

HEALTH FINANCING ACTIVITIES THAT SUPPORT POLICY REFORM: THE A.I.D. MISSION EXPERIENCE

Report on a survey of USAID Missions
as part of the REACH Project Internal
Assessment of Health Financing Activities

Resources for Child Health Project

August 1990

REACH



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REACH Project Internal Assessment of Health Financing Activities**

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Resources for Child Health



A John Snow, Inc. project

REACH

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Dear Colleague:

We are pleased to send you the enclosed report on USAID Mission experience with health financing policy reform.

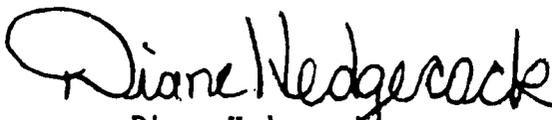
The report presents findings from the recent Mission survey that ST/H/HSD and REACH conducted as part of the project's end-of-project internal assessment. The report

- o provides the field perspective on current issues and the state-of-the-art in health financing;
- o identifies lessons learned through Mission experience with health financing policy reform during the 1980s;
- o provides the Mission view on factors that have affected their role in health financing, as well as Ministries of Health's consideration of policy reform; and
- o identifies global and regional patterns, as well as country examples, of changes that have taken place in the past five years.

Missions' responses to the survey questions represent a major contribution to documenting the evolution and changing patterns of USAID involvement and policy dialogue in health financing in the past five years. As this report shows, Missions have played a leading role in that evolution and many Missions now have 5-10 years experience as a base from which to identify some key lessons about the trends and patterns of health financing policy reform in developing countries.

We want to extend a special appreciation to the field personnel who took the time to respond to the questionnaire. Many provided especially thoughtful and detailed information. We hope this report on their experience and insights helps reinforce and advance Mission efforts to strengthen health financing in countries they are serving.

Sincerely,


Diane Hedgecock
Project Director


Holly Fluty
REACH Project Cognizant Technical
Officer, Agency for International
Development

LIST OF ACRONYMS

ACCS	Accelerated Cooperation for Child Survival
AFR	Africa region
A.I.D.	Agency for International Development
ALO	A.I.D. Liaison Officer
ANE	Asia and Near-East region
CAR	Central African Republic
CARG	Central African Republic Government
CCCD	Combatting Communicable Childhood Diseases
DOH	Department of Health
GOJ	Government of Jamaica or Government of Jordan
GOK	Government of Kenya
GOP	Government of the Philippines
GOTG	Government of The Gambia
HCF	Health care financing
HMO	Health maintenance organization
HPN	Health, Population and Nutrition Bureau
IBRD	International Bank for Reconstruction and Development (World Bank)
IMF	International Monetary Fund
KNH	Kenyatta National Hospital
LAC	Latin America and Caribbean region
MOH	Ministry of Health
MOHSA	Ministry of Health and Social Action
MSW/PH	Ministry of Social Welfare and Public Health
NGO	Non-governmental organization
NHSS	Niger Health Sector Support
ORS	Oral rehydration solution
PRITECH	Technologies for Primary Health Care Project
PVO	Private and voluntary organization
RDO/C	Regional Development Office/Caribbean
REACH	Resources for Child Health Project
REDSO/WCA	A.I.D. Regional Development Support Office/ West and Central Africa
SHPC	Strengthening Health Planning Project

S&T/H/HSD	Bureau of Science and Technology/Health/ Health Services Division
TA	Technical assistance
TPHCP	Tihama Primary Health Care Project
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
YARG	Yemen Arab Republic Government

INTRODUCTION

This report presents the USAID Mission experience and perspectives on health financing policy reform in developing countries during the 1980's. It is based on information from a survey of USAID Missions that REACH conducted in April and May 1989, as part of its end-of-project internal assessment.

The purpose of the REACH internal assessment was to complement the final, external evaluation, with a focus on providing an overall review of results and lessons learned over the five years of the Project (1985-1990). For the internal assessment, REACH undertook several special studies to review the "state of the field" of health care financing and changes that have occurred in A.I.D.'s involvement and in countries' perceptions, strategies, and initiatives during the life of the Project.

The USAID Mission survey represents one of the special studies REACH undertook for the internal assessment. The main purposes of the Mission survey were to incorporate the field perspective on the state-of-the-art of health financing; identify lessons learned through Mission experience with health financing policy reform; and to identify global and regional patterns, as well as country examples, of changes that had taken place in the past five years.

The Mission survey was conducted through a request in April 1990 from A.I.D./Washington (S&T/H/HSD) to all Missions, Representatives, and Liaison Offices, asking them to respond to six questions about Mission and country experience with health financing, whether or not the REACH Project had been involved in health financing activities in that country. The survey asked Missions to identify:

1. health financing policy issues the Mission is currently discussing, compared with 5 years ago, and if possible, compared with the early 80's;
2. other health financing issues under discussion in the country, if different from Mission discussions;
3. factors that have promoted and inhibited Ministry of Health (MOH) consideration of health financing policy change;
4. one successful and one unsuccessful policy dialogue experience;
5. factors that support or constrain the Mission's ability to play a significant role in health financing; and
6. suggestions about how the process and/or content of technical assistance might be made more effective in supporting the Mission in its health financing activities.

Missions' responses to the survey questions represent a major contribution to documenting the evolution and changing patterns of USAID involvement and policy dialogue in health financing in the past five years.

As the following report shows, Missions have played a leading role in that evolution and significant changes in health financing policy dialogues and reform activities have begun to take place during the life of the REACH Project. A variety of international and domestic factors, and USAID, as well as Ministries of Health, characteristics have affected these changes. Many Missions now have 5-10 years experience as a base from which to identify some key lessons about the trends and patterns of health financing policy reform in developing countries. The following report presents these from the Mission perspective.

I. USAID MISSIONS AND HEALTH FINANCING POLICY DIALOGUE

Profile of Mission Involvement in Health Financing

More than half (38) of the 75 Missions and A.I.D. Offices responded to the S&T/REACH survey. Of the respondents, 23 Missions (60 percent) have recently been involved in health financing dialogue.¹ An additional four Missions had held financing discussions with respect to family planning, though not health, services. Table 1 summarizes statistics on the response rate and profile of respondents.

TABLE 1. Responses to the REACH Internal Assessment of Health Financing Activities

<u>Survey Statistics</u>	<u>A.I.D. Geographic Regions</u>			
	<u>AFR</u>	<u>ANE</u>	<u>LAC</u>	<u>TOTAL</u>
Total Missions surveyed.....	38	16	21	75
Total respondents.....	17	9	12	38
Percent responding.....	45%	56%	57%	51%
Total with recent health financing dialogue.....				
	7	7	8	23
Total with population, but not health, financing dialogue.....				
	2	1	1	4

Mission Respondents, by Geographic Region

<u>AFRICA</u>	<u>ASIA, NEAR EAST</u>	<u>LATIN AMERICA CARIBBEAN</u>
Botswana	Kenya	Belize
Burkina Faso	Madagascar	Bolivia
Cameroon	Mozambique	Brazil
Cent.Afr. Rep.	Niger	Chile
Chad	Nigeria	Costa Rica
Cote d'Ivoire	Senegal	Dominican Republic
Ethiopia	Sudan	Ecuador
Gambia	Zimbabwe	El Salvador
Guinea-Bissau		Haiti
	Bangladesh	Jamaica
	Egypt	RDO/C
	Indonesia	Venezuela
	Jordan	
	Morocco	
	Oman	
	Pakistan	
	Philippines	
	Yemen	

¹For ease of reference, all respondents are called "Missions" in this report.

In terms of absolute number, the 23 Mission respondents who are currently involved in health financing activities are a relatively small sample. But they represent about one-third of all Missions and A.I.D. Offices and a substantial portion of all the Missions who are engaged in health financing issues worldwide.

The characteristics of Missions and countries represented by the respondents provide a fairly representative picture, both globally and regionally, of USAID field experience and perspectives on health financing. Both large and small countries and Missions, Representatives, and Liaison Offices (ALOs) responded. Missions with complex, multiple health financing issues and ongoing assistance, as well as those with single issues, or start-up efforts, replied. Forty-five percent to fifty-seven percent of the Missions in each geographic region responded.

Missions who responded reflect a range of historical and recent experience with health financing. Six (25 percent) of the Missions currently involved in health financing report that they have been addressing health financing issues since the early 80's; nine more (about 40 percent) indicate involvement since 1985; and the remaining 35 percent for the past 3 years or less. Missions with longer experience with health financing have not, however, all had continuous experience. Several (e.g., Senegal, Gambia, El Salvador, Philippines, Ecuador) report a hiatus over the past five years during which the Mission did not pursue health financing issues. Others report lack of knowledge about earlier Mission experience in health financing due to staff turnover.

