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**Health Financing
and Sustainability
Project**

FINAL

BIBLIOGRAPHY OF ABSTRACTS

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CONTENTS

| | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| INTRODUCTION | 5 |
| APPLIED RESEARCH PAPERS | 7 |
| Major Applied Research | 7 |
| Smaller Applied Research | 12 |
| <i>Health Policy and Planning: Special Issue on “Improving Quality, Equity and Access to Health Services through Health Financing Reform in Africa”</i> | 17 |
| THEME PAPERS AND POLICY PAPERS | 21 |
| TECHNICAL REPORTS | 23 |
| TECHNICAL NOTES | 31 |

INTRODUCTION

THE HEALTH FINANCING AND SUSTAINABILITY PROJECT (HFS) was a six-year initiative funded by the U.S. Agency for International Development (USAID). HFS was directed by Abt Associates Inc., in collaboration with Management Sciences for Health, The Urban Institute, Clark Atlanta University, and Tillinghast.

Between 1989 and 1995, HFS worked with over 30 developing countries around the world to assess, develop, and test alternative health financing policies and mechanisms. HFS sought to influence policy change by advancing knowledge; testing and improving analytical tools; strengthening institutional capacity; and facilitating decision making. The purpose was to increase the resources available to the health sector and to sustain more accessible and better quality health care for all sectors of the population, including the poorest.

HFS prepared papers and reports on its technical assistance, applied research, and training activities in five main technical areas:

- ▲ Alternative cost recovery systems;
- ▲ Social financing at the national and community level;
- ▲ Collaboration between the public and private sectors in the management and delivery of health care;
- ▲ The allocation, use, and management of resources; and
- ▲ Costing, delivery, and production of specific health care services.

This bibliography of abstracts includes only technical, research studies. Available separately is a complete list of *all* HFS publications, indexed by author, geographic area, subject, and title.

APPLIED RESEARCH PAPERS

Health Financing Research in Developing Countries

Synthesis of Results from Applied Field Research under the HFS Project, 1989–1995

Ricardo Bitrán

60 pages (August 1995) • Order No. ARS

This document presents the results from the applied research in health care financing conducted by the Health Financing and Sustainability (HFS) Project in over 40 developing countries. It describes the conceptual framework of and outlines the research agenda. It presents the research results, summarizes the findings and policy recommendations, and points to areas for future research to support policy reform. Nine general topics of research are covered: 1) quality of care and cost recovery; 2) protecting the poor under cost recovery; 3) efficiency in consumption; 4) provider incentives; 5) extending social financing; 6) public-private differences in efficiency; 7) private sector development; 8) public-private collaboration; and 9) reallocating public sector spending.

MAJOR APPLIED RESEARCH

The Private Sector Delivery of Health Care in Senegal (Phases 2 and 3)

Major Applied Research Paper 16

James C. Knowles, Abdo S. Yazbeck, and Steven Brewster

81 pages (December 1994) • Order No. MAR 16

Available in French: La Prestation de Soins de Santé par le Secteur Privé Sénégal (Order No. MAR 16F)

As in many developing countries, the uneven performance of public sector health facilities in Senegal has spurred people to turn increasingly to the private sector, including traditional healers, pharmacies and other drug retailers, private physicians and paramedics, nongovernmental providers (e.g., church-run facilities), and government physicians running after-hours practices. Prepared for the Health and Human Resources Analysis for Africa (HHRAA) Project of the U.S. Agency for International Development (USAID), this paper assesses the capacity of the private sector in Senegal to support the achievement of public health goals and examine the appropriateness of existing public-private linkages. The study emphasizes the need for an increased private sector role, particularly in urban areas, and recommends that efforts to enhance the role of the private sector be directed to: 1) distribution of public health commodities (such as contraceptives, oral rehydration salts, and iron supplements); and 2) delivery of public health services. The study identifies some significant constraints to further development of the private sector, including government regulations, taxes, and subsidies, and makes specific recommendations for action to spur private sector development.

Social Financing and Fee-for-Service Cost Recovery in Niger (Phases 2 and 3)

Major Applied Research Paper 15

Abdo Yazbeck and Mark Wenner

89 pages (December 1994) • Order No. MAR 15

Available in French: Recouvrement des Coûts au Moyen du Financement Social et des Paiements à l'Acte au Niger (Order No. MAR 15F)

In order to test two payment methods and three interventions for quality of care improvements, the Government of Niger implemented a cost-recovery pilot project in its Boboye and Say districts. A third district was used as a control. One payment method tested was a form of social financing (tax + fee); the second was a fee charged for each episode of illness. This paper examines the issue of access—primarily, the effect of cost recovery on the use of health systems by vulnerable groups, including the poorest quartile and the elderly. In general, the social financing method was preferred by an overwhelming majority of the respondents over both the current system and the proposed fee per each episode of illness. A larger percentage of respondents in the social financing district than in the other two test districts sought preventive and curative care.

Private Sector Delivery of Health Care in Tanzania (Phases 2 and 3)

Major Applied Research Paper 14

Gaspar K. Munishi, Abdo Yazbeck, Denise DeRoeck, and Denise Lionetti

86 pages (February 1995) • Order No. MAR 14

Available in French: Prestation de Soins de Santé dans le Secteur Privé en Tanzanie (Order No. MAR 14F)

This study provides baseline information and analysis that the Ministry of Health in Tanzania can use to further elaborate policies to enhance public-private partnerships in the health sector in order to expand coverage, strengthen quality and efficiency of health services, and improve the health status of the population. Tanzania has at times deliberately restricted private sector activity in health and at other times has encouraged and supported growth of certain types of private sector providers. Since the early 1990s the government has made private sector development a cornerstone of its health sector reforms. Prepared for the Health and Human Resources Analysis for Africa (HHRAA) project of USAID, the study has three main components: a description of the size and scope of the private sector in health care delivery in Tanzania and an assessment of the actual and potential role of the private sector in promoting the public health agenda; a description of the current linkages between the public and private sectors in health care and an examination of areas where collaboration could potentially improve health services delivery; and an examination of the factors that affect development of the private sector in Tanzania, especially legal, regulatory, tax, and financial matters.

Quality of Health Care and Cost Recovery in Africa

Evidence from Niger and Senegal (Phases 2 and 3)

Major Applied Research Paper 13

Annemarie Wouters

58 pages (October 1994) • Order No. MAR 13

Available in French: Qualité des Soins de Santé et Recouvrement des Coûts en Afrique: Preuves du Niger et du Sénégal (Order No. MAR 13F)

Also Available: Applied Research Brief, in English (Order No. MAR 13-BRIEF) and in French (Order No. MAR 13F-BRIEF)

This paper presents findings from comparative research on health care quality and cost recovery in Niger and Senegal and also draws conclusions applicable to other African countries. It presents data from provider, patient, and household surveys conducted from 1992 to 1994. The relationships between quality of care and cost recovery reforms in Niger are analyzed. Detailed information is presented on the differences between the public and private sectors in Senegal and the relationships between quality of care and efficiency among health care providers. The study shows how strategies to improve quality can increase efficiency, raise demand for services, and help generate funds to sustain quality improvements in African health systems. This extensively illustrated study was prepared for the Health and Human Resources and Analysis (HHRAA) Project of USAID.

