen as the cornerstone for generating funds as the community displayed a willingness to pay for these. On the other hand, preventive care was delivered free of charge as the community did not seem to spontaneously seek this type of care.

## CONCLUSIONS

A major operational question for many researchers was how much to try to learn about PHC demand and how to go about learning it. There was clearly a difference in this regard between studies aimed at policy change and studies aimed at the design of specific micro-level financing schemes. The policy-level studies relied on quantitative results which documented health expenditures or use of services. For policy change, they needed to produce convincing statistics. Studies in Honduras, Somalia, and Mexico collected data relevant to policy issues. Data was collected using surveys and expert opinion. In Honduras, using multiple methods of data collection proved to be especially useful in confirming the results to skeptical decisionmakers.

The micro-level studies used more heuristic techniques for establishing service preferences and negotiating the design and management of the community financing scheme. In the real world, most managers cannot wait a year for the analysis and results of a survey in order to make an operational decision. Large baseline surveys are critically important for establishing patterns of resource consumption in order to shape policy, but they are less useful for design and management decisions on a specific scheme. Qualitative community-level

data were generally found necessary for predicting willingness to pay for new health care services.

Working at the community level on the development of financing alternatives, several researchers found that data collected on some of the larger macro questions, such as actual health expenditures, proved less useful than relatively simple questions on kinds of goods and services people are used to paying for and their other specific preferences. For example, in Bolivia and Liberia, researchers used simple preference matrices to identify financing alternatives acceptable to the communities. Though the principal investigator of the Liberia study collected data on expenditures, he did not use the data collected on annual income for operational decisions. His knowledge of the community and their basic preferences seemed to be enough to initiate the financing scheme. In Brazil, the researchers found that the communities' preferences and values differed from those of health professionals. This underlined the importance of researchers/managers not assuming that they understand the demand/preference for services without consulting the clients.

Finally, some researchers used pre-design surveys at least partly as entrees to generate community discussion and participation. The process of involving the community in aspects of the study proved to be as critical to the success of the scheme as the findings of the data collection phase in Liberia, Bolivia, Philippines, and Swaziland. Community involvement resulted in greater acceptance of the scheme.

Researchers in Zaire and Benin valued the resources actually used in providing services, using shadow prices for resources that were donated. Cost data were collected in the following categories : time period (6 months) ; preventive and curative functions ; input line item; geographic location (Zaire across regions, Benin across zones in the same health center service area).

As can be seen in Chart 2, the methodologies for the Zaire and Benin studies were similar ; each valued all input and applied the same assumptions for amortization. Results are difficult to compare, nevertheless, because PHC Services were at different levels of development in the two countries. Investment costs differed because Zaire's was an on-going program while Benin's was new. Recurrent costs were calculated in the same manner, though researchers in Benin collected very detailed data about a small service area, while in Zaire the analysis covered many health zones and was necessarily less detailed. Researchers in Benin allocated indirect costs through a complex functional analysis, while researchers in Zaire simply divided regional office costs by the number of health centers supervised. Zairian researchers interviewed staff to estimate unrecorded resource use, while researchers in Benin did a thorough time and motion study to estimate personnel time needed for various function. In the case of Benin, PRICOR-supported cost analyses evolved into a routine management information system so that cost monitoring continued after research ended.

In Benin, recurrent costs for the period between July 84 and June 85

averaged \$ 3.00 per person per year for a population of 10,000 persons. This figure included all costs incurred in the implementation of PHC for the entire commune, including those for both health center and village level activities. Curative care and logistics together represented almost 25 % of total recurrent costs. Personnel alone accounted for 70 % of recurrent costs. Researchers estimated that if the Pahou Demonstration Project were replicated in an area with a similar ecology, recurrent costs could be reduced by as much as 50 %, because of lower personnel, transport, and infrastructure costs. Baseline surveys and the expense of internships would also be eliminated.

In Zaire, researchers calculated three cost measures for curative care, namely, costs per capita, costs per visit, and costs per episode (defined as all visits needed for a single course of treatment). At the health center level, the greatest operating expenses were for medical supplies, personnel, and transport, in that order. Calculations included costs of associated supervision and mobile team support from the zonal level.

All three costs measures varied enormously from one center to another. Costs per capita in the period October 1984 to September 1985 varied from 2 cents in Tshileo health center to 90 cents in Lukunga. Costs per visit were lowest in Kangoy at 4 cents and highest in Katanda at \$ 3.46. Costs per episode ranged from 27 cents in Kangoy to \$ 7.46 in Katanda. Most calculations involved ten health centers in five health zones scattered throughout the country.

The enormous variations reported from Zaire may have been partly due to data inconsistencies but differential utilization, coverage, and distribution of resources appear to have been more important. Tshileo reported extremely low utilization per capita in addition to low per capita costs; the center is clearly responsible for a large population than it has the resources to serve. The Kangoy center achieved its extremely low per visit and per episode costs partly because of its high utilization, since this spread fixed costs over many visits. Katanda, on the other hand, reported very low utilization and high fixed costs.

The average health center studied in Zaire incurred costs of 95 cents per episode for health center salaries, zonal supervisor and mobile team salaries for the time spent on field work, all in service training, administrative and maintenance supplies, drugs, vaccines, kerosene, minor building repairs, and transport for personnel and materials including supervisors and the mobile team. Medical supplies accounted for nearly half of all costs, though the proportions ranged from a low of 8.8 % in one center to a high of 70.1 % in another. Expenditures for preventive care (not included in the figures above) accounted for 22 to 34 % of health center costs.

Zonal level operating costs other than direct support costs (also not considered above) ranged from \$3,500 to \$ 5,500 per year in four of the five zones studied, even through the number of health centers that the zonal offices supervised ranged from 6 to 47. Certain zonal

offices were obviously better able to support subordinate health centers than were others.

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B,2 service characteristics and resources B,3 planning projects B,4  
designing projects B,5 implementing projects

SUMMARY:  
COMMUNITY PARTICIPATION OBJECTIVES

Researchers in Liberia, the Philippines, Benin and elsewhere were most interested in strengthening the community's role in primary health care and saw locally managed financing as a useful focus and facilitating factor. The degree to which community participation was considered necessary for achievement of the financing objectives of various studies is discussed in Chapter 7.

#### QUALITY, ACCESSIBILITY, AND UTILIZATION

While service fees and drug charges are generally believed to reduce utilization, the overall effect may be the opposite when new revenues replace previous, inequitably obtained resources, or are used to expand the service mix and number of facilities. Some PRICOR researchers explicitly sought this results. In Liberia, for example, a major study goal was to bring basic drugs to the community and save patients the time and travel costs of going to regional centers. In Zaire, decentralization forced health zones to rely on their own resources for maintaining and improving services. Fixed service fees were promoted as a way to increase service utilization by doing away with the unpredictable fees sometimes arbitrarily set by clinic personnel. The Dominican study was at least as much concerned to improve drug distribution and reduce stockpots as it was to develop user financing. New fees were also used to make services more accessible in Brazil (Lassner).

#### LEVEL OF EFFORT

Researchers in Benin, Bolivia (Gonzalez), Liberia, the Philippines, and elsewhere made numerous visits and allowed significant time to elapse in order to obtain design decision, or at least expressions of interest, from participating communities. These efforts served the

dual functions of (1) improving the "fit" between scheme design and community interest and capacity and educating and motivating residents to support PHC activities later on. Intensive community-by-community discussions also encouraged local residents to "buy-in" to PHC and financing, giving them a sense that results were partly of their own design.

In Benin, researchers held a series of meetings with community leaders to discuss financing alternatives and to establish modes of payment, price levels, VHW remuneration arrangements, and membership of community committees for financial management. These consultations were particularly fruitful because they increased public understanding, hence financial support, for preventive care and supervision. The principal investigator in Liberia made two pre-design visits to participating communities, the first to explain the study and seek cooperation, and the second to obtain nominations for the health committee and for health worker training. During subsequent visits, health committee members constructed preference matrices which were then used for detailed scheme design. Working first through assemblies and then through leadership groups, researchers and residents in the Philippines chose the health services to be financed, the specific drugs to be provided, and the individuals who would manage boticas. CPAIMC staff in Brazil mainly designed financing schemes themselves using survey results, but community leaders were given veto rights.

#### TRAINING AND TECHNICAL SUPPORT

As researchers have intended, many community groups took an active role in scheme management. Roles performed by one or more groups included :

- . Consultations on CHW salary increases (Benin)
- . Monitoring of CHW activities (Benin)
- . Consultation on service changes (Benin)
- . Revenue collection and management (Liberia, Philippines, Benin, Bolivia/Gonzalez)
- . Pressure on community residents to get them to pay overdue clinics fees (Benin), drug charges (Philippines), or assessments
- . Inventory management and restocking (Thailand, Philippines, Liberia)
- . Provision of labor for CHW fields (Liberia, Swaziland), or for clinic cleaning and maintenance (Brazil/Lassner)
- . Payment of utility bills, provision of office and clinical supplies (Brazil/Lassner)

#### ACTIVITY AND FINANCIAL MANAGEMENT

## Drug Procurement

Two issues were common in drug procurement, namely, which drugs to buy and where to get them. A related issue was whether to buy drugs by brand name or in generic form. In Dominica, RDF managers selected items from the national drug formulary and sought generic suppliers as a way to reduce costs. In Liberia, drugs were purchased wholesale from the Koahun Health Cooperative, which in turn obtained them from the Christian Health Association of Liberia; selection was limited to essential generics. Researchers in the Philippines, on the other hand, found that people strongly preferred brand name drugs and attributed part of their success to sale of familiar items; they were purchased from private sector drugstores in the nearest town. Thai RDFs were resupplied by the Government Pharmaceutical Organization which maintained stocks at each provincial health office.

## SUPERVISION AND AUDIT

PRICOR experience that some community or outside oversight is needed both for routine supervision and for auditing. In Liberia, elders in one village wanted to use RDF proceeds to cover funeral costs for a prominent chief. The VHW refused, and a research assistant had to step in to prevent decapitalization. A similar problem appeared in Dominica where interest earned on RDF monies was spent on items that had not been budgeted for. Researchers in Dominica worked with the government to develop procedures for annual closing. In the Philippines, most villages appointed an auditor, but several ended up entrusting this function to the PRICOR researchers.

## SERVICE FEES

PRICOR studies in Benin, Brazil, and Zaire designed or refined service fee systems, while the India/Elkins study documented existing practices in 8 cooperatives. Data on service fees are also available from a PRICOR-supported study in Mali. This chapter concentrates on the decisions made in the solution development studies in Benin, Brazil, and Zaire. Chart 7 provides details.

## PRICING

### What to Charge For ?

In each case, researchers/managers had to decide what specific services to charge for and how to "package" them. Fee arrangements varied from one community to another in Brazil. Some clinics charged for selected types of visits (all physician visits, all or annual family planning visits), others for such selected services as pap smears, injections, blood pressure checks, first aid, pregnancy tests, and IUD insertion. Still others charged registration fees. Various combinations of these service fee schemes were implemented - charging for some preventive and curative services while offering others free of charge.

In Benin and parts of Zaire, curative care was charged for as episodes rather than as discrete visits or services. Patients paid a single fee at their first visit for a given condition and then received all related care free of additional charge. In Zaire, five health centers continued existing fee per visit systems and five collected fees per episode; analyst hoped to study effects of payment scheme on PHC costs and utilization. In Benin, a fee for episode scheme was implemented in health units in four areas. The Zaire and Benin results suggest consumer preference for episode-based fees, provided they are affordable, though disgruntled staff in some Zaire centers obstructed their full implementation. Confounding factors unfortunately prevented an objective comparison of visit and episode fees in Zaire.

Program managers charged for some preventive care in both Zaire and Brazil. Even though preventive interventions were free of charge in Benin, those costs were foreseen and added to the cost of curative care.

### How Much to Charge ?

In setting fee levels, PRICORE researchers considered : (1) the magnitude of costs that had to be covered; (2) the ability and willingness of users to pay, and, (3) the fee levels of other local health care providers. (The second and third factors were obviously closely related.) As noted in the chart, PRICOR researchers in Benin and Zaire sought to fully cover certain PHC costs. While Brazilian researchers sought cost sharing only. The former, in other words, needed good cost data on which to base prices, while the latter needed only a general understanding of magnitudes. Only in Benin was a technical method used for price setting.

Prices in Brazil reflected results of a survey of prices charged for similar services in neighboring communities and an analysis of CPAIMC's costs. Researchers and managers agreed that prices should not be lower than actual service costs nor higher than local market prices; that low income families should be able to afford them, both individually and in common combinations; and that prices should be adjusted periodically to reflect increasing costs and the government-mandated minimum wage. Though communities varied in the services charged for, they did adopt uniform prices for those fees that they did collect.

In Zaire, fees were to reflect drug and service delivery costs and the population's economic status. The mode of setting them varied from one health center to another, in some cases giving greatest weight to the community's preference, in others to the staff's. Disputes about fee levels led to at least one staff resignation. Some per visit fees may have been negotiated by the worker and patient directly.

In Benin, prices were based on drug costs for specific illness and age groups, plus a percentage of the recurrent costs of petrol, VHW remuneration, and certain minor items. The percentage mark up was calculated by estimating the number of cases of the disease and the proportion of personnel time devoted to its treatment. The price of

curative care also included a proportion of preventive care costs not directly charged for. Prices were calculated by the same method for each disease, but varied with patient age since this affected drug utilization. Sophisticated cost and utilization information systems were required for these estimations, but the end result was that most treatment fees were set at approximately three times the cost of the basic drugs that were used. See Box 3 for further details on price calculations in Benin.

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SUMMARY:  
ACTIVITY AND FINANCIAL MANAGEMENT

### Fee Introduction

In Brazil, new fees were introduced for [replacing free services, while in Zaire, the most important changes were from fees for service to fees for episode. In Benin, service fees applied to new services in previously unserved areas. Staff and community reactions naturally varied from one place to another.

In Zaire, reactions to the shift in payment scheme were strong and unexpected. Several health personnel preferred the old fee for service system because it gave them some control over price levels. In one health center, the auxiliary nurse was dismissed after showing open hostility; he then set up a private dispensary and drew away most of the center's clients. In another, open conflict arose between members of the village development committee and the auxiliary nurse. One health post was closed for a period of time, and in some posts staff worked less productively or with a lower standard of care. Community members, on the other hand, preferred the fee for episode system because prices were publicized and not subject to bargaining; utilization of the one health center that changed from one episode to visit fees dropped significantly because of the public's reaction.

### BOX 3. Factors Considered in Setting Fee Levels in Benin

Costs Included:

VHW remuneration  
Equipment depreciation  
Gas for the mopeds  
VHW and community health center supplies  
Electricity and other general operation expenses  
Costs of preventive services and health education

#### Factors Considered in Distributing Costs;

Incidence and treatment of frequently seen illness  
Percentage of personnel time and travel used in the treatment of each disease  
Desired coverage - 100 %  
Population size - 10,000

#### Adjustments;

Adjustment for patient age based on likely drug use and number of repeat visits for the same condition  
An across-the-board increase of 50 % to provide incentive for people to choose a prepayment scheme  
Quadrupling of charges for persons residing outside the project area.

In Benin, fees were increased by a factor of four for people who wished to use project services but lived outside the project area. This was done to limit the influx of outsiders and to prevent them from obtaining and selling the project's low cost drugs. It also had a significant effect on project revenue. "Outsider" treatment fees were also applied to project area residents seeking care at the health center without a proper referral; the objectives in these cases were to increase the stature of health workers and encourage people to follow the established hierarchy.

#### Revenue Collection and Management

In Benin, receipts from the health center and VHWs were placed in a cash box under the control of a financial management sub-committee of the Commune Health Committee. This sub-committee included three community leaders and the health center's head nurse. In Brazil the personal prepayment, personal service fees, and drug sales were managed by the CPAIMC service providers and managers who normally operated the health units and miniposts.

When new charges were instituted for previously free services, problems occurred with collection from some people who either could not or did not want to pay. As mentioned earlier, some programs extended credit to those temporarily unable to pay, but those who did not want to pay presented different problems. In one of the centers in Brazil, the staff at first felt uncomfortable charging patients with whom they had developed a close relationship and to whom they had previously given free services. The research team indirectly supervised by scrutinizing reports from health center staff. In Zaire at the village level, collection of payments sometimes caused problems because villagers were not used to paying for services in the manner that the project had planned. Re-trained village midwives, for example, had to begin charging for childbirth services that they had previously provided at little or no cost. Several "important persons" thought they should not have to pay - that the VHWs should extend them credit - which put the VHW in a difficult position. Community pressure

helped ensure payments by elite community residents in Benin.

### Recordkeeping

Researchers in Benin developed forms for systematically recording diagnoses, financial management and routine project monitoring.

After treating a patient in Benin, the village health worker recorded the diagnose, treatment and payment received. Drug usage and total revenues were calculated daily and monthly for comparison with drug stocks and expected revenue. Whenever receipts were lower than expected, the missing amount was deducted from the responsible person's salary.

Lack of standard records was identified as a crucial problem in the Zaire study.

### Use of Funds

The revenues generated from payments for curative care in Benin were used to pay village health workers and replenish drug supplies. As the study progressed, revenue from curative care was used to finance personal preventive interventions, maintenance costs of the health center, petrol used for supervision and mobile MCH clinics, and the village level information system. In one "cercle" in Mali, service fee revenue was used to pay for drugs, petrol, and clinic furniture.

High CHW turnover was also experienced in Nigeria (Gray), one barangay in the Philippines (Osteria), Liberia (Cole I), and Bolivia (Gonzalez).

In Gongola State, Nigeria, many CHWs left employment within one to three years because of low salaries and lack of advancement opportunity, supervision and community support. Even though all communities paid minimal wages, a survey found that CHWs at the higher end of the pay scales stayed on the job about 50 % longer than lower paid ones. Fourteen of 29 terminated CHWs had sought further training and were working in higher level health care positions. Unable to increase CHW salaries, program managers offered veteran CHWs additional training as Community Health Aides so that they could qualify for the greater pay and social prestige derived from promotion.

### Role of Volunteers

An important question for PRICOR-supported researchers and for primary health care generally concerns the potential role of volunteers. Alternatives to direct cash incentives were successfully used in Haiti (Cayemittes), Brazil (Nations), and Liberia (Wall). In Haiti (Cayemittes), inability to pay CHWs restricted effective ORT delivery, so community and church leaders, traditional birth attendants (TBAs), teachers, market sellers and others were invited to attend ORT training session. TBAs were found to be particularly effective in

promoting ORT. Another study (by Augustin) in Haiti, on the other hand, concluded that volunteers could be used for discrete activities of short duration but not for sustained community health work.

A key to successful mobilization of volunteers may be linkage with tasks traditionally performed by school children, healers, and others. In Liberia (Wall), researchers and community leaders developed preventive health modules for adolescents based on such common household activities as cooking, cleaning, washing clothes and carrying water. School children were then trained to teach others about ORT, hygiene, home sanitation, malaria prevention and hospital referral. Study results showed that the children had learned a good deal and were carrying out their lessons. They received no monetary incentives but did gain the respect and appreciation of family and friends. The major program costs were for training which was funded publicly through the regular education budget.

Program directors interviewed in India stressed the following non-material incentives to compensate CHWs for their relatively low wages:

1. Encouragement of initiative within the project design;
2. Job security to the extent possible;
3. Full support when there is unfair opposition;
4. Special public recognition for good service;
5. Opportunities for further training in health skills, including training programs with attractive features, such as trips;
6. Opportunities to share experiences with co-workers who see self-fulfillment in their service;
7. Community respect;

#### Performance Incentives

It is not enough that workers stay on the job if their performance is substandard or emphasizes services of little long-term value. Program effectiveness may also be improved through behavioral incentives to clients.

In Benin, persons presenting at the local health unit without a referral from a CHW were charged four times as much as those who had been properly referred. In Thailand, health card holders who obtained a hospital referral from a CHW were able to receive faster attention.

#### PREVENTIVE/PROMOTIVE ACTIVITIES

Though weak community demand for preventive/promotive activities was a problem nearly everywhere, researchers developed or reported a number of innovations to cover costs of water and sanitation systems, growth

monitoring, nutrition, family planning and oral rehydration therapy (ORT).

Fees for curative services in Benin and Zaire were set high enough to generate surplus revenue for preventive care.

#### UTILIZATION/COVERAGE

Researchers in Zaire and Brazil (Lassner) attempted (but with limited success) to study the effect of community financing on service coverage and utilization.

In Zaire, clinic utilization was affected more by local management factors than by either the mode of fee collection (per visit or per episode) or prices. Reactions of community members and service providers to the shift from visit to episode fees were strong and unexpected. Several personnel preferred visit fees because they were generally not fixed and could be "negotiated" with the client.

Communities generally preferred episode fees rather than visit fees because of greater :

- . Health care continuity (once payment was made, there were fewer financial reasons to interrupt treatment);
- . Ease in health center administration (since the fee level was known to everyone to facilitate monitoring of receipts);
- . Reinforcement of community solidarity (since health care prices were equally shared by all users).

Utilization of some services decreased in the one center that shifted from episode to visit fees.

Curative visits per capita varied enormously from one health center to another between October 1984 and September 1985, from a low of 3 visits per year per 100 population in Tshileo and Katanda to a high of 245 visits per 100 persons in Lukunga. (See Table 1.) One reason for this was that people seeking health care were far more likely to go to the SANRU health center in some areas than they were in others. The fifth column of Table 1 shows that the proportion of persons seeking health care who went to the health center during the 1985 two week recall period ranged from 1.4 % in Katanda (where the nurse set up a competing private practice) to 83.2 % in Lukunga (a small, well-defined, and isolated service area). A second, less interpretable, explanation was that people in some areas reported very infrequent use of any health care provider (only 10 visits per 100 persons per year in Tshileo, for example), while in other areas (Kangoy, for example) visits were up to 35 times more frequent. Results in one area were affected by the large number of followers of an apostolic faith who reported their source of care as "kotner". Visits per episode of illness also varied greatly, from scarcely more than 1.0 in Lukunga, Muadi Kayembe, and Kanlana to over 6.0 in Kangoy.

Although researchers anticipated increased use of centers charging fixed fees per episode (rather than variable fees per visit), before/after changes were inconsistent and difficult to interpret. No general conclusions can be drawn from the data collected in the two-week recall survey and the review of health center records. However, much of the variation in utilization can be explained when these data are complemented with a qualitative analysis of the context of events and behavior in each zone.

#### COST RECOVERY : OTHER

Researchers in Benin, Brazil (Lassner), and Zaire collected data on the proportion of health care costs covered through community financing.

In Benin, researchers sought to cover all essential recurrent costs at both the health center and village levels. Since the government paid salaries and electricity costs, community financing was sought for restocking of drugs and supplies, for VHW remunerating, for the transportation costs incurred in supervision and peripheral MCH clinics, for VHW treatment and home visit forms, for the cold chain, and for health center maintenance. Researchers sought to cover these costs with receipts from curative care delivered at both the health center and village levels.

Receipts collected at the village level in Benin covered 23 % of total recurrent costs and were not sufficient to cover even village-level expenses (VHW remuneration, drug costs, and transport for MCH clinics and supervision). The financing scheme was designed, however, so that non-residents using project health centers were charged four times the rate for residents; and by combining these receipts with those from the village, researchers were able to cover both village and health center costs. Initial costs were partially subsidized, and use of curative care was low. As utilization increased, profit margins also rose until income and revenue reached the break even point two to three years after project start-up.

In Zaire, fees were set in diverse ways and varied from one Health Center to another. No technical formula for setting prices was agreed upon, yet the six centers with usable revenue data reported that they covered a median of 107.3 % of their curative costs, including the costs of zonal supervision and mobile teams. (See Table 3.) Revenues generated from preventive care covered between 0.4 % and 10.6 % of associated costs only, but three centers generated revenue from curative care in excess of costs permitting cross-subsidization of preventive care. Overall, the six clinics reported median total cost recovery of 66.5 %.

While Zaire appears to have been most successful in cost recovery, it is not clear whether this should be attributed to revenue generation or to costs (i.e., expenditure) reduction. Clinics in both Brazil and Benin had supplemental funding to ensure certain quality and coverage standards, even though researchers in both instances sought the maximum feasible self-financing. In Zaire, on the other hand, health

zones were largely on their own to generate income as best they could from PVOs, external agencies, and users. Most of the shortfall that occurred had to be taken from drugs and services. As noted in Chapter 4, PHC costs per capita and per visit varied enormously in the Zairian centers studied, partly reflecting a very uneven distribution of resources.

## FACILITATING FACTORS AND CONSTRAINTS

Participants in a June 1986 conference of PRICOR-supported researchers identified a number of incidental factors that either facilitated or inhibited the success of their community financing schemes. National policy factors were summarized in Chapter 2, but there were others of a more personal or cultural nature as well. Other facilitating factors included :

- . the local origin of the principal investigator, as in Liberia, Bolivia (Gonzalez), and Benin
- . a widespread public conviction, as in Mali and Liberia, that outside help for primary health care would not be available and that self-help was essential
- . a tradition of loyalty to royal directives, as in Thailand
- . a high health services utilization rate to spread fixed costs, as in parts of Zaire
- . prior community experience in managing revolving funds, as in parts of Thailand,

Constraints, on the other hand, included :

- . the apparent availability of outside funds, as in Brazil (Lassner) and the Philippines
- . a history of receiving certain goods and services without charge, as in Benin and Brazil (Lassner)
- . prior experience of paying and getting poor results, as in Liberia and Benin
- . the periodic scarcity of cash and even in-kind resources in Bolivia (Gonzalez), Zaire, and Benin
- . weak community management skills in many locations.

DOCUMENT ID: ND.007 RECORDS: 1 YEAR PUBLISHED:  
AUTHOR: Chelemu WC  
TITLE : Essential Drugs Programme and the Bamako Initiative  
SOURCE:  
EXPERIENCE REPORTED: 15 Strategy paper  
PROVIDER LOCATION :

MAIN PROBLEM CATEGORY: policy

KEY PROBLEMS :

SUMMARY:

This paper emphasizes the importance of essential drugs to curative and preventive services. It points out differences between the Action Program on Essential Drugs (APED) and the Bamako Initiative. The author highlights in which ways the Bamako Initiative can profit from APED.

The shortage of essential drugs has been aggravated in many developing countries by: - rapid population growth - low per capita income - drop in exports and therefore inadequate foreign exchange earnings - high costs of drugs - world wide recession - rapid expansion of health facilities with increased demand for drugs and other medical supplies - poor drug management, including irrational use of drugs.

Some countries have chosen an essential drug supply program as an entry point to community financing of health care. This approach was endorsed by WHO/AFRO and UNICEF by introducing 1987 the "Bamako Initiative" (BI). It was intended to provide an initial stock of drugs to last about one year to the community, which would sell drugs at a small margin. Excess revenues could support other PHC activities.

The predecessor to the Bamako Initiative was the Action Program on Essential Drugs (APED) and Vaccines which started in the sixties. Activities were financed by donor agencies with little community contribution to this program. The selective support of countries with severe drug shortages proved to be a major problem of the program.

The main differences between the APED are describes as follows: BAMA  
 KO INITIATIVE  
 APED Community based Donor supported District level management  
 Centralized management Encourages self-reliance Donor dependence  
 Revolving funds Continuous outside input Available to any country  
 Depends on donor preference Integrated approach Vertical tendency  
 Other cost recovery alternatives More fixed on drug sales ?

BI programs should benefit from experience gained in APED. Main achievements of the APED are mentioned below: - use of existing Ministry of Health resources - formulation of national drug policies - preparation of a list of essential drugs - development of methods to quantify drug needs - evolvement of procurement procedures, including competitive bidding through tenders - development of effective storage procedures and stock keeping - establishment of quality control, including Good Manufacturing Practices (GMP) and WHO Certification Scheme - development of training modules - research - cooperation between Governmental and NONGOVERNMENTAL Organizations - shortage of foreign exchange is a problem to BI and APED, improvement could evolve from the Special Health Fund for Africa

DOCUMENT ID: 90.009 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: Knippenberg Rudolph

TITLE : The Bamako Initiative: Primary Health Care Experience  
 SOURCE: Children in the Tropics  
 EXPERIENCE REPORTED: 7 cost recovery experience  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin B,10 Guinea  
 MAIN PROBLEM CATEGORY: A policy B cost recovery C management  
 KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services  
 A,4 Health policy issues A,6 Developing management capacity B,1  
 Describing financing schemes B,2 Service characteristics and resources  
 B,8 Monitoring and evaluation B,9 Types of services C,2 Managing funds  
 SUMMARY:

This monograph provides great detail on community financing experiences in Benin (particularly the Pahou Project) and Guinea, but will be of considerable interest elsewhere in West Africa as well. Individual chapters discuss the organization of health delivery systems, increased effectiveness, cost reduction, logistical support, training and supervision, and information management. The development and use of treatment flow charts is described. Procedures for estimating clinic operating costs and setting prices are explained and fee schedules presented. Sample forms are provided for child and maternal health cards, stock registers, and drug and revenue registers, along with supervision forms for fees and treatments, financial management, and drug management. "Health care financing through user fees for treatment runs the risk that health staff will focus on curative services to the detriment of preventive activities, especially as the population expresses a stronger demand for curative care. To counteract this tendency, the programmes have tried to create a sense of rivalry among health centers, based on the presentation of monitoring results for preventive care interventions. In addition, incentive payments to health staff have been based on their performance as measured by coverage with preventive care." Two conditions are indispensable to the success of (community financing): maintenance of the population's purchasing power and continued (government) payment of salaries at sufficient levels. Without these two conditions, the fragile balance between the community's ability to pay for their health and cost recovery of the health system will be broken. This, in turn could lead to a further erosion of purchasing power, failure of community financing programmes, the downfall of the health system, and a drop in the level of health protection. If these conditions are met, the health system's reorganization in line with the Bamako Initiative principles will be able to contribute to the alleviation of some of the population's health risks and to a reduction of infant and maternal mortality, even in a context of economic crisis."