Changes in Health Financing Policy Dialogue

Mission responses indicate that three main changes in health policy dialogue and reform have occurred over the past five years. Ministries of Health (MOH) are more receptive to discussions about health financing policy reform; the Missions are discussing a broader range of health financing reforms; and there are more efforts at implementation, especially implementation of reforms affecting the whole health sector. All of these changes have occurred in all A.I.D. geographic regions, though some patterns are more pronounced in some regions than others.

Receptivity of MOHs. According to the Missions, many Ministries of Health are only recently, within the past 12-18 months, receptive to discussions about health financing policy reforms. At least half (12) of the Missions currently involved in health financing activities report that "the MOH is just beginning to think about" or is "much more receptive to" health financing policy compared with five years ago.

For example, in Yemen

"Sustainability is a number one priority for the Mission. Consequently, at every opportunity we raise cost recovery issues to counterparts, to influential officials in the Central Planning Organization and to others as opportunities arise (e.g. staff at the Faculty of Medicine)...Prior to

about eighteen months ago, these discussions were not welcomed since YARG officials always brought up the YARG constitutional provision that dictates that all health care services (education also) will be free. Even now, we have to go slow, but at least officials are willing to discuss financing issues; they finally realize that Yemen cannot afford a 'free health care for all' policy. The YARG is opening up to donor suggestions and ideas for alternate financing possibilities." (Yemen)

In the Central African Republic,

"Five years ago, health care financing was essentially a taboo subject, considered too sensitive politically for reform despite the breakdown of a system designed in theory to provide "free" health care to the population. Currently, the MOH is working to identify the modalities of a health cost recovery system following passage of legislation in April, 1989 which permits the participation of the population in paying for health care. The MOH has requested a long-term health care advisor to assist in developing, coordinating and implementing a national health care financing and cost recovery strategy." (CAR)

In the eastern Caribbean,

"The major difference in our programming today compared to a few years ago is that today we are starting to see the fruits of our labors. Governments are more proactive about initiating HCF activities and require less encouragement. They want assistance in studying the costs and budget implications of their current policies, and in gaining revenues through user fees." (Regional Development Office/Caribbean: RDO/C)

Broadening the dialogue. The second main change is that the health financing issues that many Missions are now addressing are much more comprehensive than five 5 years ago. For example, in Nigeria, "During 1989 and now in 1990, there has been dramatic change, allowing much broader perspectives to be discussed." Similarly, in Jordan "Over the past year, our discussions with the GOJ on health financing issues have focused more broadly on the health sector generally"; and in Morocco "recently, these discussions have become increasingly more sophisticated and encompass a full range of issues".

In the Philippines,

"1989 has been a high-water mark in the discussions of policy issues in HCF in the Philippines...The issues under (discussion) are wide-ranging and their resolution will bring about drastic and long-term changes in the way health care is being financed in the country." (Philippines)

Of the seven Missions that specifically referred to a change to more comprehensive issues, five are in the ANE region. As the next section of this report shows, the range of specific health financing issues tends to be more comprehensive in the ANE region than in other A.I.D. geographic regions. Nevertheless, Mission responses indicate that the pattern of addressing a

broader range of issues and the sector as a whole, rather than focusing on one or two issues as previously, affects many of the Missions who are becoming involved in health financing discussions during the period of recent receptivity to policy reform.

Move toward implementation. The third pattern of change has occurred in countries that have moved from exploratory discussions to implementation issues or activities in the past five years. For example, in Niger

"Generally, discussions in the last year have been on specific implementation issues related to developing a cost-recovery policy for basic health services, as compared with much more general discussions of previous years on the need for such a policy." (Niger)

In Kenya,

"In the early 1980's policy issues discussed were focused on general needs for financing reforms and internal efficiency/effectiveness reforms (cost savings). Most discussions were exploratory in nature, defining studies that needed to be undertaken in order to begin discussions. Political sensitivities were very high and little, if any, real policy reform was on the agenda. However, the 1980's financial crisis has forced GOK (as many other developing countries) to consider cost-recovery and cost-containment as critical objectives. In addition, more analytical work is now available to be used as a base for discussion. As a result, there are many financing activities currently taking place with Mission assistance." (Kenya)

Six of the respondents (Egypt, Indonesia, Kenya, Niger, Nigeria, Philippines) reported that they now have long-term assistance that includes comprehensive health financing change as the main focus or as a major component. Two Missions (Central African Republic, REDSO/WCA) are about to begin such long term assistance.

Mission Role in Promoting Health Financing Reform

The survey provides evidence that USAID Missions have played a substantial leadership role in setting the agenda for health financing policy reform in the past five years. The survey asked Missions to identify health financing issues under discussion in the country other than the ones Missions were addressing. In 50 percent (12) of the countries where Missions are currently involved in health financing policy dialogue, Mission responses indicated that they are addressing all the main issues under discussion in the country and/or were playing the lead role.

These responses do not indicate that other donors are not also involved and do not deny the role of donor collaboration in health financing. For example, several Missions also cited activities conducted by the World Bank, UNICEF, and particularly the UNICEF/WHO Bamako Initiative in Africa. But these other donor activities were, in some cases, not addressing a full range

of issues, or in most cases, not addressing additional issues other than those the USAID Mission is involved in the particular country.

Further, the survey reflects a broad range of knowledge about health financing issues on the part of HPN officers and staff, as well as heads of Missions or Offices. In addition, even in cases where the Mission is not involved in health financing discussions, the Mission is aware of and informed about other MOH or donor efforts in this area. More usually, no other donor is involved in health financing either. Occasionally, (e.g., Egypt, Costa Rica) the MOH is considering health financing issues that the Mission has chosen not to include in its health financing agenda or prefers the role of "observer" only.

The next section presents survey findings on the range of health financing issues Missions are currently discussing in policy dialogues with Ministries of Health.

II. HEALTH FINANCING ISSUES IN USAID MISSION POLICY DIALOGUE

USAID Missions have discussed a wide range of health financing policy issues with Ministries of Health in the past year. Missions identify these issues in terms that reflect a range of processes (e.g., resource allocation), activities (e.g., promote greater use of private sector), and financing methods (e.g. insurance; user fees).

Table 2, on the following page, lists all USAID Missions responding to the questionnaire. It shows which Missions are addressing which issues, and which have not been involved in health financing dialogues recently. There is a noticeable commonality of terms used by the majority of Missions to describe their health financing activities. Table 2 uses these terms and the following discussion indicates what Missions mean by them.

The Main Issues

As Table 2 shows, USAID Missions have been addressing seven main clusters of health financing issues. Three of these issues predominate, however. Globally, health financing issues that most USAID Missions have discussed with Ministries of Health in the past year are related to: 1) the private sector (40 percent of the Mission respondents who are currently involved in health financing activities identified this set of issues.); 2) cost recovery through user fees (40 percent); and 3) resource utilization and allocation (34 percent). Several issues -- insurance, HMOs, cost containment, decentralization -- discussed by a smaller number of Missions, tend to be dominant in only one geographic region.

Private sector. Most generally, Missions report that they discuss "expanding the role", "promoting greater involvement", or "increasing the participation" of the private sector. When specific examples are given, private sector activities take a variety of forms. For example, in Haiti private sector promotion takes the form of developing "over 8 PVO/Public Sector partnerships to deliver child survival services." In Egypt it takes the form of "facilitating credit loans to approximately 14,000 private health care practitioners with priority given to doctors starting or expanding practices in rural or peri-urban areas."

One of the most frequent forms private sector dialogues take is to discuss "privatization" of government hospitals (e.g., Jamaica, RDO/C, Indonesia, Philippines) or "contracting out" of government hospital services (e.g., Bolivia, Jamaica, Nigeria, Philippines). In other countries (e.g., Ecuador, Haiti, Indonesia, Philippines) private sector discussions include or concentrate on efforts to promote increased private provider participation in delivery of child survival services.

All Mission respondents referred to health maintenance organizations (HMOs) in the context of the private sector. Further, Mission references to insurance usually mean privately financed insurance, though a few Missions also address insurance issues related to publicly supported or administered health insurance funds (e.g., Jordan, Kenya). None of the Missions, including in the LAC region, mentioned addressing financing reforms with respect to major social security-based health insurance.