Quality of Health Care and Its Role in Cost Recovery in Africa

Cost Recovery and Improved Drug Availability in Niger—Implications for Total Patient Treatment Costs (Phases 2 and 3)

Major Applied Research Paper 12

Annemarie Wouters and Anthony Kouzis

72 pages (December 1994) • Order No. MAR 12

Available in French: La Qualité des Soins de Santé et son Rôle dans le Recouvrement des Coûts en Afrique (Order No. MAR 12F)

Previous research posited that the regressive effects of cost recovery might be offset if the accompanying quality improvements generate not only health benefits but economic benefits as well, primarily in terms of reducing additional travel to pharmacies that sold higher-priced drugs. Using quasi-experimental design methods, this study investigated a cost recovery intervention in Niger, specifically how the total costs of an episode of treatment for an acute illness for a typical patient changed when user fees were imposed and when these user fees were accompanied by an improved drug supply. Episode costs included both cash expenses and opportunity costs of time. With few exceptions, patients' total episode costs increased in the intervention sites relative to the control site. The findings showed mixed results when comparing changes in the two intervention sites (Say and Boboye districts) to the control site (Illéla district).

**Costs, Financing, and Efficiency of Health Providers in Senegal
A Comparative Analysis of Public and Private Providers (Phases 2 and 3)
Major Applied Research Paper 11**

Ricardo Bitrán, Steve Brewster, and Bineta Ba

104 pages (July 1994) • Order No. MAR 11

Available in French: Coûts, Financement, et Efficacité des Prestataires de Santé au Sénégal. Une Analyse Comparative des Prestataires Publics et Privés (Order No. MAR 11F)

This report presents the methods, results, and findings of a 1993 study of the costs, financing, and efficiency of private health providers in Senegal. It outlines the role and performance of private health care providers, compares their performance with that of government facilities, and explores the potential advantages of greater public-private collaboration in the provision of health services. The study also seeks to contribute with empirical information to the ongoing ideological discussion about the relative merits of public and private production of health care.

This private sector study was initiated following a similar HFS study of government health care providers in Senegal that revealed important deficiencies in the public health care system, including poor quality care, inefficient use of human and other resources, a malfunctioning referral system, and inappropriate pricing practices.

Costs, Financing, and Efficiency of Government Health Facilities in Senegal (Phases 2 and 3)

Major Applied Research Paper 10

Ricardo Bitrán, Steve Brewster, and Bineta Ba

110 pages (August 1994) • Order No. MAR 10

Available in French: Coûts, Financement, et Efficacité des Etablissements Sanitaires Publics au Sénégal (Order No. MAR 10F)

The study assesses the costs, financing, and efficiency of public health facilities in Senegal. It finds that although government resources are spent primarily on personnel, medical staff productivity is very low. At the same time, utilization rates for curative, preventive, obstetric, and family planning services are low. The quality of health care in public facilities is poor primarily because of a lack of drugs and medical supplies, poor staff training, inadequate or nonexistent protocols and standards for care, and insufficient supervision. The pricing system does not promote efficient patterns of consumption among the various levels of care in the health care system or among various types of services. The study identifies opportunities for making significant improvements in the performance of the system within existing resource levels. It recommends that the government decentralize management of its health services; focus scarce resources on those services and activities with the greatest social return such as preventive services and on facilities that are cost-effective and that benefit the needy; force urban facilities to rely more on cost recovery; and undertake initiatives to improve management and information systems to monitor the efficiency and equity of public health spending.

Factors Affecting the Development of Private Health Care Provision in Developing Countries (Phase 1)

Major Applied Research Paper 9

Peter Berman and Ravindra Rannan-Eliya

100 pages (October 1993) • Order No. MAR 9

Privatizing existing public health care services and enhancing development of private health care provision are two of the main health policy innovations that have been promoted throughout the developing world since the 1980s. However, little is known about health care privatization. This paper analyzes the development of the private health care sector in the developing world, outlining what is known about the development of the private sector in developing countries and the major components of a conceptual framework that can be used to address these issues in future research. Included is a typology of private health care providers based on variation in the organizational form and other characteristics, such as economic or commercial orientation, and in the therapeutic system. Major regional patterns are summarized and some of the important factors determining them are highlighted. Four case studies are included: Papua New Guinea, Republic of South Africa, Chile, and the United Kingdom.

The study identifies the following key factors that influence the demand for private health care: income, price, quality, private and social insurance, transport infrastructure, the structure of the medical referral system,

demographic and epidemiological factors, education and cultural factors, health-seeking behavior, and previous historical experience. The key factors that influence the supply of private health care are found to be: demand, availability of inputs—including medical labor, capital, and medical technology—and the impact of insurance mechanisms on the nature of competition in the market for health care services. Governments are found to critically influence the development of private health care provision, either indirectly through effects on the general social and macroeconomic environment or directly through specific interventions.

Quality of Health Care and Its Role in Cost Recovery (Phase 1)

Major Applied Research Paper 8

Annemarie Wouters, Olusoji Adeyi, and Richard Morrow

90 pages (December 1993) • Order No. MAR 8

This paper looks at the interrelationship of cost recovery and quality improvements in the health sector of developing countries. Included are in-depth literature reviews of five major types of studies: facility-based studies of the effect of cost recovery on utilization; econometric health care demand studies; hedonic pricing studies; contingent valuation studies; and cost-recovery intervention studies. By reviewing these studies, the paper provides a conceptual framework for considering people's willingness to pay for quality improvements in health care by looking at how demand behavior interacts with supply, especially in terms of promoting the financial sustainability of government services. This paper also presents a preliminary design for possible field research activities.

Means Testing in Cost Recovery of Health Services in Developing Countries (Phase 1)

Major Applied Research Paper 7

Carla Willis

101 pages (November 1993) • Order No. MAR 7

In developing countries, the importance of means testing has risen along with increased reliance on user fees to help finance services. This paper provides a conceptual framework for understanding the role means testing can play in promoting equity in the health sector. Means testing is placed in the broader context of targeting and contrasted with other targeting mechanisms. The paper examines important policy and practical issues involved in the design and implementation of means tests, including how the target population and eligibility criteria are defined, and how these definitions differ from those used in income transfer programs; what the tradeoffs are between spending on benefits and spending on improved means-testing accuracy; and how outcomes are evaluated. The study also includes a survey of over 60 means-tested programs worldwide, which suggests that certain design elements can enhance or diminish the likelihood of success. An agenda for future research is proposed.