DOCUMENT ID: 88.010 RECORDS: 1 YEAR PUBLISHED: 1988  
 AUTHOR: Mandl Pierre E  
 TITLE : Community Financing Experiences for Local Health Services in Africa  
 SOURCE: UNICEF Staff Working Paper No.2  
 EXPERIENCE REPORTED: 7 cost recovery experience  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin B,9 Ghana B,21 Zaire  
 MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

**KEY PROBLEMS** : A,2 Microeconomic factors A,3 Health services  
A,4 Health policy issues B,1 Describing financing schemes B,2 Service  
characteristics and resources D,3 Collaborating with other sectors

**SUMMARY:**

What the case studies of various countries have shown to have in common, though the technical modalities of applications differ (not only by country, but even within each country), are:

1. A political will to plan and implement these objectives, which affect several ministries;
2. The recognition by these Governments of the desirability of establishing an essential drugs policy if one is not already in existence;
3. Community involvement through decentralization to the district and local levels;
4. Government commitments to the retention of revenues at the local level;
5. User fees fixed in relation to the costs of consultation/treatment and also to the ability of the users to pay, sometimes in conjunction with a broader PHC approach that integrates income-generating activities and other developmental components;
6. Allowance for the very poor in the community through exemption or subsidies;
7. In most cases, continued Government support for certain types of costs, such as salaries of health personnel and teaching, has been necessary;
8. A particular emphasis attached to training, monitoring and supervision, with external funding for the duration for the start-up phase nation-wide;
9. Focus on a range of PHC/MHC activities and not on drugs alone;
10. Drugs in regular supply to the periphery and community revolving fund have actually strengthened and sustained PHC/MCH.

DOCUMENT ID: 88.011 RECORDS: 1 YEAR PUBLISHED: 1988

AUTHOR: Mandl Pierre E

TITLE :

SOURCE: UNICEF, Staff working Paper No.3

EXPERIENCE REPORTED: 12 Bibliography

PROVIDER LOCATION : A,1 Sub-Saharan Africa

MAIN PROBLEM CATEGORY: A Policy B Cost recovery C Management D  
Communications

**KEY PROBLEMS**

**SUMMARY:**

This annotated bibliography covers several Sub-Saharan countries; as

well as papers from Asia and South America. It also contains a section on essential drugs. In addition to the bibliographic reference abstracts are provided.

DOCUMENT ID: 90.012 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: UNICEF

TITLE : Revitalizing Primary Health Care / Maternal and Child Health: The Bamako Initiative, Progress Report

SOURCE: United Nations Children's Fund, Executive Board

EXPERIENCE REPORTED: 16 Progress report

PROVIDER LOCATION : A.1 Sub-Saharan Africa Nigeria, Benin, Guinea, Sierra Leone, Ghana

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

The principles of the Initiative include: (a) commitment to accelerate access to primary health care (b) decentralization of decisionmaking to district level (c) local retention of revenue (d) imposition of fees at higher levels comparable with those at lower levels (e) maintenance of government health budgets for districts and lower levels (f) essential drug policies (g) measures for ensuring that the poorest people have access to PHC services (h) clear definition of management objectives and indicators. The report discusses the following activities: - mobilization and advocacy, among donors, national governments, and at the community level - the strengthening of national health systems, including planning, operations research, and improvement of the quality of care - improving health care financing, and - improving drug and supply management. "Equity has been a major concern of the Initiative since its inception. There is a specific need to ensure that the poorest people benefit from PHC. Countries have adopted a variety of approaches to protect the poor, depending on cultural norms and government tradition. Many countries, including Ethiopia, Nigeria, and most francophone countries, have established a system for issuing certificates from local authorities to enable the poor to receive free treatment. It is recognized that, in many cases, the distribution of these certificates may not be based on need. Some countries, such as Benin, Guinea, and Sierra Leone, rely on mutual help in the communities. This can be structured or be more ad hoc based on exemptions at the discretion of health care providers. In Ghana, church hospitals have created funds for the sick and poor which are used on the recommendation of the parish priest. . . . "The (Bamako) Initiative has started by concentrating on strengthening the community level, but a number of countries are already planning to examine the consistency of cost-sharing at higher referral levels. Guinea is perhaps the country most advanced in this regard. The 1990 work plan includes the formulation of a policy for hospitals that will seek the referral system at district and higher levels and establish financial mechanisms similar to those instituted for health centres. In Ghana, charges are the same at all church-assisted and public health institutions and the fees increase with the complexity of care." Information on individual countries is summarized in the profiles.

The present report is prepared annually as requested by the 1983

Executive Board. It describes the progress made with preparatory activities and individual country programmes for implementing the Bamako Initiative. The report continues the analysis of constraints and operational issues that have arisen during the implementation period. It describes the activities that UNICEF and the World Health Organization have undertaken, at the country level, in assisting Governments to revitalize primary health care, paying special attention to the poorest and most vulnerable groups, especially women and children.

During 1989, the Initiative has made considerable progress in gaining acceptance for its ideas, in developing programmes of action in 24 African countries and in demonstrating further progress in those countries which are already implementing programmes, namely Benin, Guinea, Nigeria and Sierra Leone.

There is now an urgent need to secure donor support for specific activities, totalling over \$32 million in supplementary-funded projects previously approved by the Executive Board. This African Initiative has now been adopted by many communities and the financial support being provided is an indication that they are convinced of its importance. A similar financial commitment from the international community is now critical.

DOCUMENT ID: 89.013 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: UNICEF

TITLE : Recommendations to the Executive Board for Program Cooperation within the Framework of the Bamako Initiative

SOURCE: United Nations Children's Fund, Programme Committee

EXPERIENCE REPORTED: 15 Strategy paper

PROVIDER LOCATION : A,1 Sub-Saharan Africa

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

The Executive Director recommends that the Executive Board approve special support to countries developing and testing approaches to the acceleration of PHC within the framework of the Bamako Initiative for the period 1989 to 1991 in the amount of \$10,500,000 from general resources, subject to the availability of funds.

1. In 1988, the Executive Board approve an allocation of \$1 million per year for 1988 and 1989 to cover the costs of initial planning and preparatory work to accelerate PHC/MCH in Africa within the framework of the Bamako Initiative (E/ICEF/1988/3). The Board also authorized UNICEF to seek \$30 million in supplementary funding for initiating action at the country level and requested that the individual country programme proposals be submitted to the Executive Board for approval.

2. In the past year, as indicated in the progress report (E/ICEF/1989/L.3), several countries have taken great strides in planning and preparation and have formulated proposals for the 1989 Executive Board. These countries are Sierra Leone, which has a "stand-alone" proposal (E/ICEF/1989/P/L.22) and Benin, Kenya, Nigeria

and Togo, whose proposals form part of the full country programme submission (see E/ICEF/1989/P/L.4, E/ICEF/1989/P/L.2, E/ICEF/1989/P/L.8 and E/ICEF/1989/P/L.9, respectively).

3. The progress report outlines the significant activities taking place in African countries as MoH and their partners examine PHC systems and plan for the revitalization of these systems under the Bamako Initiative. Interest in accelerating PHC/MCH in the African setting has also been demonstrated at meeting of the Organization of African Unity, as well as at other international meetings.
4. The countries planning to restructure their PHC systems are attempting to address the issues raised by the underlying principles of the Bamako Initiative, which are also contained in the progress report. The potentially necessary substantive changes in policy and resource allocation and the need for improved infrastructure and logistics systems imply that the preparatory phase of planning and programming will be intensive and will last for a relatively long period of time. The need to field test community-financing mechanisms before full-scale projects can be designed adds to the delay in implementation.
5. In 1988, the Executive Board requested UNICEF to support careful and detailed preparations for the development of programmes or for initiating actions in selected districts or areas in a country as the basis for expanding to national coverage. In addition to the above-mentioned 5 countries presenting proposals to the 1989 Executive Board, another 12 countries are preparing proposals and need either financial or technical support in areas such as operational research and project development before going to scale. National experts are devoting great care and attention to this phase in order to ensure that the projects will be based on sound planning and will be replaceable.
6. UNICEF and the WHO are committed to ensuring that the Bamako Initiative helps to improve national expertise in operational research as well as in monitoring and evaluation. This is being assured through workshops, joint consultations and inter-country exchanges of technical experiences. These exchanges are essential for upgrading national and regional capacities to provide technical support for PHC in the Africa region.
7. During 1989-1990, a number of meetings and seminars will be held with the participation of international agencies and technical experts involved in health care in Africa.

**BURKINA FASO** The additional funds being sought in 1989 will support the following:

- (a) The provision of drugs to 6 of the 30 provinces in the country, covering 147 health units and 1,000 PH post, as a transitional measure from the essential drugs programme to the Bamako Initiative;
- (b) Operational research on community-financing mechanisms, including

the management of community-generated funds;

(c) The strengthening of the distribution and supply system and of the control of drug stocks in at least 144 community drug depots;

(d) The training of 144 persons responsible for the depots in the simple techniques of drugs stock control and the management of funds.

ETHIOPIA now requires \$600,000 to develop its plan for revitalizing PHC. A full programme recommendation for the period 1992-1996 will be submitted to the Executive Board in 1991, during which period national-scale implementation is envisaged. These funds will support the following:

(a) The formation of a national task force involving relevant sectors and agencies;

(b) Situation analyses to assess existing mechanisms and to identify gaps that would hinder implementation of the Bamako Initiative;

(c) Preparatory activities for undertaking advocacy, policy formulation, legislative reforms and the strengthening of infrastructure and management capability;

(d) Activities to increase the capacity of Epharm and Epharmecor (drug production and distribution authorities) in areas of drug production and distribution;

(e) Start-up projects in the first 20 awrajas and the development of guidelines and procedures for regional, awraja and community-level management committees.

GHANA Unicef proposes to allocate \$2.5 million for the period 1989-1990 to strengthen PHC in Ghana. Of this amount, \$2.0 million will be used to assist the Ministry of Health and the Programme of Actions for Mitigating the Social Costs of Adjustment secretariat in the Ministry of Local Government in providing essential drugs and undertaking related projects along the lines of the Bamako Initiative. For further improvements in PHC management at national, district and community levels, \$500,000 will be utilized for training, supervision, monitoring and evaluation. The country programme recommendation being prepared for submission to the 1991 Executive Board will include further assistance for the development of PHC based on the strategy of the Initiative.

MALI requires \$300,000 for the period 1989-1990 to initiate this detailed process of analysis and planning. Funds will be used specifically to:

(a) To formulate policy guidelines for the Initiative, which include reference to the establishment of an effective national essential drugs policy;

(b) To strengthen existing activities in the regions of Timbuktu

(health warehouses project, supported by the European Economic Community and managed by Medecins Sans Frontieres), Mopti (District Health Planning Unit supported by UNICEF) and Kolikoro (district health strengthening support by UNICEF);

(c) To support the training of key personnel in the principles of the Bamako Initiative;

(d) To support detailed assessment and programming activities.

**INTERREGIONAL SUPPORT** The activities to be undertaken within the programme of interregional support will include:

(a) Social mobilization and advocacy, including conferences, workshops and the production of information materials;

(b) Participation in country programme assessments and preparations, including strategy planning and undertaking programme previews and reviews at regional and country levels;

(c) Field visits and operational research to document experience and develop guidelines and case studies for PHC programme development, in collaboration with WHO and other agencies;

(d) The provision of short-term staff to provide technical and operational assistance at global and regional levels;

(e) Intensive staff development and training in the planning and management of PHC and essential drugs, in collaboration with WHO and other agencies.

In order to achieve all the above-mentioned objectives, it is proposed that an amount of \$10.5 million be made available from general resources for the period 1989-1991.

DOCUMENT ID: 89.014 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: UNICEF, HAI, OXFAM

TITLE : Report on the International Conference on Community Financing in Primary Health Care

SOURCE:

EXPERIENCE REPORTED: 10 Conference proceedings

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin B,9 Ghana B,11 Guinea-Bissau B,19 Sierra Leone

MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services

A,4 Health policy issues A,6 Developing management capacity B,1

Describing financing schemes B,2 Service characteristics and resources

D,3 Collaborating with other sectors

SUMMARY:

This is an unusually well-prepared summary of a meeting conducted in Freetown, Sierra Leone in September 1989. In addition to providing a good list of analytical and operations research questions (pages 40-42), the report summarizes considerations regarding pharmaceutical

cost recovery: "A specific constraint related to community financing is that people are asked to pay many taxes and contributions, as well as to construct health facilities. The degree of support, therefore, to running costs should be assessed as there is a limit to the amount that people can contribute. It is hard to define who should be exempted from payment. This should be defined in the community. The community should also define who should pay for the poorer people. Community participation is complex. Health committees which are supposed to represent the people should be composed in such a way that they are representative and competent. It should be recognized that an initial abortive experience of participation can jeopardize any other future attempt. Before implementing a community financing scheme, quality services should be provided to the people. This is impossible if there are insufficient and incompetent staff. Staff should be motivated and sufficiently informed on the content of the programme. Health staff who will implement community financing schemes should be trained in communication and education skills. Likewise, people in the communities should be trained in management skills. In relation to constraints concerning the community financing of essential drugs, it should be recognized that people and most of the health workers prefer brand-name drugs over generic drugs. Parallel sources of supply and sale of illegal drugs should be assessed. Operational problems in drug supply which interrupt their availability should be carefully examined. "Constraints relating to implementing cost recovery should be clearly recognized. These include: Decisions taken in a hasty manner; Governments lacking control of parastatal or private institutions involved in the supply of drugs; Lack of human resources at the peripheral level and poor working contacts; Insufficient supporting material and financial resources; Lack of supervision, control, evaluation, and operations research. "Constraints related to decentralization and coordination should also be clearly recognized. These include: Serious problems if the government does not allow autonomy in the management of funds raised by the people, does not obtain foreign currencies, and does not allow tax exemptions on essential drugs. Problems due to the lack of banking or other saving facilities at peripheral level. Lack of coordination between the government and the different partners, including NGOs, churches, bilateral and multilateral agencies, and among the partners themselves."

The Freetown Conference, which brought together experts in PHC and community financing from African countries, NGOs, bi-lateral and multi-lateral organisations, helped reach a greater understanding of the issues and constraints in this area of work, especially as concerns the Bamako Initiative. The need for increased communication and co-ordination between all partners in PHC development in Africa was one consensus reached at the conference. It was clear that the focus of such concentrated action should be in each individual country, through participation in multi-agency, and multi-sectoral committees supporting the development of PHC.

The aim of the Bamako Initiative in focussing back on some of the essential aspects of PHC was recognized, acknowledging that PHC is not just a health programme, but a strategy for more general development.

The impact of economic structural adjustment on the health sector was recognised. Strengthening PHC was viewed as an essential measure by which the harmful consequences of adjustment policies might be mitigated.

The specific outcomes of plenary discussions and workshops show that the conference participants view community financing initiatives as an important component of PHC and Essential Drugs Programmes. It was however stressed that the financial problems confronting the health sector in many countries should also be addressed through greater cost-efficiency, and savings, and that the financial contribution of governments to health care should not diminish. The participants formulated constraints in implementing community financing schemes at different levels of the health care system and came up with a list of guiding principles for consideration at the policy level. Adherence to these guiding principles implies a slow and cautious approach, to which the operations research group gave suggestions for research at the various levels of the health care system.

Follow-up suggestions to the Conference emphasize the need to improve analysis and documentation of existing experience in community financing schemes supporting PHC development. This would greatly facilitate an increase in the exchange of information about experiences between African countries. It would also usefully facilitate the emergence of partnerships between health care workers, academics, NGOs and donors in specific action, such as operations research, training and the dissemination of key information.

The Sierra Leone experience in community financing for PHC development stimulated the conference proceedings by injecting practical experience, including both progress and constraints into the discussions. The openness and frankness of the Sierra Leone government in allowing such access to its work is acknowledged and greatly appreciated.

Whilst sponsorship of the conference was shared between Health Action International, OXFAM and UNICEF, the financial support of the British and Dutch governments, a number of NGO funding agencies (notably Christian Aid, Christian Medical Commission, Cebemo, the International Organisation of Consumers Unions, Medico International, Memisa Medicus Mundi, Misereor, OXFAM and Save the Children Fund), along with the financial support of UNICEF itself, made the conference possible. The UNICEF office in Freetown undertook the organisation of the conference itself, playing a major role in creating a conducive environment, and its support is also greatly appreciated.

DOCUMENT ID: 90.015 RECORDS: 1 YEAR PUBLISHED: 1990  
AUTHOR: Fabricant Stephen J  
TITLE : Community Health Financing in Sierra Leone: Initial Results of an Operations Research Study  
SOURCE:  
EXPERIENCE REPORTED: 5 Household survey  
PROVIDER LOCATION : A,1 Sub-Saharan Africa

MAIN PROBLEM CATEGORY: B Cost recovery  
KEY PROBLEMS : B,10 Operations research  
SUMMARY:

PROVISIONAL RECOMMENDATION Sierra Leone is indeed in the forefront of African countries in implementing the Bamako Initiative, especially in the domain of cost-recovery. However, there are several areas in which improvements may be made so that the system works to the advantage of the people who need it most. Household interviews with patients indicated that the prices charged by dispensers at governments PHUs frequently exceed the officially established levels. These prices may well remain affordable for the majority of the rural population, at least during some times of the year (e.g., post-harvest). However, this situation points to the need to examine the financing system more broadly, and particularly to explore the possibilities for greater community responsibility in PHC management. Such an approach could enable a number of important concerns, including provision of adequate incentives for staff, greater public awareness of the charges for health care, and increased local understanding and decision-making about health services, to be addressed by both government and by communities themselves.

Second, it is necessary to simplify the current pricing schedule to make it more accessible to illiterates. A fee-per-treatment schedule, accompanied by pictorial representations of the complaints, may be a workable approach.

Finally, some consideration should be given to a system of differential pricing based on the results of quick surveys which will be developed from the present study. The aim would be to simultaneously maximise recovered costs and minimise deterring people from using health facilities. It would also surely add some complexity to the administration of the system. In an advance stage, a differential price system could require different charges in different districts, at different times of the year, and for people of different socio-economic status. At the same time the present system could be simplified by developing price groups for certain drugs, rather than having many individual but similar prices for drugs.

FURTHER RESULTS FORTHCOMING FROM THIS STUDY Data analysis to date has been based on only 40% of the rural household interviews. It is anticipated that data entry will be finished by June 1990, and by July the data will have been cleaned and the analyses presented in this report can be repeated. More complex analyses which will reveal the relationships between socio-economic status and ability to pay for health care, and which should permit some recommendations to be made about management of exemptions will be carried out in late summer 1990, at which time another preliminary report will be issued.

It is hoped that the PMISU will carry out a small-scale rainy-season follow up study in August or September 1990. The data from the follow up will be added to the computer database, and a final report which includes case studies and the highlights of the focus groups will be prepared by the end of 1990.

DOCUMENT ID: 89.016 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: Campagne Pierre

TITLE : Technical Conference on Community Financing to Strengthen  
Local Health Services in Francophone Africa

SOURCE:

EXPERIENCE REPORTED: 10 Conference proceedings Synthesis Report of  
meeting organized by UNICEF in cooperation with the French Committee  
for UNICEF

PROVIDER LOCATION : A,1 Sub-Saharan Africa Senegal, Mauritania,  
Congo, Togo, Burkina Faso, Zaire

MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services

A,4 Health policy issues A,6 Developing management capacity B,1

Describing financing schemes B,2 Service characteristics and resources

D,3 Collaborating with other sectors

SUMMARY:

An interesting and creative review of community financing experiences, raising questions regarding: the degree of diversity that should occur within countries at what level management decisions should be made alternative ways to ensure access by the poor how to share financing burdens equitably between regions should community bodies be legally constituted? training needs for community financing what evaluation schemes should be encouraged? "How in reality do new financial relationship between State and communities evolve? What legal solutions and derogations have been tried?" "The absence of shortages and a price reduction of drugs encourage the demand for health care. This translates into a significant increase in the aggregate quantity of drugs used. . . . In Pikine, SENEGAL, for example, this aggregate value has increased 14 times in 10 years. We find comparable figures in other countries, notably in MADAGASCAR and in MAURITANIA. The same phenomena occurs in CONGO where the number of consultations per inhabitant per year has gone up from 0.2 to 2 or even 3 in certain health centers. In TOGO as well, the number of consultations in certain health posts practicing community financing is higher than in neighboring health posts operating in the classical system. In certain areas of BURKINA FASO, the number of consultations per head per year has gone from 0.22 to 0.5." Within francophone countries, diversity is seen in: payment modalities price setting methods of collecting funds management practices decisionmaking processes. "It is necessary to simplify management systems and to set up a control mechanism, possibly at the national level, as in Zaire, for example, where the Fonds National Medico-sanitaire (FONAMES) is responsible for supervision, evaluation, monitoring, and training. The same is foreseen in Mauritania. Structures, such as the Committee for the Survival and Development of the Family established in MADAGASCAR at the local and provincial levels can provide much control. "Many communities are accumulating money. The utilization of these funds is yet to be clearly defined. This requires training for budget planning. ----- ANALYST: WS

SYNTHESIS REPORT In organizing the Technical Conference on Community

Financing to Strengthen Local Health Services, the goals of UNICEF and the French Committee for UNICEF were twofold:

18 months after the launching of the "Bamako Initiative", it was essential to give the main actors in the new projects of community financing for local health services the opportunity to exchange their first experiences. One could also envisage asking those who, prior to Bamako, had devised similar solutions, to join the group in order to share their experiences of sustainability and replicability of different systems.

The principal aim was to give the opportunity to learn from each other about the possibilities and the constraints, the successes and the failures of various projects that have been undertaken. The Technical Conference focused on one limited component of the "Bamako Initiative": the system of community financing.

At a time when most countries are considering the extension of community financing, a debate was necessary, not on a theoretical level, but among those who will be the main actors in setting up projects on a national scale. What is working successfully and what is not? What generalizations can be made? Are there some problems that can be addressed in small-scale projects which cannot be solved once the system goes to scale?

In order to reach their principal objective, the organizers of the Conference strived to articulate the debates around four main issues, taking into account that various topics addressed are closely linked. These themes, representing four fundamental questions, are as follows:

- How can community financing help to solve the problem to health care by the poorest?
- What are the various systems of financing that have been set up and what management problems are raised by each system?
- How to organize efficient training and monitoring system?
- What criteria, indicators, and evaluation methods should actually be used or devised, so that they could serve as efficient tools to monitor the system, especially when it is extended to a national level?

In fact, on the one hand, the working groups' debates have confirmed that the two first issues are closely interrelated and on the otherhand, that the problems of training and evaluation must be addressed at each operational level of the community financing system. These are: the elaboration and the establishment of the system, the cost recovery payment scheme, the decision on how to use the funds, the actual expenditure process, the financial management and the relationship between the local and national levels.

In trying to synthesize the work accomplished during these days, it is difficult to give feed-back on all the experiences, all the problems

that have been exposed and the solution that were found. Therefore we have chose to highlight the most frequently mentioned problems while attempting to provide a maximum amount of information. The main problems and solutions have been organized around the following seven points:

1. The problem of access by indigents cannot only be limited to those designated "the poorest" and accepted as such in the local community or at a national level. It necessarily entails an examination of the wider issue of payment by various social groups.
2. The community financing system is already confronted with the problem of different economic zones and thus of populations that, according to their geographical location, cannot be treated equally with regard to their capacity to participate financially.
3. This necessarily different treatment raises the problem of redistribution and more generally the need for solutions such as national solidarity funds.
4. But the way of dealing with the disparities among different economic areas may make decentralization an even more critical need. How in reality do new financial relationships between State and communities evolve? What legal solutions and derogations have been tried?
5. Many countries have very different payment schemes within the country while others have already started to implement more homogeneous approaches. Should this diversity be maintained once the system of community financing is to be implemented on a national level? Does this diversity only result from the fact that payment schemes are heavily dependent on very different types of assistance, or is it due also to the variety of situations encountered within a single country?
6. How should training be conducted on a mass scale at all levels and how should the balance be attained between:
  - a necessarily democratic management of the funds and their use; -
  - community monitoring of this management; - a necessary simplification of financial flows and monitoring that will secure efficiency while avoiding abuses.
7. How to evaluate?

For each of these issues, it is now possible to highlight:

- What is already known (lesson learned) from the experiences reported in this Conference;
- Questions for which solutions must now be found.

Lessons learned and unsolved questions will be set within the context

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of extending community financing nationwide. It must be said that references to each country are necessarily incomplete and refer to specific, concrete experiences that were discussed in the working groups or described in the documents brought by participants.

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AUTHOR: REACH

TITLE : Proceedings from the Resources for Child Health (REACH)  
Project Workshop in Health Care Financing

SOURCE:

EXPERIENCE REPORTED: 10 Conference proceedings

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,4 Central African  
Republic B,6 Congo B,8 Gambia B,10 Guinea B,12 Ivory Coast B,13  
Liberia B,17 Nigeria B,20 Togo B,21 Zaire

MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services  
A,4 Health policy issues A,6 Developing management capacity B,1  
Describing financing schemes B,2 Service characteristics and resources  
D,3 Collaborating with other sectors

SUMMARY:

EXECUTIVE SUMMARY: Between March 24-26 1988, approximately 150 participants from 31 African countries, France, Switzerland, the United Kingdom and the United States assembled at the Hotel President in Yanoussoukro, Cote d'Ivoire, for a highly participatory look at a wide range of health care financing issues. This REACH workshop constituted the first three days of the ACSI-CCCD Project Consultative Meeting. The goals of the REACH Workshop were: a) to explore the many conflicting and complex issues that enter into health care financing; b) to recognize problems of health care financing and approach them responsibly; c) to collaborate with colleagues in identifying creative approaches to health care financing; and, d) to assess the feasibility of these approaches.

Cost Recovery in Central African Republic: Results from Two Preliminary Surveys and Selected Interviews

The Government of the Central African Republic has agreed to consider recovering the costs of some health services as a means of financing recurrent costs. This report contains results from interviews with policy makers and health facility managers regarding cost recovery strategies, as well as results from a preliminary survey of patients about their expenditures on health care.

Two hospitals in the CAR are undertaking cost recovery measures and may serve as models for future discussion and development of cost recovery strategies. Each of these health facilities use revenues generated through fees to pay for a range of service delivery costs, such as salaries, pharmaceuticals, maintenance and supplies. The survey showed that managers in these facilities are dealing with issues of determining prices for services, providing care for the indigent population, and procuring necessary supplies.

The results of the preliminary survey show that individuals are paying

a considerable amount for their health care. The average expenditures ranged from 10.848 FCFA (\$36) for consultations plus pharmaceuticals, surgery and hospitalization in one facility, to 493 FCFA (\$1.60) for consultations and pharmaceuticals in another. Over 75% of respondents replied they would be prepared to pay for health services at government facilities. The results suggested that quality of care was a factor in choosing a health provider.

The study recommended that a roundtable discussion take place with policy makers to outline a strategy for establishing a pilot cost recovery project in public health facilities in the near future.

#### Analysis of Health Services Expenditures in the Gambia: 1981-1991

The Government of The Gambia is working towards the restructuring and strengthening of its health system. To this end, the government is negotiating with the International Development Association, the World Bank, and other donors for funds to carry out the National Health Project. The study identified past and current expenditures, estimated past and current shortfalls in recurrent spending, estimated future donor contributions to program costs, estimated the recurrent costs of the National Health Project and its components, and projected NHP operating expenses until 1991.

In the past seven years, the GOTG's total budget for recurrent spending increased 180%. A large proportion of that increase was due to a growth in debt service obligations, which increased from 5% to 40% in 1987. There have been several shortfalls in the financing of:

1) Drugs and dressings; 2) Other expendable supplies; 3) Maintenance and operation of transport; 4) Maintenance of facilities, and 5) Replacement of equipment.

These shortfalls have resulted in a serious disruption in the delivery of services.

The NHP is an ambitious effort to restructure and strengthen the entire health system of The Gambia with implementation to take place over five years. However, in order for this project to support and strengthen the health system, several recommendations were made:

1) Attention should be paid to meeting current shortfalls in government financing of health services; 2) Support for the creation of a cost recovery system for drugs should be developed. 3) The Ministry's capacity to coordinate donor assistance should be strengthened; 4) The Ministry's capacity to budget and plan for health financing needs to be strengthened; and, 5) Staff should be consolidated rather than expanded.

#### Pricing for Cost Recovery in Primary Health Care in Guinea

This report provides an analytical framework for policy-makers to help facilitate the decision-making process regarding the choice of cost recovery strategy for the CCCD Project. The report addresses the

advantages and disadvantages of alternative payment structures (fee-for-service, fee-for-episode, fee-for-drugs, prepayment for services, and simple versus complex price schedules for services) for CCCD activities.

In addition, an analytic model allows policy makers to see the financial implications of assumptions, such as coverage targets, demand for care, and costs of providing services based on impressions and existing country data. Using a Lotus 1-2-3 spreadsheet, the model calculates the "break-even price" for services, depending upon the assumptions used. In this manner, the features of a sustainable pricing system for primary care can be developed.

The report discusses the advantages and disadvantages of alternative pricing schemes and payment structures in terms of:

1) Efficient resource allocation; 2) Equitable distribution of the financial burden; 3) Financial risk to the population; and, 4) The administrative burden of implementing these strategies.

For the CCCD Project, the report suggests that if uniform prices are charged in health centers, some will have losses while others will generate surpluses. The health system will "break-even" as a whole, but the surplus-generating health centers will need to subsidize those centers which are operating at a loss because of differences in utilization/demand for services.

Two recommended steps for follow-up were made:

1) A choice about financing strategy needs to be made with key decision-makers; and, 2) A pilot cost-recovery site should be selected and preparations made for implementation.

#### Comparative Analysis of CCCD Project Health Care Financing Activities

The purpose of this study was to compare the financing experience of the 13 countries which have implemented CCCD Project activities in Africa (Burundi, CAR, Cote d'Ivoire, Congo, Guinea, Lesotho, Liberia, Malawi, Nigeria, Rwanda, Swaziland, Togo, and Zaire). The comparative analysis reviewed existing REACH study documents and CCCD Project economic evaluations to assess the range of program costs and performance in cost recovery. In addition, the study examined the similarities and differences among these countries with respect to their macro-economic performance. The study also described possible alternative financing strategies which could be explored in these countries in lieu of Fee-For-Service (FFS) systems or in addition to FFS.

The study makes several conclusions and recommendations about CCCD Project financing:

1) Country-specific financing strategies should be adopted rather than relying solely on user fees as the means of sustaining project activities.