TABLE 2. HEALTH FINANCING POLICY ISSUES THAT USAID MISSIONS HAVE DISCUSSED WITH
MINISTRIES OF HEALTH IN THE PAST YEAR

USAID MISSION RESPONDENTS	Private Sector	Insurance	HMOs	Cost Recovery /Fees	Resource Utilization/ Allocation	Efficiency/ Cost Containment	Decentra- lization	Other Issues	None/None Recently/No Health Prog.
AFR									
Botswana									Botswana
Burkina Faso				Burkina Faso	Burkina Faso				
Cameroon				Cameroon					
Cent. Afr. Rep.				CAR					
Chad									Chad
Côte d'Ivoire									Côte d'Ivoire
Ethiopia									Ethiopia
Gambia									Gambia
Guinea-Bissau									Guinea-Bissau
Kenya	Kenya	Kenya		Kenya		Kenya			
Madagascar									Madagascar
Mozambique									Mozambique
Niger				Niger	Niger	Niger			
Nigeria	Nigeria						Nigeria		
Senegal					Senegal			Senegal	
Sudan									Sudan
Zimbabwe									Zimbabwe
AME									
Bangladesh									Bangladesh
Egypt	Egypt	Egypt	Egypt	Egypt					
Indonesia	Indo.	Indo.			Indo.				
Jordan	Jordan					Indo. Jordan			
Morocco	Morocco	Morocco	Morocco	Morocco		Morocco			
Oman									Oman
Pakistan	Pakistan	Pakistan			Pakistan	Pakistan		Pakistan	
Philippines	Phil.	Phil.	Phil.	Phil.	Phil.	Phil.			
Yemen	Yemen	Yemen	Yemen	Yemen					
LAC									
Belize	Belize			Belize	Belize	Belize			
Bolivia	Bolivia			Bolivia	Bolivia		Bolivia		
Brazil									Brazil
Chile									Chile
Costa Rica									Costa Rica
Dominican Rep.				Dom. Rep.	Dom. Rep.				
Ecuador	Ecuador			Ecuador	Ecuador		Ecuador	Ecuador	
El Salvador				El Sal.	El Sal.				
Haiti	Haiti								
Jamaica	Jamaica	Jamaica		Jamaica	Jamaica		Jamaica		
RDO/C	RDO/C			RDO/C	RDO/C	RDO/C			
Venezuela								Venezuela	
TOTALS:	15	8	4	16	13	9	4	4	15
(Total respondents, this question: 38)									

Cost recovery. Mission cost recovery discussions uniformly refer to charging user fees. Most (70 percent) of the Missions who are addressing cost recovery issues mentioned applying these discussions to "fees for services" or, specifically to fees for hospital, clinic, and basic health services. One Mission (RDO/C) also included cost recovery for drugs, along with fees for services. Two Missions reported applying cost recovery discussions only to essential medicines (Cameroon, Burkina Faso).

One Mission mentioned a special initiative in cost recovery for child survival services. In Egypt,

"The Mission is holding a series of policy discussions with the MOH to promote an increase in the price of ORS packets...to reflect more realistically the actual cost of ORS packets and to promote greater interest in private pharmaceutical firms to augment ORS production in Egypt...(and) to permit private pharmaceutical firms to continue to operate at an appropriate profit...For ORS, this means a continued price rise from fE55 to approximately fE87." (Egypt)

Resource allocation. Under the resource allocation concept, the dominant issue that Missions address relates to relative government spending for preventive and curative health services. Three-fourths of the Missions citing resource allocation illustrated with examples about increasing government funding for preventive services and/or reallocating government funding for curative (often hospital-based) services to preventive services. Some of these Missions also cited shifting responsibility for funding curative services from government to the private sector.

Cost containment. Missions who mentioned cost containment and efficiency generally cited the concepts only. When listing specific examples, Missions uniformly cited cost containment and efficiency issues with reference to the public sector and almost always with respect to hospitals. One Mission (RDO/C) has addressed "production efficiencies through improved drug supply management systems, health information systems, divestiture of services and improved technology." One Mission (Morocco) has applied cost containment discussions to "improved planning and guidelines for the installation and use of sophisticated and expensive technologies and equipment."

Decentralization and other issues. The several Missions who are currently discussing decentralization as part of their health financing policy dialogue are addressing decentralization of authorities to the regional or local administrative level (Nigeria, Bolivia, Ecuador). One Mission (Jamaica) is addressing decentralization issues for both the health facility and administrative level.

Some issues were cited by only one or two Missions. Table 2 lists these in the "Other" category. For example, only Senegal mentioned "financial management" and only Venezuela mentioned "increased donor funding."

Four Missions -- Botswana, Cote d'Ivoire, Costa Rica, and Bangladesh -- said they had addressed financing issues with respect to family planning, though not for health services. These cases could also be included in the

"Other" category, since these are very similar issues and often also involve Ministries of Health. The listing in Table 2, however, follows a literal definition and puts these Missions with those who had not recently held health financing discussions (last column), since in most cases these Missions have no health programs.

Regional Patterns

As Table 2 shows, survey responses from the Africa region indicate that health financing discussions are primarily focussed on cost recovery through fees for services and medicines. Both health and family planning financing dialogues are phrased in these terms and all but one (Senegal) of the Africa Missions with financing dialogues identified this cost recovery issue. Four of the seven Africa Missions with health financing activities are addressing two or three issues, but only the Kenya Mission reports that it has addressed a full range of health financing issues. Only two of the seven Africa region Missions with health financing dialogues, Kenya and Nigeria, currently address private sector issues.

Missions in the ANE region cover the broadest range of issues. Every issue named globally is discussed in the ANE region, with the exception of decentralization, and nearly all ANE Mission respondents who are involved in health financing dialogues cover a full range of issues (at least 4 of the seven issues named globally). Further, only the ANE Missions have discussed HMOs in the past year and, six of the eight Missions with discussions about health insurance are in the ANE region.

As Table 2 shows, Missions in the LAC region show a similar pattern to ANE, with the majority of Missions involved in discussions with Ministries of Health about at least four health financing issues. Decentralization is a more frequent issue in LAC region than elsewhere and most of the Missions discussing resource allocation issues are in the LAC region. The concept "equity" was cited only in the LAC region and only specifically named by one Mission, RDO/C. Equity was not, in that case, however, part of the main health financing dialogue, because, "...governments are already very aware of equity of distribution issues."

The next section presents Mission perspectives on factors that affect Ministry of Health receptivity to financing policy reforms.

III. FACTORS AFFECTING MINISTRY OF HEALTH CONSIDERATION OF FINANCING POLICY REFORM

Factors that Promote Policy Change

Since 1985, when the REACH Project began, many Ministries of Health have become interested in alternative ways to finance health services. According to USAID Missions, several (6) factors have promoted MOH consideration of health financing policy changes. Table 3 on the following page shows the presence of these factors in each of the A.I.D. regions, as reported by Missions.

The most commonly cited factors derive primarily from international sources, or forces external to the countries. The dominant influence -- cited by 23 Missions -- derives from "the economic crisis" these countries face. Fourteen Missions also considered the donor role to be important in promoting health financing policy change by: 1) providing information through studies (30 percent of the Mission respondents currently involved in health financing activities cited this factor.); 2) supporting "successful" health projects or experiments in the country (26 percent of the Missions); and 3) by providing persistent recommendations or pressure (26 percent).

A smaller number of Missions (under 20 percent) also cited factors internal to the countries in which they are working. These domestic factors are related to characteristics of government officials, public demand for quality, and other considerations specific to individual country circumstances.

Nearly all Missions responding to this question cited at least two factors promoting health financing change, but only one-third of the responding Missions included both international and domestic influences. The majority cited international economic and donor influences only.

Economic crisis. According to USAID Missions, the dominant factor promoting MOH interest in health financing policy changes has been "the economic crisis" of the 80's and/or a "budget crisis" deriving primarily from government budget cutbacks due to macroeconomic difficulties. As Table 3 shows, all geographic regions have been affected by these "crises" and all but four (Senegal, Belize, Ecuador, and Morocco) of the 23 Missions who are involved in health financing discussions cited economic and budget problems as having contributed to MOH consideration of health financing policy reform. In addition, other Missions not currently involved in health financing discussions (Mozambique, Bangladesh, Oman) mentioned, nevertheless, that the MOH in their country was considering health financing change because of the economic crisis.