Economic Impacts of Malaria in Kenya and Nigeria (Phases 1, 2, and 3)

Major Applied Research Paper 6

Charlotte Leighton, with Rebecca Foster, in collaboration with the Vector Biology Control (VBC) Project

98 pages (November 1993) • Order No. MAR 6

This paper analyzes the short-run economic impact of malaria in Kenya and Nigeria based on field data. The study concentrates on the annual malaria-related production loss at the national, sectoral, and household levels; for urban and rural populations; and for men and women. Included are schooldays lost to teachers' absence from school, children's affliction with the disease, and the proposed corresponding household spending to combat malaria. The study estimates the reduced productivity of those individuals who return to work during a malaria episode. Popular impressions about the disease also are reviewed.

The study uncovered widespread discrepancies in the identification and definition of malaria in the absence of laboratory tests, due to the fact that other diseases have similar symptoms. In addition, three determinants were identified as critical to making accurate estimates: 1) malaria prevalence is quite high in general for those who live in malarious zones, regardless of gender or whether the areas are urban or rural; 2) even in the face of inaccurate estimates of true malaria for those who do not undergo lab exams, indications are that the illness represents a significant burden for these countries; 3) estimates on the effectiveness of malaria control tend to be overestimated due to the inaccuracy of estimating true malaria incidents. This and other related studies stress the importance of including caretaking costs in malaria's economic impact.

Public and Private Interactions in the Health Sector in Developing Countries (Phase 1) Major Applied Research Paper 5

Randall P. Ellis and Mukesh Chawla

89 pages (February 1993) • Order No. MAR 5

One option for developing countries to remedy budget constraints in health care may be to encourage the private sector to assume a greater role in financing and providing health services and to increase collaboration between the public and private sectors. This alternative requires consideration of concepts such as sharing public resources with private providers and determining the division of service financing and provision by sector. Many physicians in developing countries allocate their time between jobs in both sectors, and this study examines such multiple job-holding and the impact on both sectors. A review of existing literature reveals that on public-private interactions are not well documented. Future research in the area of public-private interactions is recommended for four specific countries—Egypt, Kenya, India, and Pakistan—because of special attributes in their systems of health care.

Efficiency in the Consumption of Health Services Concepts and Research Needs (Phase 1)

Major Applied Research Paper 4

Robin Barlow, with Christine Kolars, Cathy Peters, and Bilkis Vissandjée

190 pages (June 1993) • Order No. MAR 4

This paper develops a conceptual framework for analyzing “consumption inefficiencies” in the provision of government health services in developing countries and also reviews the empirical literature in this field. The inefficiencies, which cause health losses for the population, result from such factors as price distortions, misinformation, and externalities. The inefficiencies may be corrected with user charges and health education programs. A project of field research on consumption inefficiencies is proposed, based on estimating cost-effectiveness ratios for selected government health services.

Extending Coverage and Benefits of Social Financing Systems in Developing Countries (Phase 1)

Major Applied Research Paper 3

Gerard LaForgia, Charles Griffin, and Randall Bovbjerg

100 pages (March 1993) • Order No. MAR 3

Social financing is a popular and possibly very effective solution to the demand for pooling risk to lessen the effects of catastrophic losses. Social insurance, however, often creates equity, coverage, institutional, and equity problems in health care. This study examines the concept of social financing, particularly economic and equity factors, as well as types of health insurance and their possible application to the health financing concerns of developing countries. Case study summaries offer information and variables concerning all aspects of health insurance in developing countries. A chronological review of health insurance development in the United States is used to offer additional data on financing sources, strategies, and analyses.

Technical and Economic Efficiency in the Production of Health Services (Phase 1) Review of Concepts, Literature, and Preliminary Field Work Design

Major Applied Research Paper 2

Ricardo Bitrán

59 pages (December 1992) • Order No. MAR 2

This report completes the first phase of the HFS Project’s three-phase major applied research project on “Private Sector: Private and Public Differences in Efficiency.” This first phase lays the groundwork for phase two (field work) and phase three (analysis) of the research project. This report includes a selective review of studies of the efficiency of health service production. He examines techniques used to measure efficiency, methodological problems associated with these measurements, and possible solutions. The review also provides information about the efficiency of public and private health services in developing countries. Finally, the report discusses efficiency measurement techniques for data analysis and describes opportunities for phase two field work on a comparative study of hospital efficiency in Ecuador for five different types of providers, and a study of productive efficiency for private and public facilities in Senegal, including facilities from various levels.

**Provider Incentives and Productive Efficiency in Government Health Services (Phase 1)
Review of Concepts, Literature, and Preliminary Field Work Design
Major Applied Research Paper 1**

Ricardo Bitrán and Steven Block

56 pages (September 1992) • Order No. MAR 1

The authors review the relevant concepts and literature and present the preliminary field work design for research regarding provider incentives and productive efficiency in government health services. In addition to providing a basic conceptual framework of the issues, the authors present empirical and anecdotal evidence from developed and developing countries to assess the potential for provider incentives to improve the efficiency (as well as equity and quality) of health care in developing countries. The discussion includes both monetary and non-monetary, physician and hospital incentives. Finally, the authors consider both the methodological problems and prospective field work activities necessary for completion of phases 2 (field work) and 3 (analysis) of the HFS Project's applied research program.

SMALLER APPLIED RESEARCH

**Utilization and Demand for Health Services in Senegal
Smaller Applied Research Paper 18**

Abdoulaye Sadio and François Diop

80 pages (August 1994) • Order No. SAR 18

Available in French: Utilisation et Demand de Services de Santé au Sénégal (Order No. SAR 18F)

This report presents the findings of an econometric investigation into the demand for health care in Senegal based on data from a nationwide survey of 10,000 households carried out in 1991–92. The large size of the sample of patients (about 14,500) made it feasible to stratify the analysis of health care demand between rural and urban areas in order to identify disparities in the supply of modern health services and in income levels. The investigation shows inequalities in access not only to modern health services in general, but also to the services available at the various levels of the care delivery system. The findings suggest, on the one hand, that this inequality of access to modern health care is brought about primarily through the quantitative rationing of services stemming from the poor geographical coverage of the public health facilities in rural areas. On the other hand, the affordability of modern health care in urban areas is constrained by low incomes and poor coverage of the health insurance schemes prevalent in the modern sector of the economy. The data also suggest that Senegalese households spend sizable sums on the treatment of illness.

**Multiple Job-Holdings by Government Health Personnel in Developing Countries
Smaller Applied Research Paper 17**

Mukesh Chawla

90 pages (December 1994) • Order No. SAR 17

This study examines sharing labor resources between the public and private health care sectors in developing countries. It establishes a data-collection protocol in India and uses an econometric model to estimate labor market participation, wages, and hours worked in the public and private sectors. The study suggests a three-pronged policy to improve health care delivery: 1) cutting down hours worked to reduce the salary burden without adversely affecting delivery; 2) introducing some measure of competition into physicians' primary employment to give them incentives to work harder; and 3) using a system of rewards to improve physicians' incentives to work.

