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**Cost Recovery for  
Immunization:  
A Worldwide Survey of  
Experience**

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## **ABSTRACT**

The Expanded Program on Immunization (EPI) has made substantial gains in coverage worldwide since the program's inception in the mid-1970s, encouraging the acceptance of ambitious new goals for the EPI. These goals include the addition of new and improved vaccines and specific targets for the eradication of polio, elimination of neonatal tetanus, and control of measles. Supporters of the EPI have raised concerns about the sustainability and affordability of these efforts, given that large amounts of additional donor funding for the EPI do not appear to be forthcoming. Developing countries may need to seek additional domestic resources to sustain and expand immunization coverage of their populations.

This document presents the results of a comprehensive survey of cost recovery mechanisms for EPI which are currently in place or which have been attempted recently in developing countries. Information was collected from 79 countries in the African, Asia/Near East, and Latin America/Caribbean regions regarding the national policy towards consumer payments for immunization and/or primary health care (PHC) and the existence of any financing schemes for the EPI or PHC.

Results of this survey show that a wide variety of cost recovery or alternative financing mechanisms have been tried in many developing countries to raise additional resources for the EPI or PHC. Initiatives in both the public and private sectors are described. The authors recommend that detailed assessments of the most promising mechanisms be undertaken so that these experiences can be shared with other developing countries facing difficulties in financing immunization programs.

## TABLE OF CONTENTS

FOREWORD .....	i
ACKNOWLEDGEMENTS .....	iv
ABBREVIATIONS .....	v
<b>I. <u>OVERVIEW</u>, Allison Percy .....</b>	<b>1</b>
A. Introduction .....	1
B. Methodology .....	2
C. Findings .....	3
1. Main Cost Recovery Mechanisms .....	5
2. Regional Patterns .....	7
3. Revenue Generation Capacity .....	9
4. Impact on Utilization .....	10
5. Health Financing Policy Context .....	10
D. Implications of the Findings .....	10
1. Multiplicity of Approaches .....	10
2. Revenue Generation and Utilization .....	11
3. Overall Health Financing Context .....	12
4. Next Steps .....	13
<b>II. <u>REGIONAL REPORT FOR AFRICA</u>, Logan Brenzel and Marie-Odile Waty .....</b>	<b>14</b>
A. The EPI in Africa .....	14
B. The Economic Context .....	15
C. Health Financing Patterns in the Africa Region .....	15
D. Findings in the Africa Region .....	16
<b>III. <u>REGIONAL REPORT FOR ASIA AND THE NEAR EAST</u>, Allison Percy .....</b>	<b>20</b>
A. The EPI in Asia and the Near East .....	20
B. The Economic Context .....	21
C. Health Financing Patterns in the ANE Region .....	21
D. Findings in the ANE Region .....	23
<b>IV. <u>REGIONAL REPORT FOR LATIN AMERICA AND THE CARIBBEAN</u>, Allison Percy .....</b>	<b>26</b>
A. The EPI in Latin America and the Caribbean .....	26
B. The Economic Context .....	27
C. Health Financing Patterns in the LAC Region .....	27
D. Findings in the LAC Region .....	29
REFERENCES .....	32
APPENDIX A. COUNTRY SUMMARIES: AFRICA REGION .....	35
APPENDIX B. COUNTRY SUMMARIES: ASIA/NEAR EAST REGION .....	52
APPENDIX C. COUNTRY SUMMARIES: LATIN AMERICA/CARIBBEAN REGION .....	67

## LIST OF TABLES

Table 1:	Profile of Country Survey . . . . .	3
Table 2:	Countries Included in Review . . . . .	4
Table 3:	Cost Recovery Mechanisms Reported for Public and Private Sectors, by Region (1990) . . . . .	5
Table 4:	Summary of Cost Recovery and Financing Mechanisms for Immunization, Africa Region (1990) . . . . .	17
Table 5:	Summary of Cost Recovery and Financing Mechanisms for Immunization, Asia/Near East Region (1990) . . . . .	24
Table 6:	Summary of Cost Recovery and Financing Mechanisms for Immunization, Latin America/Caribbean Region (1990) . . . . .	31

## FOREWORD

This report is part of the REACH Project's ongoing work in cost and financing issues related to immunization programs in developing countries. The focus here is on cost recovery policies and practices that countries have undertaken to mobilize resources for immunization programs. Cost recovery activities are among the most prominent efforts countries have made to promote financial sustainability of the Expanded Program on Immunization (EPI). The report presents findings from a worldwide survey of these policies and practices and is the first in a series of activities REACH plans to undertake that specifically focus on cost recovery and resource mobilization for immunization programs.

"Cost recovery" is a term now widely used in the health sector to refer to various means of generating revenues -- other than general tax revenues that support the government budget -- to pay for the cost of providing health services. In developing countries, cost recovery often takes the form of contributions made collectively by communities, as well as payments from individual users of the services. It often includes in-kind contributions and donated labor, as well as a variety of cash payment mechanisms (e.g., fee-for-service, entrance fees, pre-payment, charges for health cards).

Many ministries of health and donors have come to regard cost recovery as a key strategy to consider in developing sustainable health service delivery programs. But the concept has special implications when applied to the public health sector, especially to preventive services such as immunization. In the for-profit private health sector, cost recovery is taken for granted. It is expected that for-profit health practitioners will charge for their services, whether preventive or curative, at rates sufficient to cover all their costs, plus provide a profit.

In the public sector, however, cost recovery is not only a relatively new idea in many developing countries, but controversial. Some of the main controversies in developing countries about use of cost recovery for health services in the public sector include issues related to equity, impact on utilization, amount of revenues generated in relation to need, financial management, appropriateness of different cost recovery mechanisms, and the respective roles of the public and private sectors in assuring health service delivery and access.

Several findings of this review have implications for these broader health financing and sustainability issues. Findings from the survey show that cost recovery efforts for immunization are widespread. Over half of the 79 countries for which REACH collected information reported the existence of some kind of cost recovery activity at the national or local level, in the public, as well as the private, sector.

Many of these activities reflect not only the commitment of governments and NGOs to finding additional resources to support EPI, especially in the context of limited government funding of ministry of health budgets. These cost recovery efforts also show that people and communities are willing to pay and contribute resources to immunization services in both the

public and the private sectors.

Findings from this survey also make it clear that, in the three geographic regions of this survey, countries that are relatively poor and have relatively less developed health systems are as likely as the better off, more developed countries to undertake these efforts. Different types of cost recovery mechanisms tend to predominate in each of the regions included in this study: Africa, Asia and the Near East (ANE), and Latin America and the Caribbean (LAC). But most countries who have any cost recovery activity for immunization have several mechanisms operating at the same time.

This prevalence, complexity, and variety of cost recovery activities for immunization represent, in part, a response to larger policy and economic pressures. The cost recovery activities reviewed in this report were in most cases undertaken in a policy environment that became increasingly open in the 1980s to consideration of alternatives to the government health budget for financing health services. They were also undertaken in an economic environment that, for all except a handful of countries in Asia, presented primarily severe constraints and crises.

This report provides details on these patterns, globally, regionally, and for individual countries. The authors also place the findings in the economic context and broader health financing systems of each of the geographic regions. In addition, the report lays the foundation for subsequent analysis of financing and sustainability issues for immunization in a larger context of resource needs for primary health care and linkages among the public, private, and NGO sectors.

In general, the purpose of REACH analyses of cost recovery policies and practices is to contribute to knowledge about concrete steps that countries can take to promote financial sustainability of their immunization programs. Cost recovery focused specifically on immunization is not the only -- or necessarily the most promising -- means to do this. Many factors affect whether or not a financing approach targeted only on immunization would be the most effective and equitable means to assure sustainability of the services in a given country.

At the same time, findings from this review suggest that there may be a greater possibility than previously thought to capitalize on people's willingness to pay for, or contribute resources to, health services they value, such as immunizations for their children, and do so in a way that does not detract from equity or discourage necessary utilization.

REACH plans to follow up on this report with further analyses, case studies and field work to evaluate these issues related to the impact and effectiveness of cost recovery efforts for immunization. For example, REACH plans to follow up with in-depth country case studies of promising efforts, analysis of factors that contribute to effective strategies, technical assistance, and evaluation of the impact of different strategies on revenue generation, utilization, and equity.

REACH could not have collected as much information worldwide on this subject without

**the assistance of UNICEF and the Pan American Health Organization (PAHO). We look forward to continuing collaboration with these agencies and hope that their field staff, as well as USAID missions and ministries of health, find this document useful as they consider financing options for immunization programs.**

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## ABBREVIATIONS

ANE	Asia/Near East region
BCG	Bacillus Calmette-Guerin vaccine against tuberculosis
CIE	Centre International de l'Enfance
CREDES	Centre de Recherches et d'Etudes pour le Développement de la Santé
DOH	Department of Health
EPI	Expanded Program on Immunization
GDP	Gross domestic product
GNP	Gross national product
IDB	Inter-American Development Bank
LAC	Latin America/Caribbean region
MOH	Ministry of health
NGO	Non-governmental organization
PAHO	Pan American Health Organization (WHO)
PHC	Primary health care
PVO	Private voluntary organization
SEARO	South East Asia Regional Office (WHO)
TT	Tetanus toxoid vaccine
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## **I. OVERVIEW**

### **A. Introduction**

The Expanded Program on Immunization (EPI) has been supporting immunization of infants worldwide since the mid-1970s. As the decade of the 1990s begins, many countries have achieved the goal of Universal Childhood Immunization (UCI, defined as 80 percent or more of the country's population of children under one year of age fully immunized with all vaccines). Others are still striving to reach this target. Countries in the Americas are rapidly approaching the regional eradication of polio, and the EPI Global Advisory Group has agreed to a set of recommendations which include the addition of new and improved vaccines and specific targets for the eradication of polio, elimination of neonatal tetanus, and control of measles.

Supporters of the EPI have raised concerns about the sustainability of these efforts and the economic burden that these additional initiatives will place on the already strained health resources of developing countries. Large amounts of additional donor financing for the EPI do not appear to be forthcoming. As a result, developing countries themselves may need to seek additional domestic resources to sustain and expand immunization coverage of their populations.

While increased government funding for immunization and other preventive health measures is desirable, alternative possibilities include seeking additional resources from the communities, families, and individuals who receive immunization services. Many countries have undertaken efforts to recover some of the costs of immunization from the beneficiaries, but until now, no systematic examination of the range of EPI cost recovery experience has been undertaken.

This document presents the results of a comprehensive survey of cost recovery mechanisms for EPI which are currently in place or which have been attempted recently in developing countries. This assessment was designed to describe and classify the range of experience found worldwide. To the extent possible, the findings with regard to the financing of the EPI are presented within the context of the financing of the health sector as a whole and the economic performance of countries in each region. As this is the first such comprehensive review of revenue generation efforts for immunization, the purpose is to shed light on this area and identify countries where it might be reasonable to undertake follow-up assessments of the most promising approaches.

While this review does not attempt to evaluate specific financing mechanisms in detail, some consideration was given to what might constitute a successful cost recovery initiative. A key criterion for success is the initiative's ability to generate needed revenues. The amount of resources needed would vary from one context to another, and as a result no single revenue level or cost recovery ratio can be applied across all countries. Another important measure of success is the initiative's effect on utilization of immunization services. If the revenue generation effort raises all the needed resources but significantly reduces immunization coverage, it cannot be

considered successful. These success criteria should be developed further and applied in country-level assessments of some of the initiatives that have been identified by this review.

Because immunization is only one of several primary health care (PHC) interventions, the study was also designed to explore revenue generation efforts for PHC, although in less detail than for immunization cost recovery. It was anticipated that many countries would not single out immunization for revenue generation initiatives, but might undertake cost recovery efforts to support PHC services more generally. In these cases, revenues raised for PHC might also help pay for, or cross-subsidize, immunization services.

## **B. Methodology**

The main source of information for this review comes from a survey that REACH conducted of developing countries in three regions. With the cooperation of UNICEF and PAHO, telexes were sent to the UNICEF and PAHO field offices in Africa, Asia, the Near East, Latin America, and the Caribbean. For purposes of this report, findings are presented in three regional groupings in order to conform with the A.I.D. regional groupings at the inception of the study. The telexes sent to the field offices requested responses to questions regarding:

- ◆ the national policy toward consumer payments for immunization and/or primary health care
- ◆ existence of any financing schemes for EPI or PHC such as:
  - payment for immunization cards
  - payment of fees per shot or for full immunization
  - prepayment
  - earmarked taxes
  - coverage of immunization under social insurance
  - lotteries
  - community contributions of money, labor, or goods
  - fundraising
  - other financing schemes
- ◆ existence of any studies examining cost recovery for PHC and/or immunization in that country

In addition to this survey data, the authors collected information for the three regions and selected countries from (a) REACH Project overseas offices; (b) REACH staff communications; and (c) a review of the literature. In addition to the information collected on EPI and PHC cost recovery, the authors collected documentary background on the economic status of countries and health financing patterns prevailing in each region. Sections which highlight relevant portions of this information provide a backdrop for the findings of this study.

### C. Findings

Table 1 summarizes the number of countries reviewed in each region and the number which reported the existence of some type of cost recovery mechanism for immunization. Over 60 percent of countries for which information was available in Africa and Asia/Near East and nearly 30 percent of the countries in Latin America/Caribbean reported some type of cost recovery effort for EPI. This finding reveals that such mechanisms may be more common than previously believed. A list of the 79 countries for which information was available and which are included in the study is provided in Table 2. It should be kept in mind that in some cases these mechanisms were in effect only in a small part of the country.

Sections II through IV present a complete report on the findings in each region. In these sections, background is provided on the EPI, the economic context, and health financing patterns in the region. A table in each regional report (Tables 4 through 6) summarizes the findings for each country in that region. Appendices A-C contain brief narrative summaries for each country which outline the findings, incorporating both the responses to the UNICEF and PAHO telexes and data gathered from other sources.

Table 1:  
Profile of Country Surveys

Region	Number of Countries Surveyed	Countries Responding		Total Countries Included in Report	Countries Identifying a Cost Recovery Mechanism for Immunization	
		No.	%		Number	Percent
Africa	42	25	57%	34 a/	21	62%
Asia/Near East	37 b/	27	73%	27	17	63%
Latin America/Caribbean	24 b/	18	75%	18	5	28%
Total	103	69	67%	79	43	54%

a/ To provide a more complete sample of African countries, REACH included information it had available on nine of the countries that did not respond to the UNICEF telex. See footnotes in country summaries (Appendices A-C) for sources used.

b/ Note that the Pacific Island nations and countries in the Eastern Caribbean were grouped together and each counted as a single country in this analysis.