A typical link between the economic crisis and health financing policy reform is described as follows, for the Central African Republic,

"Over the past five years there have been two essential factors working in favor of a new health financing regime. Firstly, the CARG has had to come to grips with a prolonged economic crisis and has committed itself

TABLE 3. FACTORS THAT HAVE PROMOTED MINISTRY OF HEALTH CONSIDERATION OF HEALTH FINANCING POLICY CHANGES IN THE PAST 3-5 YEARS

<u>USAID MISSION RESPONDENTS</u>	<u>Economic/Budget Crisis</u>	<u>Donor Studies/Information</u>	<u>Successful Projects in Country</u>	<u>Donor Pressure</u>	<u>Characteristics of Gov. Officials</u>	<u>Public Demand for Quality</u>	<u>Other</u>
AFR							
Botswana							
Burkina Faso	Burkina Faso	Burkina Faso	Burkina Faso				
Cameroon	Cameroon		Cameroon				
Cent.Afr.Rep.	CAR		CAR				
Chad							
Côte d'Ivoire							
Ethiopia							
Gambia	Gambia	Gambia					
Guinea-Bissau							
Kenya	Kenya	Kenya					
Madagascar							
Mozambique	Mozambique						
Niger	Niger	Niger	Niger	Niger			
Nigeria	Nigeria			Nigeria	Nigeria		Nigeria
Senegal							
Sudan							
Zimbabwe							
ANE							
Bangladesh	Bangladesh			Bangladesh			
Egypt	Egypt					Egypt	
Indonesia	Indonesia			Indonesia			
Jordan	Jordan	Jordan					Jordan
Morocco							
Oman	Oman						
Pakistan	Pakistan						
Philippines	Philippines	Philippines			Philippines		Philippines
Yemen	Yemen		Yemen	Yemen		Yemen	
LAC							
Belize					Belize	Belize	
Bolivia	Bolivia		Bolivia	Bolivia			
Brazil							
Chile							
Costa Rica							
Domin. Rep.	Domin. Rep.						
Ecuador							
El Salvador	El Salvador				El Salvador		
Haiti	Haiti				Haiti		
Jamaica	Jamaica						
RDO/C	RDO/C	RDO/C					
Venezuela	Venezuela						
TOTALS:	23	7	6	6	5	3	3
(Total respondents, this question: 24)							

to an ambitious series of economic reforms in collaboration with the IMF, IBRD and bilateral donors. Given sluggish economic growth, budgetary constraints and a commitment to reform, health care financing became a logical item on the agenda." (CAR)

Similarly, in the Philippines,

"DOH consideration of HCF issues was brought about by a confluence of factors the more important of which are the economic crisis in mid-1980's...(which) hampered the capability of the GOP to provide the necessary and appropriate level of health services. At the same time, shrinking household budgets and increasing medical costs made it very difficult for families to avail of medical services. Gradually, the allocational and distributional dimensions of health sector problems began to emerge as important policy issues. The economic crisis spawned a number of HCF issues, such as: How much should the government spend on health care? What should be the proper role of government in health delivery? How can the government enhance its role in the financing of health services?" (Philippines)

For some countries the "budget problem" is, as the Missions report, specifically linked to recurrent costs of child survival programs (e.g., Bangladesh, Pakistan) or to operating costs of new facilities added in the recent past (Pakistan). Alternatively, in Bolivia, "the economic crisis experienced in most of the Developing World during the 80's was much more severe..., where inflation rates reached more than 20,000%. Since then the financial structure of the health sector is being fundamentally re-structured..."

Donor Studies. In total, 8 Missions thought that information from donor-supported studies had promoted MOH consideration of financing change. A variety of different types of studies have been helpful. For example, USAID/Jordan cited studies that have "questioned the long-term sustainability of subsidized health care." In the Philippines, health financing has been elevated to "a major policy area" through "policy studies in health (covering such diverse topics as drug consumption, manpower production, hospital costs, and HMO operations..."

In the eastern Caribbean,

"Positive considerations of health care financing (HCF) policy changes have resulted from a growing appreciation for the inability to maintain the status quo. This appreciation has developed through cost studies, undertaken by the LAC/HCF Project of Victoria Hospital in St. Lucia and by the REACH Project of Holberton Hospital in Antigua... The two hospital cost studies...were very successful in convincing the respective governments of the need to seriously review user fee systems, including exemption policies, as noted ...(by) the Permanent Secretary of Health in Antigua." (RDO/C).

Donor studies appear to have played an especially important role in Africa. Sixty percent of the Africa Missions who are currently involved in

health financing reported that donor studies had helped persuade Ministries of Health to consider health financing change. In Kenya,

"The REACH Provincial and District Studies (1989) provided the MOH policy-makers with vital information needed before and after (Ministry initiatives in) cost-sharing...The USAID-financed REACH study of KNH has enabled it to play its main function increasingly as a national referral hospital and a teaching hospital. Due to reduced case load and increased effectiveness KNH is gradually improving the quality of its services." (Kenya)

In The Gambia,

"A short-term REACH consultancy mission to assess the financial needs of the health sector, held in 1985, concluded that there was need to embark on a cost recovery programme to meet shortfalls in health care expenditures due to (the) increasingly difficult economic situation in The Gambia. For sustainability purposes, the expansion of services in the face of serious resource constraints was questioned. There was also an analysis of a five year budget of the MOH (1980-85). The information provided was used to justify an increase in the GOTG budget allocation to the health sector (and a) cost recovery programme was inaugurated in 1988, for all levels of service delivery." (The Gambia)

Donor projects. Missions also thought that donor projects or experiments that test alternative health financing methods perform a similar role to studies by providing country-specific information about what works in the local situation. For example, "Tests so far in Niger have shown that cost-recovery works; when people pay and drugs are available, utilization of health services increases."

In the CAR, the presence of a well-perceived USAID health project (CCCD) in the country facilitated discussion of sector-wide health financing issues.

"Over the past five years there have been two essential factors working in favor of a new health financing regime ... Secondly, the Project REACH ... was well placed to assist the CARG in its consideration of health care financing issues. The success of the CCCD Project and good relations with the Ministry in general facilitated REACH's access and the receptivity of the CARG to outside advice on such a sensitive policy." (CAR)

Donor pressure. As Table 3 shows, one-fourth of the Mission respondents currently involved in health financing activities cited the role of persistent donor discussions urging Ministries to consider health financing changes. For example, Missions cite "collective donor pressure to address cost issues" (Bangladesh); "pressure from donors, not necessarily consistent in approach but consistent in calling for cost-recovery." (Niger); and "an A.I.D. office willing to support the Minister of Health in introducing innovations." (Nigeria) The Mission in Yemen describes the role of "steady pressure of donors" as follows.

"Three years ago, Mission staff attempted to get Ministry approval to carry out a financing study in the Tihama region of the country. The MOH refused to even discuss the matter and rudely dismissed the USAID staff. (We consequently have a major sustainability problem with the Mission-funded Tihama Primary Health Care Project (TPHCP). We kept up the pressure, however, and dropped suggestions at every opportunity.

Some successes have occurred because of the pressure: three months ago the Director of Yemen's largest hospital (550 beds -- all services provided free) asked USAID to send a consultant to Yemen to conduct a study on the possibility of initiating some type of insurance scheme and/or HMO in Sana'a. Also, the Director General for Health in the Tihama region told us two months ago that he was going to conduct an experiment in fee collections in one of the TPHCP-supported health centers in the region and wanted our assistance. We will do so under our newer child survival project (ACCS)." (Yemen)

Domestic factors. The two most common domestic factors that have led Ministries of Health to consider financing change have been related to characteristics of government officials and demands from the public for quality health services.

In some cases, certain unique characteristics of MOH officials facilitate consideration of policy change. For example, in the Philippines, "The academic backgrounds and private sector experiences of the DOH Secretary and his Undersecretaries have helped immensely in initiating policy discussions on HCF." More generally, it is "a Minister of Health who is creative and open to change." (Nigeria)

The success of a proposal for health financing policy reform may be highly dependent on the characteristics of decision-makers in place at the moment. For example, in Haiti

"With a bankrupt government and a dynamic Minister of Health, USAID was able to parlay resources with policy dialogue to allow the MOH to get credit for providing health services through PVOs, and eight PVO programs were effectively given greater responsibility in the delivery of health services. With another less visionary Minister, a major initiative for fee for service to remunerate health volunteers and provide a greater variety of child survival services was stifled for political concerns." (Haiti)

In some countries the public's demand for quality is beginning to play a role in prompting MOH's to consider health financing changes. For example, in Yemen this phenomenon takes the form of "Demands of the public for better quality services and failure of YARG to improve these services, lack of funds being one factor limiting quality improvements. (The public pays under the table now, but services stay the same.)" The Mission in Belize describes the dynamics of this process as follows.