Schistosomiasis Control Strategies in Northern Cameroon
A Study Based on Household Survey Data from the Extreme North Provinces
Smaller Applied Research Paper 16

M. Muhamed Khan

45 pages (December 1994) • Order No. SAR 16

This report builds upon work on schistosomiasis control conducted by Tulane University in northern Cameroon, including a pilot project undertaken with the Cameroonian Ministry of Public Health in 1990. The study analyzes data collected from this same pilot project and from a 1993 household survey regarding knowledge of the disease, sources of water supply, water contact behavior, and willingness and ability to pay for various control interventions. The costs of diagnosis and treatment of schistosomiasis are explored, as well as the costs of snail control and health education programs. The political feasibility of community management, financing, and implementation of schistosomiasis control programs is examined.

Study of Availability and Price of Drugs in Algeria
Smaller Applied Research Paper 15

A. Touat

119 pages (December 1994) • Order No. SAR 15

This report presents the results of a study conducted in 1993 on the price and availability of drugs in Algeria using surveys of pharmacies and hospitals as well as interviews with health professionals in the public and private sectors. The study examines the nature of drug shortages by looking at problems in drug importation and distribution networks. It describes factors related to price increases and disparities in prices. There is extensive comparative data between public and private enterprises in the drug sector. The recent emergence of the private sector in drug importation and distribution is assessed for its impact on price levels and availability. The study provides details on how availability problems are related, not to a drop in imports, but to specific problems in the wholesale and retail distribution networks. Large increases in drug prices are shown to result from both monetary devaluations and the increasing commercialization of the drug sector, which is detailed in data on profit trends, generic versus brand-name imports, expansion of retail pharmacies, and import monopolies. Because many of these problems were aggravated by the shift from a planned to a market economy, the study suggests possible regulatory mechanisms and ways in which the public sector can manage the drug sector.

Financing Health Services through Insurance
A Case Study from Kenya
Smaller Applied Research Paper 13

Germano Mwabu, Joseph Wang'ombe, Gerishon Ikiara, and others

75 pages (October 1993) • Order No. SAR 13

This report documents a survey undertaken in three Kenyan districts to determine the feasibility of developing private and public health insurance plans. A total of 153 employers, insurance companies, and health care providers were interviewed. Results confirmed that most employers already purchased some type of insurance for their employees, commonly worker's compensation and group medical insurance. Employers, however, are generally dissatisfied with their current options and would be interested in more refined mechanisms. The study recommends development of some or all elements of four promising insurance schemes: the national hospital insurance fund, Harambee movement funds, private insurance, and prepayment schemes. Additional actions are also recommended, including revised tax laws that support insurance purchases by employers and households and basic insurance education for the public.

The Role of Quality in the Demand for Health Care on Cebu Island Province,
The Philippines
Smaller Applied Research Paper 12

David Hotchkiss

39 pages (December 1993) • Order No. SAR 12

A mixed multinomial logit model is used in this study to estimate the effects of quality, price, distance, and individual demand for health care on Cebu Island in the Philippines. Data is collected from both households and

health care facilities, ensuring that information is included concerning individual characteristics and facility attributes of all relevant obstetric care alternatives, which vary greatly in quality and price. Estimation results confirm that factors such as facility crowding, practitioner training, patient education, and family economic level are all important considerations that influence consumer choice.

Unit Cost and Financial Analysis for the “Hospital 12 de Abril” in Bolivia

Smaller Applied Research Paper 11

Manuel Olave and Zulma Montaña

45 pages (December 1993) • Order No. SAR 11

The Social Security System is one of three major subsectors that provide health care to Bolivians. To determine whether Social Security System facilities are underutilized, a sample hospital was studied over a period of four months. The Hospital 12 de Abril is a referral hospital with 58 beds that cares for children 15 years old and younger with infectious diseases. Data was collected on factors such as production, occupancy level, and length of stay. It was determined that, in general, the hospital's inefficiencies stemmed from a high level of staffing and a low number of patients. Unit costs of in-patient services were determined, alternate financing mechanisms were proposed, and results were discussed with the Social Security management.

Health Subsidies Model for the Chilean System

Smaller Applied Research Paper 10

Jorge Claro, Gabriel Bitrán, and Bernardo Luque

101 pages (November 1993) • Order No. SAR 10

Available in Spanish: Modelo para la Asignación de Subsidios de Salud (Order No. SAR 10S)

In Chile, the right to health care is constitutional. Which route is most appropriate for achieving this objective is subject to wide debate. This study is intended to contribute to the solution of these problems by analyzing what would be involved in implementing a health system based on the allocation of subsidies to individuals, in which the presumptive providers of health services would be private firms participating in competitive markets.

Estimating the Willingness to Pay for Quality of Care

Comparison of Contingent Valuation and Two-Step Health Expenditure Methods

Smaller Applied Research Paper 9

Marcia Weaver, Ruth Kornfield, Michael Chapko, and others

40 pages (October 1993) • Order No. SAR 9

There has been strong interest in establishing user fees as a source of revenue for public health facilities to be used to improve the quality of health care services. This study provides an analysis of how facility utilization can be affected by increased fees and improved care. Two methods were employed to estimate the willingness to pay for improved quality of care: contingent valuation and a two-step health care expenditure model. This report documents median willingness to pay for seven quality improvements: 1) facility maintenance; 2) personnel supervision; and pharmaceuticals to treat: 3) malaria, 4) sexually transmitted diseases, 5) acute respiratory infections, 6) intestinal parasites, and 7) diarrheal diseases. The results demonstrate that willingness to pay would exceed the estimated cost for each quality improvement.

Synthèse des Etudes Relatives au Financement de la Santé

Sénégal

Smaller Applied Research Paper 8

Robin Barlow, François Pathé Diop, and Ngoné Touré Sene

57 pages (September 1991) • Order No. SAR 8F • Available in French only

Au moment où le gouvernement Sénégalais étudie des plans de réforme du financement du système de santé, il semblait souhaitable de passer en revue toute l'expérience déjà acquise avec les autres méthodes de financement utilisées pendant ces dernières années; une expérience qui a fait l'objet de plusieurs études dans le passé. L'examen de ces documents a été confié à une équipe de trois consultants, lesquels ont lu et fait la synthèse des trente neuf rapports qui ont été publiés depuis 1980. Les résumés individuels de tous ces rapports sont joints au document. Dans les dits documents, certains aspects du financement de la santé ont été abordés de manière assez

approfondie. Parmi ceux-ci, on note le financement de la santé en général et les opérations financières des hôpitaux, le système d'approvisionnement en produits pharmaceutiques, et les projets de soins de santé primaires au Sine-Saloum et à Pikine.

Cost Recovery and Quality of Care in the Congo

Smaller Applied Research Paper 7

Basile Tsongo, Carla Willis, David Deal, and Holly Wong

40 pages (September 1993) • Order No. SAR 7

This report documents a study conducted in the summer of 1992 to examine the relationship between quality of services and fees in the Congo. The study hypothesized that private facilities can charge higher fees than public facilities because private health care is perceived to provide higher-quality services. A total of 399 outpatients at eight health centers were surveyed. Five general topics were addressed in the questionnaire: patient and household identification, socioeconomic information, curative care, patient satisfaction, and payment. The authors also used data comparing pricing practices in rural and urban areas and analyzed patient characteristics in conjunction with their choice of facility.