**Table 2:  
Countries Included in Review**

**Africa**

Angola  
Benin  
Botswana  
Central African Rep.  
Congo  
Côte d'Ivoire  
Djibouti  
Ethiopia  
Gabon  
The Gambia  
Ghana  
Guinea  
Guinea-Bissau  
Kenya  
Lesotho  
Liberia  
Madagascar  
Malawi  
Mali  
Mauritius  
Mozambique  
Namibia  
Niger  
Nigeria  
Rwanda  
Senegal  
Sierra Leone  
Somalia  
Sudan  
Swaziland  
Tanzania  
Uganda  
Zaire  
Zimbabwe

**Asia/Near East**

Afghanistan  
Algeria  
Bangladesh  
Bhutan  
China (People's Rep. of)  
Egypt  
India  
Indonesia  
Iran  
Korea (Rep. of)  
Laos  
Lebanon  
Malaysia  
Maldives  
Morocco  
Myanmar  
Oman  
Pacific Islands\*  
Pakistan  
Papua New Guinea  
Philippines  
Sri Lanka  
Syria  
Thailand  
Tunisia  
Yemen  
Vietnam

**Latin America/Caribbean**

Argentina  
Bolivia  
Brazil  
Chile  
Costa Rica  
Cuba  
Dominican Republic  
Eastern Caribbean\*  
Ecuador  
El Salvador  
Guatemala  
Haiti  
Honduras  
Mexico  
Panama  
Paraguay  
Peru  
Venezuela

\* Countries in these subregions were grouped together because country-specific information was not available.

## 1. Main Cost Recovery Mechanisms

Table 3 summarizes the specific cost recovery mechanisms reported by countries in each region. Over half of the 79 countries in the sample were undertaking some type of resource generation effort for immunization in the public sector. The most common types of mechanisms identified were fees (per shot or for an immunization card) and voluntary efforts (fundraising, lotteries, or contributions of labor or goods). Many countries (41%) also identified cost recovery efforts for primary health care that were not specific to immunization. There appeared to be significant under-reporting by countries in at least three areas: fees in the private sector, coverage of immunization under social insurance programs, and fundraising and voluntary contributions for PVOs.

Table 3:  
Cost Recovery Mechanisms Reported for  
Public and Private Sectors, by Region (1990)

(By Percentage of Countries Identifying Specific Mechanisms)

Region	For Immunization:						For PHC:
	Fee for Shot, Series, or Card	Pre-payment	Cross Subsidization	Social Insurance	Earmarked Tax	Fundraising, Lottery, or Voluntary Contributions	Fee or Prepayment
Africa	41%	6%	12%	6%	6%	24%	65%
- public	38%	6%	12%	6%	6%	24%	59%
- priv./PVO	3%	0%	0%	n.a.	n.a.	0%	26%
Asia/Near East	44%	11%	0%	19%	0%	41%	30%
- public	7%	11%	0%	19%	0%	41%	19%
- priv./PVO	37%	0%	0%	n.a.	n.a.	4%	11%
Latin America/Caribbean	4%	0%	0%	11%	0%	17%	11%
- public	4%	0%	0%	11%	0%	17%	6%
- priv./PVO	0%	0%	0%	n.a.	n.a.	0%	6%
Total	35%	6%	5%	11%	3%	29%	41%
- public	23%	6%	5%	11%	3%	28%	33%
- priv./PVO	14%	0%	0%	n.a.	n.a.	1%	16%

**Note:** Public sector includes national or local programs. Private sector includes private for-profit sector and PVOs. Discontinued programs and programs under consideration are excluded. Percentages for public and private sectors may add up to more than total as some countries reported both.  
n.a. = not applicable

The most common mechanism, identified by over one-third of countries, was the levying of fees for immunization services or cards. Twenty-three percent of countries identified fees for

immunization at public sector facilities, while 14 percent reported the existence of fees in the private sector at for-profit clinics or PVO facilities.

Nearly every country in the world has private physicians who provide services, including immunization, on a fee-for-service basis. However, only 11 countries (14 percent) reported fees for immunization in the private sector. This is probably due to the relatively small contribution that the private sector makes to overall EPI coverage in most countries (a notable exception is the Republic of Korea, which will be discussed below). In fact, in some countries the EPI intentionally does not encourage private physicians to provide immunization since the program could have little control over vaccine, cold chain, and service quality in the private sector.

For the most part, countries reporting fees for immunization in the public sector indicated that these fees were very low, ranging from US\$0.03 to \$0.40. While apparently not intended to cover the full costs of providing immunization services, the fees may generate supplemental funds needed at the local level. Where fees were charged for cards, some respondents indicated that the fees were intended primarily to give a value to the cards so that mothers would retain them. Often the fee was less than US\$0.10.

Private sector charges for immunization were considerably higher. Where identified, the cost per visit to a private clinic for immunization was found to range from US\$2 to \$6. Some countries reported that PVO clinics sometimes charge a small fee for immunization, usually in the range of US\$0.50 to \$1.00.

Some variation in pricing policy was sometimes reported within a country. In the People's Republic of China, the existence and level of fees vary depending on the economic circumstances of the area. While health providers charge for services in relatively well-to-do townships, village doctors in poor rural areas are remunerated for their preventive health services through government subsidies.

Voluntary efforts were the second most common type of mechanism identified. These included lotteries, fundraising efforts, and voluntary contributions of cash, labor, or goods given to support the EPI. Twenty-nine percent of countries noted these mechanisms. Voluntary contributions of labor were often important in supporting immunization campaigns and building health clinics. Other kinds of voluntary efforts that exist in more countries than survey respondents reported include the activities of such PVOs as Rotary, which has carried out extensive local fundraising efforts for polio immunization and eradication.

Mechanisms that were identified infrequently included coverage of immunization through social insurance programs, prepayment schemes, and cross-subsidization of the EPI through charges for other health services. The least common mechanism identified was earmarked taxes targeted toward immunization, found in only two countries.

Eleven percent of countries reported that immunization services were covered by social insurance systems. In some cases, this indicated that immunization services were provided at

facilities run by the social security institute. In other cases (e.g. Costa Rica), the social security institute was contributing funds for the purchase of immunization supplies. In still other instances (e.g. Republic of Korea), social insurance programs reimbursed individuals who sought immunization services from the private sector.

Immunizations are probably provided at social security facilities in more countries than the survey indicated, particularly in Latin America. Under-reporting of this mechanism may have occurred because social security covers relatively small proportions of the population and would not contribute substantially to overall national immunization coverage in most countries.

Prepayment systems for EPI in the public sector were identified in six percent of the countries, while no countries identified such systems in the private sector. A particularly innovative prepayment mechanism for EPI known as the "contract system" is in operation in some areas of China and Vietnam. This scheme, which is discussed in more detail in Section III and in the country summaries in Appendix B, generates resources for the EPI by charging a fee for full immunization coverage and guaranteeing compensation to the family of any child who is immunized according to the recommended schedule and still becomes ill with one of the EPI target diseases.

Direct cross-subsidization of the EPI by payment for other services was rare, with only five percent of countries noting such a system, all of them in the public sector. One example of this type of mechanism was found in one area in the Sudan, where charges levied for children's curative services were allocated to the EPI.

Only two countries mentioned the existence of earmarked taxes targeted toward immunization. In some regions in the Sudan, local funds for the EPI have been raised through a special tax on sugar, bus fares, and/or cinema tickets. In Ghana, some districts have levied communities to raise funds for EPI recurrent costs.

Finally, with respect to PHC, 41 percent of countries reported some type of fee or prepayment system for primary health care that was not specific to immunization: 33 percent in the public sector, and 16 percent in the private sector. In some cases, the fees were very small. For example, in India, Bangladesh, and Indonesia, health centers charge small registration or entry fees ranging from US\$0.03-0.13 for primary health services. In other cases (e.g. Zaire), cost recovery efforts are of major importance in supporting primary health services throughout the country.

## **2. Regional Patterns**

The variety of cost recovery patterns found among regions is evident in Table 3. However, several distinct patterns can be perceived within each region. The most common form of cost recovery mechanisms for the EPI found in each region are:

- Africa:** fees in the public sector per shot or for an immunization card
- ANE:** private sector provision of immunizations (on a fee-for-service basis), plus voluntary contributions and fundraising efforts for the public sector and PVOs
- LAC:** voluntary contributions, particularly of labor to support immunization campaigns

These patterns coincide to some degree with the overall health sector financing systems found in each region. The overall health financing patterns are discussed in detail in Sections II through IV and demonstrate that: ministries of health in Africa are exploring innovative cost recovery efforts as government resources become inadequate to provide basic health services to the population; a vibrant private health sector exists in many countries in the Asia/Near East region; and public health services are financed overwhelmingly by the government in most Latin American and Caribbean countries.

Fees for immunization services appear to be more common in Africa and Asia than in Latin America. Most cases of fees for shots or cards in Africa were in the public sector, while the majority of those reported in Asia were in the private sector. This finding is consistent with the existence of a more robust private sector in many Asian and Near Eastern countries than in Africa. It should be noted, however, that private sector reporting is incomplete, particularly for Latin America.

Prepayment schemes for immunization were infrequent in Africa and the Asia/Near East region, and no such schemes were reported in the LAC region. Cross-subsidization programs (revenue generated from other health services but used to support the EPI) were reported only in Africa. They are often part of Bamako Initiative programs which rely on the sale of essential drugs to finance primary health care, including EPI.

Coverage of immunization under social insurance programs was reported infrequently in every region, as providing public health services is generally considered the direct responsibility of ministries of health, leaving social security programs only a minor role to play in providing for immunization and other preventive services. Moreover, in many countries only a small portion of the population is covered by social insurance. Staff communications indicate that immunizations are provided at social security facilities in some Latin American countries that did not report this. Under-reporting may be due to the small role that social security institutions play in overall EPI coverage.

Earmarked taxes for EPI were reported in only two countries, both in Africa. However, in Indonesia, a major source of funds for the EPI is a special budget set-aside known as the Presidential Instruction (INPRES) fund. This fund is not likely to be affected by the annual budgeting process and thus is more protected from ministry budget reductions.

Fundraising, lotteries, and voluntary contributions for immunization were mentioned in each region, although they were reported by nearly half of the countries in Asia and the Near East but only 24 percent of the countries in Africa and 17 percent in the LAC region.

With respect to primary health care as a whole, fees or prepayment plans were much more common in Africa than in either the ANE or the LAC region. Insufficient public funds for primary health care and expanding goals of Health For All have encouraged the public sector in nearly 60 percent of the African countries to attempt some sort of cost recovery for PHC.

### **3. Revenue Generation Capacity**

Many of these mechanisms have been adopted to generate additional resources to help compensate for government budget problems. In principle, they could be designed to recover all or only a part of the costs of providing immunization services.

As reported in this survey, fees charged for public sector immunization services tend to be nominal (less than US\$1.00). While it was not possible in most cases to assess the amount of revenues collected through these cost recovery efforts nor to compare these revenues to the costs of services, it is unlikely that these nominal fees approach the total cost of producing these services. Nevertheless, evaluations of some cost recovery initiatives have shown that they can provide an important source of revenues for the EPI. For example, the EPI contract system in Hebei Province, People's Republic of China, raised 9 million yuan (US\$1.9 million) in 1986, while paying out compensation totaling only 10,000 yuan (US\$2,128), providing evidence that the system is "an extremely effective way of raising funds for EPI in low disease-incidence situations."<sup>1</sup> An estimate of the total cost of the EPI in that province is not available for comparison.

Several studies have been done of Bamako Initiative programs in Africa. These programs generate funds for primary health care through charges for services and/or the sale of medications at a percentage markup. As will be discussed in Section II, health centers in Benin were able to generate an average of 43 percent of their total costs, while in Guinea the health centers recovered, on average, 47 percent of their total costs. In both cases, a wide range of revenue generation capacity was observed among health centers, with rural health centers experiencing much more difficulty in covering their costs than urban health centers. In some health centers, this program provides a potential to cross-subsidize EPI costs or free up government resources for EPI.

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<sup>1</sup>S.W. Jarrett, "Financing Immunization of Children in China," *Future* 26-27, Autumn-Winter 1989, p. 55. See the Country Summary in Appendix B for details on the EPI contract system in China.

#### **4. Impact on Utilization**

Cost recovery mechanisms often have an impact on the utilization of services through the financial incentives or deterrents they create. Few studies have been made of the impact of cost recovery mechanisms on use of immunization services in developing countries. Proponents of the contract systems in China and Vietnam assert that these systems support utilization because families prepay for the full immunization of their infants and compensation is paid only if the recommended schedule was followed. A survey of communes in Vietnam where a contract system was pilot tested showed that most mothers were ready to pay and were requesting full immunization of their children. Immunization coverage increased and disease incidence decreased in the survey area. Other studies of the effect of price changes on health services utilization in developing countries have shown differing results, with some demonstrating significant declines in the demand for services when prices rise (high price elasticity of demand), while others have found little impact (low price elasticity). These varying results indicate a need for further research into this issue.

#### **5. Health Financing Policy Context**

In the overwhelming majority of countries, the stated policy of the government was to provide free immunization and primary health care through the ministry of health. In this context, the variety of cost recovery initiatives found in the public sector indicates that government policy and practice often differ, especially at the local level. The inadequacy of government health budgets, in conjunction with government free-care policies, has failed in some countries to ensure sufficient resources at the local level. This situation has increasingly resulted in efforts on the part of individual health facilities, communities, and local governments to generate additional resources through cost recovery and alternative financing schemes.

Even at the national level, the evolving nature of health financing often requires that policy lag somewhat behind practice. Policy-makers usually prefer that initial steps towards cost recovery be tested on a pilot basis. Pilots can be assessed for their acceptability to users, as well as their ability to generate additional revenues while not discouraging utilization before being enshrined in policy.

#### **D. Implications of the Findings**

##### **1. Multiplicity of Approaches**

The number and variety of cost recovery mechanisms reported in this survey indicates that many countries are currently grappling with the issue of health services financing. Some cost recovery efforts have been linked directly to service provision (e.g. fees for shots, prepayment for full immunization) while others have been linked to unrelated services or products (e.g. Bamako Initiative, earmarked taxes, cross-subsidization). Some efforts have attempted to tap alternative financing sources which are already in place, such as health

insurance or social security programs.