"The MOH is receptive to dialogue on health financing policy change since a specific national goal is the provision of adequate health care to all

Belizeans, and the ineffective and poor management of scarce resources seriously jeopardizes attainment of this goal. Additionally, primary health care and child survival programs have been generally successful in Belize but very little attention has been paid to the sustainability and maintenance of these programs. Consequently, the MOH is well aware that gains in these areas are now jeopardized due to the lack of proper resource management. In general, there is a growing lack of faith by Belizeans regarding the MOH's ability and commitment to provide adequate health care and this has clear social, economic, and political ramifications." (Belize)

Other factors. There is also a range of individualistic, country-specific factors that have played a role in promoting MOH consideration of financing change. For example, the Philippines Mission cited the "emergence in the past few years of NGOs and HMOs as new forms of health care delivery"; in Jordan "The creation of a National Medical Institute as a public corporation responsible for all publicly financed hospitals (has) prompted examination of the costs of improving the quality of curative health care." In Nigeria, factors promoting health financing change include "a national health policy that now focuses on primary health care."

Factors that Inhibit Policy Change

Considerations related to general government policies and to politics appear to play a much more important role as constraints to Ministry of Health consideration of financing change than do technical or methodological considerations. As Table 4 on the following page shows, Missions share a broad consensus on two factors that have inhibited MOH consideration of financing policy change in the past 3-5 years: the government's "free care" policy and "political risks." About half of the Missions who are currently involved in health financing activities cited at least one of these two considerations.

Various internal MOH constraints play the next most important role in presenting obstacles to financing policy reform. One-third of the Mission respondents cited inhibiting factors related to lack of MOH expertise and implementing capacity; and one-fourth named bureaucratic inertia and instability.

By far, the majority of inhibiting factors Missions identified are related to domestic influences or characteristics. Several (one-fourth) of the Missions did, however, mention an international or externally induced obstacle to change related to the economic situation or donor activities in their countries.

In general, Missions identified a wider range of factors that have inhibited, than have promoted, Ministry consideration of health financing change. A majority of the Missions identified two or more obstacles to change, but these did not occur in any consistent pattern or clusters. Major regional differences in the obstacles Missions cited are not apparent.

TABLE 4. FACTORS THAT HAVE INHIBITED MINISTRY OF HEALTH CONSIDERATION OF HEALTH FINANCING POLICY CHANGE IN THE PAST 3-5 YEARS

<u>USAID MISSION RESPONDENTS</u>	<u>Free Care Policy</u>	<u>Political Risks</u>	<u>Bureaucratic Inertia/Instability</u>	<u>Lack MOH Expertise/Capacity</u>	<u>Negative Economic/Donor Impacts</u>	<u>Lack Models/Info</u>	<u>Other</u>
AFR							
Botswana							
Burkina Faso							
Cameroon	Cameroon						
Cent.Afr.Rep.	CAR	CAR		CAR			
Chad							
Côte d'Ivoire	Côte d'Ivoire	Côte d'Ivoire			Côte d'Ivoire		
Ethiopia							
Gambia				Gambia			
Guinea-Bissau							
Kenya		Kenya	Kenya				
Madagascar							
Mozambique					Mozambique		
Niger							
Nigeria				Nigeria		Nigeria	
Senegal							
Sudan	Sudan	Sudan	Sudan		Sudan		Senegal
Zimbabwe							
ANE							
Bangladesh							
Egypt	Egypt						
Indonesia							
Jordan	Jordan						Jordan
Morocco				Morocco			
Oman							
Pakistan		Pakistan		Pakistan	Pakistan		
Philippines	Philippines	Philippines	Philippines	Philippines	Philippines		
Yemen	Yemen						
LAC							
Belize	Belize						
Bolivia					Bolivia		
Brazil							
Chile							
Costa Rica							Costa Rica
Dominican Rep.							Dominican Rep.
Ecuador	Ecuador	Ecuador	Ecuador				
El Salvador	El Salvador	El Salvador	El Salvador	El Salvador			El Salvador
Haiti			Haiti				
Jamaica		Jamaica	Jamaica			Jamaica	
RDO/C	RDO/C	RDO/C				RDO/C	
Venezuela							
TOTALS:	11	10	8	6	6	4	4
(Total Respondents, this question: 24)							

Except for the widespread prevalence of the free care and political risk factors, only two other obstacles operated in as many as four countries, and all the other obstacles Missions named operated in fewer countries.

Free Care Policy. In general terms, Missions cited government "free care policies" or the "right to health care" provided through public financing as a major factor inhibiting health financing policy dialogues with the Ministries of Health. More Missions agree on the role of this factor than on any other inhibiting factor and, as Table 4 shows, this factor operates fairly equally across all geographic regions.

The Philippines Mission describes the way in which free care policies inhibit health financing discussions as follows.

"Notwithstanding significant strides made in raising HCF as an important policy area, certain factors inhibit proper understanding of HCF issues. Firstly, 'conventional wisdom' views all health care provision as primarily a government domain. The Constitutional 'right to health' is frequently invoked to mean that the government should provide health services free. In this light, any HCF initiative is interpreted as 'making the poor pay'." (Philippines)

Political Risks. Political considerations represent the second major factor inhibiting health financing policy change, cited by almost half of the Missions who identified such obstacles. Missions identified these considerations variously as "political risks", "lack of political consensus", "lack of political will" or "lack of political courage", and fear of protests. As Table 4 shows, perceptions of political risk appear to operate equally in the Africa and LAC regions, but may be somewhat less prevalent in the ANE region. Nevertheless, according to the Pakistan Mission,

"Political considerations appear to be the most important constraint to MOH consideration of health financing policy change. Several years ago, an attempt to introduce user fees at health facilities in the Punjab was rescinded because of political protests." (Pakistan)

Political considerations do not always prevent the initiation of a health financing initiative, but remain in the forefront to be carefully monitored especially during early stages of implementation. As the Kenya Mission reports,

"The political sensitivity of cost-sharing and the public's reaction to date make this new policy initiative fragile. Any changes which would add to this financial burden are approached with great caution." (Kenya)

Similarly, in the eastern Caribbean,

"...politics has played an obvious role in inhibiting governments from pushing resource mobilization issues. Although today governments realize they cannot avoid this issue forever, timing of reforms is still critical in the implementation strategy. For example, a comprehensive package of HCF reforms has been designed by the Ministry of Health in Dominica.

Implementation is scheduled for later this year -- after elections in May." (RDO/C)

MOH expertise, capacity. One-fourth of the Missions who identified inhibiting factors thought that a lack of expertise in health financing or a lack of implementing capacity was an important MOH constraint to considering health financing policy change. For example, two Africa region Missions cited "organizational capacity to implement such a programme" (Gambia) and "overall management and administrative weakness (and) the absence of a coherent operational strategy for the health sector as a whole." (CAR) LAC and ANE region Missions focussed on lack of expertise, including "lack of technical knowledge of how to approach and accomplish policy change" (El Salvador); and "limited expertise on the mechanics, operational aspects, and policy implications of HCF initiatives" (Philippines).

Bureaucratic inertia and instability. One-third of the Missions identified either "bureaucratic inertia" (Nigeria, Ecuador, El Salvador, Jamaica) or MOH instability (Haiti, Kenya, Sudan) as important obstacles to policy change. Several Missions used the general term "inertia" and the Nigeria Mission specified this characteristic as "Decision-makers who are reluctant to test innovative change." Frequent turnover of MOH decision-makers also produces an instability that can frustrate consideration of policy changes. In Haiti there have been "at least 7 different Ministers of Health over the past three years." In the Sudan,

"Because of political turmoil with frequent changes in political leadership in the MOH, effectively no policy formulation has taken place in the past five years. The Mission is unable to establish policy dialogue with the MOH officials. With the constant turnover of officials, they have been more concerned with positioning themselves politically...(and take) little interest in the formulation of policy (which can get you fired or put in jail in the current political climate)." (Sudan)

Negative economic and donor impacts. Two Missions (Cote d'Ivoire and Mozambique) suggested that declining incomes, due to the economic crisis, were presenting an obstacle to health financing change. In the Cote d'Ivoire, for example, "It appears that the majority of the population already impoverished due to economic recession in recent years...will not be in the position to pay for health services." In other countries the overall impact of "the economic crisis" ultimately has a paralyzing effect.

"Sudan is broke and has no hard currency to purchase needed drugs or supplies. This has caused virtually total collapse of the health care system. These are the major inhibitions to any policy or progress in Sudan."