- 2) The objective of the health financing component of the CCCD Project should be directed at the sustainability of the health service delivery system upon which CCCD services rest, not specifically CCCD activities in isolation.
- 3) Fee-For-Service financing strategies are in widespread use in these countries; however, further analysis should be conducted on the impact of this strategy on utilization of services and access to health care for the indigent population.
- 4) Fee-For-Service and user fee strategies raise revenue to cover primarily local currency costs, and 60% to 75% of the total cost of CCCD Project activities (based on results from cost analyses) requires foreign exchange. Future financing strategies will need to address this requirement in order to sustain project activities.
- 5) It is important to implement mechanisms to monitor continuously CCCD Project costs and financing performance in order to improve the management and operation of the project, but also to increase the potential for sustainability.

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AUTHOR: Dunlop David W

TITLE : A Comparative Analysis of CCCD Project Health Care Financing Activities

SOURCE: REACH Project

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,4 Central African Republic B,6 Congo B,8 Gambia B,10 Guinea B,12 Ivory Coast B,13 Liberia B,17 Nigeria B,20 Togo B,21 Zaire

MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

KEY PROBLEMS : A,1 Macroeconomic environment A,2 Microeconomic factors A,3 Health services A,4 Health policy issues A,6 Developing management capacity B,1 Describing financing schemes B,2 Service characteristics and resources B,8 Monitoring and evaluation B,9 Types of services D,3 Collaborating with other sectors

SUMMARY:

Thus, it was envisioned that CCCD project services would ultimately be financed in two ways: a) from user fees, and b) general government revenues obtained by taxes and/or other charges. Given the mix of CCCD services, a theoretical case can be made for financing these services in such a manner. The preventive immunization services yield positive social benefits which extend beyond those which accrue to any individual. In such instances, a classic public finance rationale exists for publicly supporting the delivery of such services so that the eradication benefits will be realized by the entire society. It is assumed that the private benefits which accrue from the other two CCCD services (ORT and malaria prophylaxis) to individuals and households in cases where fees are charged which equates the private marginal benefit of using the service with the marginal cost of providing the service equate with the social benefits which accrue from the consumption of those two services. To the extent that either

of the curative services yield social benefits which are subsidization of these services as well. This situation would clearly pertain where enhanced opportunities for child survival represents a necessary condition for a reduction in the demand for additional children, and, therefore, the rate of population growth.

The analysis of the financing component of the CCCD project unfortunately shows that while some progress has been made to achieve financial sustainability of the project in CCCD countries, particularly with respect to the development and implementation of user fees, the theoretical financing strategy outlined above has not yet been achieved in any of the country projects.

### CCCD Project Financing Activity Review

As was mentioned above, at the time of country-specific ProAg signing, it was envisioned that CCCD service financial sustainability would be attained by a) obtaining government commitments to finance a share (generally an increasing one) of the recurrent cost of the project's services and b) develop and implement a fee-for-service system. This review of the financing activities undertaken under the CCCD project has established several important findings pursuant to that objective.

First, in order to establish a financing strategy, it is important to know how much CCCD services cost and what the structure of those costs are. An important assumption was made in the design of the project that CCCD services would be provided via the existing publicly-supported health care facilities. This assumption implied that the CCCD project was to provide the incremental cost support for CCCD services and the financing strategy was designed to support the incremental recurrent cost support for the services subsequent phase of the project. The analysis of the various studies and evaluation reports indicate that:

### Conclusions

While a number of specific conclusions arise from such a comprehensive review of health financing effort via the CCCD project, it is important to highlight seven major conclusions:

1. In reviewing the available information regarding the cost of CCCD projects, the fact that about 60 to 70% of the cost is foreign exchange using requires that future financing strategies for CCCD and the related health care delivery system structure address this financing issue explicitly. Embodied in the country-specific project agreements for the CCCD services was an assumption that such cost element would be financed via government support. However, given the macroeconomic context of most CCCD project countries, that assumption is not supported by the evidence of the last seven years during which this project has been operating. As a corollary to the above finding it is assumed that alternative, foreign exchange saving technologies will be reviewed by both economists and the medical community to find economical ways to reduce the foreign exchange cost components of these

and other potentially substitutable services, such as inpatient pediatric care.

2. Since virtually all other health financing options only raise local currency, it is incumbent upon the donor community to explicitly address its financial responsibility for sustaining these important child survival activities in some of the most impoverished countries in the world for the foreseeable future, in combination with efforts to improve domestic financing capacity. However, without assurances that foreign exchange will be available from donors, if necessary, efforts to resolve the financial sustainability issue will be thwarted.
3. It is important that the objective of the health financing component of the CCCD project be the financial sustainability, not solely of the incremental cost of the CCCD project services, but of the health care delivery system through which CCCD services are primarily provided. This observation implies that a more careful analysis of health care service delivery costs be conducted on a periodic basis in order that the full financing responsibility is known and addressed. The past is replete with examples of underrepresenting the true cost of health service provision and sustainability problems result from the use of such tactics. To ensure that the health financing problem be addressed in this manner, it is important to provide the CCCD project with additional support from the REACH project, and by the other AID and other donor health financing activities underway in each country.
4. There appears to be considerable diversity in the set of health financing options which individual countries find appropriate in their specific settings. This finding implies that country-specific health financing strategies, according to the present efforts being developed in various Nigerian states, become the modus operandi in future CCCD project activities.
5. Fee-for-service health care financing is a reality in virtually all countries. The efforts which have been initiated via the CCCD project to develop and utilize this financing mechanism should be strengthened within the context of a more broadly defined financing strategy. It is important to recognize, however, that in most CCCD project countries, there are no good mechanisms presently available to convert locally raised resources into the necessary foreign exchange required to provide CCCD project services. In addition, ways to address the adverse impact of fees on the medically indigent must become an integral component of any effort to use fees as a mechanism for financing health care services. This latter comment implies that additional analysis of the impact of fees on service use be conducted on a regular basis. Further analysis must be conducted of the revenue and service use impact of alternative ways of packaging services within a particular fee structure and how the resulting implied subsidies of one type of service, i.e., immunizations, may affect the use of health care services.
6. There appears to be an emerging experience in many CCCD project countries with various forms of prepayment and/or health insurance.

This experience requires a more in-depth analysis in terms of what is being presently financed, how the premiums are being collected and administered, how providers are being reimbursed, what the benefit package may be, what actuarial information underlies the benefit and premium structure, what service use experience is emerging, given various forms of benefit coverage, and what problems these insurance entities have experienced and addressed. In conducting this review, it is important to ascertain the role of the social security system in each country, and in providing health care coverage as one component of that system.

7. In some countries, particularly those in which Islamic culture predominates, the recent experience is that considerable health care financing is occurring via locally controlled philanthropy. In addition in several West African countries there are "friendly societies" which help local people regularly finance weddings, funeral, and other significant life events. The potential for such financing sources to provide health care has apparently be overlooked in many countries given the generally low and potentially variable per capita income levels which exist. However, in some situations, this financing mechanism may warrant greater attention than it has received to date and it warrants further study.

## Recommendations

1. In future CCCD project financing activities, it is important that country-specific health financing strategies be developed and tailored to the context existing in each country. This approach implies that an agreed upon set of financing options which have been reviewed by country health and finance officials are developed and a strategy for implementation is established. Further, this strategy must be sector-wide which includes CCCD project activities, but which is more comprehensive than that.

2. It is important to implement a more continuous monitoring of health care costs and financing activities which are operating throughout CCCD countries in order to improve upon the policy recommendations considered to date. Without continuous improvement in what is known about health financing experience, it will be impossible to know what works, and how and why it works in specific contexts. Studies about alternative health financing modalities, including the revenue raised, services used and other contextual economic, cultural, administrative and social attributes which may influence its financial and administrative viability, are required on a regular and periodic basis for each country where the CCCD project is operational or contemplated. Some of these envisioned studies must be undertaken within the context of an "operational research" strategy which will provide the initial capital necessary to start drug revolving schemes on a national rather than solely on a community or local basis, implement alternative health insurance schemes, or raise revenue from fees in consort with regular infusions of foreign exchange from external sources tied to various forms of conditionality.

3. The language of the forth coming country-specific ProAg amendments (or initial agreements) must contain more carefully crafted language about analytical studies required, operational research activities to be developed and monitored, and agreements regarding the regular infusions of the necessary foreign exchange to financially sustain these services. The World Bank has begun to require that health financing analyses predicated the development of a country's health project and that certain country policy problems be addressed prior to the initiation of donor support. The idea warrants inclusion into the subsequent planning for the continuation of the child survival services which have become more widely available as a consequence of the initial effort by AID and other donors throughout Africa.

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 AUTHOR: Dunlop David W  
 TITLE : A Comparative Analysis of CCCD Project Health Care Financing Activities  
 SOURCE: REACH Project  
 EXPERIENCE REPORTED: 7 Cost recovery experience  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,4 Central African Republic B,6 Congo B,8 Gambia B,10 Guinea B,12 Ivory Coast B,13 Liberia B,17 Nigeria B,20 Togo B,21 Zaire  
 MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications  
 KEY PROBLEMS : A,1 Macroeconomic environment A,2 Microeconomic factors A,3 Health services A,4 Health policy issues A,6 Developing management capacity B,1 Describing financing schemes B,2 Service characteristics and resources B,8 Monitoring and evaluation B,9 Types of services D,3 Collaborating with other sectors  
 SUMMARY:  
 CCCD Health Service Package Defined

It is important to define the set of health services which are included in the CCC project/program package from a health financing perspective. Typically, the project set of services includes:

- a) immunization services for children and women of childbearing age (tetanus-toxoid);
- b) appropriate case management, including oral rehydration therapy for diarrhoea in infants and young children; and
- c) treatment and chemoprophylaxis for children and pregnant women for malaria.

#### CCCD Project Costs

##### i. Total Cost

In Table 8, comparative total project cost data is presented from two sources, the CCCD project Annual Report for 1986 prepared by the CDC in Atlanta, Georgia, and the set of mid-term project evaluations which were conducted between June, 1984 and October 1987. For the 8 countries for which comparative data are available, 5 country project

cost data were comparable, Burundi, Congo, Lesotho, Rwanda and Togo. For the other 3, Zaire, Liberia, and Malawi, substantial differences appeared between the 2 sources of cost information. In part, these differences were due to differences in the way in which other donor contributions were evaluated by each information source as either being a part of the CCCD project or not. For example, in some cases, UNICEF's activities were counted as a part of the project activities and in other instances it was not.

Second, Table 8 indicates that the mid-term evaluation estimates are generally at minimum estimate. This is due to the fact that in most instances no estimate was provided of the country contribution to CCCD project staffing and the related salary and fringe benefits related thereto. In addition, most project documents referred to other donor participation in the projects, but the actual cost contribution was often not included.

Finally it was unclear in many evaluations whether the country project cost component was, in actuality, funded by the US via PL430 or CIP local currency generationism or by actual budget allocations which would indicate a true reallocation of resources within the country's own budgetary resources. Thus, the distinction between the US contribution from AID and the local budget was often blurred.

As a consequence of the aforementioned problems, it is difficult to know whether any of the cost information in any evaluation or the CDC Annual Report (1986) provides a true cost estimate of any of the country specific CCC projects. This situation appears to be one where the recently prepared Guidance for Costing Health Services Projects (1987) prepared by the REACH Project for the Asia/Near East (ANE) Bureau of AID could be used with an impact.

Again while the cost information may contain certain problems as defined above and represent only the incremental cost of the delivery of these services, the per capita cost figures suggest that the CCCD project child survival services are relatively inexpensive on a per capita basis.

To the extent that information is available about the structure of fees, the data presented in Table 10 suggest that fees are most commonly levied as a registration fee for outpatient care (generally based on the illness episode) and inpatient care (generally based on the length of stay) and for drugs, either separately, via the mechanism of the village or community pharmacy, or at the health facility itself. In general, drug fees are established by marking up the procurement price of the drug by a certain percentage in order to generate a surplus which can then be used not only to replenish pharmaceutical supplies, but also pay for the acquisition of other goods and services used in the delivery of CCCD and related services.

This typical fee structures described above generally implies that for CCCD project supported services the 2 curative oriented services, i.e., chemotherapy for malaria and ORS for diarrhoea, comprise the

principal source of fee revenue, either via charges on drugs and/or via service registration fees. Several countries, including the Congo, Guinea, Lesotho, and Togo have implemented a policy to charge for immunizations via the selling of vaccination cards or by charging for well-baby visits (in the case of Lesotho).

Table 12: An Analyses of the Empirical Evidence About Financing CCC Project Activities from Evaluations and Reach Product Studies: Comments on Fees, etc.

**CENTRAL AFRICAN REPUBLIC** At two government facilities fees are 3 levied for curative services, mainly in-patient care. At one of the 2, fees are not collected or recorded. At others, fees are lower and retained at unit and more is collected. At a mission hospital and related rural units, a prepaid preventive plan exists and fee-for-service for in-patient and out-patient covers large share of recurrent cost. Experience indicates a willingness to pay for quality health care and that user fees can cover a large share of the recurrent cost.

**CONGO** ORS is rarely purchased. There is disincentive for doctors who make money when IVs are used. The country has experienced great economic hardship since 1985 when the price of oil dropped by more than 50%. This has meant that government revenue has fallen as well and the MOH budget has been cut by about 50%.

**COTE D'IVOIRE** Check with World Bank.

**GUINEA** Fees are just being implemented as of 1987 and are supported by World Bank and the African Development Bank, in addition to the CCC project.

**LIBERIA** Out-patient fee schedule has a small registration fee which varies between hospital and clinic and age of patient.

Also there is a repeat visit fee which similarly varies. Uner 5 years of age the fee is \$0.25. In-patient fees also exist and are based on services provided.

Drug fees are based on cost and vary from \$0.25 per course of treatment to \$1.00. No fees are charged to IB and Leprosy. Immunizations charged a registration fee only. No fees are charged if referred to hospital, etc. All fees are deposited in the government treasury until a local financial management system can be developed.

Fee system is simple and has few loop-holes. Present fees cannot recover a large share of cost of preventive services.

The system is more equitable given discrimination according to age and disease.

There are some development projects where third party payment for health care services exists, i.e. firms.

**NIGERIA** Fees are being considered as one of a number of ways in which health services, including those of CCCD, financed.

**TOGO** The government has agreed to implement a self-financing system to recover costs of chloroquine and kerosene for refrigerators.

The system is to be based on vaccination card sales via village development committees and chloroquine sales via TogoPharma outlets.

Chloroquine is to be sold at cost including transport and cards will cover cost of kerosene on a 4 year phased basis.

**ZAIRE** Fee-for-service is widely used in country as a primary cost-recovery method. Other cost recovery methods employed include prepayment and third party payment by firms for their employees. Some preventive services, such as arte-natal and young child care, charge fees equivalent to out-patient care. Post fees are charges on a per episode basis. Medicine is sometimes included in the initial fee and sometimes is additional. Hospital fees are on a per service basis and greatly vary from zone to zone.

It is considered inappropriate to charge for immunizations due to adverse impact on demand, but fees are levied on chloroquine and ORS although they vary substantially.

External contributions via NGOs and the GOZ each provide about 15% each of the total capital and recurrent cost of zones.

...Ten health zones in Zaire. The amounts raised varied from the substantial share reported to the ten health zones in Zaire of at least 80% of the total recurrent cost (not including an allowance for depreciation and expatriate personnel), to a low figure of about 7% in Rwanda, as reported by Shepard, Carrin and Nyandagazi, (1987).

Other African countries are also beginning to have experience with various forms of health insurance, which, for the most part, are individually subscribed or operated by individual firms or groups of firms for their own employees. At the present time, it does not appear as if any CCCD project activity or service has been included within the context of any health insurance plan in the project countries. However, it would appear that efforts in this direction may expand rapidly in the next decade as more organizations and groups become involved in resolving health financing problems throughout the world.

However, there are at least three problems which health insurance programs must address. The most important economic problem with individually subscribed health insurance programs is the problem known as adverse selection, where only those individuals or households who have information about or suspect that their health status is poor enroll for the program. Where this phenomenon occurs, the financial basis upon which the insurance premium has been established is clearly eroded. In addition, it is well known that in more affluent countries, those who are medically indigent typically are not enrolled in such insurance programs due to their inability to finance the

premium, even though they made be aware that it is important for them to be enrolled in such a program based on the adverse selection argument raised above. Finally, where a health insurance benefit package is not designed to include small but positive fees (deductible clauses) and possibly a modest co-insurance component, there is a tendency for those who are enrolled in a health insurance program to over-consume (or engage in the behavior known as moral hazard) due to the fact that the price to the consumer at the point of consumption is lower than would be the case without insurance.

### Donor Financing Option

While it is recognized that financial independence is only a necessary, but not a sufficient condition for the achievement of sustainability, since it is a necessary condition, it is one that is critical to resolve. The macroeconomic contextual analysis section of the paper unambiguously shows that virtually all of the CCCD project countries have experienced serious macroeconomic problems during the lives of the CCCD projects, from trade imbalances, poor and deteriorating terms of trade, governments deficits, low growth rates, poor agricultural output growth, increasing external debt financing problems and a lack of foreign exchange to finance imports of all types. This analysis, coupled with generally poor prospects for improvement in the next few years, implies that continued donor assistance will be necessary in light of the many other competing claims on foreign exchange allocations if CCCD type services, which have been expanded during the existing projects, are to be sustained to the point where individual countries can provide the financial backing necessary to ensure continuation of the activity from its own resource base.

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 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,4 Central African Republic B,6 Congo B,8 Gambia B,10 Guinea B,12 Ivory Coast B,13 Liberia B,17 Nigeria B,20 Togo B,21 Zaire  
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 SUMMARY:  
 Criteria for Evaluating Potential Health Financing Options

There are a number of attributes of the afore-defined health financing options to review prior to establishing a preferred set for use in financing a CCCD type or other health care providing project. In this analysis, eleven such attributes, cum criteria have been chosen for

use in evaluation these options. The included attributes are:

a) revenue raising potential; b) potential for generating foreign exchange; c) ease of understanding by policy makers; d) contribution to the efficient use of scarce resources; e) contribution to improved equity in the sense of sharing risk; f) political feasibility; g) cultural feasibility; h) social feasibility; i) organizational feasibility; j) ease of implementation; and, k) managerial requirements.

It should be mentioned that while Bitran et al., have shown that user charges have successfully raised substantial amounts of revenue for financing CCCD and other health care services in Zaire, there are few other examples in Africa where such amounts of revenue have been raised in public sector facilities, except possibly in Ethiopia, where CCCD type services are free. In all of the other CCCD project countries where evaluations and REACH studies have been conducted, there are no other examples where large amounts of revenue have been documented as having been raised by user charges.

#### Foreign Exchange Potential

Thus, to sustain the CCCD country specific projects, it will be necessary to retain the external support for the project at least over the next five years, and undoubtedly through at least the year 2000.

#### Equity

Another equity attribute which deserves mention is that of risk sharing. To the extent that the medically indigent have a poorer health status which may imply a greater need for medical care if medical care is allocated on the basis of fees-for-service, a regressive situation exists where those who are likely to require more health care due to their poor health status must pay more of their income for it than those not so unfortunately situated. (This would be true unless fees were adjusted across individuals or households to equal the same share of income for each.

#### Cultural and Social Feasibility

Within the context of the CCCD project countries of West and Central Africa, it is important to mention there are a number of social and cultural differences which have influenced the institutional fabric of how saving and investment activities are typically organized. For example, in a number of West African countries from Guinea to Ghana, men and women societies exist for social mobilization and cooperative labor purposes, and in urban areas of former British controlled countries, "friendly societies" which serve as informal banks and/or lending institutions with rural areas are active and prevalent for financing accidents, marriages, and funerals. These and other social mechanisms which already exist in CCCD project countries could conceivably be used to implement innovative forms of health care financing and warrant further study.

## Organizational Feasibility

Little analysis has focussed to date on how decentralization is politically implemented and what must be established in terms of management and control procedures and information flows between the local and central level so that central governments can relinquish their authority and control over these revenues and still retain some responsibility to the public and information about how the scarce resources are being managed.

### Summary

On the basis of the above analysis, it is clear that a number of options are available for financing health care services, including those which comprises the CCCD project set. Some options, like governmental and donor sources, have raised substantial sums for use in financing health care. Further, the foreign exchange requirements of the health care system operated by the government have traditionally been met from these sources, even though government budgetary allocations do not directly ensure foreign exchange availability for the health sector. At present, the only guaranteed source of foreign exchange funding is that which is obtained for external donors.

To the extent that CCCD project countries are gradually making progress to stabilize their economies, (refer to the macroeconomic context section of the paper) governmental sources of revenue, perhaps enhanced by the gradual development and (expansion in the case of francophone countries) of health insurance programs and typically operated by a governmental entity, will likely comprise the dominant sources of financial support for publicly operated health care programs, including CCCD type services. Irrespective of other decisions which might be made to enhance the financial viability of the health care system in most CCCD project countries, it is clear that these two sources will remain important sources of financial support for the CCCD and related services.

Where user charges can be implemented and well managed, the evidence from Zaire suggests that a large share of the total cost of providing health care services can be financed by fees, in part by subsidizing one type (i.e., preventive with curative) or location of service (i.e., rural clinics with hospitals) by another. Other CCCD project countries, including Rwanda, Burundi, Lesotho, Swaziland, and perhaps others have also implemented fee systems within their health care systems and are collecting modest amounts from the provision of health care via publicly operated health facilities. In addition, with additional external management and technical support, perhaps via the CCCD and REACH projects, it is conceivable that additional financial support can be obtained from that source, particularly if fees are tied to known efficacious treatments like chloroquine, for malaria prophylaxis. The mechanism does enhance efficient use of health services on the part of consumers since they must decide whether they are receiving any thing of value for their time. The problem of financial accessibility by the medically indigent can be addressed by

developing innovative "free care" as well as by other bundling strategies where packages of care are sold for varying prices based on some form of means testing, which has de facto been in effect in many countries for some time.

The most serious problems with various fee systems appears to be that of accountability and control of financial resources, and ensuring that service quality, in the form of continuous drug supplies and diagnostic countries testing capabilities, is maintained via an adequate supply of foreign exchange for the sector. Thus, without politically motivated donor support, it is important to maintain sound macroeconomic policies in order to ensure the continued flow of foreign exchange necessary to complement service fees.

In some settings, community financing will remain an important source of financial support to the health care system, including CCCD services. This appears to be particularly true where:

- a) Islamic cultures provide the local institutional support for a regular flow of donations;
- b) the local governmental structures have been given substantial financial jurisdiction and control over their own affairs; or
- c) other community organizations (religious, ethnic or otherwise) exist and have been involved in similar activities in the past.

This form of financing does not appear to be the type of support, however, that a CCCD type program can rely on for financial sustainability throughout the present set of countries, with the possible exception of Nigeria.

Finally, various forms of prepayment and third party payment systems (in the form of employer fringe benefit package) appear to be emerging throughout the CCCD countries. How these mechanisms will be involved in financing the publicly operated health care system is unclear, since, in most instances, these forms of financing are typically tied to private health care delivery systems, including facilities operated by religious entities. If publicly operated health facilities could be ensured of an uninterrupted supply of medical supplies and drugs, it is conceivable that such facilities could compete for service subsistence and related financing support which has become privatized in the last decade.

DOCUMENT ID: 87.020 RECORDS: 1 YEAR PUBLISHED: 1987

AUTHOR: Brenzel Logan E

TITLE : Planning the Financing of Primary Health Care: Assessing Alternative Methods

SOURCE: REACH Project

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,21 Zaire

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services

A,4 Health policy issues A,6 Developing management capacity B,1 Describing financing schemes B,2 Service characteristics and resources B,6 Incorporating microeconomic factors B,8 Monitoring and evaluation  
SUMMARY:

This paper proposes a framework for establishing financial planning as an integral part of overall PHC planning in developing countries. Its objective is to show how implementation of financial planning tools can serve to strengthen the implementation of PHC.

The framework to be proposed is based on several fundamental observations about the dynamics between health systems development, financing and costs of PHC, which include:

- 1) Ways of organizing PHC service delivery and methods for financing services are closely interrelated.
- 2) The costs of producing certain PHC services are often significantly affected by the way they are organized and financed. For example, government health centers which are staffed but under-utilized result in large government expenditures for salaries not commensurate with level of activity.
3. "Integrated" PHC programs which share the same inputs, such as a community health worker who performs immunizations, provides basic curative care, and offers health education, can raise the level of benefits relative to the overall cost of that program. However, integration places a high premium on adequate supervision and logistics systems. "Integration" may be relatively more costly in the medium term as this process requires inputs for strengthening supervision, transportation and communication components of PHC. These components cut across a variety of PHC activities and are essential for program success.
- 4) Selective interventions using mass campaigns or vertically organized programs may be extremely cost-effective in the short-term, but much less cost-effective over the long-term because of their inability to deliver sustained benefits and to increase the capacity of the health sector to assure funding sources for the costs incurred;
- 5) Governments often accept donor funding of PHC programs without assessing the full impact of the total recurrent costs of a donor program.
- 6) Because PHC is not a homogeneous service or concept, optimal methods for organizing and delivering PHC services are likely to be different for alternative combination PHC services. Each combination requires different levels and types of inputs, and results in a variety of benefits to a range of population groups.
- 7) Simply providing PHC services does not guarantee that those services will be demanded or accepted by the populations. The organization of the supply and financing of services should enhance public demand for services so that larger public benefits will result.

Planning the financing of PHC services is best conceived as an iterative process, in which adjustments to PHC program design are made after successive efforts to estimate the effects of alternative financing methods.

The iterative process can be conceived of as having four major decision-making steps:

- 1) Determination of what to include in the PHC services package and how to organize the delivery of each discrete component of that package;
- 2) Analysis of the likely investment and recurrent costs of each component of the PHC services. A costing framework has been developed and described in detail in "A Simplified Costing Format for PHC Activities".
- 3) Identification of alternative methods and sources of financing the costs of PHC, and analysis of the effects of these methods and sources on equity, efficiency, demand for services, and other suitable criteria; and,
- 4) Analysis of the merits of the original PHC design on how the chosen financing methods may impact short- and long-term costs. This last stage should be followed by changes in the organization and financing of PHC as warranted.

To meet the goal of "Health for All", Zaire is in the process of establishing a network of health zones to total 300 zones and 6,000 health centers.

The zones have been given a high level of autonomy in decision-making so that they have been allowed to develop cost recovery schemes which are suitable to local conditions. During the initial phases of zone development, little attention was paid to cost recovery performance. The REACH-funded study was aimed at analyzing the health zones' cost recovery systems and recommending measures to improve the zones' cost recovery potential. Ten health zones were chosen among the best organized in the country and had relatively successful cost recovery systems. The main findings of the study are as follows:

- 1) There is a great deal of community participation in decisions about how to manage the health zones and how to finance health care within the zones.
- 2) There is cross-subsidization between services (curative to preventive services) and between communities (wealthier to poorer).
- 3) Some of the zones are experimenting with pre-paid health systems which are successful in recovering recurrent costs.
- 4) The health zones included in the study were able to finance a substantial proportion of their operating expenses through user fees. The cost recovery potential ranged from 90 to 67% with the average

being 79% of total recurrent costs.

5) The Government of Zaire and non-governmental organizations played an important role in financing the proportion of operating expenses not recovered by the zones. The total contribution in 1985 resulted in 21% of total operating cost.

The study made several recommendations for the improvement of the health zones cost recovery potential. In the first place, additional studies on the demand for services, including PHC, need to be performed. Understanding the population's behavior with respect to price of health care services will help to find the optimal payment schemes from the viewpoint of both accessibility and cost recovery.

DOCUMENT ID: 85.021 RECORDS: 1 YEAR PUBLISHED: 1985

AUTHOR: Stevens Carl M.

TITLE : Cost Recovery by Government Hospitals in LDCs: A Key Element in Strategy to Increase the Commitment of Resources to Primary Health Care (PHC)

SOURCE: REACH project

EXPERIENCE REPORTED: 15 Strategy paper

PROVIDER LOCATION : A, I Sub-Saharan Africa

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS :

SUMMARY:

Cost Recovery by Government Hospitals in LDCs: A Key Element in Strategy to Increase the Commitment of Resources to PHC

I will outline this approach very briefly, but with enough detail, I would hope, to provide grist for the mill of subsequent discussion.

This strategy will be most appropriate in LDCs in which:

- 1) There is little prospect in the foreseeable future of significant increases (in real terms) in the overall resources available from the government for the MOH.
- 2) The hospital sector now claims on the order of 60-70% of the MOH budget with PHC share being on the order of 10-15%.
- 3) Although there may now be little cost recovery by government hospitals, the policy makers are not, in principle at least, opposed to more significant cost recovery by these facilities. All of the LDCs in which I have worked conform to these provisos.

At this point, in putting this package together, we arrive at an apparent impasse. We require increased efficiency and quality of output if significant cost recovery by government hospital in most LDCs is to be a realistic, feasible approach. To accomplish this, we need a change in the organization formats for these facilities. But, to get this change, we need budget procedures which are based on a system under which the hospital markets services and retains revenue resulting from these fees, i.e., in which cost recovery is working

successfully. But, to make this system work we need improvements in efficiency and quality--and so we come full circle.

It is at this point that a health-financing project may come to the rescue. Without attempting to spell out details, the central notion is that the project might provide funding to simulate the system that would obtain if the hospital(s) selected for a trial run in this domain marketed services and retained and agreed upon part of the revenue thus generated, to be used by hospital management in accord with agreed upon rules. This would provide an opportunity for a trial run to test the proposition that the incentives and management-opportunities provided by the new organization format would result in improved efficiency of facility performance including improved quality of output. It should be noted that, owing to the chicken-egg problem sketched foregoing, without project funding to run the simulation (as a kind of social experiment) this potentially important proposition might not be testable at all.