Often, a single country reported several unrelated local initiatives. This may imply that the community has perceived local resource needs and is trying to identify ways to meet these needs. Some countries which are undertaking major reforms of their entire health financing systems are also attempting to implement cost recovery for primary health care and the EPI.

This multiplicity of approaches shows that a widespread interest appears to exist in tapping non-budgetary resources for immunization and primary health care. This interest springs from concerns at the local and national levels about the adequacy of resources for the EPI both currently and in the future. Global initiatives to add new and improved vaccines to the EPI and set targets for eliminating or controlling specific diseases are likely to add to these concerns and increase the financial burden on countries. In the next few years, it would not be surprising to note an increase in countries' efforts to generate additional resources for immunization through alternative financing mechanisms in order to meet the rising costs of immunizing their population.

## **2. Revenue Generation and Utilization**

Cost recovery and alternative financing mechanisms for immunization and other primary health care interventions may be able to generate needed local resources to support Universal Childhood Immunization and sustain this coverage into the future. More thorough evaluations of both the revenue generation capacity and the effect on utilization of cost recovery mechanisms are necessary to understand more fully their implications for financing immunization and primary health services. It appears that few countries have tried or been able to generate a large amount of resources by targeting cost recovery efforts solely on the EPI. Experiments which have linked revenue generation to other services (e.g. primary health care, provision of drugs) have been shown in some cases to produce sufficient funds to contribute to financing of the EPI at individual facilities. However, little is known about the ability of such programs to provide substantial resources at a national scale on an ongoing basis.

In many countries, local resources generated through cost recovery efforts may not be able to be converted into foreign exchange necessary to purchase immunization supplies and equipment. Funding needs for this type of expenditure will remain in these countries even if 100 percent of the EPI costs can be generated in local currency.

The greater the resource gap which the EPI attempts to fill through alternative financing mechanisms, the greater the amount of resources that will need to be generated and, as a result, the more attention planners will need to pay to the demand for immunization. In order for individuals or communities to be willing to bear an increased financial cost, they must perceive real benefits from these services. This requires that added attention be given to communicating these benefits to the population and obtaining their feedback on service quality, resource needs, and other issues.

Moreover, the selection of financing mechanisms must be monitored for impact on utilization, particularly by the poor. Where appropriate, waiver mechanisms for low income households can and have been developed. For example, a prepaid health card scheme in Thailand provided free health cards to people with an annual income below 3,500 baht (US\$200). These cards allowed the holders to receive treatment for a specific number of illness episodes and to receive free immunization and maternal/child health care. Some of the poor were asked to contribute labor and were given a card covering fewer illnesses than the paid card, thus restricting use of the exemptions to the very poor.<sup>2</sup> Such waiver systems can ensure that utilization of immunization services by the most needy is not adversely affected by cost recovery efforts.

### **3. Overall Health Financing Context**

Cost recovery mechanisms for EPI or PHC should be assessed in the context of the financing of health services in the country as a whole. The range of experience reported in this survey indicates that many financing mechanisms for immunization and PHC may be appropriate in different circumstances. The Republic of Korea has achieved very high immunization coverage financed through universal health insurance and delivered largely via private sector clinics. The LAC region is rapidly approaching the eradication of polio from the Americas relying almost exclusively on government and donor financing. In each case, financing mechanisms were chosen to enable both covering the costs of immunization and achieving high utilization. Also in each of these examples, the financing of immunization follows the financing pattern of the health sector overall. In Korea, private sector provision and insurance financing are the most important elements of the health financing system; in most Latin American countries, public health services are seen as a government responsibility and are provided and financed by ministries of health.

As discussed earlier, health financing policy and practice were often found to differ. Over time, financing policy and practice will probably need to be brought into line in a way that ensures sufficient resources are available to meet the national EPI goals. The eventual mix of public and private financing and service provision will continue to differ substantially among countries. Ideally, however, the financing mechanisms chosen will enable immunization efforts to be funded adequately while not posing unsurmountable financial deterrents for families to immunize their children.

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<sup>2</sup>See Brian Abel-Smith and Ajay Dua, "The Potential of Community Financing of the Health Sector in Developing Countries," in Asian Development Bank, Economic Development Institute of the World Bank, and East-West Center, Health Care Financing, Proceedings from the Regional Seminar on Health Care Financing, 27 July-3 August, 1987, Manila, Philippines, pp. 58-59.

#### **4. Next Steps**

**In-depth field evaluations of some of the mechanisms which were identified in this study would contribute to a better understanding of these mechanisms. Field evaluations would also contribute to the development of guidelines for assessing alternative financing mechanisms in other countries. Such guidelines would help countries develop the most productive and appropriate strategies for generating additional revenue for immunization in their own country context.**

## **II. REGIONAL REPORT FOR AFRICA**

### **A. The EPI in Africa**

The EPI began in Africa in 1978. Progress in reaching the target population of children less than one year of age was slow in the first six years of implementation, with average coverage rates of 30 percent for the first dose of DPT. Drop-out rates between the first and third doses of DPT and OPV were high and measles coverage rates low (5%). National immunization programs had to overcome logistical difficulties and insufficiency of financial, human and material resources to accomplish ambitious objectives.

Beginning in 1984, UNICEF supported a worldwide movement to accelerate immunization coverage, particularly in Africa. Between 1984 and 1989, nearly all African countries conducted national or local-level immunization campaigns.<sup>3</sup> Most of these campaigns were opportunities to supply national programs with essential material infrastructure for immunization delivery, such as cold chain equipment, vehicles, syringes, and needles, among other supplies.

Acceleration efforts generally increased average immunization coverage. In July 1990, regional coverage of children less than one year of age was estimated by the World Health Organization (WHO) to be 67 percent for BCG and 47 percent for DPT3, polio3, and measles. Twenty-five percent of pregnant women in the region have been immunized with at least two doses of TT.<sup>4</sup>

While tremendous gains in coverage have been made, programs in Africa are particularly vulnerable to recent declines in donor funding of EPI recurrent costs. A major issue for African immunization programs in the 1990s will be how to finance the costs of EPI to maintain or expand services so that gains in coverage made in the previous decade are not eroded.

New initiatives to eradicate polio, eliminate neonatal tetanus, and reduce measles incidence have received priority in the region. In 1989, eight countries in the African region reported zero cases of polio. However, in many countries efforts to reduce or eliminate these specific diseases are still in the planning phase. Substantial progress remains to be made before many countries in the African region reach their immunization coverage and disease control goals.

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<sup>3</sup>Michael Favin, "Acceleration of Immunization: An Assessment," mimeo prepared for UNICEF, 1987.

<sup>4</sup>Expanded Programme on Immunization Global Advisory Group, World Health Organization, report on the 13th Meeting, October 14-18, 1990, in Cairo, Egypt.

## **B. The Economic Context<sup>5</sup>**

Many sub-Saharan African countries experienced severe economic crises during the 1980s, in part due to declining world commodity prices. The African region underwent the greatest decline in real per capita GDP of any region during the 1980s. In many countries, living standards fell to 1960 levels by the end of the decade. From 1980 to 1989, real per capita GDP in the region fell by 2.2 percent annually. This rate of decline exceeds that of the LAC region (0.6 percent) and contrasts with positive real per capita growth rates in Asia and the Near East. High population growth rates in the region continue to be a problem. While the World Bank estimates that total GDP in the region will grow by 3.7 percent annually from 1989 to 2000, projected population growth rates are likely to result in a net 0.5 percent per capita GDP growth rate during the same period.

Discouraging economic growth rates are coupled with already low levels of economic development in most countries in the region. In many African countries, per capita GDP in 1988 was below US\$500, with a range from \$74 in Mozambique to \$1,617 in Botswana. In contrast, many countries in Asia/Near East and most in Latin America and the Caribbean have per capita GDPs well over \$1,000.

Stagnating economic growth in Africa combines with other factors to increase poverty in the region. From 1985 to 2000, the World Bank projects that the number of people living in poverty in Africa will rise by nearly 100 million. In contrast, the absolute number of poor in all other developing regions is expected to decrease significantly.

## **C. Health Financing Patterns in the Africa Region**

During the economic crises of the 1980s in Africa, government allocations to the health sector generally decreased. As is true in most of the world, curative health services consume the largest proportion of total health expenditures. Health services in Africa are delivered primarily by ministries of health, though non-governmental and church mission organizations also provide health services in selected sites and regions and, in some countries, provide a major alternative source of care.

Until recently, almost all African governments followed policies of "free care" for most services provided by ministries of health. These policies do not mean, however, that people have not had to pay for health and medical services in the public sector. Lack of uninterrupted drug supplies in public health facilities often makes it necessary for individuals to purchase medications at local pharmacies. Many ministries of health also have policies requiring payment for some hospital-based services, though these are often nominal and unevenly implemented.

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<sup>5</sup>Information for this section was drawn from the World Bank's World Development Report 1990 (Washington, D.C.: World Bank, 1990).

Estimates of the percentage of health services financed privately in African countries, including services provided by private sector providers, range from 48% in Botswana to 73% in Ghana.<sup>6</sup>

The instability of drug supply, apparent willingness of individuals to pay for health services, especially medicines, and declining resources in the public health sector have led ministries of health to consider introducing user charges for primary and preventive health care, as well as for hospital services. For example, African countries recently adopted the principles of the Bamako Initiative. One of the goals of the Initiative is to improve primary health care services by ensuring a stable supply of essential drugs through revolving funds managed at the local level. Under this scheme, some health facilities have been able to generate sufficient revenues to cover all or a portion of their operating costs.<sup>7</sup>

#### **D. Findings in the Africa Region**

The national policy in all 34 African countries included in this review is to provide immunization and primary health services free of charge to the population. However, there is an apparent contradiction between national policy and practice: 21 (62%) of the African countries reported some kind of cost recovery mechanism specifically for immunization in the public (20 countries) or private (1 country) sector. In 20 African countries, fee-for-service or prepayment strategies for PHC not specific to immunization are operational at national or local levels in the public sector. This prevalence of cost recovery activities, in spite of national "free care" policies, reflects the extensive experimentation with alternative financing schemes in sub-Saharan Africa.

For example, pilot studies initiated by the national government are underway in specific localities in an effort to evaluate whether user charges or other financing strategies would be an effective way to reduce the gap between the cost of providing services and declining ministry of health budgets. In addition, non-governmental organizations frequently provide health services to their communities on a fee-for-service or fee-for-episode basis. Finally, some cost recovery activity was reported for private practitioners, who, as expected, charge for immunization services.

Survey findings indicate that fees for immunization services and/or cards are the most prevalent method of cost recovery for EPI in Africa. Twelve African countries (35%) reported that fees are charged for immunization or Road-to-Health cards. Of these 12 countries, fee-for-

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<sup>6</sup>David de Ferranti, Paying for Health Services in Developing Countries: An Overview, World Bank Staff Working Paper Number 721 (Washington, D.C.: World Bank, 1985).

<sup>7</sup>International Children's Center, "The Bamako Initiative: Primary Health Care Experience," Children in the Tropics, No. 184/185, 1990.

Table 4: Summary of Cost Recovery and Financing Mechanisms for Immunization  
Africa Region

Country	Fee per Shot/Series	Fee for Card	Pre-payment	Cross-Subsidiz.	Social Insurance	Earmarked Tax(es)	Fund Raising	Lottery	Voluntary Contrib. (cash)	Voluntary Contrib. (labor/kind)	Fee or Prepayment for PHC
Angola	--	--									--
Benin		L									L
Botswana	--	--		N							N
Cent. Afr. Rep.									N	N	L
Congo	L	L	L								L
Cote d'Ivoire	L	N									L
Djibouti	--	--					L				L
Ethiopia	--	--			N						
Gabon		L								N	--
The Gambia		N									*
Ghana	N	N	--								N
Guinea		N	N			L	L				N
Guinea-Bissau	--	--		N							N
Kenya											N
Lesotho		*		N							L
Liberia		N									L, PVO
Madagascar	--	--									PVO
Malawi	--	--									N, PVO
Mali		N									--
Mauritius	PS	--									--
Mozambique	--	--									L, PVO
Namibia	--	L	--								PS
Niger	--				*						N
Nigeria		N									N
Rwanda	--	--									*
Senegal	N										L, PVO
Sierra Leone	--	*	--	*							N, PVO
Somalia	--	--								L	N, L, PVO
Sudan	--	--									N
Swaziland		N		L		L			L	L	--
Tanzania	--	--	--	--							N, PVO
Uganda				*							
Zaire											*
Zimbabwe	--	--			N		L				N
Total: Pub./Priv.	4/1	12/0	2/0	4/0	2/na	2/na	3/0	0/0	2/0	5/0	20/9

Note: Cost recovery mechanisms which are no longer in effect or are under consideration are not included in totals.

Key:

N = at national level

L = at local or regional level

PS = in private (for-profit) sector

PVO = by PVOs/NGOs

-- = reported not to exist

() = no longer in effect

\* = under consideration

Blank indicates no information available

na = not applicable

17

card strategies operate at the national level in eight countries and at the local or district level in four. According to survey findings, the cost for a vaccination or Road-to-Health card is usually minimal (e.g., ranging from US\$0.02 to \$0.07).

Fees for immunization services -- per injection or per series -- were the next most common cost recovery method. Four countries (12%) reported the existence of this cost recovery method in the public sector, either nationally (Ghana and Senegal) or locally (Congo, Côte d'Ivoire). The survey produced limited information on fees for immunization services in the private sector. One country, Mauritius, noted the existence of private practitioner charges specifically for immunization.

Other types of strategies include entry fees at public health facilities to cover some immunization program costs (The Gambia). Prepayment for immunization services also exists in the region. For example, in one regional project in the Congo, mothers register each newborn child and pay \$3.50. Children are followed for two years and receive immunizations and preventive services.

Eight countries (24%) had experience with local fundraising or voluntary contributions for immunization programs. Countries which have organized national or local immunization campaigns often have experiences with significant mobilization of community resources for transportation, food and voluntary labor.

An ingenious strategy proposed to finance immunization program costs at the local level is the sale of energy derived from solar energy panels. In Zaire, a pilot project is underway to install solar cold chain equipment with a higher-than-needed capacity in order to sell the surplus energy to the community for charging batteries.

In the Central Region of Sudan, legislation was passed to tax bus fares and cinema tickets. The revenue generated from this scheme amounted to nearly \$40,000 in the mid 1980s and was used to finance child health. In Darfur, another region of Sudan, some districts have levied a periodic earmarked tax on sugar to raise local funds for the EPI.