Several Missions identified negative influences deriving from donor activities in their countries. The dynamics of these negative donor impacts are, however, quite varied. In the Philippines "There are political groups that are wary of reforms initiated by the donor community... viewed as needless interference." Alternatively, in Pakistan,

"Different donor agendas have been a further constraint to consideration of health financing policy change. Some donors, such as (Donor X), have actually contributed to the budgetary crisis by financing 'high-tech' hospitals with exorbitant operating costs. In addition, the MOH has been very successful in obtaining agreements from some donors to fund operating costs or commodities, thereby postponing difficult decisions." (Pakistan)

Similarly, in Bolivia,

"Perhaps the role of (Donor X) during the past two and a half years has been the single most important factor for changes in attitude within the MSW/PH. Those changes, however, did not promote stronger cost consciousness nor the development of cost benefit and efficiency criteria suggested by other (Donor X) initiatives...On the contrary, the existence of large amounts of (cheap) loan funds has given rise to the hiring of more central administrative staff...the increasing financial role of international agencies as the main provider of health services...(and) the payment of salary supplements to MSW/PH employees to ensure successful projects...Such a solution is creating internal conflicts between the traditional and 'not-so-lucky' personnel and the 'lucky ones' hired especially for the implementation of specific projects...(and) negates the use of cost or efficiency measures... for policy purposes." (Bolivia)

Lack of models and other factors. In some cases, MOH consideration of financing policy changes has been inhibited by "the lack of successful models for them to replicate" (Jamaica) or the existence of "few examples of success in developing health financing policies in developing countries." (Nigeria) Other inhibiting factors the Missions named ranged from "lack of convincing data which demonstrate the full costs of the health care system" (RDO/C); to "relatively plentiful government resources in the past" (Jordan); to "the existence of other national issues of perceived greater importance (war, earthquake, etc.)." (El Salvador)

IV. FACTORS AFFECTING USAID MISSION ABILITY TO PLAY A SIGNIFICANT ROLE IN HEALTH FINANCING

Since the beginning of the REACH Project, many USAID Missions have begun to address health financing issues in a more active or extensive way than they had previously. Along with Missions who have been involved in health financing for many years, this broader experience now makes it possible to identify some of the main factors that have supported or inhibited Mission ability to play a significant role in health financing in the countries in which they work.

Mission perceptions of influences on their health financing role do not generally vary significantly by geographic region. According to the Missions, three factors predominate in their influence on Mission ability to play a significant role in health financing: 1) Mission funding or program level (15 Missions cited this factor); 2) Ministry of Health characteristics (13 Missions); and 3) technical assistance (9 Missions). Each of these factors, however, can have both positive and negative influences. They have supported some Missions and posed constraints to others, and can also change over time in the same Mission and country.

In addition to the three dominant factors, Missions named several other factors that support (e.g., good relations with the MOH) and that limit (e.g., Mission staff and time constraints; Congressional restrictions) their role in health financing.

Missions focused more on constraints than supports in response to the survey questions. Almost twice the number of Missions identified constraints (30 Missions) than those (17) who identified factors supporting their role in health financing. Missions appear to perceive both USAID and MOH factors equally as supports. But they are much more likely to perceive USAID, than MOH, characteristics as obstacles to their ability to play a significant role in health financing.

Tables 5 and 6 summarize survey findings for the factors supporting and inhibiting the Mission role in health financing. The following describes these briefly then discusses the role of the main factors that can have positive or negative impacts on Mission health financing activities.

Factors that Support Mission Role

USAID Missions identified five main factors that support their ability to play a significant role in health financing. If all responses are taken together, the Mission view is that it is important to have a receptive Ministry (or good relations with the Ministry); effective technical assistance; and a sufficient level of USAID activity, or a successful health project, underway with the MOH. Some Missions also report that the private sector's, or population's, interest in health financing changes have promoted their role in health financing.

As Table 5 on the following page shows, the two supporting factors most frequently identified are MOH receptivity and effective technical assistance

TABLE 5. FACTORS THAT SUPPORT MISSION ABILITY TO PLAY
A SIGNIFICANT ROLE IN HEALTH FINANCING

<u>USAID MISSION RESPONDENTS</u>	<u>MOH Receptivity</u>	<u>Effective TA/US Expertise</u>	<u>Good Mission Relations with MOH</u>	<u>Level of USAID Funding and Programs</u>	<u>Successful USAID Projects with MOH</u>	<u>Local Providers/ Population Interest in Change</u>
AFR						
Botswana						
Burkina Faso	Burkina Faso	Burkina Faso		Burkina Faso	Burkina Faso	
Cameroon	Cameroon				Cameroon	
Cent. Afr. Rep.			CAR		CAR	
Chad						
Côte d'Ivoire						
Ethiopia						
Gambia						
Guinea-Bissau						
Konya						
Madagascar						
Mozambique						
Niger	Niger	Niger		Niger		
Nigeria	Nigeria					
Senegal						
Sudan						
Zimbabwe						
ANE						
Bangladesh						
Egypt						Egypt
Indonesia		Indonesia	Indonesia			
Jordan		Jordan				
Morocco	Morocco			Morocco		
Oman						
Pakistan						
Philippines	Phil.					Phil.
Syria						
Yemen						Yemen
LAC						
Belize		Belize	Belize			
Bolivia		Bolivia	Bolivia		Bolivia	
Brazil						
Chile						
Costa Rica						
Domin. Repub.						
Ecuador						
El Salvador						
Haiti	Haiti			El Sal.		
Jamaica			Jamaica	Jamaica		
RDO/C		RDO/C				
Venezuela						
TOTALS:	7	7	5	5	4	3
(Total respondents, this question: 17)						

(TA). Most (two-thirds) of the Missions who identified a supporting factor identified two -- at least one related to Ministries of Health and one related to USAID factors.

Some regional pattern is evident in the role of the supporting factors. For the five Africa region Missions who identified factors that support their roles, the majority named MOH receptivity and successful USAID projects in the country. The six LAC region Missions who identified supporting factors concentrated on good MOH relations and effective TA. The only majority view evident in the ANE region is with respect to the role of local provider or population interest in health financing changes. Further, Missions in the ANE region are the only ones who identified this factor.

Factors that Constrain Mission Role

Missions identified six main constraints to their ability to play a significant role in health financing. All but one of these constraints are related to characteristics of USAID programs, Missions, or resources.

As Table 6 on the following page shows, the three most frequently cited constraints to a Mission role in health financing are: 1) limited USAID funding or program level (cited by 10 Missions); 2) MOH constraining characteristics (cited by 9 Missions); and 3) limited Mission staff knowledge or time (cited by 8 Missions). These are followed in importance by "other Mission priorities than health or health financing" and "Congressional restrictions", each cited by 5 Missions. Several (3) Missions also cited constraints due to unavailability of consultants to provide TA.

A variety of other obstacles, cited by only one Mission range from "strongly politicized medical union groups" (Ecuador); to "the almost exclusive rural orientation held by USAID which leaves the urban areas to other institutions like the World Bank, who are not necessarily following the same health care financing objectives" (Bolivia); to "lack of standards in developing health financing policies in developing countries." (Nigeria)

Most constraints that the Missions named are relatively equally distributed in all three regions. "Other Mission priorities" (e.g., agriculture) appear to limit health financing activities more in Africa, however, than in other regions. Three of the five Missions citing this factor are in the Africa region and none in ANE.

Mission perceptions of constraints deriving from their own situation and processes appear to be higher and more common than their perception of locally based constraints. Only 30 percent (9) of the Missions who identified constraints to their role cited MOH as a constraint at all. Most (21) Missions cited only USAID factors; five Missions cited only MOH factors; and less than 15 percent (4) of the 30 Missions who identified constraints cited both MOH and USAID factors.

TABLE 6. FACTORS THAT CONSTRAIN MISSION ABILITY TO PLAY
A SIGNIFICANT ROLE IN HEALTH FINANCING

<u>USAID MISSION RESPONDENTS</u>	<u>Level of USAID Funding and Programs</u>	<u>MOH Constraints</u>	<u>Mission Staff/Time Constraints</u>	<u>Other Mission Priorities</u>	<u>Congressional Restrictions</u>	<u>TA Constraints</u>	<u>Other</u>
AFR							
Botswana	Botswana		Botswana	Botswana			
Burkina Faso							
Cameroon							
Cent. Afr. Rep.	CAR						
Chad							
Côte d'Ivoire	Côte d'I.						
Ethiopia					Ethiopia		
Gambia				Gambia			
Guinea-Bissau							
Kenya		Kenya					
Madagascar							
Mozambique			Mozambique				
Niger							
Nigeria		Nigeria					Nigeria
Senegal			Senegal	Senegal			
Sudan		Sudan			Sudan		
Zimbabwe	Zimbabwe						
ANE							
Bangladesh	Bangladesh						
Egypt		Egypt					
Indonesia							Indonesia
Jordan	Jordan						
Morocco			Morocco			Morocco	
Oman			Oman				
Pakistan			Pakistan				
Philippines		Philippines					
Yemen							
LAC							
Belize							
Bolivia							Bolivia
Brazil					Brazil		
Chile					Chile		
Costa Rica	Costa Rica						
Domin. Repub.		Domin. Rep.					
Ecuador		Ecuador	Ecuador				Ecuador
El Salvador							
Haiti	Haiti	Haiti	Haiti	El Sal.		Haiti	
Jamaica		Jamaica					
RDO/C	RDO/C						
Venezuela	Venezuela				RDO/C	RDO/C	
TOTALS:	10	9	8	5	5	3	4
(Total Respondents, this question: 30)							

The Main Influences on Missions' Role in Health Financing

The three dominant factors that Missions identify as having an influence on their ability to play a significant role in health financing can have a positive or a negative impact. The following describes how Missions see these influences affecting their role.