DOCUMENT ID: 88.022 RECORDS: 1 YEAR PUBLISHED: 1988

AUTHOR: Bitran Ricardo A

TITLE : Health Care Demand Studies in Developing Countries

SOURCE: REACH project

EXPERIENCE REPORTED: 6 Demand analysis

PROVIDER LOCATION :

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Topics covered:

RESEARCH QUESTIONS Pattern of Provider Use Effect of Prices, Income, and Other Variables on Demand Price Measurement Problems Are user Fees Regressive? Effect of Payment System on Demand Effect on Quality of Health Services on Demand Consumer Behavior Under Uncertainty

BEHAVIORAL ASSUMPTIONS Models of Consumer Behavior Econometric Estimation of Behavioral Models

METHODS OF QUANTITATIVE ANALYSIS Discrete versus Continuous Demand Equations Estimation of Discrete Demand Equations Estimation of Continuous Demand Equations.

SAMPLING Why Sampling? Sample Size Sampling Techniques Cross-Section versus Longitudinal Surveys Collecting Data from Users at Health Facilities

DATA REQUIREMENTS What Information to Collect? Who are the Respondents? What Recall Period to Use?

## 1) EXECUTIVE SUMMARY

This paper presents a review of the literature on health care demand studies (HDSs) in developing countries. The objectives of the paper are to describe the findings of previous studies, highlight the

methodological aspects where disagreement exists among researchers, and pinpoint the areas where more research is needed.

In addition to price, there are other facility-specific variables that affect the choice of provider and the amount of care demanded, and which can be altered to achieve wanted outcomes. These are quality of care, and travel distance to the facility, among others. Most HDSs have placed a disproportionate emphasis on the effect of price on demand, and have often overlooked the potential for influencing utilization through changes in non-monetary, facility-specific variables. Consumer and environmental variables also affect demand decisions. However, these are generally viewed by decision-makers as constraints in the medium term.

Several HDSs are reviewed in this paper. The analysis suggests that their findings depend largely on the behavioral assumptions made and the statistical techniques used to estimate demand equations.

## 2) INTRODUCTION:

Although HDSs provide valuable information, they are expensive. In order to obtain reliable estimates of demand parameters, large sample sizes are necessary. Collecting household data requires well-designed questionnaires and well-trained enumerators. Furthermore, poor infrastructure and bad weather make the data gathering process costly.

There is a further argument in favor of conducting additional demand studies: The lack of consensus regarding the appropriate methodology. For example, a recent study that uses a somewhat different methodology from previous ones suggests that prices do have an important effect on demand, contrary to what has been found in previous studies, and that the poor may be more adversely affected by prices than the wealthy.

## 3) RESEARCH QUESTION:

Two increasingly popular research issues are : 1) How do out-of-pocket prices of services affect consumers' decision to seek care from a given provider? and, 2) How do out-of-pocket prices affect the amount of services consumed?

The way prices, income, and other variables influence demand decisions has been analyzed by several authors. Many of them have found that prices charged by providers have an unimportant effect on the choice of provider and the amount of care consumed (Heller, 1982; Akin, 1985; Mwabu, 1985). However, a recent study which uses an innovative econometric technique (Gertler et al., 1986) suggests that fees may indeed have an important effect on demand. Further, the authors of that study show that the poor are more adversely affected by prices than people with higher incomes and wealth.

DOCUMENT ID: 88.023 RECORDS: 1 YEAR PUBLISHED: 1988  
AUTHOR: Lewis Maureen A  
TITLE : The Private Sector and Health Care Delivery in Developing

Countries: Definition, Experience, and Potential

SOURCE: REACH project

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A, 1 Sub-Saharan Africa

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A, 2 Microeconomic factors A, 3 Health services  
A, 6 Developing management capacity B, 1 Describing financing schemes  
B, 8 Monitoring and evaluation

SUMMARY:

Table VI-2 Summary of AID's Options for Privatizing and Promoting the Private Sector in Health Care Delivery

### 1. Promoting Private Sector Investment and Activity in Health Care Delivery

#### Summary of Options

- a. provide access to loan capital including foreign exchange to allow private investments (or expansion and improvements) in health.
- b. assist the government in developing and establishing requirements for incentives to cover health care for employees, especially with regard to catastrophic care.
- c. provide modest grants for feasibility or management review of existing private health care investments for indigenous companies. This would not include multi-national corporations.
- d. review laws, legal restrictions, regulations, and other impediments to private activity in: investing in the health sector or investing in financing and delivering health care.
- e. assist the government in determining impediments to the expansion of health insurance and other financing mechanisms at both the community and national levels.
- f. assist the government or parastatals gain access to relevant and appropriate expertise.
- g. assisting cooperatives set-up member access to services through information, technical assistance and loan funds.

#### Explanation and Implications of Options

- a. Shortage of foreign exchange and limited access to capital can restrict the operation and expansion of health care services. Investments in infrastructure and replacement of (imported) equipment are essential to maintain standards and quality in private facilities. Loan funds can provide these entities with the necessary capital to achieve improvements that keep patients.
- b. encouraging or requiring employers, employee organization to provide health insurance or cover (some part of) health care, especially catastrophic care not only promotes demand for private

care, but it relieves the government of costly, long term care for individuals who could afford to pay if risks were pooled.

c. often a simple management review, which private hospitals and clinics typically cannot afford, can improve the financial viability and profitability of private health investments. Because physicians often run medical service companies and health administrators are scarce, this modest intervention can help to maintain the existing private sector.

d. interest rate policies, licensing requirements, tariff barriers and unnecessary restrictions on physicians' and health providers' medical practices, restrictions on financial institutions (such as insurance companies) and implicit discouragement to alternative forms of delivering health care are the kinds of issues that can be examined and addressed to promote greater private sector activity. High cost of capital (high real interest rates) and of imported goods (tariffs) inhibit quality private care. Other impediments that restrict private operations in the health field range from medical to financial issues.

e. this is a refinement of 1d above, but is specifically focused on insurance, because this financing mechanism is a key element in promoting demand for private health care. (Wason & Hill, 1986 describe many of these impediments and most are mentioned in the text in the Insurance and Employee Benefits section).

f. AID can serve as a broker for government and government bodies in locating and (in appropriate instances for parastatals) supporting technical assistance in how to promote private enterprise in the health sector.

g. rural cooperatives provide an ideal community for establishing cooperative health services or at least a risk-sharing pool to cover catastrophic care for its members. Information and assistance in designing, establishing and operating such a system and perhaps access to concessionary loan funds might help develop health insurance for curative care.

## 2. Assisting Government to Increase Reliance on the Private Sector in Delivering Health care to its Target Population

### Summary of Options

a. pursue feasibility and viability of alternative financing options for health care delivery for both the indigent and non-indigent.

b. assist government in exploring, experimenting and evaluating alternative privatization options including both technical assistance and funding to underwrite the efforts.

c. assist the government in developing a health reimbursement system on a trial basis.

d. social marketing or sale of subsidized pharmaceuticals.

## Explanation and Implications of Options

- a. the following are examples of possible intervention: paying the capitation; payment for indigents (and perhaps some portion for "near-indigents) to enroll them in private HMOs; developing private-public insurance schemes where government pays some portion of the premium for its target population, and employers and employees contribute (close to) full cost.
- b. these encompass privatization efforts and could include: privatizing hospital services, such as: laundry, food service, housekeeping services, management of the facility with the company bearing the benefits of improved efficiency, also could make the company at risk for losses, but it would entail greater private sector control of hospital operations and policy; leasing hospital(s) to a private company to run with the government covering cost of indigent care through some reimbursement mechanism (see below); sell of (part of) the public hospital system to private investors.
- c. reimbursing private providers allows government to finance health care without delivering and allows them to narrow the subsidized group to those who cannot afford health care. Develop alternative reimbursement options: reimburse private fee-for-service; government pays (some part of) HMO capitations fee; government pays (some part of) private insurance premium. The basis of reimbursement must be considered in designing and implementing such projects.
- d. subsidizing generic or other needed (essential) drugs and letting the private market distribute them using the profit motive will increase availability and keep costs down; alternative arrangements with the same incentive structure within public hospitals can at least provide a subsidized back-up for "free" drugs, which typically are unavailable; piggybacking other private distribution networks such as those of soft drinks or tea could also help to distribute key items (this is an unrealistic and not particularly effective means of distributing all drugs).

## CONCLUSION

This paper has attempted to clarify the meaning and concept of private sector activity in health, and has summarized the salient developing and developed country experiences. The options contained in the previous section offer a sense of the range of interventions that are possible under a private sector program.

Despite the potential complexity of the issues involved in promoting the private sector, there are a number of straightforward actions that can be taken that are appropriate in any setting and that lay the groundwork for possible subsequent interventions. Reviewing impediments to the private sector, and modest grants for feasibility or simple management reviews are examples of appropriate initial steps. Experience with these kinds of activities can not only address some narrow, but important gaps, but can also help point up areas of

further interest and need in health and the private sector.

Of course, the kinds of long term intervention that are appropriate in any given setting will depend on that setting. For example, a country with a limited insurance industry is unlikely to be an appropriate site for expanding insurance coverage and a weak Health Ministry is unlikely to be able to handle a reimbursement system for financing care or any serious privatization effort. This, however, does not suggest that private sector interventions are inappropriate, but only that a simpler approach is called for. Privatization of hospital services and alternative reforms in health care finance might be more appropriate options, although prescriptions in the abstract are of limited relevance. In short, the local context is key to determining how to approach promotion of the private sector in health care.

Hopefully this paper will help to identify major areas for possible activity, and will highlight the strengths and weaknesses of alternative options, which in turn will reflect on the appropriateness of any particular action in a given country.

DOCUMENT ID: ND.024 RECORDS: 1 YEAR PUBLISHED: ND  
AUTHOR: Birch and Davis  
TITLE : Evaluating Health Care Financing and Privatization Alternatives  
SOURCE: Birch and Davis International Inc.  
EXPERIENCE REPORTED: 15 Strategy paper  
PROVIDER LOCATION :  
MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
KEY PROBLEMS : A,3 Health services A,6 Developing management capacity B,1 Describing financing schemes  
SUMMARY:  
HEALTH SECTOR PRIVATIZATION OPTIONS

As an outgrowth of our experience in many countries Birch and Davis International, Inc. (BDI), has prepared a short concept paper concerning most of the health sector privatization issues that have been considered in the field and that have been discussed in health literature. In approaching the concept of privatization, it is important to recognize that privatization can be viewed broadly from two rather distinct perspectives. The first perspective concerns the appropriate burden of cost to be borne by Government as compared to that borne by individuals at the point of consuming services. The second perspective concerns the actual delivery of services, and involves deciding how much and which services should be delivered by the private sector as compared to those services delivered by Government Agencies.

The case of leasing public hospitals to private sector doctors and/or management groups has some extremely attractive elements and is not inconsistent with the positive conclusion reached on the advisability of decentralizing hospitals generally in public systems. It is recommended that health ministries consider pilot projects in experimenting with this option, funding the demonstration

prospectively on the basis of projected utilization and provision of services at the same rates charged in providing these services in public hospitals of the same type and standard. This will allow them to collect sufficient data to appraise the desirability of this option from an analytically sound perspective.

BDI emphasizes that caution be exercised in contemplating privatization, particularly since very little data and experience are available in most countries concerning many of the privatization options that should be considered. Experiments and demonstrations should be conducted in each country in order to collect the necessary data and experience on which to base definitive conclusions.

DOCUMENT ID: 90.025 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: UNICEF

TITLE : The State of the World's Children

SOURCE: UNICEF

EXPERIENCE REPORTED: 16 Progress report

PROVIDER LOCATION :

MAIN PROBLEM CATEGORY: A Policy

KEY PROBLEMS : A,1 Macroeconomic environment A,2 Microeconomic factors A,3 Health services A,4 Health policy issues

SUMMARY:

THE STATE OF THE WORLD'S CHILDREN 1990. Children paying: Over the last few years, a decline in health spending per person has been documented in more than three quarters of the nations of Africa and Latin America, and the decline is almost certainly more widespread than these figures suggest. Hundreds of health clinics have been closed down, and many which remain open are understaffed and lacking essential supplies. Family planning services have been cut back, imported drugs have become more expensive, and in the first part of 1989 the health services of Ecuador, Panama, Paraguay, and Peru have been unable even to buy vaccines.

Fragmentary evidence of the tragic and inevitable results is gradually becoming available. Infant mortality is known to have risen in parts of Latin America and Africa south of the Sahara. The incidence of low birth weight, a sensitive indicator of the well-being of women, has increased in 7 nations out of the 15 for which recent information is available.

The Specific Opportunities: It is not only a question of money and technology. It is also a question of the delivery systems and the infrastructure, the management skills and the training, and the use of all possible channels to inform and support parents in applying today's knowledge. But to put the problem into an overall perspective, the additional costs, including delivery of a program to prevent the great majority of child deaths and child malnutrition in the decade ahead might reach approximately \$2.5 billion per year by the late 1990s.

Two and a half billion dollars is a substantial sum. It is 2% of the poor world's own arms spending. It is approximate costs for 5 sStealth

bombers. It is as much as the Soviet Union has been spending on vodka each month. It is as much as U.S. companies have been spending each year to advertise cigarettes. It is 10% of the European Economic Community's annual subsidy to its farmers. It is as much as the developing world is paying every week to service its debts. It is as much as the world as a whole spends on the military every day.

Whatever other reasons may be given, and however difficult the economic climate of the decade ahead may be, it is impossible to accept for one moment the notion that the world cannot afford to prevent the deaths and the malnutrition of so many millions of its young children

**Major Killers:** Because diarrhoea and coughs and colds are the most common illnesses of childhood, the parents of the developing world are already spending an estimated \$1 billion each year on anti-diarrhoeal drugs, cold remedies, syrups, decongestants, and similar products, almost all of which are ineffective. That same amount of money would be enough to pay for effective treatment -if it were available- and to save many millions of children's lives each year.

For both diarrhoeal disease and respiratory infections, the change from bad therapy to good must begin in the home. It is the right of all parents to know how to react rationally, in the light of today's knowledge, when their children are ill. And if parents can be reached and persuaded by invalid messages about ineffective medicines, then it must also be possible to reach them with accurate information and low-cost treatments which will genuinely protect their children's lives and health.

To protect children from life threatening and nutritionally damaging bouts of diarrhoeal disease, parents need to know the essential of both prevention and treatment. Using all possible channels, all families should be informed that diarrhoeal disease can be prevented. It can be prevented by breast-feeding, by having children fully immunized, by using latrines, by keeping food and water clean, and by washing hands before touching food. Similarly, many respiratory infections can be prevented by breast feeding, immunization and safe weaning.

**Restructuring in Health:** We are therefore brought back to the question of whether or not an up-to-date health worker for every 200 or 250 families is a practical possibility in the foreseeable future.

To gain some perspective on the question, the ratio of 1 to every 200 families suggests that 1 million health workers would need to be trained to serve the poorest fifth of mankind, the poorest billion people in the developing world. At an average training cost of \$500, the total training cost would be \$500 million. Such a sum is the equivalent of 1/50 of 1% of the developing world's GNP or 1% of the industrialized world's aid budget, or one day's interest on the third world's debt.

Such figures serve to show that whatever other difficulties they may

be it is absurd to suggest that it is financially impossible to put a trained health worker within easy reach of every family in need.

But, the world is not yet marching in that direction. In the 1990s, the developing nations are set to train tens of thousands of additional doctors, many of whom will be unemployed and few of whom will work in rural areas. Mexico has 4,000 doctors unemployed today, Pakistan has 6,000. In the last % years, Latin America has trained an estimated 200,000 doctors even though, for the same expenditure over the same period of time, it could have trained, say, 150,000 doctors and both trained and paid a decent salary to half a million primary health workers.

Meanwhile, the impact of the debt crisis and adjustment programmes means that existing training schemes are running into trouble. In countries such as Botswana and Jamaica, the training of community health workers has recently been suspended. For different reasons, the country which has done more than any other to pioneer PHC, the People's Republic of China, has also largely dismantled its barefoot doctor system.

Urban hospitals have largely escaped the cuts. Almost 3/4 of central government resources available for health in the developing world are still devoted to hospitals providing relatively expensive curative care for a minority of the population. Brazil, for example, devotes almost 80% of its national health budget to hospital care in urban areas, mainly in the south of the country, while rates of illness and infant mortality in the north-east are among the highest in the world.

Reducing the proportion of health expenditures devoted to hospitals from an average of 75% to something in the region of 45% or 50%, even if achieved gradually by postponing next expenditures and allowing PHC to expand at, say, twice the rate of hospital care would release significant resources for meeting the basic health care needs of the poor.

**UGANDA:** Health in 8,000 schools. In the past, health education in Uganda has been aimed at adults and carried out by health workers who are not trained as educators and are also too busy giving curative care. Other forms of communication have only limited outreach, Radio, Television and the print media, for example, reach only about 10% of the population, mainly in urban areas.

Yet 70% of Uganda's 3 million 6 to 11-year-old children are enrolled in primary school. They have the potential to become "health messengers", introducing new ideas about health to their families and communities. As the parents of tomorrow, their knowledge and attitudes are also a crucial influence on the health of future generations.

Schoolteachers are also respected and are influential members of their communities. Their example and advice could help to inform families and community leaders about simple, low-cost methods of preventing disease and promoting health.

The new health syllabus covers 19 topics including common diseases, food and nutrition, accidents and first aid, sanitation, family health and social problems.

4 School Health Kits on Immunization, Water and sanitation, Diarrhoeal and AIDS control have also been produced and distributed to schools, church groups and other non-governmental organizations. Each kit consists of a set of posters, information sheets, cartoons, flip charts and games.

The syllabus is also accompanied by a "Teacher's Guide" with attractive illustrations and suggested activities for each grade. Group discussions and role plays are also encouraged on topics such as the spread of disease and the use of latrines.

An emergency AIDS Awareness Program was also developed for secondary school students and later approved for use in the top 3 primary school classes. AIDS is a highly sensitive topic, and many parents believe that sex education leads to early sexual activity. The emphasis of the emergency program is on promoting responsible sexual attitudes and behaviour rather than simply encouraging the use of condoms. The program ended in March 1989, after 550,400 students and 5,500 teachers in 782 schools had been educated about AIDS. The next stage is to develop a Health Science Syllabus for secondary schools including education about AIDS and other sexually transmitted diseases.

DOCUMENT ID: 89.026 RECORDS: 1 YEAR PUBLISHED: 1989  
AUTHOR: McGuire Judith S  
TITLE : Beyond Survival: Children's Growth for national Development  
SOURCE: Assignment Children, UNICEF  
EXPERIENCE REPORTED: 15 Strategy paper  
PROVIDER LOCATION :  
MAIN PROBLEM CATEGORY: A Policy  
KEY PROBLEMS : A,3 Health services

SUMMARY:

"Beyond survival lies the pursuit of growth. The task is to unlock children's potential. Forty per cent of the world's children under five years of age, 141 million, are chronically undernourished. The concept that growth retarded children are stunted but healthy and therefore need no attention is false; for these children and their countries, small is unhealthy. Growth promotion strategies can lead to stronger, smarter and healthier children and adults. A country's human capital is enhanced. Investing in children's growth accelerates national development".

The authors explain in some detail why small and undernourished children consume more resources of the health sector, such as more intensive pre- and post-natal care, more curative care as well as care related costs like time and transportation.

DOCUMENT ID: 89.027 RECORDS: 1 YEAR PUBLISHED: 1989  
AUTHOR: Jiggins Janice

**TITLE :** How Poor Women Earn Income in Sub-Saharan Africa and What Works Against Them

**SOURCE:** World Development

**EXPERIENCE REPORTED:** 3 Analytical paper

**PROVIDER LOCATION :** A,1 Sub-Saharan Africa

**MAIN PROBLEM CATEGORY:** A Policy

**KEY PROBLEMS :** A,8 Women in development and health care

**SUMMARY:**

How Poor Women Earn Income in Sub-Saharan Africa and What Works Against Them: In Sub-Saharan Africa, household-base agricultural activity remains the foundation of rural livelihoods - and women do most of the work. Their activities are under increasing stress: they and their children are falling into poverty even as their need for cash income is increasing. Although they keep a foothold in the household economy, increasingly women are dependent on self-employment or wage work for survival; they have little access to services and few opportunities to become more productive. Their situation is exacerbated by continuing male dominance and unequal household responsibilities. The informal sector offers opportunities for entrepreneurship, especially in trading or small-scale agroindustry, but unlicensed activity is discouraged in many countries. Some women also find themselves competing with businesses that are run or licensed by the state. Several micro level interventions are identified that support women's income-earning activities and may halt further deterioration in rural livelihoods.

Despite recent negative trends, there are areas of greater promise and prosperity, and a growing body of experience to guide policy choices and microlevel interventions on behalf of poor women in sub-Saharan Africa. Support for rural women's income-earning activities and capacities is essential to check further deterioration in the welfare, economic viability, and food security of rural households and to build market demand in rural areas. Any such support will require sensitivity to complex environmental and legal issues, a sustained capacity and willingness to assist and to respond to local initiatives and a sharp eye for what is strategically opportune and practically possible.

**Giving Women Credit:**

Poor women in developing countries often turn to self-employment as a way to support themselves and their families but these small-scale activities rarely yield enough income to lift them out of poverty. Recently NGOs and donor agencies have sought to assist these women by providing credit, which is otherwise largely unavailable to them. The broad aims of these programs vary, as do the strategies which range from simply offering credit (a "minimalist" approach) to providing training and technical assistance as part of the credit package (a "credit plus" approach). The channels used (bank schemes, intermediary programs, parallel programs, or poverty-focused development banks) also vary. So far the last 3 channels have been more effective than the first in improving women's access to credit. However, not enough is known about which strategies have the greatest economic impact for particular groups of women, and further evaluation

is needed.

DOCUMENT ID: 88.028 RECORDS: 1 YEAR PUBLISHED: 1988

AUTHOR: WHO

TITLE : Guideline for the Implementation of the Bamako Initiative

SOURCE: WHO, Regional Office for Africa

EXPERIENCE REPORTED: 15 Strategy paper

PROVIDER LOCATION : A,1 Sub-Saharan Africa

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services

B,1 Describing financing schemes

SUMMARY:

Guideline for the Implementation of the BAMAKO INITIATIVE

1. The Bamako Initiative established by the WHO African Regional Committee (Resolution AFR/RC37/R6) at Bamako, Mali, in September 1987 called on UNICEF and WHO to help accelerate PHC implementation at district level, giving priority to women and children,
2. That Bamako Initiative aims at strengthening community based actions for improving the survival and quality of life of women and children in particular through developing a system of community financing, principally based on the supply and sale of basic essential drugs and supplies.
3. The goal of the Bamako Initiative is universal accessibility to PHC/MCH. The attainment of this goal would be enhanced through a substantial decentralisation of health decision-making to the district level, community level management of PHC, user-financing under community control and a realistic national drug policy and provision of basic essential drugs, leading to a self sustaining PHC with emphasis on the promotion of the health of women and children.
4. The Bamako Initiative is designed to encourage maximum community involvement in PHC, through provision of basic essential drugs and supplies to build up a system of user-financing and cost-recovery and a revolving fund which together with support from the district and higher levels will assure sustained health care.
5. Measures for ensuring that the poorest people can use and benefit from the PHC should be considered. This could be through fee-exemptions or subsidies for which criteria should be laid out with the community.

Integration:

The various elements of PHC should be combined so that the mother and child receive all necessary services on one visit to the health centre, without separation of curative and preventive care. The personnel working in the various "vertical" programs could work out the process of integration, with the District Medical Officer through joint workshops and training programs. If separate records are being kept for each family or child (e.g. separate immunization cards,

growth monitoring and attendance cards) they should be merged into one child health card. Again, the community should be involved in decisions about these changes.

### Resources for the health system

#### User financing/cost recovery

The Bamako Initiative will undertake to supply drugs to each district for a maximum of 3 years, after which the community will replenish its stock using funds realized from the sale of the previous year's supply of drugs. Consumers would pay for their drugs right from the beginning of the program. The drug sale price will comprise of the CIF price, plus local transportation and/or other charges, established at national level, plus a mark-up. This drug sale price will still be lower than the price at which the community obtains drugs from other sources. In some cases there might be a need to increase the mark-up still further in order to cover those 20 to 30% of the community who might be indigent or fall within special groups unable to pay for the full amount charged.

There are 3 main methods of collecting user-charges for drugs through:

- (i) Direct payment: on the spot for services rendered.
- (ii) Indirect payment: through a third party before or after receiving services.
- (iii) Combination of (i) and (ii) above.

The 3 systems mentioned above are all aimed at increasing financial resources. Each has its advantages and disadvantages.

The funds locally generated from the user financing/cost recovery schemes will be utilized in the following manner:

(i) Local operating costs: The communities will retain the funds obtained from the mark-up on the sale of drugs supplied during the 3 year period, for use within the community health systems and services to cover various operating and recurrent costs such as community health workers salaries, fuel and other supplies, basic maintenance and for development projects. Each community will organize, manage and determine the use of these funds.

(ii) District Savings Account: In each of the districts where the Bamako Initiative is implemented a District Savings Account (DSA) will be established, which will become their revolving fund of purchase of drugs. This DSA, in local currency, will be fed by revenue from the sale of the basic essential drugs and will be equivalent to the cost of the basic essential drugs plus transport and other charges. It is important that the DSA be established during the first year of the project and the amount corresponding to the total purchase cost of the first year's supply of drugs provided through the Bamako Initiative be deposited on this account. During the second and third years of the

project, the cost of drugs recovered from the sale of the drugs supplied will not be deposited in the DSA, but will be transferred to the special GOVERNMENT/UNICEF/WHO/PHC fund, and will be used for the purchase by the government of basic essential drugs and supplies from then onwards for that.

(iii) Special GOVT/UNICEF/WHO/PHC Fund: At the national level a special fund will be created which will be built up from proceeds of the sale of basic essential drugs, transferred by the districts during the second and third years of the project. This fund will be managed by the Government (MOH), UNICEF & WHO (Joint Bamako Initiative Commission). It will be used for the strengthening and expansion of the Bamako Initiative within PHC system. The Commission will jointly agree on the details of the use of the fund. It will be necessary to transfer funds to start a National Health Revolving Fund in the third year.

(iv) National Health Revolving Fund (NHRF): The NHRF will be built up from the funds received/transferred from the different DSAs, starting with the fourth year of implementation of the project in each district. The NHRF will become the mechanism for the Government to continue to finance community health activities within the Bamako Initiative from the fourth year onwards.

DOCUMENT ID: 86.029 RECORDS: 1 YEAR PUBLISHED: 1986

AUTHOR: Lieberman Joseph

TITLE : Draft Report Health Sustainability in Africa: An Evaluation of the Factors of Sustainability in the Lesotho Rural Health Development Project

SOURCE: USAID

EXPERIENCE REPORTED: 2 Project evaluation

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,22 Lesotho

MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services

A,4 Health policy issues A,6 Developing management capacity B,3

Planning projects D,2 Linking with institutions

SUMMARY:

Health Sustainability in Africa:

The Lesotho Rural Health Development Project (RHDP) was unusual--it was able to provide health care at reasonable cost by using para-medical "physician-extenders".

Quite often, when an AID project ends, the LDC has difficulties funding project costs. That was not a problem with RHDP, partly because the design included a planned annual phase-in of host government financial contributions. As counterparts and Nurse Clinicians were trained and assigned to project operations they were included on the GOL civil service rolls and their salary was included in the GOL budget. By the end of the project, when the project was fully staffed, the GOL was funding all personnel costs and nearly all training and supervision costs.

The only threat to financial sustainability was the low level of user fees. For political reasons, the GOL had decided not to charge patients the full cost of medical treatments. The problem is that GOL revenues have been falling and the IMF reform package will require increased budget stringency. The GOL is already having problems financing the present level of health services. Further expansion of health coverage will not be possible. MOH technical specialists recognize the problem and know that user fees must increase. GOL politicians must now be convinced. Indications are that pressure from the World Bank and bilateral donors will move the GOL to make changes.

## RECOMMENDATIONS FOR SUSTAINABILITY A PROGRAM DESIGN CHECKLIST

This evaluation identified a number of factors that were important elements in building a sustainable program. They have been grouped under four categories: Economic and financial factors; the way a donor designs and implements a project; the project organization and management structure; and finally the political and bureaucratic context.

The Executive Summary provides a brief discussion of the conclusions of this Sustainability Evaluation. The text provides detailed analysis of the factors of sustainability. We thought that it would also be useful to provide a brief checklist of sustainability factors that were important in the RHDP Project. These same factors would be important in other health projects.

### ECONOMIC AND FINANCIAL FACTORS

1. The project design matched Lesotho's level of development and economic conditions. The "physician-extender" approach and the use of Nurse Clinicians is a fairly sophisticated health intervention, but it worked well in this country. For most LLDCs it would be too sophisticated.
2. Effective rural PHC is not cheap. Adequate user fees are necessary for financial sustainability. Other health financing decisions are also important to sustainability; the way a government allocates its health budget between curative/preventive care; between rural PHC/Hospital based care and the role of private versus PHC.
3. To avoid inequitable bias, the user fee structure should not discriminate against the poor.
4. In the short-run, a completely new investment is often more expensive than upgrading and improving an existing investment. A project stands a better chance of succeeding if it builds on an existing capacity.
5. Recurrent costs are easier for and LDC to handle if the marginal increases are small and the increases are budgeted and phased-in each year.

6. An orderly phase-in plan must be in place for the host government to take over project funding.

7. Even if a project is a success and the LDC has good intentions, it may still lack the resources required to maintain full project efforts. Donors should be ready to provide that small extra margin needed to ensure sustainability. Such support should be time limited.

DOCUMENT ID: 86.030 RECORDS: 1 YEAR PUBLISHED: 1986

AUTHOR: Bekele Abraham

TITLE : Financing Health Care in the Sudan: Some Recent Experiments in the Central Region

SOURCE: Social Science in Medicine

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,22 Sudan

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,6 Developing management capacity B,1 Describing financing schemes

SUMMARY:

Financing Health Care in the Sudan: Conclusion: In an average year, about S 1,222,577 in net revenues is generated for the RMOH by the seven experiments described here. This is a considerable sum, representing 30% of the annual RMOH operating budget, though it excludes salaries and capital expenditures, which are fixed transfers from the central government. Moreover, the experiments have increased the supply of health care to low income families through the establishment of People's Pharmacies and evening clinics. The Central Province's experience suggests that resources can be generated through various financing mechanisms. Appropriate incentives, sound management and clear objectives, however, are the implicit components that have allowed some degree of success.