Twenty of the African countries (59%) reported some type of fee or prepayment mechanism in operation for primary health care in the public sector; nine countries (26%) reported this method for the private or PVO sector. Many of these instances involve revolving drug funds. In these strategies, essential drugs are sold at a markup price to help defray recurrent costs, such as costs of transportation, storage of drugs, replacement of drugs supply, remuneration of health workers, and supervision.

In the context of the Bamako Initiative, the national EPIs in Guinea and in Benin have adopted the priority that some of the local operating costs (e.g., kerosene for cold chain and sterilization equipment, fuel for motorcycles) be financed through cost recovery at the health centers. A evaluation of an early phase of the initiative in Benin estimated that revenue from fees for services and medications covered, on average, 43% of overall costs of health center

operations. In Guinea, revenue from fees for drugs and health cards covered an average of 47% of all operating costs at the health facility level, though the cost recovery ratio varied widely from center to center.<sup>8</sup>

Findings from the literature review conducted for this report suggest that several factors need to be considered when analyzing cost recovery for immunization and PHC in Africa. First, there is a paucity of information on the total revenues generated and cost recovery rates for any of the strategies reported for Africa. Second, the sale of vaccination cards has been instituted in countries more as a method of attributing value to the card to increase retention rates, than to raise revenues per se. Finally, fees for services may provide some revenue for operating costs requiring local currency (e.g., for office supplies and salaries). But, in countries with foreign exchange constraints, these strategies do not resolve problems related to the foreign exchange that is usually necessary for procurement and replacement of cold chain equipment, vehicles, and fuel.

Other considerations regarding implementation of cost recovery strategies for EPI and PHC in Africa include the following:

- a) Pricing policies have often been weak and do not adequately reflect costs of providing services. Results reported for cost recovery efforts often exclude costs of salaries, equipment amortization, drugs, vaccines, technical assistance and supervision/management.
- b) There is a need for feasibility studies to assess the break-even point of revolving funds and other community strategies. Many community schemes in Africa have had trouble becoming self-sufficient.
- c) There have been few well-designed studies of the impact of user fees on utilization rates for immunization services.
- d) Decentralization of management and retention of revenues at health facilities are often said to contribute to higher cost recovery rates and sustainability of cost recovery strategies. Many of the African experiences with generating resources for EPI in this review would provide useful case studies for more systematic analysis of these approaches.

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<sup>8</sup>Children in the Tropics, op. cit.

### **III. REGIONAL REPORT FOR ASIA AND THE NEAR EAST**

#### **A. The EPI in Asia and the Near East**

The Expanded Program on Immunization was initiated in Asian and Near Eastern countries in the late 1970s. Overall coverage for the region surpassed 75 percent for DPT3 and polio3, 80 percent for BCG, and 60 percent for measles in 1988-89.<sup>9</sup> However, these figures obscure a wide variation among countries. For DPT3, country-level coverage ranges from 17 percent to 97 percent; the range in polio3 coverage is from 17 percent to over 99 percent; for measles, the range is from 15 percent to 99 percent; and BCG coverage varies from 27 to 100 percent. In general, fairly well-to-do countries in the Near East tend to be at the high end of the range, while poor countries in South and South-East Asia tend to have coverage at the low end of the range.

TT coverage for pregnant women and women of childbearing age lagged behind infant immunization coverage, particularly in the Near East, where two countries report coverage for pregnant women of less than ten percent. A few countries, however, have made significant gains in coverage for pregnant women, including Saudi Arabia (TT2+ = 62% in 1989) and Maldives (TT2+ = 83% in 1989).

Most countries in Asia and the Near East (ANE) have adopted goals for polio eradication, elimination of neonatal tetanus, and reduction of measles by 1995 or 2000. In countries where disease surveillance and reporting systems are still weak, attention is being placed on improving them to support these efforts. Several countries are considering the addition of new or improved vaccines to the EPI, particularly hepatitis B vaccine. The cost of this vaccine raises concerns regarding the implications for the financial viability of the EPI.

Sustainability has been an issue of growing concern for many countries in the region. For example, WHO's South East Asia Regional Office (SEARO) has made financial sustainability of the EPI one of its key objectives in the coming years. Currently, approximately 63 percent of the total costs of the EPI in the SEARO region are funded by national governments, with most of the remaining costs being met by international donor agencies.<sup>10</sup> In several countries in the SEARO region, national governments are funding less than half of their EPI costs. A substantial increase in government funding for the EPI to support the goals of polio eradication, NNT elimination, and measles reduction, as well as the addition of new and

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<sup>9</sup>Expanded Programme on Immunization Global Advisory Group, World Health Organization, report on the 13th Meeting, October 14-18, 1990, in Cairo, Egypt.

<sup>10</sup>See I. Mochny, A. Fric, G. Presthus, and N. Srivastava, EPI in South East Asia: Sustainability (New Delhi: WHO/SEARO/EPI, 1989).

improved vaccines, would put a strain on limited national resources of some of the poorest countries in Asia and the Near East.

## **B. The Economic Context<sup>11</sup>**

As a group, countries in Asia and the Near East showed positive economic growth during the 1980s, in contrast to their counterparts in Africa and Latin America during the 1980s. Economic growth rates in Asian countries in particular outpaced growth in countries in all other regions included in this review. Growth in real per capita gross domestic product (GDP) from 1980 to 1989 in South Asia averaged 3.2 percent, while countries in East Asia achieved 6.7 percent growth. The growth rate in the Near East was less than one percent. In comparison, real per capita GDP in Latin America and the Caribbean fell by 0.6 percent per year, and shrank by an annual rate of 2.2 percent in sub-Saharan African countries.

These averages mask striking differences among countries in the ANE region in level of development and recent economic performance. For example, per capita GNP in Bangladesh in 1988 was only US\$170, while the Republic of Korea, Oman, and several other countries in the region had per capita GNPs over US\$3,000 per year. Similarly, Korea's average annual GNP growth rate from 1965 to 1988 was almost 7 percent, while Bangladesh's economy grew at less than one half of one percent per year during the same period.

These economic differences are reflected in disparate health infrastructures, as well. In many poorer countries, governments find it difficult to extend essential PHC to the entire population, while other nations have developed sophisticated medical services comparable to those available in Europe or the U.S.

## **C. Health Financing Patterns in the ANE Region<sup>12</sup>**

The Asia and Near East countries present a diverse set of experiences both in terms of total spending per capita on health and patterns for financing health services. One study of 12 Asian countries found that per capita health spending from all sources ranged from US\$2 per capita in Nepal to over US\$140 per capita in the Republic of Korea. This study found that per capita health expenditures as a proportion of per capita GDP was lowest in the poorest countries

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<sup>11</sup>Information for this section was drawn from the World Development Report 1990 (Washington, DC: World Bank, 1990).

<sup>12</sup>Much of the information in this section was drawn from the country papers in Health Care Financing, Proceedings from the Regional Seminar on Health Care Financing, 27 July-3 August, 1987, Manila, Philippines, co-sponsored by the Asian Development Bank, the Economic Development Institute of the World Bank, and the East-West Center.

in the region.<sup>13</sup>

A wide variety of patterns of financing these expenditures can be observed in Asia and the Near East. In most countries, the government plays a significant if not predominant role in financing and/or delivering health services. The public sector's share of national health expenditures ranges from one quarter to over 90 percent, indicating diverse perceptions of the role of the public sector in financing health services and differing resource levels available to the government. Many governments in the region, faced with growing health care costs and inadequate government resources, are beginning to explore alternative financing mechanisms, including community financing, user fees, insurance, and an expanded role for the private sector.

Even in countries where the government provides free health services, the private sector plays an important role in service provision. The private sector is particularly important in service provision in some of the more developed countries in the region, such as the Republic of Korea. Moreover, private expenditures play an important role in the financing of health services. These private expenditures include fees paid to private providers, purchase of pharmaceuticals, insurance premiums, co-payments, and user fees paid to government health facilities. User fees constitute a major source of revenue to public facilities in some of the countries in the region (e.g. Thailand), while in other countries fees are nominal or nonexistent (e.g. Papua New Guinea, Sri Lanka).

Few countries in the Asia/Near East region have comprehensive social insurance programs, unlike Latin America, where social security programs play a very significant role in service provision and financing in nearly every country. In some countries, social insurance programs are nonexistent or cover only a small proportion of the population which works for the government or in selected industries. Other programs cover only job-related injuries. Several countries, including Indonesia, the Philippines, and Papua New Guinea, have begun to consider expanding insurance programs to cover a larger proportion of the population. In China, social insurance covers 20-30 percent of the population.

The Republic of Korea has the most extensive insurance system in the countries reviewed. In that country, the vast majority of health services are provided by the private sector and financed through a combination of government-mandated health insurance and household payments. Mandatory participation in an insurance program has been universal since mid-1989. In 1986, health expenditures financed through insurance premiums outweighed government health expenditures by two to one. Combined with medical assistance for the poor, universal insurance coverage ensures that everyone has access to health services.

Community contributions to health financing can be found in nearly every country in the

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<sup>13</sup>Charles Griffin, Health Sector Financing in Asia, World Bank Internal Discussion Paper, Asia Regional Series, Report No. IDP 68 (Washington, DC: World Bank, 1990), pp. 7-8.

region. Such contributions are particularly important in the rural areas of China, where many cooperatives provide annual lump-sum compensation to village doctors in return for their health services. Collective expenditures on health in China make up almost 30 percent of total national health expenditures, with private expenditures less than 20 percent and government expenditures just over 50 percent.

#### **D. Findings in the ANE Region**

While the above description demonstrates that the health sector in most ANE countries draws upon a wide variety of financing sources, country policies for financing immunization and preventive care reflect a belief that government should play the predominant role in financing these services. In nearly every country surveyed, government policy stipulates that immunization and primary health care will be provided free of charge at public facilities.

Although the findings in the African region demonstrated that much experimentation is underway and financing policy and practice do not always coincide, in most countries in the ANE region immunization services are in fact provided free of charge in the public sector, as shown in Table 5. Only China reported that fees are charged for immunization services in many parts of the country. One country (Laos) noted that the public sector charges a small fee for an immunization card.

As was the case in the financing of the health sector overall, the private sector also plays a role in the provision and financing of immunization and PHC. In nearly every country, some proportion of the population seeks immunization services from the private sector. In 10 countries (37%), respondents reported that fees were charged in the private sector and/or by PVOs. In the Republic of Korea, the majority of immunization services are provided by private clinics. In most other countries a relatively small percentage of people go to private physicians and clinics for immunization services. In general, it is the upper income segments of the population that seek private sector services because their higher incomes allow them to take advantage of perceived quality differences and the shorter waiting time normally found at private clinics. Some governments (e.g. Oman) provide vaccines to private physicians free of charge in order to encourage them to provide immunizations.

Five countries (19%) reported that immunization services were paid for and/or provided by social insurance programs. However, as noted above, in many of these countries social insurance programs cover only a limited segment of the population. In Korea, where the entire population is covered by health insurance, 80 percent of private sector charges for immunization can be reimbursed. Individuals may also obtain free vaccinations at public health clinics.

Some countries have introduced innovative schemes which aim to increase the funds available to the EPI as well as to motivate parents to complete the immunization of their children. China and Vietnam have both instituted an insurance or contract system for the EPI in some regions. Under these systems, parents usually pay a fixed fee which covers all required

Table 5: Summary of Cost Recovery and Financing Mechanisms for Immunization  
Asia/Near East Region

Country	Fee per Shot/Series	Fee for Card	Pre-payment	Cross-Subsidiz.	Social Insurance	Earmarked Tax(es)	Fund Raising	Lottery	Voluntary Contrib. (cash)	Voluntary Contrib. (labor/kind)	Fee or Prepayment for PHC
Afghanistan	--	--	--	--	--	--	--	--	--	--	--
Algeria	--	--	--	--	--	--	--	--	--	--	--
Bangladesh	PS	--	--	--	--	--	--	--	--	--	--
Bhutan	--	--	--	--	--	--	--	--	--	N	N
China (PRC)	L	--	L	--	N	--	--	--	--	L	--
Egypt	--	--	--	--	--	--	--	--	L	--	L
India	PS	--	--	--	N	--	N	--	--	--	--
Indonesia	PS	--	--	--	--	--	L	--	--	L	L
Iran	PS	--	--	--	--	--	--	--	N	--	N
Korea (Rep. of)	PS	--	--	--	N	--	--	--	--	--	--
Laos	--	N	--	--	--	--	--	--	--	--	PS
Lebanon	PVO, PS	--	--	--	N	--	--	--	--	--	--
Kalaysia	PS	--	--	--	--	--	--	--	--	--	--
Maldives	--	--	--	--	--	L	--	--	PVO	PVO	PS
Morocco	--	--	--	--	--	--	--	--	--	L	--
Myanmar	--	--	--	--	--	--	--	--	--	--	--
Oman	PS	--	--	--	--	--	--	--	--	L	--
Pacific Islands	--	--	--	--	--	--	--	--	--	--	--
Pakistan	--	--	--	--	--	--	--	--	--	--	PS
Papua New Guinea	--	--	--	--	--	--	--	--	--	--	--
Philippines	--	--	--	--	--	--	--	--	--	--	*
Sri Lanka	--	--	--	--	--	--	--	--	--	--	--
Syria	--	--	--	--	--	--	--	--	--	--	--
Thailand	PS	--	L	--	--	--	--	--	--	--	--
Tunisia	PS	--	--	--	--	--	--	--	L	--	L
Yemen	--	--	--	--	N	--	--	--	--	L	--
Vietnam	--	--	L	--	--	--	--	--	L	L	--
Total: Pub./Priv.	1/10	1/0	3/0	0/0	5/na	0/na	3/0	0/0	3/1	8/1	5/3

Note: Cost recovery mechanisms which are no longer in effect or are under consideration are not included in totals.

Key:  
 N = at national level  
 L = at local or regional level  
 PS = in private (for-profit) sector  
 PVO = by PVOs/NGOs  
 -- = reported not to exist  
 () = no longer in effect  
 \* = under consideration  
 Blank indicates no information available  
 na = not applicable

AC

childhood immunizations. Provided the child completes all of his or her immunizations according to the recommended schedule, the system will compensate parents if the child contracts one of the EPI target diseases. Usually this compensation covers only the cost of treatment. Proponents of this type of system argue that it provides important revenues for the EPI and encourages parents to ensure that their child completes all recommended immunizations on time. In China, similar insurance systems also exist in some regions for other preventive programs.