Quality of Health Care in Relation to Cost Recovery in Fiji

Focus Group Study

Smaller Applied Research Paper 6

E. B. Attah and Nii-K Plange

36 pages (September 1993) • Order No. SAR 6

An earlier HFS report on the role of and potential for cost recovery in government facilities and services in Fiji concluded that there was probably a need to improve the quality of care at public facilities so that a clientele could be maintained as fees were introduced or increased. Nine focus group sessions were conducted over a two-week period to determine general perceptions of quality care in Fiji health services, particularly in the public sector. Immediate, intermediate, and long-term actions are recommended that would act as catalysts for the changes needed to induce patients to choose government health facilities when fees are instituted.

The Effects of Population Aging on Health Care Utilization and Costs for the Centro de Asistencia del Sindicato Médico de Uruguay (CASMU)

Smaller Applied Research Paper 5

Michael Micklin, Holly Wong, and Stephen Heinig

135 pages (August 1993) • Order No. SAR 5

This study seeks to discern the costs of the demographic and epidemiologic transitions occurring in many developing countries. Since that aging process has already occurred to a large extent in Uruguay (with more than 10 percent of the population aged 65 and over), the authors estimate the effects of population aging on costs and utilization of hospital services over the next two decades for a single Uruguayan health care organization, the Centro de Asistencia del Sindicato Médico del Uruguay. Using baseline data from 1991, utilization and average cost figures are calculated for three illness categories: all diagnoses, neoplasms, and cerebro/cardiovascular diseases. Four different projections of the CASMU population are made for the years 2000 and 2010 which incorporate different assumptions about the speed of the aging of the population and about the size of the CASMU membership. Combining the baseline data with the four projections, the effects of aging on costs and utilization are estimated for the CASMU population as a whole and for specific age and gender categories. An indicator, termed an "age elasticity of cost," is developed for determining how costs may change with changes in the proportion of elderly in the population, and estimates are made for each of the four projections using varying assumptions and time periods.

**Health Insurance Practice
Fifteen Case Studies from Developing Countries
Smaller Applied Research Paper 4**

Gerard LaForgia and Charles Griffin, editors, with contributions by Nuria Homedes, Patrice Korjenek, Joseph Scarpaci, and Taryn Vian

225 pages (March 1993) • Order No. SAR 4

A companion to HFS Major Applied Research Report 3, this document offers 15 case studies of insurance programs in developing countries. Each case study addresses the scheme's organization and the role of insurers, consumers, providers, and employers; the economic considerations underlying the scheme, such as cost control and moral hazard; and the advantages and weaknesses of the scheme as an effective model for other countries. The 15 case studies are grouped into five categories: 1) community-based risk sharing/rural health insurance (Zaire, Thailand, Guinea Bissau); 2) social security coverage extension (Panama, Costa Rica, Ecuador, Mexico); 3) national insurance systems (Korea, Chile, China); 4) limited catastrophic coverage (Philippines, Kenya); and 5) pre-payment plans (Uruguay, Dominican Republic, Philippines).

**Local Retention of User Fees in Government Health Facilities
Smaller Applied Research Paper 3**

Keith McInnes

38 pages (June 1993) • Order No. SAR 3

This study examines the theory of locally retaining user fees collected from government health facility cost recovery programs. Benefits of such a theory are discussed, including improved motivations for fee payment and collection and new accountability at the local level. In addition, critical viewpoints are presented, including the problem of perceived earmarking of funds. The cost recovery programs of four countries—Belize, the Central African Republic, Cameroon, and Swaziland—are detailed as examples, including information about legal considerations, legislation, fee management, and use of funds. These case studies indicate that health centers in developing countries that retain fees locally would enjoy benefits such as an increased percentage of costs recovered and increased health center utilization and quality. Local fee retention, however, is only one of several factors affecting cost recovery and the sustainability of health services. Another important factor is the level of prices.

**Expenditure Patterns and Willingness to Pay for Health Services in Belize
Analysis of the 1991 Belize Family Life Survey
Smaller Applied Research Paper 2**

James North, Charles Griffin, and David Guilkey

45 pages (February 1993) • Order No. SAR 2

The authors combine information on expenditures and health care use patterns with hypothetical responses about willingness to pay. The data on use patterns indicate considerable success in the public sector in delivering prenatal and obstetrical services, but with little or no selectivity about targeting public subsidies for those services to specific groups of women. The result is considerable self-targeting: while prenatal care is widely delivered through health centers, higher educated, wealthier, urban women are most likely to deliver their babies in government hospitals, while less educated, poorer, rural women tend to deliver at home. There is some informal targeting by virtue of the fact that a small proportion of the women opt out of the public system and use private physicians for deliveries. Public subsidies reach those who use the public system.

For acute outpatient care, the private sector—broadly defined to include physicians, pharmacists, and traditional healers—is a much more important supplier of services, accounting for about half of visits. Roughly 65 percent of the sample incurs some expenditures for outpatient care; of this group, well over 90 percent use the private sector and about 60 percent use the public sector. Drugs and medicines account for well over half of expenditures, which are quite high: households are estimated to spend 3–7 percent of annual income on acute health care alone, not counting expenditures related to pregnancy and the care of young children.

Respondents showed an extremely high willingness to pay for existing government health services and a virtually unanimous willingness to pay more for improved government services offering reasonable waiting times, supplies of drugs, and pleasant waiting rooms. These responses indicate that the government has more flexibility in considering cost recovery in the health sector than it has exercised in the past. The results also indicate that there are substantial opportunities to improve the targeting of public subsidies under a user-fee system.

Analysis of the Demand for Inpatient and Outpatient Care from Embaba Hospital, Cairo, Egypt

Smaller Applied Research Paper 1

Randall P. Ellis and Elizabeth Stephenson

50 pages (November 1992) • Order No. SAR 1

The authors use an econometric analysis of household data collected by the HFS Project to determine the impact of changing fee structures to improve cost recovery at Embaba Hospital, a public hospital in Cairo. Their analysis includes a description of present health care utilization patterns, estimates of the determinants of demand, and simulations of changes in demand in response to changes in certain key variables. The analysis, conducted separately for inpatients and outpatients, shows that Embaba Hospital is considered to be of low quality and that demand for inpatient care is less responsive to fee levels than demand for outpatient care. While the authors find that there is a significant willingness to pay for perceived higher quality of services, they caution that the results do not provide a clear indication of the potential demand response to increasing fees at Embaba Hospital.

HEALTH POLICY AND PLANNING

Special Issue: Improving Quality, Equity and Access to Health Services through Health Financing Reform in Africa

Volume 10, Number 3

Guest Editors: Charlotte Leighton and Nena Terrell

Overview

Charlotte Leighton

This article presents an overview of the financing reform context in recent years in Africa and introduces the articles in this special issue of *Health Policy and Planning*, which presents findings from field research conducted in sub-Saharan Africa by the HFS Project, particularly the evidence gathered on the impact of three broad strategies for health financing reform: 1) cost recovery through user fees to expand access and improve quality of health services, along with means testing to increase equity; 2) reallocation of existing resources to improve efficiency and access; and 3) assessment of the efficiency and quality of private health providers, with a view toward making better use of the private sector in expanding access to quality health services.