Financial Management:

Yet, a major consideration for any country in launching cost recovery efforts for services, or for taxing particular activities, is the cost of collection. Some evidence in transportation and other sectors suggests that the resource needs of collection may negate any possible benefit from the imposition of fees. The evidence compiled here for 6 of the 7 revenue generating experiments suggests that collection costs are quite modest as a percentage of gross revenues.

Programs expend between 1.7% and 13.0% of their gross revenues on collection; an average of 4.9% of revenues goes toward collection. The 13% for the cinema surcharges is an outlier, perhaps reflecting the relatively low level of revenue generated by the tax on cinema tickets. Collection methods and their costs vary across the experiments. The surcharges on bus and cinema, for example, involve a full-time accountant to administer the accounts, and a half-time use of a RMOH vehicle; no supplies are necessary since these are provided by the bus company and cinema owners. An additional cost is the 5% of revenues paid to the tax department as its fee for handling and implementing the scheme. People's Pharmacies, evening clinics,

visitors' fees and fee-for-service hospital beds all employ part-time or full-time accountants and cashiers to handle the collection and storage of revenues.

Although collection costs have posed a deterrent to the imposition of fees in the past, the Sudan experience in charging for health care delivery and in local taxation demonstrates that the costs of tariff collection need not be high for any form of taxation or fees and that the benefits can clearly outweigh the costs, fees are retained by the collection entity for its own allocation, and cost savings do not jeopardize subsequent budgets, as they do in many countries. For example, the visitors' fees and the charges for upgraded hospital care are under the direct control of the hospital and are used to finance the running of the hospital without interference by the provincial or central government. Hence, strong incentives encourage close hospital supervision, faithful collection and careful handling of collected funds.

DOCUMENT ID: 87.031 RECORDS: 1 YEAR PUBLISHED: 1987

AUTHOR: Alihonou E

TITLE : Community Financing in the Pahou Primary Health Care Project

SOURCE: PRICOR

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,4 Health policy issues B,1 Describing financing schemes B,2 Service characteristics and resources

SUMMARY:

Within this optique, two community financing strategies were proposed to the community: fee-for-episode for curative treatments (with prices being marked up to cover other costs) or a prepayment insurance-type scheme (which gave subscribers free access to a range of PHC services). Even though the choice was made separately by each family, almost everyone chose the fee-for-episode. This choice corresponds closely to the existing active demand for health services which is concentrated in curative care.

Curative treatment prices were fixed such that they would cover the costs of curative and preventive drugs, village health worker (VHW) remuneration, transport costs for supervision and MCH clinics and other functioning costs. Even after all these additions, the prices were still at a level affordable for the community, especially in comparison with the exorbitant costs of prescriptions that were common practice before the project.

In choosing the payment scheme for the community financing system, the community was closely implicated. Two different payment schemes were proposed to the Commune Health Committee: An annual prepayment (insurance) and payment for treatment of illness episodes.

Although the community saw the advantages of the prepayment scheme, few people chose to pay the "cotisation". Community members explained that it was difficult to collect enough money to pay the annual

prepayment for all member of a family at once. In addition, as the project was just starting, the Community was hesitant to sign a blank check over to the health center in exchange for treatment which might be eventually be needed during the year.

Even when charging for curative services, the receipts collected at village level were not sufficient to cover the expenses incurred at village level: remuneration of the VHW, drugs used, and transport for MCH clinics and supervision. However, by combining receipts from the VHWs with those obtained at the health center, these village level costs plus those incurred at the health center (functioning, cold chain) can be covered.

The strategy of the community financing system in Pahou is to cover the essential recurrent costs incurred in the implementation of PHC for the entire commune (health center and village level activities). As the Government pays the salaries of the health personnel and the electricity costs.

#### Fixing Prices:

As receipts from curative services must be sufficient to cover the above costs, the prices must be fixed in consequence. Using as the base the costs for the drugs used in each treatment, the price of each treatment was determined to also include a portion of the costs of preventive services and support activities (supervision/logistics).

How were these treatment prices determined? The price for each curative treatment was based to the following series of calculations:

1. during the microplanning, the drugs/material costs of preventive care, the preventive care, the petrol costs and the functioning costs were estimated.
2. the total curative drug/supplies costs were then calculated based local epidemiology and on having 80% utilization rates.
3. the ratio between the total functioning/preventive care costs and the total curative drug costs was calculated.
4. this proportion was the increase added on top of the drug costs for each curative treatment.

These calculations resulted in the price being a doubling of the cost of the essential drugs provided as part of the treatment. However, when monitoring of coverage in the project revealed that curative utilization rates were less than 50%, treatment prices were raised by 40% to compensate for this lower utilization and to recuperate the necessary resources for the fixed costs to be covered. Thus, treatment prices became a tripling of drug costs. As these drugs are bought under their generic names from UNICEF or IMPAS, even this tripling of the price is still below the pharmacy prices and far below the cost of a classical prescription. The majority of the treatment prices are less than \$1.

#### Charging for Services: Who Pays?

Those living in the 15 village of the Pahou project and who were

registered in the family file system pay one price while those living outside the project boundaries are considered "outsiders", "strangers" and pay a price 3-4 times higher. This differential pricing was instituted with 2 goals in mind: to discourage "strangers" from coming to our project and exploiting the low prices to acquire drugs that they'd sell at a profit for themselves and to discourage a crowding out of community members by these "strangers" leading potentially to drugs being out of stock, poor quality due to overwork of health staff, etc..

Another distinction is made in determining which price will be charged. When a patient from one of the village with a VHW comes directly to the health center without being referred by his VHW, he also pays the price charged to "strangers". This formula was adopted so as to facilitate the recognition of the VHW's competence (reinforced by support from his supervisors) and to assure that villagers respect the referral system.

### Evolution Toward Self-financing

In the start of the project in 1989, total receipts did not cover total expenses.

Thus, over time curative care utilization increased and with it receipts whereas costs remained relatively stable. This phenomenon resulted in an increasing "profit margin" above the cost of the curative drugs, allowing finally for recovery of the fixed costs.

The fact that expenses and receipts do not increase in the same manner and that costs start out relatively high means that the initial debt must be subsidized. If the community financing system is well managed, based on the Pahou experience, the break-even point (self-financing) can be reached after 2 to 3 years. It goes without saying that this self-financing can only be reached if the Government continues to cover the costs of the health personnel and the referral system.

After discussions with the community, the problem identified in some villages was that the population was not used to paying in currency for deliveries.

In other villages the reason cited was that certain drugs (especially for malaria treatment) were available at the local market at a similar price. However, in the beginning as there was no differentiation in treatment prices between children and adults, mothers could treat their children for less if they bought the drugs at the market. Thus, it was decided to reduce the price of malaria and certain other treatment for children. As a consequence, the price was reduced from 70 FCFA to 30 FCFA for children and raised to 100 FCFA for adults.

Shortly after the beginning of village level services, the cost of VHW remuneration threatened to endanger the viability of the community financing system. It was decided that prices would have to be increased and an increase of 40% was agreed upon.

However, by involving the community in the decision-making process, the community financing system was able to avoid certain wastage or unnecessary expenses. Using the above example of increasing the VHW remuneration, after explaining to the Commune Health Committee the consequences of increasing these expenses (a concomitant increase in treatment prices), they themselves saw the need to keep VHW remuneration at a reasonable level. Remuneration was raised from 1.500 FCFA/month/VHW to 3.000 FCFA/month.

The community financing system has facilitated the achievement of high level of coverage with preventive care in 2 ways: preventive care is delivered free of charge and the VHWs are remunerated.

#### Recurrent Costs

This amount represents the costs of curative and preventive drugs, VHW remuneration, gasoline and maintenance costs for motorcycles used for supervision and MCH clinics, petrol for the cold chain, the VHW information system and certain health center functioning costs.

#### Material Costs

Material costs of equipment, the information system and other investment in material were calculated based on accounting records (or equivalent market values), life expectancy of each item was determined and finally these costs were amortized per semester.

For material costs related to start-up activities (training material, survey forms, vaccines, etc...), these were totaled by activity and amortized semi-annually over a period of 5 years.

#### FUNCTIONAL ALLOCATION

##### Allocation to each Direct and Support Service Function

Once costs per period and per category were collected, these costs were allocated to 11 different functional classifications. The direct services functions used in this cost analysis are the following: CURATIVE CARE, MATERNAL CARE, CHILD CARE, IMMUNIZATIONS, and ENVIRONMENT. The support services functions are: SUPERVISION, TRAINING, ADMINISTRATION/LOGISTICS, INFORMATION/MONITORING, PROGRAM DEVELOPMENT, and SECURITY/MAINTENANCE.

DOCUMENT ID: ND.032 RECORDS: 1 YEAR PUBLISHED: ND

AUTHOR: NN

TITLE : Projet de Developpement Sanitaire Pahou: Rapport de la Recherche Operationelle

SOURCE: Pahou project

EXPERIENCE REPORTED: 5 Household survey 7 Cost recovery experience

PROVIDER LOCATION : A, 1 Sub-Saharan Africa B, 1 Benin

MAIN PROBLEM CATEGORY: B Cost recovery

KEY PROBLEMS : B,1 Describing financing schemes B,2 Service characteristics and resources B,10 Operations research

#### SUMMARY:

Pour répondre à ces questions, nous avons initié des études ou enquêtes qui nous ont permis de collecter un certain nombre d'informations que nous avons estimé nécessaire pour répondre aux questions que nous nous sommes posées pour la recherche.

L'analyse des données de l'échantillonnage du travail consiste à déterminer le pourcentage du temps que chaque individu dépense pour chaque activité de chaque intervention qui aide à la répartition de certains coûts (salaires, per diem, etc...)

#### ETUDE DU TRAVAIL DES A.V.S.

La collecte des informations a été réalisée sur la base du temps que prend chaque traitement que l'A.V.S. fait et le temps que chaque autre activité ayant un rapport avec les stratégies du Projet.

#### ENQUETE SOCIO-ECONOMIQUE ET DES MALADES DES DOUZE JOURS PRECEDANT L'ENQUETE

#### DEPOUILLEMENT DES FICHES DE TRAITEMENT (INDIVIDUEL DU C.C.S ET POUR TRAITEMENT AU VILLAGE)

Pour cette étude, un échantillon complet de tous les traitements avec fiche a été étudié pour la population du Projet, plus précisément les membres de cette population ayant utilisé à quelque niveau que ce soit, les soins curatifs du Projet (C.C.S., U.V.S.).

#### DEPOUILLEMENT DES RECETTES ET COUTS

#### CONCLUSIONS

Après 4 ans de fonctionnement, on est arrivé à couvrir jusqu'à 81% des dépenses par les recettes provenant de la population des villages du PDSP. L'autosuffisance pour le niveau commune n'est pas encore complètement atteint. Cependant, le pourcentage des dépenses couvertes par les recettes a augmenté dans le temps, et continue d'augmenter. Si l'on considère les étrangers, on couvre toutes les dépenses et il se dégage même un surplus.

Cependant, on a noté deux points sur lesquels on pourra influencer pour améliorer le niveau d'auto-suffisance: la prescription des médicaments et la récupération des recettes. Il est apparu qu'au niveau de CCS, puisque les ordigrammes ne sont pas vraiment suivis, les prescriptions des médicaments ne sont plus rationnelles, ce qui augmente le prix de revient des traitements. De plus, sans une prescription rationnelle, il est difficile d'appliquer une tarification rationnelle, problème qui se pose pour les diagnostics multiples. Donc, il serait possible d'augmenter les recettes et/ou réduire les dépenses en médicament par une mise en œuvre effective

des ordinogrammes.

#### POSSIBILITE D'AUGMENTER LE TAUX D'UTILISATION DU PDSP

A parti d'une enquete des maladies declarees, environ 30% des maladies sont traitees a des sources de soins modernes autre que le PDSP (produits pharmaceutiques du marche et des autres formations sanitaire). On en deduit qu'il existe encore une demande de soins modernes non couverte par les services du projet. Il y aurait, donc, possibilite de detourner une partie de ces utilisateurs au profit du PDSP si l'on pouvait savoir les raisons pour lesquelles ceux-la n'utilisent pas les services.

De toutes les raison evoquees, celles liees aux services, soit 12% peuvent trouver leur solution a travers une amelioration des services offerts au plan du comportement de l'equipe ou a travers une planification conjointe des activites avec la communaute. Pour ce qui concerne les raisons de preferencel, soit 28% une campagne de sensibilisation serait necessaire pour convaincre au moins une partie de ceux-la a utiliser les services de PDSP. Les raisons d'accesibilite des soins (distance evoquees comme raison de non-utilisation), peuvent etre contourner en partie si l'on decentralise au niveau des deux grands villages (Pahou et Ahozon) qui n'ont pas encore des AVS.

L'allure de la courbe suggere une stagnation de nombre de premieres visite par tete par an au niveau du CCS au meme moment qu'il y a une forte augmentation d'utilisation au niveau des AVS, meme apres cette augmentation.

De ce tableau, on peut deduire qu'il y a une accesibilite financiere reduite pour le groupe a niveau socio-economique bas. Il sera meme indique de regarder ces montant depenses par groupe socio-economique.

DOCUMENT ID: 90.033 RECORDS: 1 YEAR PUBLISHED: 1990  
 AUTHOR: GBEDONOU Placide D  
 TITLE : L'INITIATIVE DE BAMAKO DANS LE CADRE DU PROGRAMME ELARGI DE  
 VACCINATION INTEGRE AUX SSP AU BENIN  
 SOURCE: UNICEF  
 EXPERIENCE REPORTED: 7 Cost recovery experience  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin  
 MAIN PROBLEM CATEGORY: B Cost recovery  
 KEY PROBLEMS : B,1 Describing financing schemes B,2 Service characteristics and resources B,9 Types of services B,10 Operations research  
 SUMMARY:

Il s'agit d'ailleurs d'un essai d'analyse plus apprfondie d'une partie des donnees disponibles a la Direction Nationale du Programme Elargi de Vaccination au BENIN pour parer au manque de documents exploitables malgre la grande quantite de ces donnees sur la mise en oeuvre du financement communautaire.

## CONCLUSION

Le financement communautaire basee sur la vente des medicaments et la participation communautaire a la gestion ou Initiative de BAMAKO puisqu'il faut l'appeler par le nom consacre, est et demeure une source d'espoir dans l'amelioration de la couverture sanitaire.

En effet, par la disponibilite des frais de fonctionnement local qu'il genere, la participation a la base dont il peut beneficier et qu'il peut d'ailleurs renforcer, on peut etre sur d'obtenir une amelioration quantitative et qualitative des soins de sante prodigues aux populations du BENIN.

DOCUMENT ID: 88.034 RECORDS: 1 YEAR PUBLISHED: 1988  
 AUTHOR: TRAORE Abdoulaye  
 TITLE : RESUME DE L'ETUDE DE LA CONSOMMATION DE MEDICAMENTS AU BURKINA-FASO  
 SOURCE: UNICEF  
 EXPERIENCE REPORTED: 6 Utilization analysis  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,2 Burkina Faso  
 MAIN PROBLEM CATEGORY: B Cost recovery  
 KEY PROBLEMS : B,1 Describing financing schemes B,2 Service characteristics and resources B,10 Operations research  
 SUMMARY:  
 INTRODUCTION

Le present rapport presente les resultats preliminaires de l'etude sur la consommation des medicaments au BURKINA-FASO.

Rapport dépenses de fonctionnement, prix du médicament et fréquentation des centres de santé.

La population moyenne d'un CSPPS est de 10.000 personnes. Le taux d'utilisation courant est estime a 22%. Avec l'amelioration des centres et l'approvisionnement du médicament on peut esperer une augmentation du taux d'utilisation a 50%.

Le profit marginal du médicament depend du circuit d'approvisionnement. Il est de 32% si le médicament est obtenu directement a la SONAPHARM et de 13% s'il provient d'une pharmacie. Les PSP ont un rabais de 7%.

Si l'approvisionnement est fait a UNIPAC; le médicament revient a environ 3 fois moins cher. On peut donc en doublant le prix avoir un benefice tout en baissant le prix du médicament.

Des etudes plus precises, par médicaments peuvent etre envisagees.

DOCUMENT ID: 88.035 RECORDS: 1 YEAR PUBLISHED: 1988  
 AUTHOR: SONDO Blaise  
 TITLE : PARTICIPATION COMMUNAUTAIRE DANS L'ORGANISATION DES SOINS PREVENTIFS DANS LA PROVINCE DU HOUET.

SOURCE: MOH Burkina-Faso

EXPERIENCE REPORTED: 2 Project evaluation

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,2 Burkina Faso

MAIN PROBLEM CATEGORY: B Cost recovery

KEY PROBLEMS : B,1 Describing financing schemes B,2 Service characteristics and resources B,10 Operations research

SUMMARY:

La presente etude decrit la methodologie deployee pour executer le projet, les resultats obtenus en 9 mois et met en exergue le role catalyseur joue par l'"osmose" services de sante de premier echelon (CSPS) et communaute tout le long du processus d'execution du programme.

Les populations ont participe au financement du programme par le paiement des episodes a risques : La repartition du co-financement entre les differentes parties prenantes du programme est decrite. En depit de l'importante contribution communautaire, il est reste au 31.12.86 dans les caisses de chaque CSIV, un solde positif suffisant pour financer l'achat des medicaments essentiels prefu dans le cadre du programme de rationalisation des soins curatifs, programme initie pour l'annee 1987.

La mefiance des autorites administratives et politique d'une part et des bailleurs de fonds de l'autre : pour les premiers, le projet introduit une certaine innovation, le financement de soins au niveau des CSPS qu'aucun texte ne consacre a ce jour. Mieux les textes existants font obligation de reversement au tresor public de toute recette collectee dans les services publics. Cependant le Haut Commissaire ayant autorise l'execution du projet, il n'y a pas eu d'obstacle majeur au niveau des departements administratifs.

La diversite des prix des episodes a risque n'a pas facilite la tache de controle de la gestion des fonds. Les couts des episodes varient de 500 a 1200 FCFA pour la consultation prenatale et de 200 a 500 FCFA pour la surveillance annuelle d'un enfant de moins de 5 ans. (consultation infantine). Mais dans la mesure ou notre objectif etait d'acquiescer l'adhesion du maximum des populations au principe de la PC, nous avons tenu a laisser l'initiative aux masses populaires qui, mieux que quiconque connaissent leur pouvoir d'achat et leurs priorites du moment.

DOCUMENT ID: 89.036 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: DES ROCHERS Gilles

TITLE : COST RECOVERY IN THE PHC SERVICES OF CAMEROON

SOURCE: USAID

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,3 Cameroon

MAIN PROBLEM CATEGORY: B Cost recovery

KEY PROBLEMS : B,1 Describing financing schemes B,2 Service characteristics and resources B,10 Operations research

SUMMARY:

The first step in this process was, naturally, to review and analyze existing cost recovery schemes in order to determine the steps that would be necessary to establish an experimental system.

The GTZ propharmacy project demonstrates that the population is willing to pay to obtain medication. The system is managed in a parallel fashion, however, and its viability within a decentralized, locally managed structure remains to be demonstrated. Experience prior to that of GTZ in North West province was not positive, but that does not make it impossible. More rigorous controls were undoubtedly needed. If it were to be extended throughout the country, the GTZ system ought to be reconsidered to ensure an important role for the community in the establishment of propharmacies while maintaining controls on finances and stock to assure their viability.

#### PUBLIC PPROPHARMACIES

During the first 6 months of operation, sales reached almost 500.000 francs, or about 150 frcs per person and averaging 300 frcs per person per year, only slightly less than the GTZ figures from the NW. Comparison remains problematic, however, as long as free medications are distributed to health centres by the MOH and their impact is hard to measure because of the uncertain availability of such government furnished medications.

#### PROPOSED MODELS

In the course of the national conference, the officials of Project S.E.S.A. could propose, for purposes of discussion, one or the other of the following experimental models:

- 1) Organize the sale of essential medications within the public health centers of South and Adamaoua Provinces through the encouragement of community propharmacies. The Project would contribute 50% of the cost of the initial supply of medications in order to provide sufficient motivation to the community for the control of expenses and revenues.

DOCUMENT ID: 89.037 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: WADDINGTON C.J.

TITLE : A PRICE TO PAY: THE IMPACT OF USER CHARGES IN ASHANTI-AKIM DISTRICT GHANA

SOURCE: International Journal of Health Planning and Management

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,9 Ghana

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,6 Developing management capacity B,1 Describing financing schemes B,2 Service characteristics and resources B,10 Operations research

#### SUMMARY:

In present constrained economic circumstances, many governments have introduced or increased user charges for health services. This has been advocated by the World Bank, justified by reference to the raising of revenue, efficiency and, controversially, even the promotion of equity. This paper examines the impact of user charges on utilisation in the Ashanti-Akim district of Ghana since the

introduction of charges in 1985. In many ways, user charges have been a success: in recovering fees and maintaining urban utilisation. However, some advantages have not materialised because the health infrastructure has not changed adequately. More importantly, equity and affordability have been problematical. For some of the population, services are not longer affordable.

The focused group discussions revealed the complexity of the demand for health care. Cost was clearly a factor, but quality, accessibility and acceptability of the type of care on offer were also important. Although consumers acknowledged that charges did sometimes delay or prevent them from attending government clinics, there was a general acceptance that it was reasonable to be expected to pay for health services, as long as drugs were available. However, there were cases when either need was unmet because of the charges, or family economies were hit hard when one member was seriously ill. Consumers were anxious for more flexible credit opportunities; health workers, in contrast, were unwilling to implement such a system.

## CONCLUSIONS

### Demand-side factors Utilisation

In urban areas, after an initial negative reaction to the new levels of charges, utilisation regained its pre-charge levels. However this has not happened at the 2 rural health centres, where utilisation has remained at substantially lower levels. It could be argued that this was because there was a substantial degree of use of the services for very minor complaints before the introduction of charges. However it is not clear why this should be more so in rural than in urban areas. Moreover, it is not clear why this should be more so in merely been switched to the urban facilities. In Agogo, the only facility to have a significant increase in utilisation between 1984 and 1987, the proportion of rural/urban patients did not change. There is thus no reason to suppose that this increase was primarily due to a shift in demand by rural people who were unwilling to pay for their local services. The evidence does not suggest that rural demand was merely transplanted to government or mission facilities elsewhere. For whatever reason, the elasticity of demand for government health services was greater in the rural areas than in towns.

These issues clearly lead to a discussion of the possibility of exemptions for the poor and/or the very sick. The Ghanaian system allows for very few exemptions, and only for a limited number of specific diagnoses. In this respect, some parts of the private sector are actually more flexible. It would clearly be difficult to introduce a means-tested charging system. Perhaps it would be possible to have a system with different charges in different geographical locations e.g. lower charges in the rural areas.

### Supply-side factors

#### Use of revenue from fees

25% of revenue remained with the institution. There were many advantages to this system. The money retained by the health centre itself was used for small objects which eased the smooth running of the institution, yet would have taken a long time to order via district headquarters.

### Shift of demand to the private sector

Apart from the considerable shift in demand towards Agogo Hospital, the other major effect of the introduction of user charges seems to have been a shift in demand towards the private sector. The private sector consists of a large number of drugstores, traditional practitioners (herbal, spiritual and fetish), quacks and Allopathic practitioners. The phrase "seems to have been" is used because the evidence of this is anecdotal rather than quantitative.

### Appropriate use of facilities.

One of the disadvantages of a free health service is that it encourages patients to use high-cost hospital services when their needs could be addressed at a lower, cheaper level. If charges reflect cost, then charging will promote demand which is more sensitive to the costs of different levels. In Ashanti-Akim, the opposite happened. Because the Missions's charging policy worked independently from the government, the cost of a hospital visit, relative to the cost of a consultation at a health station, declined. Utilisation at the facility which is the most expensive to operate increased. In this respect user charges have not promoted efficiency, because Mission and government policy decisions have not addressed the same concerns.

### Quality

These experiences involved excessive waiting times, rude staff, absence of prescribed drugs, inflexible payment procedures (specifically the lack of credit opportunities) and inadequate facilities for proper physical examinations. Apart from improvements in drug supplies, there was no suggestion that any of these matters had improved in the past 3 years. Moreover, in all the interviews with health personnel, nothing was said to suggest that they thought that they should improve their performance so as to have more revenue. Many of the health worker's frustrations were centred on issues such as pay, postings and other personnel matters. As far as they were concerned, their working lives would not be made substantially easier by encouraging more patients to use their services. The 25% retained revenue was too small, delayed and indirect an incentive to have this effect.

### CONCLUSION

In many ways the introduction of user charges has been a success. The target of recovering 15% of MOH expenditure has been achieved. Urban utilisation has re-gained its pre-fees level

In other respects, the hopes of the advocates of user charges have not

been met in Ashanti-Akim. Some of the potential advantages of user charges have not been reaped because the health infrastructure as a whole has not responded to the needs of the change.

There are also some intrinsic disadvantages to the present system and these should not be ignored. Most notable are the related issues of equity and affordability. In Ashanti-Akim, the rural population seems to have suffered a disproportionate drop in utilisation since the introduction of user charges. For some of the population at least, charges have meant that services are not affordable

DOCUMENT ID: ND.038 RECORDS: 1 YEAR PUBLISHED: ND  
 AUTHOR: ISSAKA-TINORGAH Abdulai  
 TITLE : ENCOURAGING EFFICIENCY THROUGH PROGRAMME AND  
 FUNCTIONAL  
 BUDGETING - LESSONS FROM EXPERIENCE IN GHANA AND THE GAMBIA.  
 SOURCE:

EXPERIENCE REPORTED: 9 Financial analysis  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,8 Gambia B,9 Ghana  
 MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
 KEY PROBLEMS : A,6 Developing management capacity B,1  
 Describing financing schemes B,2 Service characteristics and resources  
 B,3 Planning projects

#### SUMMARY:

This chapter looks at the potential for using budgets as an information tool relevant to the promotion of efficiency. It discusses case studies of attempted budgetary reform in Ghana and of functional budgeting in the Gambia. Finally, it draws conclusions about the prerequisites for successful budgetary reform.

Because output budgeting is in practice rarely possible. Two less far reaching approaches are often used. These are programme budgeting and functional budgeting. Programme budgeting is the classification of expenditure according to programmes, which may be defined according to client groups (e.g. maternal and child health, antenatal care) or according to the type or tier of service (eg PHC, PH). Clearly, programme budgeting is conceptually inferior to output budgeting, as the effectiveness of expenditure is not considered.

The advantage of programme budgeting is that it goes part of the way towards providing at least an output orientation to the presentation of financial information.

Functional budgeting is conceptually very similar to programme budgeting, but the term is normally applied to situations at a sub-national level where each service unit has a separate budget. In a hospital there could be functional budgets for each ward, the theatre, laboratory and pharmacy. A PH office might have functional budgets for rubbish collection, inspection of buildings, water supply and sanitation. Functional budgeting is in effect a local version of programme budgeting and the terms are sometimes used interchangeably - neither classifies expenditure according to output.

Programme budgeting: the Ghanaian attempt

Prior to 1978, financial management in the MOH in Ghana followed the traditional incremental practice of setting expenditures by adding a certain percentage to the previous year's accounts, with regard to neither plans nor the availability of resources. Target setting was done in isolation from financial considerations.

This system demanded much more of sub-district, district and regional staff than had the previous "budgeting by default" system of incrementalism.

Shortage of skilled staff.

The complexity of the system meant that much of the proposal was doomed before it had begun.

Lack of credibility

A system that aims to link forward planning to the likelihood of receiving resources will not work if promised resources do not materialise and if the plans are seen not to reflect reality.

Inadequate support from other Ministries

Negotiations were necessary because the MOH's proposals were out of line with the usual incremental-cum-muddling-through practices of spending ministries.

Responsibility without power

There was thus little incentive for district-level officers to budget according to objectives when their efforts were likely to be undermined by regional interference. Budgetary power must be linked to budgetary responsibility.

Absence of political will

Politicians are always eager to avoid forcing awkward political issues to a head. A more sophisticated budgetary system would only have highlighted this discrepancy between rhetoric and practice.

If the desirable link between planning and budgeting is to be forged, however, the tradition of categorising budgets solely according to input type must be changed. The following criteria represent a compromise between stultification and untenably complex reform. The message underlying all these criteria is "don't try to change everything in once".

Accept mixed scanning

"Mixed scanning" means that a broad programme or functional budget is used to identify areas of particular concern or priority (Calden and Wildavsky 1974). A closer, more output-oriented look can then be taken at this particular area.

### Provid appropriate staff training

Changing and expanding a budgeting system has opportunity costs in terms of the use of skilled personnel. If planners managers and accountants are over-whelmed by the complexities of a system, they cease to work effectively. Moreover, many health workers acquire responsibility for budgets as their careers develop, without ever having had any training relevant to this duty. But it is clearly unfair to expect personnel to produce and use budgets if they have not received any relevant training.

### Ensure that budgetary power and responsibility are matched

Health managers will not have the incentive to link budgets to well-thought-out plans unless they feel that they have a reasonable chance of implementing these plans.

### Acknowledge political realities

A "rationality" budgeting system does not alter the unwillingness to highlight the stark realities of resource constraints and choice, although the availability of relevant information may influence the situation.

### Accept through put-oriented program and functional budgeting

A recurring theme amongst write-ups of unsuccessful budgetary reforms is the difficulties inherent in output budgeting. Firstly, there is no univeral acceptance in the health sector of how output should be measured. Secondly, such a system tends to lead to data collection so excessive that it paralyses the system. In reality, it is often only possible to use throughput (i.e. intermediate or process) measures. Examples of throughput measures are number of fully immunised children, in-patient bed days and number of latrines built.

Functional budgeting offers a pratical compromise between traditional accounting and complicated reforms, as it is based on available accounting information yet can be used to assist in planning decisions. This exlample is of the ward costings conducted in the Royal Victoria Hospital (RVH) in Banjul. The Gambia in 1985.

The basic ideas of the costing study was to re-allocate the traditional accounting categories to the operational departments of the hospital - namely the surgical, medical, pediatric, obstetrics and gynaecology, opphtamology, psychiatric and private departments and the sanatorium (all of which has both in-patien wards and out-patients clinics), plus the general, civil service, dental and audiology out-patients. These departments and clinics were called patient service areas.