Local communities in many countries have contributed labor and goods to support immunization and PHC services. Three countries (11%) reported fundraising efforts, four (15%) noted that households sometimes made voluntary cash contributions when they brought their children for immunization, and nine (33%) stated that voluntary contributions of labor or goods had been given to support the EPI. In Indonesia, voluntary contribution of labor is a vital component of the posyandu system of primary health care provision.

PVOs or NGOs play an important part in service provision in many lower income countries. Many of these organizations charge a nominal fee for PHC and immunization services. For example, NGOs in Lebanon charge from US\$0.50 to 1.00 for immunization. In some countries, PVOs seek voluntary contributions from those receiving services or raise funds among the community at large. Rotary India, which raises funds throughout the country, is a major contributor to India's polio control efforts.

Concerning primary health care other than immunization, eight countries (30%) reported that fees were charged or prepayment plans were in effect for PHC at government or private sector facilities. User charges for primary health services are being considered in Papua New Guinea as part of efforts to revise the financing of the health sector as a whole.

While many of the cases of cost recovery found in Asia and the Near East were local or regional, they point to a wider variety of financing mechanisms used for EPI than may have been previously understood by the international community. Evaluations of the efficacy of these programs (e.g., in terms of resource generation capability) and their impact on health status and equity would provide valuable insight for the EPI and other primary health care interventions worldwide.

#### **IV. REGIONAL REPORT FOR LATIN AMERICA AND THE CARIBBEAN**

##### **A. The EPI in Latin America and the Caribbean<sup>14</sup>**

The Expanded Program on Immunization was initiated in the Latin American and Caribbean (LAC) region in 1977. Since that time, significant progress has been made in immunization coverage. For example, in 1978 only 35 percent of the infants in the region had received three doses of polio vaccine.<sup>15</sup> By 1988, coverage of children under one with polio<sup>3</sup> had risen to 82 percent. Coverage rates for infants with other vaccines also attained a record high in 1988, with the percent of infants receiving vaccine by their first birthday reaching 59 percent for DPT3, 63 percent for measles, and 70 percent for BCG.

These coverage rates, high compared to those found in other regions, mask a wide variation in national rates. For example, coverage in 1988 with three doses of DPT vaccine ranged from a low of 39 percent in Bolivia and the Dominican Republic to a high of 97 to 98 percent in several Caribbean nations. These variations reflect the contrasting economic status of countries in the region, disparities in health infrastructure, and differences in population characteristics.

The LAC countries have undertaken a major initiative to eradicate polio in the region. Two important components of this initiative are national vaccination days and improved disease surveillance. These efforts have reduced the number of confirmed cases of polio from 947 in 1986 to 10 in 1990. The polio eradication effort was intended to work within and strengthen the EPI as a whole.

Progress is also evident for another EPI target disease, measles. Measles in the English-speaking Caribbean has reached an all-time low, with several countries reporting no cases for five years or more. Indeed, the ministries of health in the English-speaking Caribbean have set a target to eliminate measles by 1995.

Efforts continue to improve and maintain immunization coverage in the region. Several major challenges remain for the EPI in the region, including reducing missed opportunities for immunization, lowering high drop-out rates from the first to the final dose of vaccine, and improving disease surveillance. Disease surveillance for EPI target diseases other than polio, including measles, neonatal tetanus, and pertussis, remains underdeveloped.

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<sup>14</sup>This overview draws on the report of the 13th meeting of the Expanded Programme on Immunization Global Advisory Group, October 14-18, 1990, in Cairo, Egypt.

<sup>15</sup>From mid-term evaluation of USAID Grant Number CAR-0005-G-00-6971-00 to PAHO for the Child Survival Accelerated Immunization Project, August 1989.

## **B. The Economic Context**

Since the early 1980s, the LAC region has been beset by a serious economic crisis which has resulted in declining and even negative rates of real GDP growth per capita. These low growth rates contrast sharply with strong positive economic growth in the 1960s and early 1970s. For the region as a whole, annual real GDP growth per capita fell from 3.7 percent during the period from 1965-1973, to 2.6 percent from 1973-1980, to -0.6 percent from 1980-1989.<sup>16</sup> This economic crisis has been linked to rapid growth in external debt servicing requirements.

Government efforts to address the macroeconomic crisis have often resulted in reduced levels of public spending on health care, particularly on investment and non-personnel recurrent expenditures (maintenance, supplies, etc.). One REACH study found that, on average, an increase in total debt service payments of US\$1 million was associated with a 1.0 percent reduction in the health sector's share of total public sector expenditures in the following year.<sup>17</sup> Similarly, a World Bank study found that the health sector was extremely vulnerable to falling government expenditures.<sup>18</sup> Overall, health expenditures were found to decline 25 percent more than government expenditures during the period from 1980-88. Moreover, within the social sectors, the economic crisis was found to have a greater impact on the health sector than on education or other social sectors. Health budgets have tended to be cut more than budgets for most other sectors when public sector budgets are reduced. Quality of care has declined as the physical plant of government facilities deteriorates and drugs and other medical supplies become scarce. The decrease in public health spending has occurred at the same time that rising unemployment and falling incomes have increased the demand for free or low cost government health services.

## **C. Health Financing Patterns in the LAC Region**

Three main sources of financing for health care exist in the LAC region: government funding from general tax revenues; social security supported by employer, employee, and government contributions; and private financing (including out-of-pocket expenditures for

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<sup>16</sup>World Bank, World Development Report 1990 (Washington, DC: World Bank, 1990), p. 11.

<sup>17</sup>Jack Fiedler and Larry Day, "Health Sector Financing and External Debt in the Developing World," REACH/JSI, unpublished paper, 1990.

<sup>18</sup>Margaret Grosh, Social Spending in Latin America: The Story of the 1980s, World Bank Discussion Paper No. 106 (Washington, DC: World Bank, 1990), p. 19.

services and drugs, employer-sponsored insurance programs, and NGO health services).<sup>19</sup> In each country, the relative contribution of each source of financing differs. For example, social security programs play a very minor role in health financing in some English-speaking Caribbean nations, while in many Latin American countries they make up one-third of all health expenditures in the country.

Throughout the region, immunization and other primary health care services are seen as the responsibility of ministries of health. Government policy in the region has been to provide these services free of charge to all. Moreover, these ministries are expected to provide curative health services to the poor for free or at low cost. Health services provided by ministries of health are supported almost exclusively through the general tax revenues that fund the government health budget, although user fees are charged for some government health services in some countries. For hospital services, in particular, user fees exist in several countries in the region and sometimes make up an important source of financing for the recurrent costs of these facilities.<sup>20</sup>

Social security programs, where they exist, often cover only a limited population employed in urban areas. The coverage of these programs varies with the level of economic development of the country: On average, during the period from 1980-1985, just under 80 percent of the total population was covered by social security in the seven Latin American countries with GDPs per capita of US\$2,000 or more, while coverage in the nine countries with per capita GDPs below this level was only 14 percent.<sup>21</sup> Some social security programs provide basic health services in rural areas (e.g. Brazil, Mexico), but in general most benefits consist of urban, hospital-based, curative services.<sup>22</sup>

Private expenditures play an important role in the financing of services, accounting for

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<sup>19</sup>For a more thorough description of health financing patterns in the LAC region, see Gretchen Gwynne and Dieter K. Zschock, Health Care Financing in Latin America and the Caribbean, 1985-89: Findings and Recommendations, (Stony Brook, NY: SUNY, 1989).

<sup>20</sup>See Catherine Overholt, User Fees in Public Facilities: A Comparison of Experience in the Dominican Republic, Honduras and Jamaica (Arlington, VA: Resources for Child Health Project/JSI, 1989).

<sup>21</sup>Castellanos Robayo, Jorge, Notes on Health Care Programs Under Social Security in Latin America (Washington, DC: PAHO, 1990), Table 5.

<sup>22</sup>William McGreevey, Social Security in Latin America: Issues and Options for the World Bank, World Bank Discussion Paper No. 110 (Washington, DC: World Bank, 1990), pp. iii and 17.

between 20 and 40 percent of total health sector expenditures in the region.<sup>23</sup> Private out-of-pocket payments are, for the most part, concentrated on pharmaceuticals and private outpatient visits. Private insurance and prepayment plans have so far reached only well-off urban groups in most countries. While NGO facilities play an important role in service provision in some countries, most rely heavily on government and international donors for their financing.

#### **D. Findings in the LAC Region**

Table 6 illustrates the pattern found for financing of immunization services in the region. Following the overall pattern of health financing in the region, immunization is provided overwhelmingly by government health facilities funded by general tax revenues. In comparison with the African region, few cost recovery efforts have been attempted for primary health care in general or for immunization in particular. As in the Asia/Near East region, social insurance programs were found to play some role in financing and/or providing immunization and primary health care. Private sector providers also play some role in service provision for some socioeconomic groups. Overall, however, the variety and scope of cost recovery and alternative financing mechanisms found was less than that found in the other two regions studied.

Although immunization services are overwhelmingly financed by ministries of health, survey responses did report the existence of selected initiatives in cost recovery or alternative financing in several countries in the region:

- ◆ Two countries (Mexico and Honduras) have or are considering the use of lotteries to raise funds for EPI.
- ◆ One country (El Salvador) noted that individuals often make voluntary cash contributions to health facilities, which are then used to pay for extra personnel or unforeseen expenditures.
- ◆ Social security systems were reported to play a role in providing and/or financing immunization services in two countries (Costa Rica and Panama).
- ◆ Some individuals, particularly in upper income groups, prefer to seek immunization services from private physicians. No information was collected on the percentage of the population that seeks immunization services from private providers or on the fees charged in the private sector.

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<sup>23</sup>These figures are based on a review of health financing in 10 countries in the region conducted by the HCF/LAC Project of SUNY/Stony Brook. The countries studied were: Belize, Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Peru, and St. Lucia. See Gwynne and Zschock, *op. cit.*, pp. 12 and 40.

- ◆ **Voluntary contributions of labor, goods, and use of buildings have been made for the large-scale immunization campaigns which have been undertaken throughout the region in recent years. These contributions have been widespread and considered by many to be vital to their success.**

Table 6: Summary of Cost Recovery and Financing Mechanisms for Immunization  
Latin America/Caribbean Region

Country	Fee per Shot/Series	Fee for Card	Pre-payment	Cross-Subsidiz.	Social Insurance	Earmarked Tax(es)	Fund Raising	Lottery	Voluntary Contrib. (cash)	Voluntary Contrib. (labor/kind)	Fee or Prepayment for PHC
Argentina	--	--									
Bolivia	--	--									
Brazil	--										
Chile	--	--									PVO
Costa Rica	--	--									
Cuba	--	--			N						
Dominican Rep.	--	--									
Eastern Caribbean	--	L	--								
Ecuador	--	--					L				
El Salvador	--	--								L	
Guatemala	--	--							L		
Haiti	--	--									
Honduras	--	--					--				
Mexico	--	--									
Panama	--	--									
Paraguay	--	--			N				N		
Peru	--	--									N
Venezuela	--	--									
Total: Pub./Priv.	0/0	1/0	0/0	0/0	2/na	0/na	1/0	1/0	1/0	1/0	1/1

Note: Cost recovery mechanisms which are no longer in effect or are under consideration are not included in totals.

Key:

N = at national level

L = at local or regional level

PS = in private (for-profit) sector

PVO = by PVOs/NGOs

-- = reported not to exist

() = no longer in effect

\* = under consideration

Blank indicates no information available

na = not applicable

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## APPENDIX A<sup>24</sup>

### COUNTRY SUMMARIES: AFRICA REGION

#### Angola

##### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge.

##### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

#### Benin<sup>25</sup>

##### **A. National policy regarding payment for immunization and primary health care**

The national policy is to provide PHC services, including immunization, free of charge. However, given the acute shortage of resources in the health sector, the Ministry of Health is supporting many health projects which have developed community financing strategies to raise additional revenue for health.

##### **B. Financing schemes for immunization and/or primary health care**

In most of the community financing schemes immunization is provided free and mothers receive a child health booklet, in which immunization history and growth monitoring are recorded for children under age 3. Treatment cards for children over age 3 and for adults are sold for a nominal amount, 50 FCFA (\$0.17).

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<sup>24</sup>Unless otherwise noted, the source of information for each country presented in this Appendix is the UNICEF field offices' response to the REACH survey questionnaire described on page two of this report.

<sup>25</sup>International Children's Center (Paris), "The Bamako Initiative: Primary Health Care Experiences," in Children in the Tropics, No. 184/185, 1990.

Under the Bamako Initiative, most of the community financing strategies in Benin intend to cross-subsidize preventive health services such as EPI from revenues generated by payment for curative services and essential drugs.

### **Botswana**

#### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge. However, a nominal fee (\$0.10) is charged for non-MCH consultation registrations.

#### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist as a regular feature but local communities, private businessmen, and government workers made labor, financial, and food contributions during immunization acceleration days throughout 1986-1989.

### **Central African Republic<sup>26</sup>**

#### **A. National policy regarding payment for immunization and primary health care**

On March 23, 1989, national legislation was passed affirming that all citizens have the right to health and to free choice of health practitioners. However, the law clearly stipulates that these rights are subject to the financial participation of citizens for different services offered in public health facilities. The law says that the State will be responsible for health care expenditures of ill persons who cannot afford their care and are holding social assistance cards. It is not clear how the law will be applied to immunization services, which remained free of charge in public facilities in 1990.

#### **B. Financing schemes for immunization and/or primary health care**

Several community financing strategies for PHC services have existed and

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<sup>26</sup>REACH Publications, Proceedings from the Workshop on Health Care Financing in the Central African Republic (Arlington, VA: REACH, 1989) and Cost Recovery in the Central African Republic: Results from Two Preliminary Surveys and Selected Interviews (1987), and REACH staff communications.

several NGO health facilities, as well as public maternities in the capital, have experimented with fees for PHC and maternity services and medications.

### **People's Republic of the Congo**

#### **A. National policy regarding payment for immunization and primary health care**

Free access to health care is constitutionally guaranteed for all citizens of the Congo. However, given the acute shortage of resources in health facilities, patients usually pay for medications and hospitalizations.

#### **B. Financing schemes for immunization and/or primary health care**

No systematic financing schemes at the national level to raise revenue for EPI currently exist. Most of the costs of EPI are borne by the Ministry of Health and external agencies. It is understood, however, that local costs, such as those for kerosene and fuel to run refrigerators and sterilizers, have to be financed at the health center itself. As a result, health centers charge people for immunizations, usually US\$0.20-0.40 per shot, and/or Road To Health cards.