USAID funding and program level. The level of USAID funding and program activities is more often perceived to be a constraint, than a support, to a Mission's role in health financing. Ten Missions named funding and program factors as inhibiting their role, compared with 5 Missions who saw these as a support. Although funding and program level are related, the dynamics of how they affect the Mission role are somewhat different.

Program level. Missions named two basic aspects of the level of USAID program involvement that affect their ability to play a significant role in health financing. Lack of a bilateral agreement with the government (Cote d'Ivoire) or lack of Mission status (CAR, Venezuela) are perceived as strong constraints, even though this clearly does not preclude even active and significant involvement in health financing (e.g., CAR), if other factors are also present.

A second type of program constraint to a significant role in health financing comes directly from "limited involvement" in the health sector (Botswana, Bangladesh, Costa Rico, Zimbabwe). Such limited involvement "provides only a minimal opportunity to discuss major health financing issues." (Botswana) As noted by the Eastern Caribbean Mission, it may also affect the sustainability of health financing assistance.

"While a number of one-term, PD&S-financed activities have been undertaken in this area, it is nonetheless evident that long term gains can only be assured with longer term (e.g., 3-5 year project-level) commitments to the process...(and with) an integrated, project approach to our health care financing efforts." (RDO/C)

When a concentrated, longer term health program effort is present, other Missions cite it as a major factor supporting a strong role in health financing. In Niger,

"The major support to USAID/Niger playing a significant role in health financing is the mechanism of the Niger health sector support (NHSS) grant, which has at its core, conditions precedent which require the MOH to develop cost-recovery policies. The NHSS has a long-term technical assistance component and long-term and short-term training funds to support policy reform activities." (Niger)

Similarly, in Burkina Faso, "Mission dialogue with the MOHSA was facilitated by...The key position gained by the Mission which started the dialogue within the overall context of the health planning activity of the SHPC Project."

In Jamaica,

"The Mission can have a significant role in health care financing... because of our long history of involvement in this area, and the fact that the bulk of our support in the health sector is in this arena. However, we can promote, suggest, and persuade, but it is ultimately the government's decision as to which policies they adopt and the degree of political risk they are willing to accept." (Jamaica)

Funding level. Two Missions specifically identified funding levels as a support to their role in health financing, either "adequate ANE Bureau and Mission funding...programmed for sector analysis and project development work" related to health financing (Morocco) or a high level of total USAID funding for development assistance in the country (El Salvador).

Five Missions, however, named USAID health, or development assistance, funding levels as a constraint (Zimbabwe, Jordan, Costa Rica, Haiti). Typically, funding constraints are perceived as limiting "leverage." For example, "with a cut-off of development assistance...the MOH is not interested in investing much in the American ideas/opinions." (Sudan), even though the MOH had worked with the Mission on cost recovery experiments in the health sector prior to the cut-off. In Costa Rica,

"As the Mission has no health funds, and does not support any major programs other than family planning, policy dialogue leverage is nil...(but) with family planning, we are attempting to reach a point where the CCSS will assume the contraceptive costs for the entire public sector program." (Costa Rica)

One Mission indicated that the lack of leverage that might be provided by larger development assistance can be offset by effective technical assistance.

"The main constraint to the Mission's ability to play a more significant role in health financing reform is the relatively low levels of USG development funding levels. The magnitude of potential USAID input in the health sector is minor in the eyes of many policy makers. This means that the only significant attraction we offer is the quality of our technical approach." (Jordan)

MOH characteristics. Missions perceive MOH characteristics as primary factors affecting both the Ministry's and the Mission involvement in health financing policy reforms. More than half (65 percent) of the Missions with ongoing health financing policy dialogues consider the MOH (either its operating characteristics or USAID-MOH relations) when they think of factors affecting their role in health financing.

In general, MOH characteristics that affect Missions' role in health financing parallel those that contribute, or present obstacles, to MOH consideration of health financing reforms. The primary characteristic with a positive impact on the Mission role is MOH, and government, "receptivity", or "openness", to considering health financing alternatives and initiatives.

Mission responses indicate that receptivity, or commitment, is especially important on the part of Ministers.

In some cases (Nigeria, Philippines, Haiti, Jamaica) Missions report both positive and negative influences from the MOH. But as Tables 5 and 6 show, in five other cases, only positive or negative influences dominate the Mission view. The primary MOH constraints named are those that Missions named as inhibiting MOH consideration of health financing policy reform (e.g., bureaucratic inertia; turnover; lack of expertise; fear of taking political risk).

Technical assistance. Nine Missions (40 percent of those currently involved in health financing), identified technical assistance as affecting their ability to play a significant role in health financing. Most (7 of the 9) identified TA as a support, citing "the effectiveness of the technical assistance which USAID has provided...and the trust with which the MOH holds USAID's technical assistance" (Indonesia); or the government's "recognition that the United States is a leader in health care financing programs with a tremendous, varied experience." (Belize)

In Burkina Faso "the provision of quality, discrete, and timely technical assistance...(played) a critical role in the planning and implementation process of health care financing activities " and in Niger, "an effective, persistent long-term technical assistance team has been critical to moving health financing policies along." In the Eastern Caribbean,

"The Mission has received excellent cooperation and technical advice from the LAC and S&T/H bureaus regarding the design of HCF programming as well as capable technical assistance from REACH and the LAC/HCF projects in project implementation." (RDO/C)

The 3 Missions (Morocco, Haiti, RDO/C) who cited TA constraints to their ability to play a role in health financing identified the "limited pool" of available, qualified health financing consultants, especially with appropriate language requirements.

Missions also made a variety of practical suggestions about how the process and content of technical assistance might be made more effective in supporting the Mission in its health financing activities.

For example, several Missions mentioned a need to develop rosters of health financing consultants with specific technical and language skills or expand the consultant pool because of competition for the time of quality consultants. One Mission mentioned a need to provide health financing training for HPN officers. Several indicated a need for more information on successful and unsuccessful efforts at health financing policy reform or regular, detailed information on A.I.D. experience in health financing that is working well or not.

Several (3) Missions commented on the support role of centrally funded projects, especially with respect to its use as a funding mechanism to help Missions take advantage of opportunities to facilitate health financing

assistance on a timely basis. For example, "It would be useful to have more central funds in health financing contracts to provide rapid responses." (Ecuador). Further,

"Because many areas in health care financing are new and politically sensitive, the Mission cannot always convince the government to use bilateral funds, if available. The availability of A.I.D./W financed technical assistance can be extremely useful in this regard. An example of this was the recent visit to Jamaica by PRITECH II consultants to assess the Jamaican Drug Procurement and Distribution System, financed by A.I.D./W. The high quality of the consultants, their report and debriefing convinced the Minister to commit himself to their recommendations. I am not sure the GOJ would have agreed to this TA, without the carrot of it being at no cost to them. The A.I.D./W trend towards leveraging Mission buy-ins is one that should be carefully thought through." (Jamaica)

By far the most frequent suggestion Missions made about technical assistance was that it needs to be culturally and politically sensitive. Three times as many Missions (33 percent vs. 10 percent) remarked on this subject than on any other single suggestion for TA. Based on their experience with successful and less successful TA, many Missions have concluded that these attributes are at least as important as technical qualifications.

The next section discusses this point further, along with other lessons Missions have learned from successes and failures in health financing policy reform activities.

V. USAID MISSION PERSPECTIVES ON HEALTH FINANCING POLICY REFORM

Successes and Failures

Although Missions report a heightened receptivity on the part of MOH's to consideration of health financing policy reform, there is a wide variation in specific reform proposals that any given MOH is willing to consider. Missions reported a whole array of health financing alternatives that they were successful and unsuccessful in having considered or tested or implemented in the countries in which they work. In addition, many of the Mission examples indicated approaches that are most successful in introducing or advancing policy reform.