DOCUMENT ID: 87.039 RECORDS: 1 YEAR PUBLISHED: 1987  
AUTHOR: BRUDON-JAKOBOWICZ Pascale  
TITLE : RAPPORT D'UNE MISSION OMS - Conakry

**SOURCE: WHO****EXPERIENCE REPORTED: 16 Progress report****PROVIDER LOCATION : A,1 Sub-Saharan Africa B,10 Guinea****MAIN PROBLEM CATEGORY: A Policy B Cost recovery****KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy issues A,6 Developing management capacity B,1 Describing financing schemes B,2 Service characteristics and resources B,10 Operations research****SUMMARY:**

Recouvrement des couts/financement communautaire

Un system de recouvrement des couts a ete adopte par le M.S. avec les caracteristiques suivants:

Les malades paieront pour le traitement completa un prix fixe au niveau central, ex. un patient avec un paludisme simple recevra le traitement therapeutique standardise : 15 comprimés de chloroquine et 6 d'acide acetylsalicylique et paiera 150 frcs guineens.

Les prix de vente au public on ete calcules a partir du cout CAF par traitement; dans la programmation PEV/SSP, ce prix de revient devait etre multiplie par 3 jusqu'a concurrence de 1.000 FG. En fait, le MS a revu les prix de baisse de facon a ce qu'ils soient a portee du pouvoir d'achat des communautes. Tous les traitements superieurs a 1.000 FG on ete subventionnes.

Dans le futur, la mission recommande que les prix continuent a etre fixes au niveau national. Pendant l'annee de mise en oeuvre du programme des informations devraient etre obtenues sur l'adequation des prix et des revenus; si les prix fixes sont acceptable pour la populationm la mmission recommande que les changements de prix se fassent en fonction du pouvoir d'achat et du revenu familial selon un pourcentage qui soit le meme pour tous les produits.

Lorsque les medicaments seront payes par les communautes, un mecanisme devra etre trouve pour absorber les trop grandes fluctuations des devises; en effet, si le frc guineen est devalue par rapport au dollaril, il sera impossible pour les communaute de reunir les fonds necessaires a l'achat des medicaments. Un fonds de stabilisation des devises ou de compensation qui garantisse un taux de change constant pourrait etre mis en place. Ce fonds devra etre gere centralement et pourrait etre fourni par les donateurs ou l'Etat. Comme l'ont fait remarquer oles autorites nationales lors de la mission : "L'Etat doit etre pret a intervenir, la communaute ne peut supporter tous les couts".

L'argent des recettes restera au niveau local pour couvrir certains couts recurrents fixes. Ces couts ne varient que peu avec la taille de la sous prefecture et le taux de couverture. Apres une periode de deux ans pendant laquelle chaque centre recevra gratuitement les medicaments, les recettes devront aussi servir a reapprovisionner les tocks. Les salaires resteront a la charge de l'Etat. La vente des medicaments sera d'abord utilisee pour financer au niveau de chaque centre:

- certains frais de fonctionnement (essenc, indemnites, entretien),
- les frais de supervision et de distribution des medicaments et le petit materiel de bureau (fiches, registres, etc...),
- les frais d'entretien de la moto et de la chaine de froid
- les frais d'amortissement

L'argent collecte par le biais de la vente des medicaments restera au niveau local et ne rentrera pas dans le circuit des finances publiques. Il sera gere par un comite de gestion au niveau du centre de sante grace a un systeme de comptabilite simple et standardise ; le developpement de ce systeme de gestion communautaire n'a pas fait l'objet d'une analyse de la mission, la mise en place de ces comites et leur formation est une condition manœuvre de la reussite du programme (voir p.35-36 rapport OMS, Berthoud/Brudon-Jakobowicz/Damour). En l'absence d'un reseau bancaire etendu, es coffres-forts doivent etre achetes pour chaque centre (a financer sur proposition UNICEF/NY).

#### Utilisation des medicaments

Le programme medicaments essentiels est base sur les notions de traitements therapeutiques standarises, de paiement par traitement et d'evaluation des besoins en fonction de la morbidite. Si ces notions ne sont pas bien comprises et acceptees, tres rapidement la consommation va etre influencee par la demande et non plus par les besoins therapeutiques avec pour consequence une dispensation irrationnelle des medicaments ne suivant pas, par exemple, le nombre de comprimés par traitement. Ces deviations auront un effet non seulement sur l'utilisation rationnelle des medicaments mnais sur le systeme de recouvrement des couts.

La formation doit donc comprendre les aspects suivants:

- 1) amelioration des capacites de diagnostic (developpement de strategies de diagnostic-traitement);
- 2) amelioration des pratiques de prescriptions et de la connaissance des medicaments (fiches d'utilisation des medicaments);
- 3) amelioration de la dispensation avec pour objectif une meilleure observance par le malade.

DOCUMENT ID: 89.040 RECORDS: 1 YEAR PUBLISHED: 1989  
AUTHOR: UNICEF  
TITLE : PROGRAMME DE RELANCE DES SSP/INITIATIVE DE BAMAKO (YH 801) ET  
PROGRAMME D'APPUI A LA NUTRITION (ZN 804)  
SOURCE: UNICEF  
EXPERIENCE REPORTED: 15 Strategy paper, project proposal  
PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy issues B,1 Describing financing schemes B,2 Service characteristics and resources B,9 Types of services

SUMMARY:

En d'autres termes, l'Initiative de Bamako a donne l'occasion de suivre deux cheminements paralleles : celui de la mise a disposition des medicaments a la population et celui, plus large, de developpement sanitaire. Une quadruple strategie a ete arretee :

- a) Decentraliser la planification sanitaire, la budgetisation et le systeme de gestion, en prenant le cercle comme unite de planification;
- b) Assurer en permanence la disponibilite et l'accessibilite des medicaments essentiels, a travers une serie de mesures dont une mise de fonds pour la creation d'un fonds roulement;
- c) Appuyer le travail des cercles par des activites de formation, supervision et recherche;
- d) Developper la participation communautaire a la gestion du systeme.

PLACE DES PROGRAMMES DE SANTE MATERNELLE ET INFANTILE (SMI)

Les programmes qui sont du ressort de la Division de Sante Familiale, SMI, Nutrition, Lutte contre les Maladies Diartheiques, ont ete developpes ces derniers annees, en partie avec l'appui de l'UNICEF. Ces programmes touchent, a l'heure actuelle, moins de 10% de la population rurale. La mission OMS/FNUAP/UNICEF de Sept/Oct. 1987 chargee d'effectuer une analyse de la situation de la ISMI, avait identifie les principaux problemes des programmes de sante familiale comme suit:

- l'absence d'integration des differents volets de la SMI et de la SMI dans les autres activites des centres de sante,
- une gestion et organisation inadeguate des services,
- la non-disponibilite des medicaments essentiels a visee SMI,
- l'absence d'information de la population sur l'offre des services.

DOCUMENT ID: 89.041 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: BRUNET-JAILLY J.

TITLE : LE FINANCEMENT DE LA SANTE DANS LES PAYS PAUVRES :  
RECOURIR

LES COÛTS OU LES RÉDUIRE

SOURCE: African Health Policy Paper, World Bank

EXPERIENCE REPORTED: 9 Financial analysis

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,1 Macroeconomic environment A,2

Microeconomic factors A,3 Health services A,4 Health policy issues A,6

Developing management capacity B,1 Describing financing schemes B,2

Service characteristics and resources B,8 Monitoring and evaluation  
B,9 Types of services

SUMMARY:

Le probleme du financement des services de sante dans les pays en voie de developpement est desormais pose en termes de recouvrement des couts. Cette orientation est en particulier celle de la Banque Mondiale, dont les activites en tant que groupe de pression visent actuellement a obtenir des pays qu'elle aide en matiere de sante au'ils s'engagent dans les 4 reformes politiques :

1) faire payer les utilisateurs des services publics de sante, notamment pour les soins curatifs et les medicaments. 2) mettre en place une assurance ou d'autres moyens de couvrir le risque de maladie. 3) faire un usage effectif des ressources autres que gouvernementales. 4) decentraliser les services de sante publics.

Ce sont donc les familles qui supportent d'ores et deja les 3/4 des depenses de sante. Et ces depenses atteignent probablement 2700 FCFA par tete en moyenne annuelle. La gratuite des soins de sante n'est qu'une fiction.

De la, il faut aussi retenir que le niveau actuel de la depense de sante par tete est faible. En 1960, le montant comparable etait deja de l'ordre de 4000 fcfa au Senegal, mais seulement de 220 fcfa au Burkina Faso en 1981.

Une solution realiste

Dans ce qui suit, on utilise une representation simplifiee du systeme de sante, tant dans son etat actuel que dans l'etat qu'il pourrait atteindre si certaines decisions etaient prises concernant son financement. La construction d'un tel modele exige que l'on precise dans quelles conditions fonctionne (ou pourrait fonctionner) le systeme de sante, et par ex. les suivantes :

- quelles sont (ou quelles pourraient etre) ses principales activites, aux differents niveaux de son organisation pyramidale?
- quel est (ou quel pourrait etre) le taux de frequentation de ces diverses activites ?
- quel est (ou quel pourrait etre) le cout unitaire de chacune des principales prestations intervenant dans chaque activite ?
- quel est (ou quel pourrait etre) le tarif applique a chacune des prestations, et donc le niveau des recettes attendre de la tarification.

Un modele extremement simple construit sur des bases explicites aue l'on peut soumettre a la discussion et modifier, permet d'apprécier comment varient a la fois le montant global du financement necessaire lorsqu'on modifie l'une ou l'autre des conditions de fonctionnement, et le montant global des ressources effectivement mobilisables. L'interet d'un tel tableau et qu'il permet de calculer immediatement

les consequences de toute modification des hypotheses qu'il contient.

## Conclusion

Les estimations ressortantes ne définissent pas dans les détails qui s'imposeraient, la solution à suggérer aux responsables de la santé publique du Mali s'ils voulaient faire face à l'effondrement des activités du système de santé. Elles montrent simplement dans quelle direction cette solution devrait être recherchée.

Cette direction rappelle beaucoup celle qui a été tracée par l'UNICEF sous le nom d'"Initiative Bamako", et, après tout, il était assez naturel que l'on se préoccupe au Mali de savoir comment l'"Initiative Bamako" pourrait reprendre corps dans ce pays. Ce qui ressort de notre analyse est que le Mali n'a pas absolument besoin de dons supplémentaires pour parvenir à rendre les médicaments disponibles dans les formations sanitaires et dans les officines. Tout au contraire, les expériences qui se sont déroulées au Mali enseignent clairement que les meilleurs résultats sont obtenus là où l'aide est la moins importante. Dans le domaine qui nous intéresse, la 5<sup>ème</sup> région, aidée par une simple ONG, a mis au point une formule pratiquement autofinancée et donc pérennisable. Dans les 6<sup>ème</sup> et 7<sup>ème</sup> régions, où l'aide extérieure a été plus importante, on ne voit pas que le système en place puisse perdurer sans être subventionné à hauteur de 3/4 de son coût, et personne ne peut dire que cela ne tient qu'au faible niveau de vie de la population. Dans la seconde région, l'exemple de Kolokani montre qu'une aide massive et désordonnée crée des comportements totalement irresponsables, et ruine durablement une décennie d'efforts patients de rénovation des services de santé. Enfin, dans la 1<sup>ère</sup> région il a été dépensé environ 6 milliards FCFA depuis 1985 sans que les conditions de fonctionnement du système de santé aient été significativement et durablement modifiées, alors qu'une aide aussi importante n'est évidemment pas généralisable à l'ensemble du pays.

Si le Mali n'a pas besoin de dons pour rendre le médicament accessible et développer la stratégie des SSP, c'est parce que la simple application des principes de l'"Initiative Bamako" concernant l'approvisionnement en médicaments conduira simultanément à un accroissement sensible de l'activité des services et à une réduction de près de 8 milliards de la facture pharmaceutique. La situation ainsi créée, repose sur des hypothèses tout à fait réalistes en matière de fréquentation et en matière de coût. Sur ce dernier point, elle considère que les médicaments sont vendus à un prix qui est 2.5 fois le prix payé au fournisseur.

Considérons quelques utilisations qui pourraient en être faites :

- constitution d'un fonds de roulement pour la PPM, de telle sorte qu'elle puisse régler comptant une proportion croissante de ses achats;
- rénovation des formations sanitaires et acquisition de petits matériels nécessaires à leur fonctionnement : actuellement le crédit

"grosses reparations" ne depasse pas 40 millions annuels, et l'on imagine au'on pourrait le decupler sans difficulte ; actuellement le credits "materiels et medicaments" ne sert qu'a parer a quealues urgences absolues, generalement dans la capitale, alors que les besoins pourraient etre satisfaits par l'incorporation au prix de vente des medicaments du cout des consommables ;

- financement du fonctionnement courant des formation ;
- instauration de primes pour le personnel des services de sante ; il faut admettre que le niveau de remunerations actuelles est insuffisant, etqu'il constitue une incitation a trafiquer ; il faut admettre aussi que les finances publiques ne pourront accorder, dans les prochaines annees, aucune augmentation significative aux fonctionnaires maliens ; par contre, on ne voit pas qu'il soit impossible de mettre en place des primes specifiques, financees sur ressources propres ; si on y consacrait 1 milliard, ces primes representeraient une augmentation de 33% de la masse salariale actuelle, et elles pourraient etre un moyen de restaurer la responsabilite et l'autorite hierarchiques, qui ont completement disparu dans le systeme de sante malien

DOCUMENT ID: 87.042 RECORDS: 1 YEAR PUBLISHED: 1987

AUTHOR: OMS

TITLE : LA PROBLEMATIQUE DU RECOUVREMENT DES COUTS DES SERVICES DE SANTE (MALI).

SOURCE: WHO-UNICEF

EXPERIENCE REPORTED: 7 Cost recovery experience 15 Strategy paper

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy  
issus A,6 Developing management capacity B,1 Describing financing  
schemes B,2 Service characteristics and resources

SUMMARY:

Les experiences de recouvrement des couts en cours.

Plusieurs experiences sont actuellement menees dont le gouvernement est fortement interesse a comparer les resultats :

- dans la 1ere region (Kayes), projet finance par la Banque Mondiale, interessant les cercles de Kita, Bafoulabe et Kenieba. - dans la 6 & 7eme regions (Tombouctou et Gao), projet magasin-sante, fiance par "Medecins sans frontieres" et UNICEF. - dans la 2eme region (Koulikoro), projet de relance des SSP a Kolokani. - Dans la 2eme region (Koulikoro) il est prevu une extension du systeme de recouvrement des couts de toute la region. -Dans la 5eme region (Mopti), des experiences limitees sont menees dans 4 cercles par des ONG (Medecins du Monde et Save the Children Fund, avec la participation de UNICEF).

Les indigents sont dispenses des paiements a l'acte et forfaitaires, s'ils sont munis d'un certificat d'indigence. Le personnel du centre de sante paye 1/2 tarif.

**RESULTATS** Les recettes proviennent des consultations, actes de laboratoire et des forfaits sont destinees a couvrir: - l'achat des medicaments pour les hospitalises - le fonctionnement et entretien du CS, hors vehicule - l'achat de materiel du bureau. Les forfaits sont suffisants et le systeme de recouvrement semble fonctionner: taux de recouvrement 88% (fin 85). Bilan positif en mai 86. Cependant les frais de bureau et de fonctionnement, tres importants (presque 50% des depenses) au depart, peuvent etre diminuees.

DOCUMENT ID: 87.043 RECORDS: 1 YEAR PUBLISHED: 1987

AUTHOR: De Vos Leo

TITLE : FACT SHEET - COST RECOVERY

SOURCE: UNICEF-Mali

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy issues A,6 Developing management capacity B,1 Describing financing schemes B,2 Service characteristics and resources

SUMMARY:

COMMENTS AND LESSONS LEARNED

The HWs have had a very positive effect on the frequentation of the health infrastructure. Even after the introduction of a small fee the attendance rate did not fall. It has also restored the credibility of the health services.

The question of management, especially of the collected funds, has been and remains a problem (not surprising when salaries of health personnel are paid 3 months in arrears).

The advantages of a lumpsum payment are multiple, it is socially acceptable and its management is simple. However price differentiation according to the drugs used could more easily trace erroneous prescriptions and fraud.

It is clear that lumpsum payments will never lead to overall recovery and that it has a detrimental effect on frequentation rates especially with regard to low-cost treatments (such as ORT and malaria-

A detailed evaluation of the project in the Timbuktu region was undertaken on the basis of consultation registers and the following elements were clearly demonstrated:

- recovery rates varied from around 20% to 70% per district, mainly due to the higher costs of drugs in certain districts (overprescribing, more expensive drugs, injectables and dressings being the most expensive), the revenues being almost equal.
- recovery rates were also influenced by the number of free of charge consultations (health personnel and their families, patients who produce a "certificat d'indigence" attesting their inability to pay.
- high percentage of local authorized costs, normally 2% in some cases reached 12% - 18 drugs and dressings represent 80% of the utilization

rate and 70% of the cost. - a major effort in training doctors with a view to better diagnoses and correct dosage of essential drugs was felt to be a necessity and could lead to major cost savings.

#### HEALTH DEVELOPMENT PROJECT KITA.

Comments and lessons learned: The project has achieved good results with the training of health personnel to improve prescribing practices. The portion representing the cost of drugs has diminished.

The cost of office supplies remains very high (15%) and can no doubt be reduced.

Serious questions have been raised concerning the affordability of the system. The cost of an average treatment has been evaluated at FCFA 2.051 which represents in the KBK area 47.3% of the average monetary income. Drugs alone represent the major item and were estimated between FCFA 1.417 and 1.888. Hence major improvements could be made if the price of drugs was brought down to a reasonable level. Thus a revision of the working methods and practices of the PPM is imperative.

Non-availability of drugs has also been underlined as a major obstacle. In 42% of the cases, according to a study done in 1987, the drugs requested were not available. This is apparently not only the fault of the PPM but also stems from poor management at the local level.

A number of anomalies need to be corrected. The introduction of a flat fee (drugs included) for the treatment of children under 5 is very positive; at the same time schoolchildren, already privileged do not pay. The same applies to a number of civil servants, who can afford payment.

The very real problem of destitute families, estimated to be 12.8% of the population in the Kita district, who cannot even afford the payment of the flat fee, needs to be resolved.

#### PHC DISTRICT OF KOLOKANI (KOLIKORO REGION).

Comments and lessons learned: Despite numerous problems, attendance rates for the health infrastructure at village level rose enormously from 590 to 16.275 consultations between October 1985 and September 1986.

Although an increase in attended deliveries can be noted. 1163 against 868 per year and more pre-natal consultations (1.413 instead of 415), we find the difference insignificant.

It is proposed to study the quality of the services rendered.

An interesting aspect of this project is no doubt the first attempt to find a solution with regard to the regular payment of village health workers.

With regard to overall management, the accounting of receipt and payments have been particularly problematic and demands further refinement and strict control.

Since the project only provides drugs for the first days, a constant supply of drugs needs to be available at the village pharmacy, which is not always the case.

DOCUMENT ID: 90.044 RECORDS: 1 YEAR PUBLISHED: 1990  
 AUTHOR: Ministere de la Sante  
 TITLE : EVALUATION DES SYSTEMES DE GESTION DES SERVICES DE SANTE EN 5EME REGION.  
 SOURCE: MINSANTE  
 EXPERIENCE REPORTED: 2 project evaluation 7 Cost recovery experience  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,14 Mali  
 MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
 KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy issues A,6 Developing management capacity B,1 Describing financing schemes B,2 Service characteristics and resources  
 SUMMARY:  
 RECOUVREMENT DES COUTS

EFFICACITE OU LE MONTANT DES RECETTES REALISEES PAR LA TARIFICATION PAR RAPPORT AUX RECETTES PROGRAMMEES.

D'une maniere generale, pour les 3 cercles visites, on constate une inadéquation entre les recettes programmees (document de programmation regionale 1989) et les recettes effectivement realisees: 33% de recettes programmees ont ete realisees a Douentza, 63% a Bankass. Le bon chiffre global de Djenne (112%) masque en fait les erreurs de programmation; si on separe les recettes ISMI des autres on obtient 0% de recettes realisees par rapport a la programmation pour la SMI et 172% pour les autres recettes.

CENTRE DE SANTE DE CERCLE.

Nombre de Consultants et de Consultations.

Deux cas de figure sont a considerer:

- la mise en place de la tarification a coincide avec la mise a disposition des IME comme cela a ete le cas a Djenne et dans une moindre mesure a Douentza: dans ce cas la tarification n'a semble-t-il pas empeche l'utilisation des services de sante par les usagers (Douentza), et on note meme une augmentation significative de l'activite de Djenne et ce malgre des tarifs plus eleves qu'a Douentza, (consultants Douentza: tarif unique a a 50 FCFA ; Consultants Djenne de 50 a 200 FCFA).

- la mise en place de la tarification a ete posterieure a la mise a la disposition des ME comme cela a ete le cas a Bankass; on assiste la a

une chute brutale du nombre de consultants en mai 89, lors de la mise en place de la tarification. La difficulté est de savoir si la tarification constitue une barrière financière pour des vrais malades et/ou si elle limite l'utilisation des Centres de Santé par des "consultants chroniques". La brusque augmentation du nombre de consultants en Oct,89 aussi bien au niveau du CSC que du CSA visite et qui est essentiellement due à des consultants bénéficiant de la gratuite (scolaires) laisse penser que la 2ème hypothèse n'est pas dénuée de fondement.

2 indicateurs peuvent être construits à partir de ces données afin d'apprécier les détournements aux dispositions réglementaires: le rapport Consultations/Consultants et le rapport Ordonnances prescrites/Consultations.

- Le rapport Consultations/Consultants peut être artificiellement augmenté en cas d'échappatoire à la tarification. En effet un consultant qui aurait dû payer son ticket peut être enregistré comme un ancien cas qui reviendrait durant la validité de son ticket.
- Le rapport Ordonnances Prescrites/Consultations est un indicateur de la qualité de l'enregistrement: un nombre supérieur d'ordonnance prescrites par rapport aux consultations indique un sous enregistrement des consultations sur le registre.

#### Autres activités

La mise en place de la tarification ne semble pas avoir affecté la fréquentation des maternités des 3 cercles. Les consultations prénatales au CSC de Djenne et de Douentza sont en augmentation (gratuites à Djenne et payantes ? à Douentza. Seul le CSC de Bankass montre une baisse, baisse qui a débuté avant la mise en place de la tarification et qui depuis cette date a pu être amplifiée par le départ de la sage-femme.

Le nombre d'hospitalisés est depuis la mise en place de la tarification en augmentation à Djenne, stable à Bankass et en diminution à Douentza (peut être en raison du système de tarification en vigueur). Par contre on ne constate pas à Douentza une chute de l'activité opératoire, qui est associée à une diminution du nombre d'hospitalisés pourrait faire craindre une baisse de la fréquentation de l'hôpital pour des patients en situation de détresse et pour qui la tarification représenterait une barrière financière infranchissable. Il est donc important de suivre ces 2 indicateurs afin de voir si la tendance à une diminution des hospitalisations se confirme.

#### EFFICIENCE

On aborde ici le 3ème indicateur, le taux de délivrance des tickets, qui permet d'approcher l'acceptabilité de la tarification par la population et par les techniciens de la santé, (le taux de non délivrance correspond au taux de gratuite consenti).

À Douentza, il faut constater la nette amélioration du taux de

delivrance de tickets pour toutes les categories d'actes.

A Djenne, le taux de delivrance en ce qui concerne les constants est tres bon.

A Bankass, le taux de delivrance des tickets pour les consultants est catatrophiques au niveau du CSC.

DOCUMENT ID: 89.045 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: UNICEF

TITLE : CONFERENCE TECHNIQUE SUR LE FINANCEMENT  
COMMUNAUTAIRE ET  
RECouvreMENT DES COUTS.

SOURCE: UNICEF, New York, Paris

EXPERIENCE REPORTED: 10 Conference proceedings

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,15 Mauritania

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy  
issus A,6 Developing management capacity B,1 Describing financing  
schemes B,2 Service characteristics and resources

SUMMARY:

Equite et protection des plus pauvres

En Mauritanie, il y a une inequite qui existe encore et pour laquelle une solution doit etre trouvee. En effet, les soins a la peripherie sont payes par le recouvrement du cout instaure par les SSP alors qu'en ville (Les grandes agglomerations) les soins sont gratuits dans les dispensaires de l'etat.

Pour l'experience mauritanienne il apparait que la notion d'indigence est tres relative et difficile a etablir, donc nous laissons cette question a la discretion du village.

Mecanismes Communautaires pour le Recouvrement des Couts

Concernant le recouvrement des couts, nous avons constate dans une region du projet (lors d'une supervision) que les villageois vendait les medicaments au dessous de leur prix d'achat. Ce qui ne permettait pas non seulement de recouvrir le prix, mais aussi ne motivait pas l'ASC.

Dans ce domaine il est difficile d'intervenir puisque chaque village a son systeme de recouvrement. Ce qu'on deplore le plus souvent se sont les ruptures de stocks en medicaments.

DOCUMENT ID: 87.046 RECORDS: 1 YEAR PUBLISHED: 1987

AUTHOR: TAYLOR HASSOUNA MARY

TITLE : FAMILY PLANNING/MANAGEMENT TRAINING PROJECT

SOURCE: Management Science for Health/MOH

EXPERIENCE REPORTED: 10 Conference proceedings

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,17 Nigeria

MAIN PROBLEM CATEGORY: A Policy B Cost recovery

KEY PROBLEMS : A,3 Health services B,3 Planning projects B,4 Designing projects B,9 Types of services

**SUMMARY:**

SUMMARY This workshop gave the participants a unique opportunity to arrive at a better understanding of the family planning program, of what is involved in financial planning and management and of the importance of financial planning and management for family planning program success. The current problems of family planning supervision arise because of the inability of family planning personnel to get to their line item to pay for travel and to pay for the consumable supplies such as alcohol, disinfectant, cotton, and other items essential for family planning delivery in Imo. This problem is one which the participants are now well on the way to resolving now that they know more about the importance of their own financial system.

The group, both finance and family planning program officers, is concerned about their long-term program. The workshop provided them with an opportunity to identify financing options which would be appropriate for their state. Similarly, the workshop provided the opportunity to identify receptivity to and interest in cost recovery ideas which they are considering.

DOCUMENT ID: 87.047 RECORDS: 1 YEAR PUBLISHED: 1987

AUTHOR: WHO

TITLE : DRUG FINANCING EXPERIENCES IN NIGERIA Readings from Workshops,

State Experiences, and Teaching Hospital Experiences

SOURCE: Ministry of Health, WHO

EXPERIENCE REPORTED: 7 Cost recovery experience 10 Conference proceedings

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,17 Nigeria

MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services

A,4 Health policy issues A,6 Developing management capacity B,1

Describing financing schemes B,2 Service characteristics and resources

D,3 Collaborating with other sectors

**SUMMARY:**

**CONCLUSION**

To ensure acceptance of drug charges by the population, it is desirable to conduct public education programs to explain the rationale behind the implementation of such programs, that drugs must be paid for like any other essential service such as electricity, water, etc. and that public participation is necessary to ensure their availability just as public participation is required in the building of health facilities, schools, etc.

A condition for success of drug cost-recovery programs is low-cost drugs. This implies access by the State authorities, when necessary, to the world market of pharmaceuticals where lowest, generic prices can be found. Such access, for tendering purposes, can only be guaranteed if foreign exchange allocations, in sufficient amounts, are made available to the procurement authorities in a timely manner (i.d., for opening of L/C or payment of invoices).

As far as possible, procurement in the private market (wholesalers, retail chemists, patent drug stores) should be avoided, as this immediately puts up the price (local margins) and thus the patient charges. Above a certain level, charges will no longer be accepted by patients - they will seek drugs elsewhere, attendances and revenues will fall at PH Institutions, leading to insufficient funds for repurchase of drugs and -unless new infusion of capital funds can be put into the system- resulting in failure of the cost-recovery program.

The Groups finally concluded by giving various suggestions to ensure the successful implementation of the DRF.

1. Firmly establish the DRF.
2. Institute patient payment for drugs and cards using the variable fee for drug system, with the Government paying for exempted cases. Children would pay 1/2 the adult fee with immunization provided free.
3. Encourage bulk purchase to reduce cost.
4. Require purchase from direct source wherever possible, to ensure quality.
5. Issue correct and clear specifications to suppliers.
6. Conduct market research to know products.
7. Train and reorient all states in EDL and DRF.
8. Institute efficient monitoring and evaluation unit using existing staff.
9. Encourage community participation, involvement and mobilisation.
10. Begin a program to offer health education and information to the general public and consumers.

DOCUMENT ID: 88.049 RECORDS: 1 YEAR PUBLISHED: 1988  
 AUTHOR: Jeanne Emile  
 TITLE : PROJET PIKINE - PARTICIPATION ET DEVELOPPEMENT SANITAIRE EN  
 MILIEU URBAIN AFRICAIN  
 SOURCE: Cooperation Belge  
 EXPERIENCE REPORTED: 16 Progress report

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,18 Senegal  
 MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
 KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy  
 issues A,6 Developing management capacity B,1 Describing financing  
 schemes B,10 Operations research

**SUMMARY:**

Le paiement se fait à l'acte. Ce choix proposé par les populations permet de réduire le coût du premier contact et facilite ainsi l'accessibilité économique de la structure. Un paiement unique au début de chaque épisode morbide serait de l'ordre de 400 Frcs et retarderait le moment de la 1<sup>ère</sup> visite d'1 jour ou 2, le temps de trouver de l'argent. Le mode de paiement à l'acte avec délivrance de médicaments au poste de santé semble bien adapté à la façon dont les Pikinois utilisent l'argent.

Lorsque le malade se présente au poste de santé, il achète un ticket de consultation auprès d'un vendeur désigné et rétribué par le comité de santé. Outre une souche qui reste en possession du billettiste, le ticket est composé de 2 parties : une pour le malade et l'autre qui

est remise au chef de poste. A la fin de chaque journee une comptabilite contradictoire est faite et les montants percus reportes sur une feuille pre-imprimee prevue a cet effet. 2 fois par semaine des versements sont effectues a la banque. Chaque comite dispose d'un compte.