In one local scheme similar to the Bamako Initiative mothers must pay US\$3.50 each time a child is born and registered in the health center. Children are then followed for two years and receive all required immunizations and additional preventive services such as growth monitoring. The revenues generated are part of a payment scheme for PHC services which covers all the expenses of the center.

### **Côte d'Ivoire**

#### **A. National policy regarding payment for immunization and primary health care**

The national policy is to provide free access to all PHC services and immunization.

#### **B. Financing schemes for immunization and/or primary health care**

Although immunizations are free in public health facilities, mothers must purchase an immunization card, and in a few health centers, they are asked to

pay for disposable syringes, which are increasingly required due to awareness of AIDS. Consultation is free for PHC services but patients have to buy medications and supplies. The revenue collected from the sale of immunization cards is integrated in the budget of each health facility and is used to pay for operating expenses.

Revenue has also been generated for EPI at local levels using such strategies as sale of stamps during vaccination sessions, sale of cards, and charges for disposable syringes.

## **Djibouti**

### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge. Social insurance covers all employees in both public and private sectors.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist. Vaccination cards are free, but there is a charge of US\$.70 for a health card. Mobilization for EPI has been carried out by volunteers from the National Women's Union.

## **Ethiopia**

### **A. National policy regarding payment for immunization and primary health care**

Immunization is provided free of charge. The national policy is for the public to pay for drugs, diagnostic services, inpatient care, etc., based on level of income. However, poor families earning less than US\$25.00/month are exempted from payment. It is estimated that more than 50% of the population are under this category.

### **B. Financing schemes for immunization and/or primary health care**

There is no cost recovery strategy for EPI, such as selling of vaccination cards or payment for immunization. Given the low income level of the population, low coverage of PHC services (50% of the population), and low immunization coverage rates, there is a strong belief that cost recovery for EPI is premature. However, plans exist for a Bamako Initiative project, with a cost recovery

scheme for all health services, which will eventually also include EPI.

### **Gabon**<sup>27</sup>

#### **A. National policy regarding payment for immunization and primary health care**

Immunizations are provided free, but in most cases, mothers must buy a vaccination card at a price ranging from 100 to 200 FCFA (US\$0.34 to \$0.68). An international vaccination card is sold at a price of 1,000 FCFA (\$3.40).

#### **B. Financing schemes for immunization and/or primary health care**

None reported, other than charge for vaccination cards.

### **Gambia**

#### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge.

#### **B. Financing schemes for immunization and/or primary health care**

A drug revolving fund commenced in August of 1988. Revenues are deposited in a special MOH account and used for repurchasing drugs.

Mothers must pay Dalasis 5.00 (\$0.60) for an immunization card, as well as an antenatal card. Retention of the cards is relatively high among the under 5 population and pregnant women in view of benefitting from free health services.

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<sup>27</sup>REACH - CREDES staff communication.

## **Ghana**

### **A. National policy regarding payment for immunization and primary health care**

National policy on payment for immunization by the population is not official, but it is accepted through practice. Under the Hospital Fees act, health services and drugs are paid for by the user.

### **B. Financing schemes for immunization and/or primary health care**

Selected districts have levied communities to raise funds for EPI recurrent costs. Some regions (urban) produced caps, plastic carrier bags and pens subsequently sold for fund raising. Present fee for immunization shots and Road To Health card is 20 cedis (\$0.16).

## **Guinea**

### **A. National policy regarding payment for immunization and primary health care**

Guinea has adopted a cost recovery system that includes EPI. But for the moment, none of the revenues from community financing have been used specifically to finance immunization services.

### **B. Financing schemes for immunization and/or primary health care**

Following the Bamako Initiative model, revenues from community financing are to cover local operating costs of the health centers, and pending a ministerial decision, will be authorized to cover fuel costs for the cold chain and gasoline costs for mobile outreach.

The population pays for services received in the health centers. The payment covers the consultation and medicines, and is based on a fixed price for adults and for children, for several illness categories. These fees range from the equivalent of US\$.08 - 3.00.

Pre- and post-natal services are prepaid with a fee (approximately US\$.90) that covers a health booklet for the mother, then the child, malaria prophylaxis, nutrition services, and immunizations for the mother and child. Vaccination cards are sold, for less than 10 U.S. cents, only to children over the age of one year who do not have a health booklet.

## **Guinea-Bissau**

### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist. A Bamako Initiative project was initiated in one region in March 1990.

## **Kenya<sup>28</sup>**

### **A. National policy regarding payment for immunization and primary health care**

The Government of Kenya recently adopted a policy of user charges in government facilities. The new policy stipulates that user charges must be paid for curative services provided in hospitals and health centers, with exemption from payment for children less than five years of age. In addition, all preventive services are provided free to mothers and children. Consultations at village dispensaries remain free.

### **B. Financing schemes for immunization and/or primary health care**

The national policy of user charges is intended to provide the opportunity to cross-subsidize the costs of preventive activities with revenues from charges for curative services.

NGOs in Kenya have a long tradition of operating community-financed and managed health projects. Many NGO facilities charge fees for PHC consultations and/or drugs.

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<sup>28</sup>REACH staff communications.

## **Lesotho**

### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist. The government is considering sale of the new Road To Health Card to help fund purchase of cards and to support PHC services. NGOs charge fees for services to cover operating costs.

## **Liberia**<sup>29</sup>

### **A. National policy regarding payment for immunization and primary health care**

Prior to the war and political changes in 1990, the Ministry of Health had a national policy which authorized the sale of pharmaceuticals including those used for primary health care. Immunization is provided free to the population, but a vaccination card must be bought for a nominal amount.

### **B. Financing schemes for immunization and/or primary health care**

In addition to the sale of vaccination cards, there is a wide range of community financing projects for PHC supported by NGOs and international donors. Many of these projects are based on revolving drug funds and/or fee-for-service systems.

## **Madagascar**

### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge.

### **B. Financing schemes for immunization and/or primary health care**

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<sup>29</sup>Financing Primary Health Care: Experiences in Pharmaceutical Cost Recovery (Arlington, VA: PRITECH, 1989).

Survey reported that none exist.

### **Malawi**

#### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge.

#### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

### **Mali**<sup>30</sup>

#### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge.

#### **B. Financing schemes for immunization and/or primary health care**

Although immunization is free, survey reported that non-indigents pay 100 CFA (\$0.35) for vaccination cards. Funds collected at facilities are sent to central level. No other financing scheme for EPI was reported.

Several major cost recovery experiences are underway with the support of the Ministry of Health. These include: 1) A fee-for-service system in The Health Development Project (PDS) in the Kayes Region, and 2) the "Magasins Sante" PHC Project in which patients pay a fixed fee for consultation and receive medications for seven days. The revenue generated from drug sales covers the cost of replacement of drugs, but not always logistics and supervision costs. EPI costs are subsidized by the MOH and donor organizations in both these projects.

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<sup>30</sup>UNICEF telex in response to survey questionnaire; J. Brunet-Jailly, "Etudes de cas sur le fonctionnement du système de santé au Mali," INRSP, 1989; and A. Strooban, M.O. Waty, et al., "Evaluation of the Project 'Magasins Santé' in Mali," Medicus Mundi, 1990.

## **Mauritius**

### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge with recognition of more community participation for effectiveness and sustainability.

### **B. Financing schemes for immunization and/or primary health care**

Private medical practitioners charge fees which average US\$6.00 per visit including vaccination injections. Prepayment schemes are organized primarily by private firms for their employees. Private clinics charge for PHC services. Vaccines sold by private traders are subject to government quality control.

## **Mozambique**

### **A. National policy regarding payment for immunization and primary health care**

Immunization services are provided free of charge.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that in 1986 nominal fees for clinic visits were instituted, though preventive services were excluded. The level of absolute poverty in Mozambique is such that charging even nominal fees has in the past excluded some groups.

## **Namibia**

### **A. National policy regarding payment for immunization and primary health care**

Immunization is provided free in all public health facilities. PHC services are free as well, although a minimal payment is expected at some hospitals and clinics for outpatient pharmaceuticals.

## **B. Financing schemes for immunization and/or primary health care**

Some localities have raised minimal funds through the sale of cards. There is a fee (approximately US\$1.00) for first consultations at government clinics.

### **Niger**<sup>31</sup>

#### **A. National policy regarding payment for immunization and primary health care**

The current government policy is that all preventive services be provided free of charge. Cost recovery is planned for some curative PHC services (e.g., provision of drugs). The country is still in the formative phase of its PHC financing policy.

#### **B. Financing schemes for immunization and/or primary health care**

There are several examples of local financing efforts for PHC. In Niamey commune, fees are charged for medical examinations for maternity cases as well as for deliveries. Two other departments in the country instituted similar systems on a trial basis. It is believed that the results of these schemes will help formulate national policy. Communities have provided support to the Village Health Worker program (local government funding of operating costs, sale of drugs through revolving drug funds, etc.). However, VHWs have not been involved in EPI. There is no evidence of a specific strategy for financing immunization services.

### **Nigeria**<sup>32</sup>

#### **A. National policy regarding payment for immunization and primary health care**

Under decentralization, local government authorities and community health committees are empowered to make decisions on health matters, including planning, resource allocation and community participation. Each state implements a distinct system of fee-for-service.

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<sup>31</sup>REACH staff communications.

<sup>32</sup>REACH staff communications.

## **B. Financing schemes for immunization and/or primary health care**

Typically, immunization is provided free of charge, but a Road-to-Health card for children and adults is often sold for a nominal fee.

### **Rwanda**<sup>33</sup>

#### **A. National policy regarding payment for immunization and primary health care**

Immunization services are provided free to the population. Individuals must pay nominal fees for PHC services.

#### **B. Financing schemes for immunization and/or primary health care**

Survey reported that no financing schemes exist specifically for immunization. But, in addition to fees for PHC services, some health facilities have experimented with prepayment for PHC. Some of these schemes are under consideration for wider adoption under the Bamako Initiative Program.

Church missions generate almost half the health facilities in Rwanda. They charge fees for PHC consultations and drugs.

### **Senegal**<sup>34</sup>

#### **A. National policy regarding payment for immunization and primary health care**

In the early 1980s, the Government adopted a policy of charging for primary health care services provided by the MOH. In the mid 1980s consultation fees ranged from FCFA 50 (\$0.17) for children to FCFA 100 (\$0.34) for adults. Immunizations cost FCFA 50 (\$0.34), as well. However, during the National Immunization Campaign in 1987, the government declared immunizations to

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<sup>33</sup>UNICEF telex in response to questionnaire, and G. Carrin, P. Nyandagazi, and D. Shepard, Self-Financing of Health Care at Government Health Centers in Rwanda (Arlington, VA: REACH, 1986).

<sup>34</sup>REACH staff communications, and REACH Publication Senegal: Rapid Assessment of Senegal's Acceleration Phase (Arlington, VA: REACH, November 1987).

be free of charge. The former policy of fees for immunizations has now gone into effect since the campaign.

**B. Financing schemes for immunization and/or primary health care**

In addition to the general practice for MOH facilities in A. above, many MOH and NGO projects for community financing of PHC have existed in Senegal. Examples of cost recovery mechanisms used include: a fixed fee for each consultation, annual membership fee for each adult, fees-for-service, fees-for-drugs and voluntary labor.

**Sierra Leone**

**A. National policy regarding payment for immunization and primary health care**

The national policy is to provide immunization and PHC services free of charge. However, the community already pays full essential drugs/treatment costs for curative care.

**B. Financing schemes for immunization and/or primary health care**

Survey reported that currently none exist specifically for EPI. However, a proposed Bamako Initiative activity would pay for EPI indirectly from mark-ups on essential drugs. There is also a proposal to sell TT vaccination cards and combined under-five immunization/road to health cards before the end of 1990.

**Somalia**

**A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge.

**B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

## **Sudan**<sup>35</sup>

### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are provided free of charge.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist at country-wide level, but several local level schemes to finance EPI and/or child health exist. The decentralized system in Sudan allows regional governments to raise local taxes. In Central and Darfur regions, district-level revenues from sugar taxes have been used to finance EPI on an ad hoc basis. These revenues have financed transportation costs.

Also in Central Region the regional government, under the initiative of the Regional Ministry of Health (RMOH), passed legislation in order to increase regional resources for child health. As a result, taxes were levied on bus fares (5-8% of the fare) and cinema tickets (20% on first through third class tickets). These taxes yielded considerable revenue, amounting to more than LS 200,000 per year (nearly US\$40,000) in the mid 1980s.

Pediatric health units in Central Region collect "child money" when a child comes for curative care, and a proportion of these funds is allocated to EPI.

There have also been ad hoc local cases of community contributions towards EPI. In one district in Eastern Region, the community contributed toward construction of two rooms for EPI in a dispensary. In other communities (in Darfur and Kordofan regions), transportation is donated through the provision of vehicles or donkeys.

## **Swaziland**

### **A. National policy regarding payment for immunization and primary health care**

Immunization is provided free of charge. Every hospital or health center service, including PHC, requires a minimum fee of 40 US cents.

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<sup>35</sup>UNICEF telex in response to survey questionnaire, and A. Bekele and M. Lewis, "Financing Health Care in the Sudan: Some Recent Experiments in the Central Region." Journal of Health Planning and Management, Volume 1, 1986.

**B. Financing schemes for immunization and/or primary health care**

Survey reported that no financing scheme for EPI exist, though health cards that include vaccination must be purchased at 40 US cents.

For PHC, there is no national scheme other than the minimum fee identified in A. above. Some church clinics charge more than double the amount charged by government health facilities.

**Tanzania**

**A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services provided free of charge.

**B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist. Draft national health policy due for parliamentary debate recommends community contributions, in cash or in kind, to PHC services.

**Uganda**

**A. National policy regarding payment for immunization and primary health care**

Immunization services are exempted from charges at government and NGO facilities. Starting October 1, 1990, cost sharing is to be introduced in government health facilities, under which 10% of revenues will be allocated to preventive services.

**B. Financing schemes for immunization and/or primary health care**

Survey reported that no financing schemes exist specifically for EPI.

## **Zaire**<sup>36</sup>

### **A. National policy regarding payment for immunization and primary health care**

The national health system was decentralized in 1982 into 306 health zones, each covering approximately 80,000 to 100,000 population. Each zone has the autonomy to design its own health delivery strategy and financing system.

### **B. Financing schemes for immunization and/or primary health care**

The Government's decentralized health system requires local level financing and cost recovery. The most common approaches reported are fixed fee-per-episode of illness and drug purchases. All zones for which information is available provide free care to the indigent population, and one zone set fees according to different socioeconomic status of the population.