The Impact of Alternative Cost Recovery Schemes on Access and Equity in Niger

François Diop, Abdo Yazbeck, and Ricardo Bitrán

The authors examine accessibility and the sustainability of quality health care in a rural setting under two alternative cost recovery methods, a fee-for-service method and a type of social financing (risk-sharing) strategy based on an annual tax + fee-for-service. Both methods were accompanied with similar interventions aimed at improving the quality of primary health services. Based on pilot tests of cost recovery in the non-hospital sector in Niger, the article presents results from baseline and final survey data, as well as from facility utilization, cost, and revenue data collected in two test districts and a control district. Cost recovery accompanied with quality improvements increases equity and access to health care and the type of cost recovery method used can make a difference. In Niger, higher access for women, children, and the poor resulted from the tax+fee method, than from the pure fee-for-service method. Moreover, revenue generation per capita under the tax+fee method was two times higher than under the fee-for-service method, suggesting that the prospects of sustainability were better under the social financing strategy. However, sustainability under cost recovery and improved quality depend as much on policy measures aimed at cost containment, particularly for drugs, as on specific cost recovery methods.

The Role of Means Testing

Protecting the Poor

Carla Willis and Charlotte Leighton

In African health sectors, the importance of protecting the very poor has been underscored by increased reliance on user fees to help finance services. This paper presents a conceptual framework for understanding the role means testing can play in promoting equity under health care cost recovery. Means testing is placed in the broader context of targeting and contrasted with other mechanisms. Criteria for evaluating outcomes are established and used to analyze previous means testing experience in Africa. A survey of experience finds a general pattern of informal, low-accuracy, low-cost means testing in Africa. Detailed household data from a recent cost recovery experiment in Niger, West Africa provides an unusual opportunity to observe outcomes of a characteristically informal means testing system. Findings from Niger suggest that achieving both the revenue raising and equity potential of cost recovery in Sub-Saharan Africa will require finding ways to improve informal means testing processes.

Improving Quality through Cost Recovery in Niger

Annemarie Wouters

New evidence on the quality of health care from public services in Niger is discussed in terms of the relationships between quality, costs, cost effectiveness, and financing. Although structural attributes of quality appeared to improve with the pilot project in Niger, significant gaps in the implementation of diagnostic and treatment protocols were observed, particularly in monitoring vital signs, diagnostic examination and provider-patient communications. Quality improvements required significant investments in both fixed and variable costs; however, many of these costs were basic input requirements for operation. It is likely that optimal cost-effectiveness of services was not achieved because of the noted deficiencies in quality. In the test district of Boboye, the revenues from the copayments alone covered about 34 percent of the costs of medicines or about 20 percent of costs of drugs and administration. In Say, user fees covered about 50-55 percent of the costs of medicines or 35-40 percent of the amount spent on medicines and cost recovery administration. In Boboye, taxes plus the additional copayments covered 120-180 percent of the cost of medicines, or 75-105 percent of the cost of medicines plus administration of cost recovery. Decentralized management and legal conditions in the pilot districts appeared to provide the necessary structure to ensure that the revenues and taxes collected would be channeled to pay for quality improvements.

Efficiency and Quality in the Public and Private Sectors in Senegal

Ricardo Birán

It is often argued that the private sector is more efficient than the public sector in the production of health services, and that government reliance on private provision would help improve the efficiency and equity of public spending in health. A review of the literature, however, shows that there is little evidence to support these statements. A study of government and non-governmental facilities was undertaken in Senegal, taking into account case mix, input prices, and quality of care, to examine relative efficiency in the delivery of health services. The study revealed that private providers are highly heterogeneous, although they tend to offer better quality services. A specific and important group of providers—Catholic health posts—were shown to be significantly more efficient than public and other private facilities in the provision of curative and preventive ambulatory services. Policies to expand the role of the private sector need to take into account variations in types of providers, as well as evidence of both high and low quality among them. In terms of public sector efficiency, findings from the study affirm others that indicate drug policy reform to be one of the most important policy interventions that can simultaneously improve efficiency, quality, and effectiveness of care. This study suggests that strategies to improve quality can increase efficiency, raise demand for services, and thereby expand access.

Increasing the Utilization of Cost-Effective Health Services through Changes in Demand

Robin Barlow and François Diop

Attaining efficiency in a health care system with a budget constraint involves increasing the utilization of the most cost-effective services. This can be achieved by adjustments to prices, costs, or demand. In this paper, the potential for demand adjustments is examined by selecting two apparently cost-effective services (prenatal care and

childhood immunization against tuberculosis), and analyzing the factors explaining their utilization. Data are used from recent household surveys in Burkina Faso and Niger. A multivariate analysis of utilization employs income, price, and taste variables. Utilization is highly sensitive to the distance which must be traveled to the health facility, a price variable. Members of certain ethnic groups tend to use the services less, other things equal. The importance of demand-side factors like ethnicity points to certain kinds of policy interventions like Information, Education and Communication activities which could increase the utilization of cost-effective services.

Does Cost Recovery for Curative Care Affect Preventive Care Utilization?

Research Note

Abdo Yazbeck and Charlotte Leighton

A concern about introducing fees in government health facilities is that utilization of preventive services would be affected negatively. Even if preventive services remain free, charging for curative services may decrease the use of the public facilities and have a spillover effect that also adversely affects the use of free services. A recent pilot test of cost recovery for curative care services in Niger (covered in the article in this issue by Diop, Yazbeck, and Ricardo Bitrán) provides an opportunity to test how charging for curative services affects the utilization of free preventive services. This research note presents findings from the Niger cost recovery pilot tests that focus on the utilization of one free-of-charge preventive service: prenatal care for pregnant women. The effect of cost recovery on the use of preventive services was one of the criteria set up by the Government of Niger for the evaluation of the performance of alternative financing mechanisms.

Price Uncertainty and the Demand for Health Care

Research Note

James C. Knowles

Consumers of health care in many developing countries face uncertain prices due to a variety of factors, including ad hoc price discrimination, uncertainty concerning diagnosis, and stock-outs of drugs and other supplies. Under these conditions, and assuming consumers are risk averse, the effect of price uncertainty on consumer behavior is similar to that of a price increase or a tax. This article examines the implications of price uncertainty for cost recovery, means testing, and demand analysis. It concludes that to the extent that cost recovery and means testing policies are formulated in ways that minimize price uncertainty to individual consumers, they should be able both to recover more resources and to target remaining subsidies more effectively, without reducing utilization. It also concludes that demand analysis should use appropriate measures of consumers' expected prices, rather than average or actual prices, and should include measures of the degree of price uncertainty in empirical models attempting to explain both the decision to seek care and the choice of provider.