Specific health financing reforms and alternatives. In general, for every health financing scheme or alternative that has "worked" in one country, there is an example of another country in which the MOH was either unwilling to consider it as an alternative or implementation proved it to be unsuccessful.

For example, according to Mission responses, the MOH in El Salvador has increased budget allocations to preventive, rural services, but in Bolivia, the Mission has been unsuccessful with its efforts to encourage the MOH to allocate more funding to primary health care. Two Missions reported cost recovery schemes for basic medicines as successful and one reported them unsuccessful. Two Missions were successful in promoting consideration of fees for basic health services, three were unsuccessful. Five Missions reported success in persuading Ministries to consider some variety of reform in hospital financing. But each of these reforms is different and several have not been in operation long enough to judge results.

It is also true that within a single country, similar alternatives may not be equally "successful." For example, the Sudan Mission reports that the MOH implemented with USAID assistance a cost recovery system for basic drugs in a rural health project but will not consider cost recovery for family planning. The RDO/C reports that governments in the eastern Caribbean implemented a major cost containment effort in drugs through reform of pharmaceutical purchasing, but will not "adopt or strengthen their prescription fee systems even though they did covenant to do so when governments signed up to participate in the project."

Alternatively, health financing reforms that are often perceived as similar or "interchangeable" may not be equally appropriate, even in the same setting, as in Jamaica.

"An example of successful policy dialogue has been the contracting out of hospital services in three hospitals implemented in 1987, which will now be replicated in Spanish Town Hospital and other hospitals in Jamaica. An unsuccessful example would be the privatization of hospitals. However, the reasons for this not moving forward was that privatization was projected to cost the MOH more money rather than save money, and it was not adopted as policy by the new Jamaican government." (Jamaica)

Successful Approaches. Workshops and studies are among the most common, and successful, vehicles Missions have found to help advance health financing policy dialogue. Half of the Missions cited workshops and studies as having helped create a breakthrough in Ministry thinking about the health financing situation. As noted in section III of this report, Missions identified donor studies as one of the main factors promoting MOH consideration of health policy reform. Several Missions also specifically cited workshops as principal examples of successful policy dialogue. For example, in Niger

"Finally a breakthrough came with the agreement to conduct an interministerial seminar to discuss options for cost-recovery. This seminar was conducted in November 1989, and yielded an agreement on the options to test, evaluation criteria to use in assessing the tests, and, in effect, gave the MOH the go-ahead to plan the pilot tests. The Minister has since then given the process his full support, and is now a major actor in pushing the process along." (Niger)

Similarly, in the Central African Republic,

"Probably the most successful experience on policy dialogue took place during a workshop sponsored by REACH in April, 1989. This workshop brought together government officials from the MOH and the Ministry of Finance as well as legislators to make decisions on the design and implementation of a cost recovery system following the adoption of enabling legislation by the national assembly in February, 1989. The participation of government officials from Senegal and Zaire was particularly useful in persuading CARG officials of the desirability/feasibility of health cost recovery." (CAR)

Lessons Learned

Missions highlighted a variety of lessons they had learned in the past decade about the process of health financing policy reform. Lessons most often noted or that are most generally applicable are that

Health financing policy reform is as much a political as it is a technical process and it requires politically and culturally sensitive assistance from USAID.

There are no formulas that apply globally.

Health financing reform takes time.

It involves substantial institutional change.

To have a lasting impact in health financing reform, it is important to move beyond the MOH and work with other government ministries.

Health financing policy reform is an iterative and a cumulative process.

The following provides an illustration of each of these lessons from the Missions' perspectives.

Health financing policy reform is a political process, requiring politically and culturally sensitive assistance. The main lesson that Missions have learned about technical assistance in health financing is the need to be culturally and politically sensitive. Forty percent of the Missions currently involved in health financing activities highlighted this point. Based on their experience with "successful" and less successful TA, many Missions have concluded that these attributes are at least as important as technical qualifications.

"The problems in this country are at least as much managerial and 'political' as they are technical. Unless consultants and advisors can operate successfully in the local environment, they have no chance of getting the technical assistance across." (CAR)

"Technical Assistance needs to focus not only on identification and evaluation of appropriate policies, but also on successful approaches to introducing and implementing politically sensitive policy change." (Pakistan).

"There are a lot of potential economic and political repercussions from any HCF initiative. Hence, a strong consensus must be established prior to any policy change. Consensus-building requires that the views of all sectors involved or affected by the initiatives must be heard. Any technical assistance must be able to take into consideration this important dimension of HCF." (Philippines)

According to Missions, the need for political and cultural sensitivity includes not only the approach of the consultant, but the content of the recommendations. For example, USAID/Philippines comments that,

"There is very strong tendency among experts to recommend the wholesale importation of concepts that work well in Western countries. This practice is dangerous in the case of HCF because of built-in socio-cultural elements (ability to pay, organizational setup, individual and household behavior towards disease, pervasive poverty, etc.) For this reason, technical assistance must (a) be aware of the various socio-cultural factors that could impinge on recommended HCF initiatives, and (b) permit experimentation of various options." (Philippines)

No formulas apply globally. The major lesson from Mission accounts of their successes and failures in health financing policy reform is that reforms that work in one country may or may not work in another; or may work, or not, at a different point in time in another country. As USAID/Egypt notes,

"The entire concept of health financing is complex, even in the United States. Thus, we should realize the evolution of health care will be a long and complicated activity. There appears to us to be no single, magic formula on how to apply health financing to a particular country,

for each has different requirements and needs. What is paramount is the need for patience from A.I.D., a need to understand each local health context, and not try to impose a 'made in USA' solution on a complex societal issue. Therefore, the content of technical assistance should ensure a healthy mix of both USA models and other world examples, modified to local circumstances and requirements. Without this approach, the effectiveness and sustainability which USAID seeks may be difficult to achieve." (Egypt)

It takes time. Many Missions noted that a particular policy dialogue effort had taken two, three, or even ten years before the MOH or government was willing to consider or implement change or even to study one component of the health financing situation. As USAID/Niger notes "We have learned to be more realistic in estimating the time required to accomplish policy change and in how many things to push at any one time." Similarly, USAID/Egypt reports that "...because one is dealing with a highly bureaucratic socialized health system and a sensitive political issue, movement can be agonizingly slow."

It involves substantial institutional change. One of the reasons health financing policy reforms take time is that they are complex and involve substantial institutional change. As USAID/Philippines notes

"There is also a tendency to expect positive results from initiated projects/programs in the short-term. This may not occur in the case of HCF. By its nature, HCF involves fundamental changes in the way health care is provided and financed. It requires new institutions, new pieces of legislation, a reorientation of health care professionals, etc. Hence, one must guard against anticipating too much too soon. It must be recalled that the U.S. HMO Act of 1973 required over ten years of follow-on grants and supportive actions to stimulate the HMO movement before this firmly and permanently took hold as it now has." (Philippines)

It is important to move beyond the MOH. The institutional complexity of health financing policy reform is one of the reasons it is often not sufficient to have discussions only at the level of the MOH. Several Missions noted the importance of interministerial dialogue and/or donor consultations with several ministries in addition to the Ministry of Health in the course of discussing health financing policy reforms. USAID/Dominican Republic describes the lesson it learned in this regard as follows.

"(Our recent attempts at MOH budgetary reform) point out two major considerations in future policy dialogue: (a) Ministries of Health apparently cannot advance faster than the public sector as a whole. In other words, the MOH cannot in and of itself crawl out from under the central government allocation of tax resources nor its antiquated fiscal policies and there appears no way you can improve a single plant when the entire garden is infested. (b) Since you cannot make improvements within any single ministry, financial policy changes must start at the central government level, something we learned very late in the game." (Dominican Republic)

Health financing policy reform is an iterative and cumulative process.

"The issue of whether HCF policy dialogue has been successful or not is not as straight forward as one might first assume, however. In fact, it could be argued that HCF dialogue benefits are cumulative; that with the right mix of economic necessity and a critical mass of appreciation for HCF, policy dialogue efforts can contribute to positive change, although the benefits may not be immediately forthcoming. For example, although the Mission was unable to convince the government of Dominica to introduce user fees for drugs in the early 1980's during a PRITECH revolving drug fund activity, we have continued to actively promote HCF to the MOH. The comprehensive HCF package now ready to be introduced in Dominica includes a flat rate co-payment fee on pharmaceutical prescriptions." (RDO/C)

"In conclusion, in matters of policy, know how far you can go and when it is prudent to sit the game out." (Dominican Republic)