A method to generate revenues specifically for EPI is underway in Zaire with the support of WHO. The pilot project has installed solar cold chain equipment at a health center along with a battery charger. The solar equipment has bigger than needed capacity so that excess energy can be sold to the community to recharge batteries and to run video machines for entertainment and health education purposes. Income generated from this strategy can be used by the health center to pay for operating expenses of EPI.

## **Zimbabwe**

### **A. National policy regarding payment for immunization and primary health care**

Immunization services are provided free. For other health services fees are paid by individuals earning above Z\$ 150 per month, with specific fees based on a sliding scale.

### **B. Financing schemes for immunization and/or primary health care**

Prepayment health insurance schemes exist for health care, including some

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<sup>36</sup>R. Bitran, Health Zones Financing Study, USAID/Kinshasa in collaboration with the SANRU Project (Arlington, VA: REACH, 1986); R. Bitran, Update of the Zaire Health Zones Financing Study (Arlington, VA: REACH, 1988; WHO/EPI/LHIS/90.1, Sale of Excess Solar Energy: Feasibility Study, First Phase (WHO Logistics for Health Series, October 1989).

PHC activities such as antenatal care and deliveries. There are several private schemes and one government insurance scheme. Enrollment is open to any citizen. The average prepayment per family is about Z\$ 75 per month under private insurance, and Z\$ 33 per month for a government plan. Government insurance did not cover the cost of drugs until recently. Some insurance schemes require co-payments or deductibles for PHC, maternity or hospital services.

Communities often contribute labor for construction and maintenance of health facilities.

## APPENDIX B<sup>37</sup>

### COUNTRY SUMMARIES: ASIA/NEAR EAST REGION

#### Afghanistan

##### **A. National policy regarding payment for immunization and primary health care**

In government-controlled areas, the policy is to give free immunization. In non-government controlled areas, NGOs deliver PHC with or without immunization services. Most of these services are delivered free.

##### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

#### Algeria

##### **A. National policy regarding payment for immunization and primary health care**

The national health system established in 1973 provides free health care to the population. No fees are charged for immunization and/or preventive services.

##### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

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<sup>37</sup>Unless otherwise noted, the source of information for each country presented in this Appendix is the UNICEF field offices' response to the REACH survey questionnaire described on page two of this report.

## **Bangladesh**<sup>38</sup>

### **A. National policy regarding payment for immunization and primary health care**

No fees are charged for immunization, although a small fee of 3 taka (US\$0.08) is charged for PHC services other than immunization.

### **B. Financing schemes for immunization and/or primary health care**

Volunteers have played a major role in social mobilization. Voluntary social agencies have been involved, as have commercial enterprises and professional groups. No estimation of the value of these contributions has been made. Private practitioners charge what the market will bear for vaccines purchased by them from local drug firms. The survey reported no other financing schemes.

## **Bhutan**

### **A. National policy regarding payment for immunization and primary health care**

The government policy is to provide immunization, other preventive, and curative services to the public totally free of charge.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist. However, due to the difficult logistical situation in Bhutan, where 50 percent of health services are accessible only by walking several hours or days, local communities provide porter services for cold boxes to assist the health workers. Health workers must walk for many hours from the 69 basic health units to more than 350 sub-posts where immunization clinics are held monthly. Plans for local community construction of shelters for immunization clinics at these sub-post locations are presently under discussion by the government.

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<sup>38</sup>Information from J.P. Chaine, REACH Chief of Party/Bangladesh, and UNICEF field office response to telex.

## **China (People's Rep. of)<sup>39</sup>**

### **A. National policy regarding payment for immunization and primary health care**

No overall national policy was identified. Fees are charged for immunization and/or PHC in economically advanced areas, while these services are often free in poor areas.

### **B. Financing schemes for immunization and/or primary health care**

Village doctors are responsible for carrying out immunization services in rural areas, where 80 percent of the population lives.

**Fees:** In some economically advanced areas, fees may be charged by village doctors for immunization services. These fees usually range from 30 to 50 fen (US\$0.06-0.11). In some areas, vaccinations are actually given at township hospitals. In this case, the village doctor may receive a portion of this fee in return for notifying parents of the need to immunize their child and ensuring that the child goes to the hospital on the scheduled day. Fees may be matched with a subsidy per shot from higher levels as an additional incentive to the village doctor.

**Subsidies:** In some areas, village doctors are provided with a subsidy by the village or a higher level of government as an incentive to perform preventive health work. At the village level, the subsidy is determined by village leaders and is often set according to performance. In less developed areas, a monthly subsidy may be provided by the county or a higher level of government. If such a subsidy is provided, generally no fee is charged for immunization. Subsidies from higher levels of government are not closely linked to performance, which is a potential weakness of this system.

**Contract system:** Some areas have adopted a prepayment scheme known as the contract system to support EPI work. While the system varies from one area to another, parents typically pay 7 to 10 yuan (US\$1.50-2.10)<sup>40</sup> upon the

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<sup>39</sup>UNICEF communication, and S.W. Jarrett, "Financing Immunization of Children in China," Future 26-27, Autumn-Winter 1989.

<sup>40</sup>A recent unpublished review article by Gong You-long and Tang Sheng-lan of Shanghai Medical University indicated that the prepayment fee actually ranges from 1 to 31.5 yuan (US \$0.21-6.70). This wide range is indicative of the decentralized and developing nature of the contract system.

birth of a child. This amount covers all immunizations up to the age of seven. If the recommended immunization schedule is followed but the child still contracts one of the EPI target diseases, compensation is paid to the parents to cover the cost of treatment. Typical compensation levels are 30 yuan (US\$6) for measles or pertussis, 100 yuan (US\$21) for tetanus, 150 yuan (US\$32) for diphtheria, 200 yuan (US\$43) for polio and 300 yuan (US\$64) in case of death from any of these diseases. Compensation is not generally provided if the child contracts tuberculosis due to difficulties in assuring the effectiveness of BCG vaccine. Premiums are shared between the county epidemic prevention station, the township hospital, and the village doctor (a usual ratio is 20%, 20%, and 60%, respectively). Likewise, responsibility for paying compensation is shared (typically, 50%, 30%, and 20%, respectively).

The advantages of the contract system include:

- linking performance and income of village doctors (poor performance increases the risk of a child contracting an EPI target disease and thus a loss of income),
- increasing quality as greater attention is paid to following the recommended immunization schedule and ensuring that vaccines have not expired,
- more accurate recording of disease incidence as parents apply for compensation,<sup>41</sup>
- encouraging parents to take an active part in ensuring that their child is fully immunized, because of the incentive of prepayment and the linking of compensation to full and correct immunization.

The contract system has raised considerable revenue in Hebei Province, a province with 8 million children under seven years of age where the contract system was initiated in 1984. 1,470,000 children have been enrolled in the system to date. In 1986, 9 million yuan in premiums were collected, while only 10,000 yuan in compensation had to be paid.

Similar contract systems also exist in various provinces for a wider range of primary health care services.

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<sup>41</sup>However, there is also a risk of under-reporting of disease incidence, since village doctors may tell the parents that the child is suffering from a non-target disease in order to avoid losing income if the parents apply for compensation.

## **Egypt**

### **A. National policy regarding payment for immunization and primary health care**

All costs of the EPI are borne by the government and donors.

### **B. Financing schemes for immunization and/or primary health care**

No community contributions are made to the EPI, and no EPI cost recovery schemes are in place. USAID has a health cost recovery project in the country.

## **India**

### **A. National policy regarding payment for immunization and primary health care**

The national policy calls for free provision of all health services, including PHC and immunization. Some states charge a registration fee of 0.5 rupees (US\$0.03) for patients reporting to health centers for the first time. No fee has ever been charged for immunization services or cards at government facilities. However, fees for immunization do exist in the private sector. The range of charges is not known at the present, but could provide a financial incentive for physicians to provide immunization.

### **B. Financing schemes for immunization and/or primary health care**

Social insurance does include immunization, but this program reaches a very limited portion of the population. No community contributions were reported by the survey other than building of PHC subcenters. Rotary India has contributed over US\$3 million for polio vaccine.

## **Indonesia**

### **A. National policy regarding payment for immunization and primary health care**

Immunization services and cards are free of charge through the public health service. Private practitioners do charge, although in theory only for the service component as vaccines are made available to them free on request by most provincial governments. Patients at public health centers and at hospitals are charged a fee of 250 rupiah (US\$0.13) for entrance. Additional charges

may be made depending on the type of services provided. In most cases drugs must be paid for, and drug prices are high. A mechanism exists whereby the Ministry of Social Affairs can authorize free treatment for those able to prove that they are destitute.

#### **B. Financing schemes for immunization and/or primary health care**

All government employees are covered under a health insurance scheme which includes immunization services, although this is hardly a benefit as immunization is essentially free of charge to all. The insurance scheme does not provide any funding to the immunization program.

Vaccine is largely funded from Presidential Instruction (INPRES) funds which are not likely to be affected by the annual budgeting process. The current INPRES contribution is Rp. 35 (US\$0.02) per head of population (not just eligibles). Next year the amount is scheduled to be Rp. 70 (US\$0.04) to include some Hepatitis B vaccine.

There are very substantial but largely unquantifiable contributions of labor through the Posyandu system that are an integral part of immunization services. In 1987, the annual volunteer labor component to run a Posyandu (of which immunization services form only a part) was estimated to be Rp. 179,243 (US\$96). The family welfare movement (PKK) makes Rp. 50,000 (US\$27) per village available annually for immunization support.

Local fundraising does occur. Rotary clubs are perhaps the best known. Additional fundraising efforts are made for discrete activities such as campaigns.

The EPI is funded principally through a nationally-controlled budget that is allocated both to the national-level immunization directorate and to the 27 provinces. Provinces, districts, and subdistricts may also contribute additional funds depending on the lobbying effectiveness of health staff, but the amount of these contributions and thus the total funds available at each level is unknown. Evidence indicates that there is a very wide variation in available funds from one year to the next and from one place to another, depending on such factors as local government wealth, the perceived importance of immunization, and the relationships between administrators and health staff.

## Iran

### **A. National policy regarding payment for immunization and primary health care**

Immunization services offered by PHC are free. PHC covers 70 percent of the population. There is a charge for immunization given by the private sector, but this only accounts for a small proportion of immunizations given and is only in cities.

### **B. Financing schemes for immunization and/or primary health care**

The survey reported that no other scheme exists and there is no significant contribution to the EPI from the public.

## Korea (Rep. of)

### **A. National policy regarding payment for immunization and primary health care**

Government clinics and hospitals provide free immunization. However, most mothers prefer to go to the clinic nearest to their home, which is usually private. Fees for vaccination at these clinics are small. The bulk of PHC and immunization services are provided by private practitioners. The government bears most of the cost of producing and distributing vaccines.

### **B. Financing schemes for immunization and/or primary health care**

All Koreans are covered by medical insurance. This insurance covers most medical care costs (except for a percentage co-payment). Care can be sought at either government or private sector hospitals and clinics.

## Laos

### **A. National policy regarding payment for immunization and primary health care**

No national policy regarding payment for PHC or immunization exists. A small fee (approximately US\$0.10) is charged for a health/immunization card.

## **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

### **Lebanon**

#### **A. National policy regarding payment for immunization and primary health care**

There is no unified national policy regarding payment for PHC or immunization services by the population, although most services are free of charge.

#### **B. Financing schemes for immunization and/or primary health care**

Social insurance covers doctors' fees, but not the cost of vaccines. PHC and immunization are provided by NGOs in a large proportion of cases. The fees charged by these NGOs range from US\$0.50-1.00. Moreover, approximately 50 percent of immunization is provided by the private sector, where charges range from US\$5-15.

### **Malaysia**

#### **A. National policy regarding payment for immunization and primary health care**

PHC services are free at government facilities. Immunization is free at government clinics for children up to one year of age. At private clinics, charges are levied for PHC and sometimes for immunization. Charges for immunization at private clinics range from US\$1.84 to \$6.56.

#### **B. Financing schemes for immunization and/or primary health care**

NGOs contribute money, labor, and goods to the EPI, and community fundraising activities have been undertaken.

In May, 1988, Malaysia raised approximately US\$20,000 for the child immunization program through a running competition organized by Save the Children and WorldRunners.

The Malaysian government buys Hepatitis B vaccine at approximately \$5 Malaysian (US\$1.84) and provides the vaccine to private clinics at \$7

(US\$2.60). These clinics are then allowed to charge up to \$15 (US\$5.58) to immunize children brought to their clinics.

### **Maldives**

#### **A. National policy regarding payment for immunization and primary health care**

No payment is made by the population for PHC services and immunization.

#### **B. Financing schemes for immunization and/or primary health care**

Communities contribute labor, particularly in the islands, but the survey reported that no specific fundraising activities exist for EPI.

### **Morocco**

#### **A. National policy regarding payment for immunization and primary health care**

Immunization and PHC services are free.

#### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

### **Myanmar**

#### **A. National policy regarding payment for immunization and primary health care**

All EPI costs are borne by the government, with substantial support from UNICEF for all foreign exchange costs and some local costs. No fee is charged for EPI.

#### **B. Financing schemes for immunization and/or primary health care**

Communities contribute to the construction of health centers. Members of religious orders are prime movers to motivate the community for any programs. Donations to hospitals are made "spontaneously," but getting such donations for non-hospital health units requires "energetic motivation." If the

felt needs of the community are met, financing efforts are generally successful.

### **Oman**

#### **A. National policy regarding payment for immunization and primary health care**

The Sultanate of Oman provides PHC and full immunization to the entire population free of charge. Furthermore, the MOH provides antigens free of charge to all private practitioners. However, private practitioners charge a fee for their services to people attending their clinics.

#### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

### **Pacific Islands**

#### **A. National policy regarding payment for immunization and primary health care**

In the 13 countries covered by the UNICEF office in Suva, Fiji, PHC services are provided free, including EPI.

#### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

### **Pakistan**

#### **A. National policy regarding payment for immunization and primary health care**

PHC and EPI services are free.

#### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist at government facilities. However, NGOs are charging for PHC. User fees for government health services are currently under discussion, but no decision has yet been made.

## **Papua New Guinea**<sup>42</sup>

### **A. National policy regarding payment for immunization and primary health care**

Government policy states that vaccinations and injections given as part of a disease control program are to be provided free of charge. Primary health services are generally free of payment. All outpatient services to children under 14 years of age are provided free of charge.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist specifically for primary services. Major initiatives for improving the financing of the health sector as a whole are being considered by the government. Application of user charges to primary health services is being considered within this overall context.