THEME PAPERS AND POLICY PAPERS

Data Collection as a Policy Tool

A Description of Collection Methods and Data Sets

HFS Theme Paper

Abdo S. Yazbeck and Eric Gemmen

50 pages • Order No. TP 4 • April 1995

The HFS Project generated 38 data sets on the demand for and the supply of health care around the world. This paper describes those data sets and provides information on the manner in which they were generated and used. The paper is organized around four questions: What type of data were collected and by what method? Why were the data needed and collected? How were the data used? And how can the data be used in the future? An appendix describes each data set, the size and characteristics of the sample, and the survey instrument.

The Use of USAID's Non-Project Assistance to Achieve Health Sector Policy Reform in Africa

A Discussion Paper

Policy Paper 12

James C. Setzer and Molly Lindner

46 pages (September 1994) • Order No. PP 12

This policy paper examines the experiences and effectiveness of using USAID's non-project assistance (NPA) to support health sector objectives in sub-Saharan Africa. Programs in Niger, Nigeria, Kenya, Togo, and Cameroon are summarized. For each country, background is provided on the health sector, and a summary and assessment of specific NPA programs are provided. Prepared for the Health and Human Resources Analysis for Africa (HHRAA) Project of USAID's Africa Bureau, the primary focus of the paper is on health finance policy reforms. It compares and contrasts country experiences as they relate to NPA. The authors' purpose is to encourage discussion within USAID of the effectiveness of using NPA as a reform tool in policy development and the broader question of how to best support desired health outcomes in Africa. The paper provides a detailed assessment of three aspects of NPA programming: program development and design, program implementation, and program evaluation. The information sources were limited to official program documentation, and did not include field work. An extensive bibliography on the topics of non-project assistance, policy reform, and health sector policy is included.

Twenty-Two Policy Questions about Health Care Financing in Africa

Policy Paper 11

Charlotte Leighton

45 pages (August 1995) • Order No. PP 11

Available in French: 22 questions sur la financement de la santé en Afrique

This portfolio of five booklets presents 22 issue briefs on policy questions that ministries of health (MOHs) in sub-Saharan Africa most commonly ask about health financing reform. The answers summarize what is known about the impact and effectiveness of reform, based on experience and research in African countries.

The 22 policy questions are grouped into five Topics. Each Topic is intended to be a brief, non-technical reference on the "state of the art" for senior decision makers, health care analysts, program planners, and facility managers. Each Topic begins with an overview that highlights the relevance and context of the policy issue(s) addressed. For readers who want more detail, each Topic includes an alphabetical list of references, which are referenced throughout the entries. The five Topics are: Health Financing Reform Policies, Goals, and Strategies; Financial Sustainability; Cost Recovery's Impact on Quality, Access and Equity; Allocation, Efficiency, and Effectiveness; and New Initiatives: Private Sector and Social Financing.

Strategies for Implementing Health Financing Reform in Africa
Synthesis of HFS Project Experience
Policy Paper 10

Charlotte Leighton and Annemarie Wouters
45 pages (August 1995) • Order No. PP 10

This paper was prepared for the Health and Human Resources Analysis for Africa (HHRAA) project of USAID. The paper synthesizes the lessons learned from HFS Project work in sub-Saharan Africa about 1) strategies for overcoming principal obstacles that African ministries of health have faced in achieving health financing reform; 2) strategies for the design and implementation phases of reform; 3) resolving specific design and implementation issues to avoid common pitfalls and create conditions for success; and 4) using research and analysis tools effectively to address key issues that arise during health financing policy debates and to monitor reform implementation.

The HFS work on which this document is based involved 1) long-term technical assistance and research in two countries (Niger and the Central African Republic) on their sector-wide health financing reform efforts; 2) periodic research assistance to Senegal in financing and economic issues related to reform; 3) short-term technical assistance activities, as well as applied research activities in 10 other countries in the region (Burkina Faso, Cameroon, Congo, Kenya, Mali, Mozambique, Nigeria, Tanzania, Togo, and Zaire); and 4) two regional workshops in health financing, each attended by representatives of more than 10 African countries. The document also considers secondary sources for the experiences of other selected countries.

TECHNICAL REPORTS

Evaluation of the Impact of Pilot Tests for Cost Recovery on Primary Health Care in Niger

Technical Report 16

François Diop, Ricardo Bitrán, and Marty Makinen

63 pages (October 1994) • Order No. TR 16

Available in French: Evaluation Economique des Testes Pilotes de Recouvrement des Coûts dans le Secteur Non-Hospitalier au Niger (Order No. TR 16F)

This document presents an economic evaluation of pilot tests undertaken by the Government of Niger and the United States to test the performance of alternative health care financing systems in rural areas of Niger. These results were part of an effort to formulate a national policy on primary health care reports and analytical and research reports produced during the course of the pilot tests. The policy implications of the pilot tests are drawn and preliminary recommendations made for use in the policy workshop on cost recovery held in July 1994, which marked the final stage of evaluation of the tests.

Developing a Health Insurance Reform Demonstration in Issyk-Kyl Oblast, Kyrgyzstan

Technical Report 15

Jack Langenbrunner, Michael Borowitz, Samir Zaman, Jane Haycock, Sheryl Rimer, Alexander Okonechnikov, Ainagoul Shayakmetova, Sarbi Arystanova, Tokon Ismailova, Alexander Danilenko, Anya Obryashchenko, and Medina Akhmetova

120 pages (July 1994) • Order No. TR 15

A health insurance demonstration to be implemented in the Issyk-Kul oblast sought to determine the feasibility of the design and propose enhancements, where necessary, in its financing, payment methods, organization and quality of care, and cost-accounting and information systems. The demonstration proposed to establish a mandatory health insurance fund organization at the oblast level, financed by a new payroll tax on employers and a per capita fee for non-workers. Health leaders have developed regulations for the collection and management of funds by this organization. However, not all financing issues have been addressed. Outstanding concerns include the poor economy of Issyk-Kul and an inequitable capitation rate. In the effort to generate needed funds, results of the HFS Project's effort indicate that some simple cost-saving measures, such as decreasing lengths of stay for inpatients, would reduce unnecessary expenses for discretionary services. An adjustment to user fees, based on co-payments, is also a possibility.

Improved efficiency in other areas of health care delivery, such as payment methods and care organization, would improve the system. Capitated payment to multi-specialty groups (APTKs) is the current preferred method of payment. In addition, hospitals could phase in payment on a case or admission basis. Facilities are encouraged to adapt more autonomous status and decentralized decision-making, which would include offering staff annual contracts. A quality assurance system that concentrates on more timely and appropriate referrals and eliminates premature discharges from inpatient environments should also be established. Implementation of information and cost-accounting systems will organize data and offer a basis for the reforms. The Kyrgyzstan Ministry of Health's medical economic standards can provide a foundation for a new cost structure.