Chaque samedi les membres du bureau executif du Comite de Sante (President, Tresorier, Commissaire aux comptes) et le Chef de Poste se reunissent. Sont traites les problemes lies a la gestion du poste, mais aussi les questions en rapport avec la marche du service et le deroulement des programmes de sante (programme de vaccinations, suivi des malades a domicile, organisation d'activites sanitaires dans les quartiers, etc...) Chaque mois un rapport est fait reprenant le bilan des recettes et des depenses et le solde du compte. C'est a partir de ce rapport que seront engagees les depenses du mois suivant.

DOCUMENT ID: 88.060 RECORDS: 1 YEAR PUBLISHED: 1988  
 AUTHOR: MILLER Lynne  
 TITLE : RAPPORT DE LA MISSION SUR LA POSSIBILITE DE MISE EN PLACE POLITIQUE DE L'INITIATIVE DE BAMAKO AU TOGO  
 SOURCE: UNICEF-Togo  
 EXPERIENCE REPORTED: 2 Project evaluation 7 Cost recovery experience 15 Strategy paper  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,20 Togo  
 MAIN PROBLEM CATEGORY: A Policy B Cost recovery  
 KEY PROBLEMS : A,2 Microeconomic factors A,4 Health policy issues A,6 Developing management capacity B,1 Describing financing schemes B,10 Operations research  
 SUMMARY:  
 TERMES DE REFERENCE

Avec l'initiative de Bamako et le fait que l'UNICEF-Lome est en train de se preparer pour la prochaine cooperation avec le Togo (1990-1994), il s'avere necessaire d'examiner la faisabilite de mettre en place un systeme de financement communautaire base sur les medicaments essentiels afin d'assurer les fonds necessaires pour le renforcement du systeme de SMI et extension de sa couverture.

#### Recouvrement de Coûts Prendra du Temps

L'experience de Blankouri montre tres clairement ce qui a ete deja remarque dans les autres pays ou un financement communautaire a ete mis en place: le recouvrement des couts PREND DU TEMPS. A Blankouri, la premiere annee, ils ont pu recouvrir jusqu'a 9% des depenses. Apres cinq ans, ils sont arrives a 40%. Ce taux croissant est du a une croissance de dans les recettes qui est plus rapide que celles des depenses. Cette annee, certains tarifs ont ete changes afin d'ameliorer le recouvrement des couts. L'idee est d'augmenter lentement les tarifs dans le but d'habituer la population.

DOCUMENT ID: 87.061 RECORDS: 1 YEAR PUBLISHED: 1987  
 AUTHOR: MILLER Lynne  
 TITLE : LES POSSIBILITES D'AUTONOMIE FINANCIERE DE LA ZONE DE SANTE AU

## ZAIRE

SOURCE: UNICEF

EXPERIENCE REPORTED: 7 Cost recovery experience

PROVIDER LOCATION : A,1 Sub-Saharan Africa B.21 Zaire

MAIN PROBLEM CATEGORY: A Policy B Cost recovery D Communications

KEY PROBLEMS : A,2 Microeconomic factors A,3 Health services

A,4 Health policy issues A,6 Developing management capacity B,1

Describing financing schemes B,2 Service characteristics and resources

D,3 Collaborating with other sectors

## SUMMARY:

Ceci demanderait que les medecins et les infirmiers soient sensibiliser et recycler sur la notion de la couverture de la population cible et ses composants.

DOCUMENT ID: 90.062 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: Bamako Initiative Management Unit

TITLE : Economic Crisis, Adjustment, and the Bamako Initiative:

Health Care Financing in the Economic Context of Sub-Saharan

AfricaEDITOR(S):

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Sub-Saharan Africa

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

## SUMMARY:

This is a well-written summary of macro-economic changes in sub-Saharan Africa and their effects on health sector spending levels and efficiency. "Many governments which have promised citizens "free" health care are considering adopting cost sharing programs of one kind or another . . . It is hoped that cost sharing will augment resources available to the sector and lead to efficiency improvements. The paper compares community financing with efforts to charge only at secondary and tertiary care hospitals. The latter is found to be advantageous with respect to the amount of revenue it can generate, and its ability to protect the poor from the adverse effects of fees. Community financing, on the other hand, appears better suited to address the political economy issues that have resulted in spending bias in favor of urban hospitals, involves greater decentralization and community participation in health care, may lead to greater efficiency gains, and appears less likely to displace government allocations." "It is increasingly felt that citizens would be willing and able to pay for services, especially if the services were of higher quality than is now available. . . . Revenue from the fees, it is hoped, could fill the recurrent financing gap . . . by financing reliable drug supplies, maintenance, and even the expansion of service. It should be noted, however, that it has never been suggested that cost sharing could recover more than a portion of public health costs. "Many economists also argue that effective pricing of health care would help rationalize utilization. Differential fees could send signals to consumers to limit demand for less important usage and improve allocational efficiency by encouraging patients to enter the system at the appropriate level. On the supply side, fees could also discourage over-prescription (if doctors knew patients would have to pay for the drugs) and pilferage

and spoilage of drugs and other supplies (if facilities charge for these goods and are made accountable for them). Fees can also be used to link revenue with performance, providing incentives for better service." "However, cost sharing carries a number of important policy issues. Can poorer communities afford to pay the fees? Will the poor, especially children, drop from the modern health care system in the face of fees? Does it make sense to pump more money into the health system - through cost sharing - before efficiency improvements are made? How will the role of government in the health sector shift as cost sharing, with its necessary decentralization, takes hold? . . . "There are several basic requirements for financing policies that are equitable and sustainable. There is a need for financing approaches to be consistent across the country, particularly between urban and rural areas. Measures need to be established to ensure accessibility of health services to the poor; experience to date suggests that these are often best determined at community level, within the framework of national policy, as a part of communities' overall management of PHC. There is also need for service quality to be improved at the same time as, or even before, cost sharing is introduced. These concerns are all incorporated within the approach of the Initiative, and are addressed in different ways in different countries."

DOCUMENT ID: 89.063 RECORDS: 1 YEAR PUBLISHED: 1989  
 AUTHOR: Blakney Richard B.  
 TITLE : Financing Primary Health Care: Experiences in Pharmaceutical Cost Recovery.  
 SOURCE:  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : Ghana, Liberia, Mali, Nigeria, Zaire  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :  
 SUMMARY:

"Community-based drug funds can succeed where local commitment exists." "Recovering drug costs and some additional costs through drug and/or patient fees is possible in a variety of country settings." "Though patients are willing to pay for drugs, significant price increases do dissuade patients." "Mechanisms do exist to protect target groups." "A dynamic tension between financial goals and public health goals is both inevitable and necessary." "Lack of finance skills and accountability commonly undermine drug funds." "Creating incentives for Sustainability Country experiences suggest the following ways to build incentives for sustainability into cost recovery projects: Community involvement Decentralized fund management Understanding the patient as a consumer Management requirements Supporting a diversity of approaches.

What Donors and Bamako Initiative-type activities ought not do:  
 Inadvertently limit country financing options (by focusing excessively on drugs) Tie support for PHC/MCH and essential drug programs to pharmaceutical cost recovery in unsupportive settings (because in some places even basic infrastructure is lacking) Raise unfulfillable expectations regarding foreign exchange availability (because revolving drug funds will increase requirements) Inadvertently

contribute to a decline in government support for health care.

What Donors and Bamako Initiative-type activities can do: Encourage countries to consider the full range of financing options and develop strategies based on cultural, political, economic, and managerial feasibility. Actively assist countries committed to cost recovery (i.e., rely heavily on local initiative). Support evaluations of patient and financial impact of cost recovery programs. Collect and disseminate practical cost recovery experience. Develop practical tools for planning and implementing cost recovery programs. Individual country experiences are referenced in the profiles.

DOCUMENT ID: 89.064 RECORDS: 1 YEAR PUBLISHED: 1989  
AUTHOR: Evlo Kodjo  
TITLE : Health Financing in Africa: Tracking the AID Experience in the Child Survival Emphasis Countries.  
SOURCE: REACH  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Mali, Niger, Zaire, Nigeria, and Senegal  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :  
SUMMARY:

DOCUMENT ID: 88.065 RECORDS: 1 YEAR PUBLISHED: 1988  
AUTHOR: Vogel Ronald J.  
TITLE : Cost Recovery in the Health Sector: Selected Country Case Studies in West Africa  
SOURCE: World Bank Technical Paper  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Ivory Coast, Mali, Ghana, Senegal  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :  
SUMMARY:

Pages 181-183 summarize recommendations. Highlights: Cost recovery should either be system-wide or start with hospitals (to maximize revenue and encourage utilization of lower level facilities). User charges must be regularly updated to reflect inflation. Observe and emulate church sponsored health services. Exemptions for the "indigent" cost dear and need not be as common as usual practice suggests. Most revenues must come from the "not-so-poor." Cost recovery, if linked to service development in unserved areas, actually improves equity. Measures are, nevertheless, needed to protect the truly indigent. Best revenue potential comes from drugs, but could be much greater if efficiently procured and distributed. Service quality must be improved as user charges are introduced. "The major administrative challenge is to enhance incentives for collection of user charges at the facility level."

DOCUMENT ID: ND.066 RECORDS: 1 YEAR PUBLISHED:  
AUTHOR:  
TITLE : Reflexions sur l'Experience du Benin  
SOURCE: Journal d'Information sur l'Initiative de Bamako  
EXPERIENCE REPORTED:

PROVIDER LOCATION : Benin

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

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 half of the country's 86 districts, representing 40% of population. System is based on sale of generic drugs at about a 300% markup and is meant to cover all local primary health care costs. (Shortfalls occur, however, due to exemptions for the indigent and losses in the system.) District managers have been trained in planning, supervision, resource management, and evaluation. The president has authorized health service retention of community-generated revenues. Results show: - people willing to pay for essential drugs and services - people accept generic drugs - growing managerial competence - increased service utilization - need for centralized drug procurement system - risk of excluding the indigent, even with very low fees - errors in management of both drugs and financing due to insufficient training.

DOCUMENT ID: ND.067 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR:

TITLE : Loi No. 89.003 Fixant les Principes Gn raux Relatifs la Sant Publique en Rpublique Centrafricaine, 1989"

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Central African Republic

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Law defines conditions under which people and organizations will pay for health care. Indigents possessing a special card will be given free care. Practitioners allowed to keep a part of fees but must share them with the state.

DOCUMENT ID: 89.068 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: Republique du Niger, Ministere de la Sante Publique

Direction des Etudes et de la Programmation

TITLE : Quelques Elements sur la Situation Financiere du Secteur Sanitaire au Niger

SOURCE:

EXPERIENCE REPORTED: Document summarizes three donor-supported studies of health sector financing.

PROVIDER LOCATION : Niger

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

First study, by Dr. Francois Decaillet, showed that the Ministry of Public Health budget (excluding donors) had increased by an average of 7.25% per year between 1983 and 1989 but that this was not as rapidly as facility expansion and demand for drugs required. The 1989 budget was 6.22% higher than the 1988 one, even though the overall

governmental budget decreased by 2.56%; Ministry of Public Health received 5.48% of total budget, the third highest of any government unit (after Finance and National Education). Government spends 870 francs per capita, up from 424 (inflation-adjusted) in 1978. Salary payments continue to increase more rapidly than the budget as a whole, while expenditures for materials (vaccines, drugs, vehicle maintenance, fuel) and transport decline. Author cites many ways in which allocations for operating expenses (supplies, maintenance, transport) have declined relative to those for personnel over the years, despite the overall increase in the budget. Tulane in 1987 studied service utilization and payments in four zones: urban, within 5 kms. of a dispensary, peripheral villages with a health team, and peripheral villages without a health team. Villages with health teams showed the highest utilization but the lowest expenditure per visit (195 francs). Total expenditures per person per year ranged from 160 francs in villages without teams to 1108 francs in urban areas. 97% of those interviewed said they were willing to participate in health care financing, preferably through an annual payment of up to 500 francs. Almost all of those willing to pay monthly said they could pay up to 100 francs (i.e., 1200 francs per year). (Detailed study results come from Ministere de la Sante Publique et des Affaires Sociales, "Enquete Nationale sur l'Utilisation des services de sante," 1987.) Belgians studied drug costs at one dispensary in Dosso during 1986 and found an average of 110 CFA per person per year. (Projet RESSFOP de la Cooperation technique belge, "Soins de sante primaires: Calcul du cout des medicaments dans un dispensaire rural.")

DOCUMENT ID: 89.069 RECORDS: 1 YEAR PUBLISHED: Octobre 1989

AUTHOR: Republique du Niger Ministere de la Sante Publique

TITLE : Recherche operationelle sur la participation des populations aux frais de sante, Experience de Tibiri (dep. de Dosso)

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Niger

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Article describes and gives preliminary evaluation of Belgian experiment in Dosso. It begins by referring to a 1985 study at Harikanassou dispensary, which found an average treatment cost of 110 francs CFA. Also, a 1987 Belgian study measured 150 francs for adult and 50 for child; this study, however, ignored certain conditions and results were almost certainly underestimated. The goal of the current study was 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 considered both episode fees and pre-payment, eventually deciding to impose 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 article describes management and administration in useful detail. A village committee was to be made responsible for both financial and drug management, but the Belgians provided initial drug stocks and were expected to manage all activities for the first year. The

system took effect on March 1, 1989. After seven months, utilization had increased by 68% over the same period in 1988, almost certainly because drug availability was guaranteed. Revenue, though, was substantially below costs, the average visit costing 235 francs but netting only 165. An excess of serious cases requiring antibiotics was the cause. (These estimates, moreover, do not include a payment to the manager, replacement of investment, transport and other costs that will have to be covered after the Belgians leave.)

DOCUMENT ID: 88.070 RECORDS: 1 YEAR PUBLISHED: 1988

AUTHOR: Wong Holly

TITLE : Cost Analysis of Niamey Hospital (Draft)

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Niger

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Niamey Hospital is a 900 bed national referral and teaching center. Author analyzed both patient costs and cost recovery, using data from the 1986-87 budget year. Costs are to be recovered both through individual fee payments and through "convention de soins," that is, fee payments by government units for treatments of staff. Major findings: - There appears to be little correspondance between fee levels and costs. Officially set fees would cover 16% of the daily cost of a ward bed, 149% of a "category I" bed, and well over double the cost of lab services (%age differs by lab service; also public and private fee levels differ). Fees, if fully collected, would cover 6 to 11% of the cost of treating the four most common conditions in a ward bed. Outpatient fees would cover 6 to 129% of costs. - Actual receipts (quite different from fee levels) covered 12% of overall operating costs for inpatient services, and 7% for outpatient consultations. Also 30% for lab tests, 30% for radiology, 19% for biochemical lab. Overall cost recovery rate for all hospital operations (excluding capital costs) was 16%. - Hospital had started some efforts to better monitor costs. An accountant had been identified to begin redesigning financial and accounting procedures. Administrator had instituted inventory and cost control system for food supplies. Recommendations: (1) Institute a cost accounting system able to track costs by service. (2) Conduct a study of the fee collection system. (3) Conduct a utilization review to assess the patterns of clinical care and their effects on costs.

DOCUMENT ID: 89.071 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: %OTHER AUTHORS:

TITLE : Seminaire/Atelier sur le Recouvrement des Coûts dans le Secteur Sanitaire

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Niger

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Five day workshop for senior government officials reviewed

principles and practices of primary health care 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. Each pilot test will entail: - "sensibilisation of the public" - a guarantee that essential drugs will be available - additional worker training, especially for drug prescription.

DOCUMENT ID: 89.072 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: Abt Associates, Inc. %OTHER AUTHORS:

TITLE : Health Care Financing, Cost, and Utilization Study

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Nigeria

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

Describes major health care financing study, said to be the most thorough in Africa. Major components include: (1) in-depth analysis of facility costs and utilization; (2) flow of funds analysis; (3) survey of household health spending and utilization. Data on cost recovery will include: (1) proportion of operating or total costs recovered; (2) whether fee exemptions are granted and how determined; (3) modes of payment; (4) price setting; (5) how prices affect utilization; (6) other funding sources.

DOCUMENT ID: 89.073 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: El-Hadj Birama N'Diaye

TITLE : Discours

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Senegal

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

Speech describes Pikine community financing scheme in great detail, including fee levels, income, and expenditures. Clinic prices are compared with other daily costs: an adult consultation, for example, cost 200 francs in 1989, while a kg. of rice cost 130 francs and a local bus fare 90 francs. Depending on clinic level, drugs and vaccines accounted for 30 to 48% of costs, and salaries for community health workers and matrones another 10 to 20%. In 1987, patient fees covered 76% of operating costs (including capital replacement).

DOCUMENT ID: 89.074 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: Munkatu Mpese

TITLE : Organisation et performance du systeme de financement des zones de sant au Zaire

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Zaire

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

**SUMMARY:**

"A summary of Zaire's well known self-financing schemes, this article makes several points: Zones received little or no central guidance on cost recovery methods or policies. While fee per episode was nearly universal, two hospitals had prepayment schemes. While health centers pay for supervision, they do not pay for such other higher level support as management training (focused on accounting and financial planning), and drug procurement and management. Zones were able to cover 67 to 90% of their costs, average 79%. Some zones have negotiated payment schemes with public and private enterprises (at higher tariffs than private payers). Success due in large measure to decentralization.

DOCUMENT ID: 90.075 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: Shepard Donald S.

TITLE : Health Insurance in Zaire (draft)

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Zaire

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Case studies of four insurance schemes, as referenced in the country profile. The study summarizes conditions favoring the successful development of health insurance: -good quality of services -competent administration -staff continuity -sufficiently developed infrastructure -little competition among similar providers -a system of population registration -ability to enroll employees -broad participation -functioning village structures -inflation-resistant investment vehicles -a financial guarantor -a referral system -a clear and simple price system.

DOCUMENT ID: 90.076 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: Alihonou E.

TITLE : Community Financing of Health Services for the Improvement of Primary Health Care

SOURCE: Panafrican Conference on Community Financing

EXPERIENCE REPORTED:

PROVIDER LOCATION : Benin, Guinea

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Discusses contextual conditions contributing to community financing and describes experiences in Benin, Guinea, and Rwanda.

DOCUMENT ID: 90.077 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: UNICEF Bamako Initiative Management Unit

TITLE : %EDITOR(S):

SOURCE: Bamako Initiative Newsletter

EXPERIENCE REPORTED:

PROVIDER LOCATION : Sub-Saharan Africa

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

Periodic newsletter describes country experiences in implementing the Bamako Initiative.

DOCUMENT ID: 90.078 RECORDS: 1 YEAR PUBLISHED: 1990  
AUTHOR: UNICEF Bamako Initiative Management Unit  
TITLE : Operations Research Issues Related to Community Financing of  
PHC Development  
SOURCE:  
EXPERIENCE REPORTED:  
PROVIDER LOCATION : Sub-Saharan Africa  
MAIN PROBLEM CATEGORY:  
KEY PROBLEMS :  
SUMMARY:

This is an excellent review of operational issues and research findings related to community financing and the Bamako Initiative. Some quotes: "Community financing is seen as a necessary approach for mobilizing resources for the health sector. . . . The Initiative was welcomed by many African governments and many other experts, although there was concern about two major issues, namely the idea of community financing which implied further sacrifices by African communities, defined by all economic criteria as being among the most impoverished in the world, and secondly the potential for indiscriminate or irrational use of drugs. "It was felt by some that Africa was being pressured by international agencies towards cost recovery and user financing measures at a period when the African economic situation was extremely difficult. Charging for drugs to help pay for PHC was seen as inherently unsatisfactory as it could encourage health workers to overprescribe drugs so as to maximize the extraction of resources from the community. Also, direct charges to poor rural patients could become an insurmountable constraint to their access to health care. . . ." It is important that the basic ideas behind operations research be made as simple and straightforward as possible, to enable meaningful participation of those health workers and community leaders . . . who would have to use the results. Too often, operations research is seen as an activity for consultants, academics, or senior staff from the central level, using abstruse and complicated techniques, generating results which make little sense to staff at the district level. The conclusions of such research therefore have little chance of being utilized. Operations research techniques and possibilities should be built into the district management system, and provision should be made for financial and human resources to make this possible." "In Mauritania and Nigeria, community level PHC systems are being studied with a managerial focus. In Togo, Ghana, Zaire, and Sierra Leone studies have been made on health financing, and in Zaire and Tanzania on drug supply systems." "There are at least 12 key issues which appear to warrant further study . . . : 1.The most effective community financing mechanisms; 2.Affordability and equity of access to services, including also studies on willingness to pay; 3.Pricing levels and systems that maximize community financing and minimize deterring people from service use; 4.Rational use of drugs; 5.Appropriateness of different methods for drug supply; 6.Financial and managerial feasibility of drug management systems; 7.Feasibility of drug management at community level; 8.Effectiveness of health education in rationalizing drug use; 9.Appropriate methods to link the

community and the programme; 10. Influence of community financing on MCH coverage and service utilization; 11. Cost-effectiveness of service delivery strategies for MCH; 12. The role of community health workers and TBAs."

DOCUMENT ID: 86.079 RECORDS: 1 YEAR PUBLISHED: 1986

AUTHOR: Departement de la Sante Publique du Zaire

TITLE : Health Zone Financing Study, Zaire: Final Report

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Zaire

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

The major part of this report deals with health zone financing in Zaire, as summarized in the country profile. Many of the report's recommendations are, however, of general interest, viz.: - Further theoretical and empirical analysis needs to be done with regard to the population attitude vis-a-vis different payment schemes. . . . Understanding population's behavior with respect to prices . . . will help to find the optimal payment schemes. - Many health centers are unable to achieve financial autonomy. . . . Cross-subsidization among centers within a zone is a solution to this problem if accepted by the centers' health committees. - We think that in the medium term health zones will have to depend on external support to build or replace their fixed assets. - Health zones should keep the price of preventive PHC subsidized until further research reveals the effect of price of preventive programs on demand. - Health zones should try to minimize the number of services provided free of charge to the population. . . . The zones should consider offering pre-paid plans for children. - Health facilities should devote time and resources to understanding their cost structure and developing accurate accounting systems. Understanding of a facility's cost is essential to formulate financially sound pricing policies. - We believe that demographic and socio-economic differences among the zones require different zones to adopt different administrative schemes, pricing policies, and health care plans. We think that the zones should be technically autonomous since the zones' management is better equipped to solve their own problems. We encourage the GOZ to provide training and guidance to the zones' personnel, but we discourage it from imposing uniform and rigid administrative schemes to the health zones.

DOCUMENT ID: 90.080, french in 90,009 RECORDS: 1 YEAR PUBLISHED : 1990

AUTHOR: International Children's Centre

TITLE : The Bamako Initiative: Primary Health Care Experience

SOURCE: Special issue of Children in the Tropics.

EXPERIENCE REPORTED:

PROVIDER LOCATION : Benin, Guinea

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

This monograph provides great detail on community financing experiences in Benin (particularly the Pahou Project) and Guinea, but

will be of considerable interest elsewhere in West Africa as well. Individual chapters discuss the organization of health delivery systems, increased effectiveness, cost reduction, logistical support, training and supervision, and information management. The development and use of treatment flow charts is described. Procedures for estimating clinic operating costs and setting prices are explained and fee schedules presented. Sample forms are provided for child and maternal health cards, stock registers, and drug and revenue registers, along with supervision forms for fees and treatments, financial management, and drug management. "Health care financing through user fees for treatment runs the risk that health staff will focus on curative services to the detriment of preventive activities, especially as the population expresses a stronger demand for curative care. To counteract this tendency, the programmes have tried to create a sense of rivalry among health centres, based on the presentation of monitoring results for preventive care interventions. In addition, incentive payments to health staff have been based on their performance as measured by coverage with preventive care." Two conditions are indispensable to the success of (community financing): maintenance of the population's purchasing power and continued (government) payment of salaries at sufficient levels. Without these two conditions, the fragile balance between the community's ability to pay for their health and cost recovery of the health system will be broken. This, in turn could lead to a further erosion of purchasing power, failure of community financing programmes, the downfall of the health system, and a drop in the level of health protection. If these conditions are met, the health system's reorganization in line with the Bamako Initiative principles will be able to contribute to the alleviation of some of the population's health risks and to a reduction of infant and maternal mortality, even in a context of economic crisis."

DOCUMENT ID: 88.081 RECORDS: 1 YEAR PUBLISHED: 1988

AUTHOR: UNICEF

TITLE : Problems and Priorities regarding Recurrent Costs.

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Sub-Saharan Africa

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

This policy review reflects a survey of UNICEF field offices on the proportion of UNICEF grants devoted to recurrent costs and actions being taken to enhance sustainability.

DOCUMENT ID: 87.082 RECORDS: 1 YEAR PUBLISHED: 1987

AUTHOR: Vian Taryn

TITLE : Financial Management Information Systems in Four Zairian Health Zones

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,21 Zaire

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

**SUMMARY:**

While specifically intended to strengthen financial management information systems (FMIS) in decentralized health zones in Zaire, this report provides useful information for others on accounting issues, concepts, and definitions. Included are: - a checklist of questions by which to assess a health center's financial and logistics management systems - a glossary - in French and English - of basic accounting terminology - a list of recent financial management decisions (indicating the types of issues for which sound information systems may be required)

DOCUMENT ID: 90.083 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: Bossert Thomas J.

TITLE : Can They Get Along Without Us? Sustainability of Donor-Supported Health Projects in Central America and Africa

SOURCE: Social Science and Medicine

EXPERIENCE REPORTED:

PROVIDER LOCATION : Zaire, Senegal

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

**SUMMARY:**

"This article presents a synthesis of five country studies of the sustainability of U.S. government funded health projects in Central America and Africa. The studies reviewed health projects with a comparative framework to determine which project activities had continued after the donor funding had ceased. This review found that health projects in Africa were less firmly sustained than those in Central America. The studies then evaluated context factors and project characteristics that were related to the sustainability of the projects. "The weak economic and political context of the African cases was found to inhibit sustainability in those countries, suggesting that broader development issues be addressed before donors expect significant sustainability of health projects in Africa. Even in Central America it was found that the strength of the institution implementing the project was an important variable for sustainability, suggesting that donor attention also be shifted toward strengthening institutional development to assure sustainability. "In addition to context factors, several project characteristics were related to sustainability in most cases and suggest sustainability guidelines for project design and implementation. The article concludes that projects should be designed and managed so as to: (1) demonstrate effectiveness in reaching clearly defined goals and objectives; (2) integrate their activities fully into established administrative structures; (3) gain significant levels of funding from national sources (budgetary and cost recovery) during the life of the project; (4) negotiate project design with a mutually respectful process of give and take; and (5) include a strong training component."

DOCUMENT ID: 90.084 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: Hatsell Theresa

TITLE : Concussions from the Study on Community Support of the Village Health Worker Program of Niger

SOURCE: PRICOR study report

**EXPERIENCE REPORTED:****PROVIDER LOCATION :** Niger**MAIN PROBLEM CATEGORY:****KEY PROBLEMS****SUMMARY:**

In 1990, a PRICOR staff person and a Nigerienne colleague spent five weeks in eight Nigerien villages conducting focus groups on community support and willingness to pay for village health teams. The study found strong verbal support for village workers as well as willingness to pay for injections, drugs, childbirth care, and transportation expenses for drug purchases and worker training. In six villages, residents expressed willingness to establish revolving drug funds, based on local collection of seed money and community management of drug sales, revenue collection, and restocking. An important question in Niger concerns financial and/or "moral" support for village workers. On this issue, the study concluded that "moral support . . . is not a problem. . . ASVs generally seem pleased and proud to serve their communities, and they patiently bear any difficulties associated with the position as the sacrifice one makes in having been assigned this role. The villagers, in turn, apparently offer the ASVs their respect and appreciation. Beyond that, villagers repeatedly admitted that they offer nothing in return for the services that the ASV provides . . . (The exception being the payment offered to matrones in the event of a birth.) As long as the ASVs are offered the slightest financial benefit, no morale problem should arise. . . Outside recognition, however infrequent, is also an important source of motivation . . . On more than one occasion it was mentioned that the idea of having a vehicle come once a year and park in front of one's hut is enough motivation to put in a good effort for the whole year." "Villagers are not prepared, however, to devise their own strategies for community support. They seem to be waiting for suggestions - even a directive from the government - on how they can best organize such an effort. . . . No single strategy would be appropriate for the whole country. . . . Plans of action should be tailored as locally as possible, perhaps with the help of an advisor. "A cooperative approach to the sale of medical supplies may be very appealing to the more structured villages. If villagers felt a sense of ownership of their drug stocks, they would probably participate more willingly and actively in efforts to ensure sustainability. The securiste's interest in helping people frequently prevents him from being sufficiently stringent in managing credit arrangements. The ASV could issue "prescriptions" for medicines sold by the cooperative. The ASV could receive a stipend for his services from the profits. "The more industrious depot owners should be involved in efforts to revise strategies for assuring drug supplies. Allow these commercants to expand their markets. Let them figure out a way to get supplies out to villages 50 kms. away!" "Community support for "intangibles" such as training and supervision . . . is by no means out of the question for certain villages.

**DOCUMENT ID:** 90.086 **RECORDS:** 1 **YEAR PUBLISHED:** 1990**AUTHOR:** McFarland Deborah A.**TITLE :** A Review of Health Financing Systems in Liberia**SOURCE:**

**EXPERIENCE REPORTED:****PROVIDER LOCATION :** Liberia**MAIN PROBLEM CATEGORY:****KEY PROBLEMS :****SUMMARY:**

Reports results of three-week assessment of revolving drug fund and fee for service cost recovery schemes in Liberia. "Essentially the RDF system in Liberia has evolved on a county-specific basis. The SERPHC counties are the most extensively organized and documented and were intended to serve as a model for other counties. Lessons learned include the need for adequate mobilization of communities for the initial seed stock contribution, adequate training of the county and health post personnel, simplified financial reporting systems, and the critical importance of routine supervision of accounts and inventories. . . . Successful experiences in other counties are often the result of one person's initiative and are quite dependent upon that one individual's continued involvement. It is not clear that these systems are sustainable without the participation of the key person."