## **Philippines**

### **A. National policy regarding payment for immunization and primary health care**

No national policy exists regarding payment for PHC services or for immunization.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist except for occasional contributions from NGOs for syringes/needles for targeted cities/municipalities.

## **Sri Lanka**

### **A. National policy regarding payment for immunization and primary health care**

PHC services, including immunization, are provided free by the government.

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<sup>42</sup>Response to UNICEF telex, and G. Rosenthal, D. Donaldson, et al., Papua New Guinea Health Sector Financing Study Project Final Report - Volume I: Health Sector Financing Issues and Options (Boston, MA: John Snow, Inc., 1990).

**B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

**Syria**

**A. National policy regarding payment for immunization and primary health care**

The national policy is to provide PHC services, including immunization services, to the population free of charge.

**B. Financing schemes for immunization and/or primary health care**

Survey reported that none exist.

**Thailand**

**A. National policy regarding payment for immunization and primary health care**

Immunization and PHC are free, except when administered in the private sector.

**B. Financing schemes for immunization and/or primary health care**

A health card scheme for health services is being tested in limited areas with some success.<sup>43</sup> Under this scheme, families have paid US\$8-12 for a health card which entitles household members to treatment of six illness episodes per year and free MCH and immunization services. If a card holder is referred from the health post to a hospital, he or she receives a letter from the health post entitling him or her to quick attention via a "Green Channel" or "Express Way" in hospitals honoring the card. The money collected by selling the cards has been used to make loans to cardholders and to reimburse service providers at the end of the year.

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<sup>43</sup>See Charles N. Myers, "Thailand's Community Finance Experiments: Experience and Prospects," in Asian Development Bank, Economic Development Institute of the World Bank, and East-West Center, Health Care Financing, Proceedings from the Regional Seminar on Health Care Financing, 27 July-3 August, 1987, Manila, Philippines.

In order to ensure that services remain accessible to the very poor, people with an annual income below 3,500 baht (US\$200) are given free health cards. Some of the poor are asked to contribute labor and are given a card covering fewer illnesses than the paid card, thus restricting use of the exemptions to the very poor.<sup>44</sup>

Individuals also contribute money on a voluntary basis for services. Survey reported that no other schemes exist.

## **Tunisia**

### **A. National policy regarding payment for immunization and primary health care**

PHC services are free. Individuals pay a fee equivalent to US\$1.50 for curative services, with the exception of those below poverty level or lower middle class who are granted a medical card for free health services which include drugs and the cost of surgery. There are no charges for immunization in the public sector.

### **B. Financing schemes for immunization and/or primary health care**

Fees are charged for immunization in the private sector (covering approximately 25% of the population), but 80% of these charges are reimbursed by social security or an insurance scheme. Survey reported that no other financing schemes exist for EPI, although rural communities sometimes contribute labor, materials, or a piece of land to build a health center where vaccination and other services are to be performed.

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<sup>44</sup>See Brian Abel-Smith and Ajay Dua, "The Potential of Community Financing of the Health Sector in Developing Countries," in Asian Development Bank, Economic Development Institute of the World Bank, and East-West Center, Health Care Financing, Proceedings from the Regional Seminar on Health Care Financing, 27 July-3 August, 1987, Manila, Philippines, pp. 58-59.

## **Yemen**<sup>45</sup>

### **A. National policy regarding payment for immunization and primary health care**

No fees are charged for health services. There is no MOH plan to recover the running costs of EPI. The policy of free PHC and EPI was in effect in both North and South Yemen before unification.

### **B. Financing schemes for immunization and/or primary health care**

UNICEF funds most of the costs of EPI activities including needles, syringes, cold chain equipment, vehicles, and some salaries and salary supplements. The EPI has been very successful in generating local support for immunization on a governorate by governorate basis. Local communities and/or the local council for community development (LCCD) are paying for the transport of the vaccine and the vaccination team from the health center to the villages at the periphery. The teams are also provided with village hospitality such as lodging and food. These costs are covered on an ad hoc basis and not documented. The MOH provides limited running costs for EPI activities, usually including staff per diem, transport, and gasoline for cold chain logistics from the central level to the governorate health office. The governorate health office picks up the costs for cold chain management and logistics to the health centers and some primary health care units. From these locations to the vaccination sites is the responsibility of the communities and/or the LCCD.

## **Vietnam**

### **A. National policy regarding payment for immunization and primary health care**

A national policy regarding payment by the population for PHC and immunization has not yet been officially instituted.

### **B. Financing schemes for immunization and/or primary health care**

An immunization insurance scheme with community financing has been tested in 1989-90 in 36 pilot communes of Hoanghoa District, Thanhhoa Province, with 118,300 inhabitants. A charge of 1,500 dong (US\$0.28) is made for a

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<sup>45</sup>UNICEF telex, and memo from Noel Brown, REACH Chief of Party/Yemen, August 20, 1990.

**fully immunized child, and 200 dong (US\$0.03) for a pregnant woman fully immunized with TT. The funds collected are used as follows:**

- 40 percent for subsidizing commune EPI workers
- 20 percent for subsidizing Vietnam women union cadres who are EPI supporters
- 20 percent for commune health budget to treat at the commune health center, free of charge, any fully immunized child contracting EPI target disease
- 20 percent for the district health budget to treat free of charge any fully immunized child contracting an EPI target disease who is transferred to the district hospital

A survey to evaluate the EPI insurance scheme was undertaken recently in 15 of the 36 pilot communes selected at random. This evaluation showed satisfactory results and impact. Most mothers are ready to pay, are requesting full immunization for their children, and are prepaying fees. Immunization coverage has increased and EPI target disease incidence decreased.

## APPENDIX C<sup>46</sup>

### COUNTRY SUMMARIES: LATIN AMERICA/CARIBBEAN REGION

#### Argentina

##### **A. National policy regarding payment for immunization and primary health care**

National law states that immunization at public or non-profit facilities is to be absolutely free. Provision of immunization at pharmacies and other private facilities is permissible. (Presumably, charges are allowed at such facilities.)

##### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.

#### Bolivia

##### **A. National policy regarding payment for immunization and primary health care**

Primary health care is free at public facilities.

##### **B. Financing schemes for immunization and/or primary health care**

There is no charge for immunization services or supporting materials such as cards through government facilities. Survey reported that operating funds for immunization are obtained from the national treasury.

A private sector organization in Santa Cruz (PROSALUD) provides PHC on

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<sup>46</sup>Unless otherwise noted, the source of information for each country presented in this Appendix is the PAHO field offices' response to the REACH survey questionnaire described on page two of this report.

a fee-for-service basis.<sup>47</sup> PROSALUD attempted a prepayment option, but this was dropped as it failed to generate sufficient revenues. Some PROSALUD facilities, particularly in urban areas, have very high cost recovery rates, although few have been able to cover their costs plus a portion of the central office costs. Facilities in rural areas have had much more difficulty covering their own costs; none had achieved over 61 percent cost recovery by 1988. This has caused concerns about PROSALUD's ability to provide self-financing services in rural areas and how facilities might be able to cross-subsidize one another so that urban facilities with surpluses could support financially strapped rural clinics.

## **Brazil**

### **A. National policy regarding payment for immunization and primary health care**

No payment required for immunization at public facilities.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.

## **Chile**

### **A. National policy regarding payment for immunization and primary health care**

No information from survey on policy per se; however, the population does not pay for immunization or primary health care. Funding is provided by the government and international donors.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.

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<sup>47</sup>See Gerald Rosenthal et al., Toward Self-Financing of Primary Health Services: A Market Study of PROSALUD in Santa Cruz, Bolivia, Health Care Financing in Latin America and the Caribbean Project (HCF/LAC) Research Report No. 6, (Stony Brook, NY: SUNY, 1988).

## **Costa Rica**

### **A. National policy regarding payment for immunization and primary health care**

The Ministry of Health (MOH) and Social Security (CCSS) share responsibility for financing immunization. The total cost of the biologicals is assumed by CCSS. The MOH delivers over 90% of immunizations, administers the program, and conducts epidemiological surveillance.

### **B. Financing schemes for immunization and/or primary health care**

No fee is charged for immunizations or cards. No information was reported in the survey on any other financing schemes.

## **Cuba**

### **A. National policy regarding payment for immunization and primary health care**

Health services, including vaccinations, are without cost to the population.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.

## **Dominican Republic**

### **A. National policy regarding payment for immunization and primary health care**

Currently, the health policy is to provide health services free to the population at government health facilities. However, cost recovery for health is being considered. It is not clear whether this would include charges for immunization.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.

## **Eastern Caribbean**<sup>48</sup>

### **A. National policy regarding payment for immunization and primary health care**

In each country in the region, primary health care and immunization are free services offered by the MOH. One exception is Bermuda, a British territory with a very high per capita income where individuals generally pay for government health services. It is not clear though whether charges are levied for immunization in Bermuda.

### **B. Financing schemes for immunization and/or primary health care**

No national schemes were reported in any of the countries. However, social security-type programs do exist in several countries (e.g., Antigua, St. Lucia, and Belize) and provide support for health services. In Caribbean countries where such programs exist, they tend to be less well developed than those found in Latin America. For example, in St. Lucia and Belize, the social security/national insurance programs make annual lump-sum payments to the MOH or a specific health facility to cover the cost of services provided to beneficiaries.<sup>49</sup> It is not clear that the amount of these payments is sufficient to cover the cost of providing health services to the beneficiaries. In Antigua, the Medical Benefits Scheme (MBS) is financed by a five percent tax on wage income, with half paid by the employer and half paid by the employee.<sup>50</sup> This scheme covers the cost of care provided to beneficiaries, either at the public hospital or by private physicians, as well as the cost of pharmaceuticals, laboratory tests, radiology services, and overseas treatments. The hospital, however, has little incentive to bill the scheme for services provided to MBS

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<sup>48</sup>For the purposes of this review, the Eastern Caribbean countries include the members of CAREC, the Caribbean Economic Community: Anguilla, Antigua, Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, St. Kitts-Nevis, St. Lucia, St. Vincent and the Grenadines, Surinam, Trinidad and Tobago, and the Turks and Caicos Islands. Information on these countries was provided by Henry Smith, PAHO/WHO Immunization Officer for the Caribbean, and from the published sources noted.

<sup>49</sup>Gretchen Gwynne and Dieter K. Zschock. Health Care Financing in Latin America and the Caribbean, 1985-89: Findings and Recommendations (Stony Brook, NY: SUNY, 1989), p. 33.

<sup>50</sup>See Michael Enright, Dayl Donaldson, and Allison Percy, Analysis of the Costs and Financing of the Holberton Hospital, Antigua (Arlington, VA: REACH Project/JSI, 1989), p. 19.

beneficiaries because payments are made to the national treasury rather than being added to the hospital budget. The MBS also provides grants for health infrastructure development and subsidies to fund MOH budget deficits. Some MBS revenues also finance non-health activities, although the amount of MBS funds used outside the health sector is not known.

In addition, several local efforts to finance EPI were noted:

- In a few health centers in some countries, nurses charge a small fee (approximately EC\$0.25, or US\$0.10) for a replacement vaccination card if the first one is lost. The first card is given for free. This charge is unofficial and therefore cannot be enforced. The money raised from these cards is used for incidental expenditures.
- In Guyana, local health centers sometimes raise money by holding a health fair. At such a fair, the health center staff show videos, give talks on health, and sell food and drinks. The money is used at that health center and may be targeted toward a specific purchase (e.g., of furniture). A mass campaign is planned in the Eastern Caribbean in June 1991, and some health centers in Guyana will be raising funds for this campaign by holding health fairs.
- Many communities provide volunteer labor during special immunization campaigns. In Jamaica, the assistance of local leaders is recruited by the EPI for social mobilization (bringing in groups that are hard to reach, encouraging mothers to bring back their children for their next dose, etc.).
- A small percentage of people go to private physicians for immunization, although the EPI generally discourages this because of uncertainty over quality control. Private physicians charge for this service, but the average charge is unknown. In four countries in the region, some health centers give free vaccines to private doctors in return for their agreement to report the number of doses they administer. However, this practice is not encouraged by EPI headquarters, and most physicians must purchase their vaccines on the private market and thus do not benefit from the low prices received by governments who participate in a revolving vaccine procurement fund for the Eastern Caribbean.

## **Ecuador**

### **A. National policy regarding payment for immunization and primary health care**

National policy is not to charge the population for immunization or primary health care.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.

## **El Salvador**

### **A. National policy regarding payment for immunization and primary health care**

Immunization and primary health care are free, as are all MOH medical services.

### **B. Financing schemes for immunization and/or primary health care**

At the level of the health facilities, voluntary contributions are sometimes given by the population to "patronatos," charitable foundations associated with the institution. The patronatos then use this money to pay personnel not contracted by the MOH (e.g., orderlies, secretaries) or for unforeseen expenditures.

No other financing schemes were reported in the survey.

## **Guatemala**

### **A. National policy regarding payment for immunization and primary health care**

Immunizations are free according to government regulation. Payment for this service is not being contemplated.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.

## **Haiti**

### **A. National policy regarding payment for immunization and primary health care**

No payment is required for immunization or PHC.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.

## **Honduras**

### **A. National policy regarding payment for immunization and primary health care**

Immunization and primary health services are free.

### **B. Financing schemes for immunization and/or primary health care**

Donation of a percentage of the national lottery is under study. Survey reported that no other schemes existed.

## **Mexico**

### **A. National policy regarding payment for immunization and primary health care**

The national policy is that all services are free, including vaccination services and cards.

### **B. Financing schemes for immunization and/or primary health care**

In 1990, the national lottery of Mexico gave a donation of 100,000 posters for the national vaccination day(s) and 500 cartons for trucks.

## **Panama**

### **A. National policy regarding payment for immunization and primary health care**

The national health policy requires that all preventive health services are free, including immunization.

### **B. Financing schemes for immunization and/or primary health care**

Social Security provides primary health services to those insured, who pay a monthly fee or premium for all services offered by Social Security. Government facilities "recover a symbolic, minimal amount for primary health services."

## **Paraguay**

### **A. National policy regarding payment for immunization and primary health care**

Immunization services are free.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.

## **Peru**

### **A. National policy regarding payment for immunization and primary health care**

No payment is required.

### **B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.

**Venezuela**

**A. National policy regarding payment for immunization and primary health care**

No information from survey.

**B. Financing schemes for immunization and/or primary health care**

Survey reported that none existed.