**DOCUMENT ID:** 89.087 **RECORDS:** 1 **YEAR PUBLISHED:** 1989**AUTHOR:** Qualls Noreen L.**TITLE :** Potential Uses of Cost Analyses in Child Survival Programs: Evidence from Africa**SOURCE:** Health Policy and Planning**EXPERIENCE REPORTED:****PROVIDER LOCATION :** Sub-Saharan Africa**MAIN PROBLEM CATEGORY:****KEY PROBLEMS :****SUMMARY:**

"How can analyses of costs and cost-effectiveness help international health care specialists to monitor service delivery, evaluate activities, plan for improvements in programs, and arrange for adequate financing? Answers illustrated in this paper include comparison of the average costs of specific services among local health care facilities for monitoring and supervision purposes; interpretation of total and average costs to increase programmatic efficiency; consideration of the relative cost-effectiveness of various immunization strategies; projection of recurrent costs to indicate the magnitude of future financing needs; and derivation of information incidental to cost analyses, but essential to program operations and personnel management. Supportive examples include results from Child Survival programs in Africa, with particular emphasis on evaluations of some national program components from the Combatting Childhood Communicable Diseases (CCCD) Project."

**DOCUMENT ID:** 88.088 **RECORDS:** 1 **YEAR PUBLISHED:** 1988**AUTHOR:** Ministry of Health and Social Welfare, Liberia Southeast Region Primary Health Care Project**TITLE :** County Health Services Operational Manual: Drugs and Medical Supplies.**SOURCE:****EXPERIENCE REPORTED:****PROVIDER LOCATION :** Liberia

MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :  
 SUMMARY:

DOCUMENT ID: 88.089 RECORDS: 1 YEAR PUBLISHED: 1988  
 AUTHOR: Ministry of Health and Social Welfare, Liberia Southeast  
 Region Primary Health Care Project  
 TITLE : Health Center/Health Post Revolving Drug Fund Manual  
 SOURCE:

EXPERIENCE REPORTED:  
 PROVIDER LOCATION : Liberia  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :  
 SUMMARY:

This manual is intended to be used by the staff of health center/  
 health posts and the revolving drug fund committee to operate a  
 revolving drug fund scheme. It provides, among other things,  
 guidelines on staff selection, training and organization, financial  
 management, supply management, procedures and forms, the daily patient  
 record book, daily cash collection/weekly remittance form, monthly and  
 annual financial reports, and stock and inventory records. Some  
 general guidelines: 1.1A RDF scheme should only be undertaken at a  
 HC/HP if the community it serves is willing to be responsible for it  
 by:

a. Raising \$300-500 or more as seed stock. b. Community representatives  
 are willing and able to monitor the daily operations on a continuing  
 basis.

1.2 The community must agree in writing that any money or stock lost by  
 whatever reason will be made good by the community.

1.3A RDF committee . . . shall be responsible for the RDF.

1.4 The RDF committee functions shall include:

a. educating the community about the RDF b. raising seed stock c. the  
 continuous monitoring of the RDF scheme, including funds and stock.

1.7A strict "no money - no drugs" policy is to be followed, that is,  
 no credit can be given to anyone.

1.8 Drugs and medical supplies must be sold at the price as listed in  
 the Ministry of Health and Social Welfare's fee-for-service policy.

1.9 No drugs may be sold for private use, e.g., for use by persons in  
 private practice or to medical stores.

1.10 The HC or HP will procure drugs and medical supplies exclusively  
 from the CHS Supply Depot or NDS except when the item is not available  
 from them.

1.11 Only items on the appropriate list . . . of essential drugs shall

be procured.

1.16 Cash boxes should be provided by the Ministry for the storage of funds in the facility, but the community is responsible for the safety of the funds beyond that. The RDF committee has the right to audit the records and cash at any time.

1.20 The drug prices in the fee-for-service policy allow for some extra money to be earned by the HC/HP.

1.21 Priorities for use of health facility funds generated by the RDF shall be:

- a. First priority shall . . . always be given to replenishing stock sold, and to increasing the stock levels to the most desirable levels.
- b. Second priority shall be to meet the costs of transporting the drugs.
- c. Third priority shall be decided by the RDF committee, and shall include: increasing capital, improving the facility or equipment, community development projects, providing incentives to staff, funding for local hires.

DOCUMENT ID: 88.090 RECORDS: 1 YEAR PUBLISHED: 1988  
AUTHOR: Ministry of Health and Social Welfare, Liberia Southeast  
Region Primary Health Care Project

TITLE : Hospital Revolving Drug Fund Manual

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Liberia

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Like the companion manual for health centers and health posts, this manual provides specific operational guidelines for revolving drug funds. Some excerpts: 2.1A Hospital Revolving Drug Fund Committee will . . . meet once a month initially; when the scheme is running smoothly it should meet a minimum of once per quarter.

2.4 The hospital should raise and provide a sum within the range of \$3000-\$5000 for the purchase of seed stock.

2.7 The hospital will procure drugs and medical supplies exclusively from the NDS except when the item is not available from the NDS, or in the event of an emergency.

2.11 A strict "no money - no drugs" policy is to be followed, that is, no credit can be given. This applies to individuals, as well as to companies and institutions. The only exception is for companies for whom prior approval has been given . . . to bill monthly.

2.12 Drugs and medical supplies must be sold at the price as listed in the MH&SW' Fee-for-Service Policy.

2.13 No drugs may be sold for private use, e.g., for use by doctors, PAs, nurses, or medical stores.

2.19 Any discrepancies in RDF funds will be thoroughly investigated and losses will be made good by the responsible party. Additionally, disciplinary action may be necessary.

2.22 The RDF committee, based on the financial performance of the RDF scheme, may decide to provide an incentive bonus for staff involved in the RDF.

DOCUMENT ID: ND.091 RECORDS: 1 YEAR PUBLISHED: n.d.  
 AUTHOR: Stewart Kathryn J.  
 TITLE : Cost Effectiveness of Child Survival Initiatives: a Literature Review  
 SOURCE: background paper for the Fourth Report to Congress on Child Survival  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : Sub-Saharan Africa  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :  
 SUMMARY:

"USAID has made a large effort toward Child Survival in the developing countries. In an era of cost constraints, it becomes necessary to evaluate all expenditures for their "efficiency." Toward this goal, this literature search was undertaken to summarize the work done in cost-effectiveness analysis relative to the major Child Survival initiatives - immunizations, oral rehydration therapy, breast feeding, and child spacing. "Because the methods of analysis were very unstandardized, and important factors were excluded from consideration, the results are lacking in sensitivity for fine comparison and therefore no policy discussions can be made from the results presented here. However, the enormous difference between the costs of a death averted (\$250,000 - 500,000) for programs in the U.S. and the costs of a death averted (less than \$200) by an immunization or ORT program in a developing country, shows the extremely efficient use of resources in a developing country. "The review of these papers elicits several important points if this economic tool is to be used to its best benefit: 1) the value of CEA is the process more than the result, 2) omission of non-monetary costs/benefits may lead to false conclusions, 3) more literature needs to be widely available to elicit discussion and consensus by experts on the calculation and application of CEA, 4) a generally useful outcome indicator needs to be agreed upon and a standardized methodology developed which is available on microcomputer, and 5) more research done to understand the value of time and health to people in developing countries." (author's summary)

DOCUMENT ID: 88.091 RECORDS: 1 YEAR PUBLISHED: 1988  
 AUTHOR: University Research Corporation  
 TITLE : ACSI-CCCD Sustainability Strategy (Draft)  
 SOURCE:  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : Sub-Saharan Africa  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :  
 SUMMARY:

Written specifically for ACSI-CCCD projects in West Africa, this Strategy Statement takes a broad view of sustainability factors and desirable project responses. Internal cost recovery for CCCD-type services may have limited potential, thus, sustainability may depend more on development of political and popular support and the strengthening of management infrastructure. Five types of factor are considered important: (a) the technical effectiveness of project interventions; (b) national leadership and commitment; (c) effective management; (d) diversified and dependable financial resources; and (e) acceptance and continuation of behavioral change at the household and individual levels. Within this framework, health education and efforts to strengthen information systems (to identify and resolve problems and to convince policymakers of impact) assume equal or greater importance than direct user charges for project services. Longterm funding is considered primarily dependent on ministries of health and, thus, on the growth of interested constituencies within the government at large and among influential private groups. Project staff and others should promote sustainability by building host country technical capacity, insisting on non-verbal manifestations of commitment (e.g., gradual recurrent cost funding, prompt assignment of high quality professional staff, acceptance of decisionmaking responsibility), building management capacity (planning, supervision, information systems, operations research capacity, financial management, decentralization), and improving health education. "To promote financial sustainability, every new and continuing project will have a financing plan, which will be reviewed and updated annually. This plan will: - analyze direct project-related costs - distinguish recurrent (including capital replacement) from development costs - distinguish local currency from foreign exchange costs - identify current and future sources of finance for each cost - provide for specific actions to achieve funding targets - specify assumptions about macro health sector financing and analyze their appropriateness, and - specify steps to be taken to ensure adequate supportive funding by other donors."

"Project agreements will require gradually increasing governmental and/or private assumption of local currency recurrent costs. AID/CCCD/MOH staff will meet this requirement by: - increasing and/or reallocating government expenditures for Child Survival activities - encouraging existing insurance schemes to cover preventive Child Survival interventions - examining the equity implications and cost recovery potential of possible user charges - where appropriate, promoting policy changes to permit or require user payments - conducting studies to set commodity prices and/or user fees and to develop policies for the indigent - experimenting with specific fee-for-service or community financing schemes - encouraging local retention of clinic fees and use of them for health services, and - collaborating with other projects and donors to reduce broader health sector financing constraints."

DOCUMENT ID: 90.092 RECORDS: 1 YEAR PUBLISHED: 1990  
AUTHOR: USAID  
TITLE : Project Paper for Burkina Faso Family Health and Health Financing Project

**SOURCE:****EXPERIENCE REPORTED:****PROVIDER LOCATION :** Burkina Faso**MAIN PROBLEM CATEGORY:****KEY PROBLEMS :****SUMMARY:**

Project paper summarizes results of Boulgou financing operations research study and describes plans for its replication. "Evidence from the Boulgou Study indicates that community health committees which are effectively trained and supervised can successfully manage revolving fund pharmacies. Under the Study, community health committees managed all funds related to the functioning of the community pharmacies, made decisions on the use of pharmacy profits, hired and supervised the pharmacy managers, and participated in all decisions relating to other cost recovery mechanisms. "The principal constraint to improving the health status of the people of Burkina Faso is a limitation on government funds for basic supplies and equipment for health facilities, maintenance costs, in-service training, and supervision expenses of health personnel. The FHHF Project will contribute to resolving this constraint by helping the GOB to develop viable health cost recovery schemes, ameliorate and extend primary health care information and services, and upgrade the skills and techniques of PHC service providers. The Health Financing subproject "is an application and further development of the Boulgou Health Cost Recovery Study. The new project will apply in five provinces the major interventions tested under the Boulgou study, including: 1) organization or strengthening of community health committees; 2) establishment or strengthening of revolving fund drug stores; 3) introduction of fees for laboratory tests . . . ; and 4) introduction of logistic and financial systems to manage cost recovery mechanisms. . . . In addition, the new project will introduce standardized diagnostic and treatment schedules, essential drug lists, and supervision systems to improve the overall functioning of PHC in the project area." "Fees for laboratory tests will be instituted . . . Tests will include the detection of urine in blood, stool and urine samples, albumin/sugar in urine and filaria in skin clips. . . . The (training) program will include sessions on recordkeeping of laboratory test results and related expenses and revenues. . . . The user fee structure . . . will be amended over time to allow for inflation and the inclusion of additional laboratory procedures. At a minimum, each laboratory will be expected to finance recurrent costs of laboratory supplies, and possibly generate a modest income to offset recurrent costs of the health facility itself. Prior to implementing the new project: (a) the legal status of the pharmaceutical warehouses and community pharmacies to be established under the project (will be) defined, including . . . their status under Cooperating Country laws, decrees, and regulations regarding payment of taxes, and the payment and employment of employees; and (b) 100% of the receipts from the sale of drugs and medicines by the pharmaceutical warehouses and community pharmacies will be retained by the warehouses and pharmacies and used (1) to finance (their) operation . . . and (2) to finance the improvement of primary health care services offered by the medical centers and combined maternities/ dispensaries.

DOCUMENT ID: 89.093 RECORDS: 1 YEAR PUBLISHED: 1989

AUTHOR: Vogel Ronald J.

TITLE : Cost Recovery in the Health Care Sector in Sub-Saharan Africa

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION : Sub-Saharan Africa

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

"Almost every single government in sub-Saharan Africa has shown serious interest in cost recovery in the previously exempt social sectors, such as education and health, in the last five to ten years. Although still politically difficult to implement, a certain amount of cost recovery in education and health is seen as increasingly necessary because of rapid population growth, and because of slow or little economic growth and budget deficits in the 1980s. Also, ministries in the different countries are now beginning to understand that selective pricing of educational and health services can be a powerful tool for achieving the efficiency and equity goals that they have officially set since independence, but towards which they have achieved little tangible progress. Although pricing policy across all the social sectors is important from an allocatory perspective, the analysis in this paper confines itself to pricing policy in the health sector simply because this subject itself is large and complex enough; although the emphasis is upon sub-Saharan Africa, the general principles that are derived could be modified and used in the social sectors in any developing country. The first section of the paper considers the rationale for cost recovery in the health care sector with respect to goals that the governments have set. Next follows a short theoretical section on government pricing with a budget constraint, and then a section on the empirical evidence. The fourth section sets forth a set of principles for systematic health care pricing, together with a proposed price schedule, developed from the principles. The fifth section considers a number of constraints that successful cost recovery (in terms of government efficiency and equity objectives) must face and overcome. The conclusion discusses topics for further empirical research on this important issue."

DOCUMENT ID: 90.101 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: Alihonou E

TITLE : Community Financing of Health Services for the Improvement of Primary Health Care." Panafrican Conference on Community Financing

SOURCE:

EXPERIENCE REPORTED:

PROVIDER LOCATION :

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Discusses contextual conditions contributing to community financing and describes experiences in Benin, Guinea, and Rwanda. Bamako Initiative Management Unit, UNICEF, 1990. Bamako Initiative Newsletter, March 1990.

Periodic newsletter describes country experiences in implementing the Bamako Initiative. Bamako Initiative Management Unit, UNICEF, 1990. "Operations Research Issues Related to Community Financing of PHC Development."

This is an excellent review of operational issues and research findings related to community financing and the Bamako Initiative. Some quotes: "Community financing is seen as a necessary approach for mobilizing resources for the health sector. . . . The Initiative was welcomed by many African governments and many other experts, although there was concern about two major issues, namely the idea of community financing which implied further sacrifices by African communities, defined by all economic criteria as being among the most impoverished in the world, and secondly the potential for indiscriminate or irrational use of drugs. "It was felt by some that Africa was being pressured by international agencies towards cost recovery and user financing measures at a period when the African economic situation was extremely difficult. Charging for drugs to help pay for PHC was seen as inherently unsatisfactory as it could encourage health workers to overprescribe drugs so as to maximize the extraction of resources from the community. Also, direct charges to poor rural patients could become an insurmountable constraint to their access to health care. . . ." It is important that the basic ideas behind operations research be made as simple and straightforward as possible, to enable meaningful participation of those health workers and community leaders . . . who would have to use the results. Too often, operations research is seen as an activity for consultants, academics, or senior staff from the central level, using abstruse and complicated techniques, generating results which make little sense to staff at the district level. The conclusions of such research therefore have little chance of being utilized. Operations research techniques and possibilities should be built into the district management system, and provision should be made for financial and human resources to make this possible." "In Mauritania and Nigeria, community level PHC systems are being studied with a managerial focus. In Togo, Ghana, Zaire, and Sierra Leone studies have been made on health financing, and in Zaire and Tanzania on drug supply systems." "There are at least 12 key issues which appear to warrant further study . . . : 1.The most effective community financing mechanisms; 2.Affordability and equity of access to services, including also studies on willingness to pay; 3.Pricing levels and systems that maximize community financing and minimize deterring people from service use; 4.Rational use of drugs; 5.Appropriateness of different methods for drug supply; 6.Financial and managerial feasibility of drug management systems; 7.Feasibility of drug management at community level; 8.Effectiveness of health education in rationalizing drug use; 9.Appropriate methods to link the community and the programme; 10.Influence of community financing on MCH coverage and service utilization; 11.Cost-effectiveness of service delivery strategies for MCH; 12.The role of community health workers and TBAs."

DOCUMENT ID: 88.102 RECORDS: 1 YEAR PUBLISHED: 1988  
AUTHOR: Carrin Guy

TITLE : Community Financing of Health Care

SOURCE: World Health Forum

EXPERIENCE REPORTED:

PROVIDER LOCATION :

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Policy-makers in developing countries may wish to guide communities as to how they should go about choosing a method for the financing of health care. With particular reference to the provision of essential drugs in sub-Saharan Africa, the author examines the pros and cons of direct payment, fee-for-service, and prepayment systems. Before advice is offered to a community, detailed information should be gathered about its preferences, socio-economic status, and administrative know-how." Chelemu, W.C. "Essential Drugs Programme and the Bamako Initiative."; also Chelemu, W.C. "Essential Drugs Programme and its Contribution to the Development of Bamako Initiative Strategies."

These two articles discuss the relationship between the Bamako Initiative and Essential Drugs Programs. Departement de la Sante Publique du Zaire, SANRU, REACH, 1986. "Health Zone Financing Study, Zaire: Final Report."

The major part of this report deals with health zone financing in Zaire, as summarized in the country profile. Many of the report's recommendations are, however, of general interest, viz.: - Further theoretical and empirical analysis needs to be done with regard to the population attitude vis-a-vis different payment schemes. . . . Understanding population's behavior with respect to prices . . . will help to find the optimal payment schemes. - Many health centers are unable to achieve financial autonomy. . . . Cross-subsidization among centers within a zone is a solution to this problem if accepted by the centers' health committees. - We think that in the medium term health zones will have to depend on external support to build or replace their fixed assets. - Health zones should keep the price of preventive PHC subsidized until further research reveals the effect of price of preventive programs on demand. - Health zones should try to minimize the number of services provided free of charge to the population. . . . The zones should consider offering pre-paid plans for children. - Health facilities should devote time and resources to understanding their cost structure and developing accurate accounting systems. Understanding of a facility's cost is essential to formulate financially sound pricing policies. - We believe that demographic and socio-economic differences among the zones require different zones to adopt different administrative schemes, pricing policies, and health care plans. We think that the zones should be technically autonomous since the zones' management is better equipped to solve their own problems. We encourage the GOZ to provide training and guidance to the zones' personnel, but we discourage it from imposing uniform and rigid administrative schemes to the health zones.

DOCUMENT ID: 90.103 RECORDS: 1 YEAR PUBLISHED:

**AUTHOR: COUNTRY PROFILE**

**TITLE :**

**SOURCE: COUNTRY PROFILE**

**EXPERIENCE REPORTED:**

**PROVIDER LOCATION : A,1 Sub-Saharan Africa B,1 Benin**

**MAIN PROBLEM CATEGORY:**

**KEY PROBLEMS :**

**SUMMARY:**

**BENIN 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES GOVERNMENT POLICIES**

"Free" care/ User charges: Government appears fully committed to cost recovery schemes already being implemented. Private sector: Employment-based health care: 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)

DOCUMENT ID: 90.104 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,11 Guinea-Bissau

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

Guinea-bissau 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES GOVERNMENT POLICIES "Free" care/ User charges: Private sector:

Employment-based health care: Decentralization: Pharmaceuticals: has 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 system. 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

DOCUMENT ID: 90.105 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,2 Burkina Faso

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

Burkina-Faso 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES GOVERNMENT POLICIES "Free" care/ User charges: Private sector:

Employment-based health care: Decentralization: Government said (Campagne) to be "studying reform of the government financial systems (to) . . . allow for the speeding up of the process of community

responsibility in the financial management of health services."  
 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. KEY INFORMANTS

DOCUMENT ID: 90.106 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE 1990

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,3 Cameroon

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

Cameroon 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES GOVERNMENT  
 POLICIES

"Free" care/ User charges: Private sector: Employment-based health  
 care: Decentralization: Pharmaceuticals: 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)

Setting prices for essential drugs: Operations research is currently  
 (1990, 1991) under way in the SESA project, sponsored by A.I.D.  
 applying a methodology published by Litvack et al. in The Lancet. "A  
 method has been developed for fine tuning the selection of drugs to  
 improve cost recovery, to promote appropriate drug use, and to make  
 more drugs more affordable. The scheme is based on a classification  
 of drug necessity (vital, essential, non-essential) and on the  
 relative costs of complete courses of treatment so that expensive  
 drugs can be subsidized by marking up inexpensive ones."

KEY INFORMANTS Eckhard Kleinau, HIID

USEFUL LITERATURE Litvack JI, Shepard DS, Quick JD. Setting the Price  
 of Essential Drugs: Necessity and Affordability. The Lancet, August 12,  
 1989.

DOCUMENT ID: 90.107 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

**EXPERIENCE REPORTED:**

**PROVIDER LOCATION :** A,1 Sub-Saharan Africa B,4 Central African Republic (CAR)

**MAIN PROBLEM CATEGORY:**

**KEY PROBLEMS :**

**SUMMARY:**

central african republic 7-12-90 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. **Private sector:** Employment-based health care: Decentralization: Practitioners allowed to keep a part of fees but must share them with the state. **Pharmaceuticals:** 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 Relatifs à la Santé Publique en République Centrafricaine, 1989"**

**DOCUMENT ID:** 90.108 **RECORDS:** 1 **YEAR PUBLISHED:** 1990

**AUTHOR:** COUNTRY PROFILE

**TITLE :**

**SOURCE:** COUNTRY PROFILE

**EXPERIENCE REPORTED:**

**PROVIDER LOCATION :** A,1 Sub-Saharan Africa B,5 Chad

**MAIN PROBLEM CATEGORY:**

**KEY PROBLEMS :**

**SUMMARY:**

Chad 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES **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."

**Private sector:** Employment-based health care: Decentralization: **Pharmaceuticals:** 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 (Oudda). "(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) KEY INFORMANTS

DOCUMENT ID: 90.109 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,6 Congo

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

congo 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES GOVERNMENT POLICIES

"Free" care/ User charges: Private sector: Employment-based health care: Decentralization: Pharmaceuticals: 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. KEY INFORMANTS USEFUL LITERATURE

DOCUMENT ID: 90.110 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,8 Gambia

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

the gambia 7-12-90 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.

Private sector: Employment-based health care: 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 indigen.

## KEY INFORMANTS

DOCUMENT ID: 90.111 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,9 Ghana

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

ghana 7-12-90 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

DOCUMENT ID: 90.112 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

**SOURCE: COUNTRY PROFILE****EXPERIENCE REPORTED:**

**PROVIDER LOCATION :** A,1 Sub-Saharan Africa B,10 Guinea

**MAIN PROBLEM CATEGORY:****KEY PROBLEMS :****SUMMARY:**

guinea 7-12-90 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. Private sector:

**Employment-based health care: 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."

(Mandl) 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. Campaign 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 Telmele. Revenues from the sale of vaccination cards, ORS packets, and chloroquine tablets will be used for local recurrent costs. KEY INFORMANTS

DOCUMENT ID: 90.113 RECORDS: 1 YEAR PUBLISHED: 1990  
 AUTHOR: COUNTRY PROFILE  
 TITLE :  
 SOURCE: COUNTRY PROFILE  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,12 Ivory Coast  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS :  
 SUMMARY:  
 cote d'ivoire 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES CCCD

GOVERNMENT POLICIES "Free" care/ User charges: 1960 circular set charges for hospital care. Two centres hospitalieres 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. Pharmaceuticals: 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 Prevoyance 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. Cote 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 Sante Publique; Institut Raoul Fallereau; Service d'Aide Medical d'Urgence; Centre Hospitaliere Universitaire de Cocody; Centre Hospitaliere Universitaire de Treichville; Centres Anti-Tuberculeux (Vogel, pp. 109-111). Polyclinique Internationale Sainte Anne Marie (Vogel, pp. 120-123) KEY INFORMANTS

DOCUMENT ID: 90.114 RECORDS: 1 YEAR PUBLISHED: 1990  
 AUTHOR: COUNTRY PROFILE  
 TITLE :  
 SOURCE: COUNTRY PROFILE  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,13 Liberia  
 MAIN PROBLEM CATEGORY:  
 KEY PROBLEMS  
 SUMMARY:

Liberia 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES CCCD, including revolving drug fund

GOVERNMENT POLICIES "Free" care/ User charges: Small visit fee authorized but drugs and medical supplies were to be free. Private sector: Employment-based health care: 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 Blakney (pp. 12-13 and Annex E) describes revolving drug funds in Grand Geddeh 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. KEY INFORMANTS

DOCUMENT ID: 90.115 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A, 1 Sub-Saharan Africa B, 14 Mali

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

mali 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES Mali is a Child Survival Emphasis country. 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 *Medicins sans Frontieres* 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 Djenne 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 *Medicins sans Frontieres*), 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 Toure, 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. Mediciens sans Frontieres 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-Sante. 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

DOCUMENT ID: 90.116 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,15 Mauretania

MAIN PROBLEM CATEGORY:

KEY PROBLEMS :

SUMMARY:

mauritania 7-10-90 CURRENT A.I.D. HEALTH ACTIVITIES Bilateral:

Centrally-Funded:

GOVERNMENT POLICIES "Free" care/ User charges: Private sector: Employment-based health care: 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 Overview: 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) KEY INFORMANTS A.I.D.

Ministry of Health

Donors

Project personnel

Others

DOCUMENT ID: 90.117 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,16 Niger

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

niger 7-12-90 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.

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. Private sector: Employment-based health care: 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.

Each pilot test will entail: - "sensibilisation of the public" - a guarantee that essential drugs will be available - additional worker training, especially for drug prescription.

Tests will begin in mid-1990 and continue for two years. 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. Male secouristes 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 A.I.D.: Carina Stover

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

Donors: Heddy (?) Vogel, Dutch Susan Farnsworth, CARE International

Project personnel: Tisna Veldhuyzen van Zanten, PRICOR Ian Sliney, Health Sector Development Proj.

#### USEFUL LITERATURE

DOCUMENT ID: 90.118 RECORDS: 1 YEAR PUBLISHED: 1990  
 AUTHOR: COUNTRY PROFILE  
 TITLE :  
 SOURCE: COUNTRY PROFILE  
 EXPERIENCE REPORTED:  
 PROVIDER LOCATION : A,1 Sub-Saharan Africa B,17 Nigeria

**MAIN PROBLEM CATEGORY:****KEY PROBLEMS****SUMMARY:**

**NIGERIA 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES** Nigeria is a Child Survival Emphasis country. \$67 million PHC loan

**GOVERNMENT POLICIES** "Free" care/ User charges: Many institutions have charged, at least for drugs, since the 1970s or earlier. Private sector: 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), Koura 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

**USEFUL LITERATURE**

**DOCUMENT ID:** 90.119 **RECORDS:** 1 **YEAR PUBLISHED:** 1990

**AUTHOR:** COUNTRY PROFILE

**TITLE :**

**SOURCE:** COUNTRY PROFILE

**EXPERIENCE REPORTED:**

**PROVIDER LOCATION :** A,1 Sub-Saharan Africa B,18 Senegal

**MAIN PROBLEM CATEGORY:**

**KEY PROBLEMS**

**SUMMARY:**

**senegal 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES** Senegal is a Child Survival Emphasis country. Project with significant financing elements being developed.

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 Sante (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 Hospital Principal in Dakar features strong financial management. Private hospitals Hopital St. Jean de Dieu in Thies also collects large sums in user fees. Kaolack Hospital Ndioum Hospital Ourosogui Hospital Fann Hospital Thies 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

## USEFUL LITERATURE

DOCUMENT ID: 90.120 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

EXPERIENCE REPORTED:

PROVIDER LOCATION : A,1 Sub-Saharan Africa B,19 Sierra Leone

MAIN PROBLEM CATEGORY:

KEY PROBLEMS

SUMMARY:

Sierra Leone 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES GOVERNMENT POLICIES "Free" care/ User charges: Cost recovery started with pilot projects in 1986. Private sector: Employment-based health care: 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 tradition 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.

KEY INFORMANTS USEFUL LITERATURE

DOCUMENT ID: 90.121 RECORDS: 1 YEAR PUBLISHED: 1990

AUTHOR: COUNTRY PROFILE

TITLE :

SOURCE: COUNTRY PROFILE

**EXPERIENCE REPORTED:**

**PROVIDER LOCATION :** A,1 Sub-Saharan Africa B,20 Togo

**MAIN PROBLEM CATEGORY:**

**KEY PROBLEMS**

**SUMMARY:**

togo 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES CCCD

**GOVERNMENT POLICIES "Free" care/ User charges:** Private sector: Employment-based health care: Decentralization: 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) **KEY INFORMANTS USEFUL LITERATURE**

**DOCUMENT ID:** 90.122 **RECORDS:** 1 **YEAR PUBLISHED:** 1990

**AUTHOR:** COUNTRY PROFILE

**TITLE :**

**SOURCE:** COUNTRY PROFILE

**EXPERIENCE REPORTED:**

**PROVIDER LOCATION :** A,1 Sub-Saharan Africa B,21 Zaire

**MAIN PROBLEM CATEGORY:**

**KEY PROBLEMS**

**SUMMARY:**

zaire 7-12-90 CURRENT A.I.D. HEALTH ACTIVITIES Zaire is a Child Survival Emphasis country. CCCD project

**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 Medico-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 Solidarite Ouvriere 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.) Reseau Mediciens 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 Prevoyance" (UPM), Kinshasa Mutualite de Solidarite Chretienne, Kinshasa MUZAS, Kinshasa LETISSA, Kinshasa Sona Bata Health Zone SNHR Employee Cooperative in Rutshuru.

See also Blakney, pp. 23-25 and Annex J; Departement de de la Sante Publique du Zaire, Executive Summary; as well as other citations below. KEY INFORMANTS Ricardo Bitran Rhonda Smith Don Shepard Eckhard Kleinau Taryn Vian Munkatu Mpese

## USEFUL LITERATURE

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