Evaluation of Health Insurance Demonstrations in Kazakhstan

Dzheskasgan and South Kazakhstan Oblasts

Technical Report 14

Jack Langenbrunner, Igor Sheiman, Samir Zaman, Alexander Okonechnikov, Sarbi Arystanova, Sergi Kim, and Alexander Danilenko

100 pages (May 1994) • Order No. TR 14

This study evaluates two health insurance demonstrations—one ongoing and one planned—in two oblasts of the Republic of Kazakhstan. Four areas concerning health insurance and related health policy changes were examined: 1) adequacy of financing, or to what extent a new employer payroll contribution and other sources of revenue

ensure adequate financing of the health care system; 2) changes in efficiency, or the effect of the health insurance structure and related payment policies and organizational changes on the efficiency in the provision of services; 3) impact on quality of care, and ultimately changes in health status; and 4) impact on equity of access to care, or what effect the new system has relative to the strengths of the old system (relative equity of access to services by various socioeconomic status groups).

The evaluation found that parts of these demonstrations can serve as potential models for health care reform for the rest of the country, and that a number of specific design features can be used to help inform the debate about the health insurance reform law by the Parliament. To strengthen the existing demonstration models, especially in the context of national reform, a series of 40 recommendations and options for action have been developed in the areas of improved financing, payment methods and efficiency, quality of care, and equity of access to care. Several areas for potential short-term technical assistance also have been identified, including development of an improved legal framework for innovative demonstration sites in the future, intensive training activity, and model hospital cost and information systems.

Assessment of Seguridad Social Campesino Rural Health Facilities and Services Ecuador

Technical Report 13

Denise Deroeck, James Knowles, Tom Wittenberg, Polibio Cordova, and Laura Raney

130 pages (February 1995) • Order No. TR 13

The HFS Project and the *Centro de Estudios y Datos (CEDATOS)* conducted an assessment of the health services of Ecuador's *Seguro Social Campesino* (Rural Social Insurance Program, or SSC), a government social insurance program providing health care and other social services to the country's rural population, which is financed in part by payroll taxes paid by urban workers. A survey of nine SSC health clinics in various regions of the country and a survey of 1,017 households in the selected clinic areas provided information on the provision, utilization, and clients' perceptions of SSC services, the cost of services, and the demand for health services among the rural population. The major problems identified in the study include: difficulty in recruiting and retaining professional staff in the clinics; clinic catchment areas that are too small to support fully functioning clinics; shortages of drugs and supplies; and, as a result of these problems, low patient volume in many clinics. Unit costs for services varied as much as fourfold among clinics; those with the lowest costs tended to have larger numbers of member households and had greater patient volume. The demand analysis indicated a strong potential for expanding membership and increasing utilization of SSC services by improving the availability of medicines and other aspects of the quality of care. The study results also indicate that these quality improvements could be financed by user fees, increases in the small monthly membership dues, or a combination of both. The report provides a series of recommendations on how the utilization of SSC services can be increased through quality improvements, changes in the management and financing of the system, and other reforms.

Organization and Financing of Rural Social Insurance in Ecuador Seguridad Social Campesino

Technical Report 12

Dieter K. Zschock and Jazmina Estupiñan

40 pages (November 1994) • Order No. TR 12

This exploratory study examines the organization and financing of Ecuador's Rural Social Insurance Program (SSC), a dependency of the Ecuadorian Institute of Social Security (IESS). SSC operates over 500 health centers that provide basic health services to 153,000 rural households that contribute monthly payments through their community organizations. The study argues that IESS and the government, which co-finance SSC, need to review SSC separately from current proposals for the reform of IESS. SSC's program is experiencing administrative and financial difficulties. The study summarizes these problems, provides an analysis of SSC financing, and offers recommendations.

Health Financing in Tuvalu

Technical Report 11

Holly Wong

32 pages (September 1993) • Order No. TR 11

This study assesses the cost recovery system in the health sector of Tuvalu, a country of nine island groupings with a population of approximately 9,000. It analyzes the costs of providing services at Princess Margaret Hospital in Funafuti, the capital of Tuvalu, and assesses the current fee structure at the hospital and the revenues generated. A step-down allocation method is used to analyze the costs of providing services at the hospital. Results demonstrated that personnel accounted for a surprisingly low 38 percent of operating costs. The study findings suggest that, while there is some potential for generating additional revenues in the sector, the likelihood of raising significant revenues in this manner is limited. Additional means of generating cost savings are discussed, along with policy reforms that would have to be undertaken if cost recovery measures were to be successful.

Policy Options for Financing Health Services in Pakistan

Technical Report 10

Marty Makinen, editor

5 volumes, 338 pages (September 1993) • Order No. TR 10

Volume I. Summary Report

Marty Makinen

38 pages • Order No. TR10/VOL1

This is the executive summary report of the work done by the Federal Ministry of Health (FMOH) of Pakistan with the assistance of the HFS Project. The task was to design four financing and organizational reform initiatives aimed at improving quality, efficiency, and equity in the Pakistani health system. The four initiatives are mutually reinforcing. Autonomy for government hospitals will allow them to more easily meet quality standards. Hospitals also will benefit from the development of private managed-care insurance plans. Managed-care insurance plans, in turn, will use the independent assessment of hospital quality to choose facilities with which to associate. Strengthened rural services will reduce the burden on government hospitals. As government hospitals improve, they will better serve as referral sites for rural care providers.

This volume summarizes the major findings and recommendations in each of the four program areas chosen by the FMOH. In addition, summaries are provided of the studies done on the role of Muslim religious funds to assist the indigent and on legal issues of health sector reform. Finally, an overall implementation plan is presented that integrates the four initiatives, the legal work, and the recommendations concerning consensus and capacity building.

Volume II. Hospital Quality Assurance through Standards and Accreditation

Greg Becker

45 pages • Order No. TR10/VOL2

Public and private leaders in the field of health care in Pakistan have agreed that establishing national standards for the delivery of health services would improve the quality of patient care that is delivered in hospitals. This document describes the steps that could be taken to develop a national system that would 1) create standards to measure the quality of health services offered through medical institutions, 2) develop an accreditation process based on these standards, 3) monitor these standards and the accreditation initiative, and 4) develop, over time, a province-based system of registration and licensing of hospitals, health care personnel, and clinics.

Volume III. Hospital Autonomy

Stan Hildebrand and William Newbrander

97 pages • Order No. TR10/VOL3

The authors base this report on the assumption that concrete benefits would result from allowing hospitals currently owned and run by the Government of Pakistan to begin to operate as autonomous entities. These benefits would include reducing the amount of government funds needed to run these institutions by replacing much of the public subsidy with user fees. Autonomous hospitals would operate using private-sector

management principles which are expected to improve efficiency in operations, contain costs, and raise the quality of health services. This would be done while still retaining the hospital's social mission of providing free care to those who are unable to pay.

This document presents principles for governance, management, and finance that would guide the running of an autonomous hospital. It recommends a phased approach to conversion starting with the Pakistan Institute of Medical Services and the Federal Government Services Hospital.

Volume IV. Development of Private Health Insurance Based on Managed-Care Principles

Zohair Ashir, Harris Berman, and Jon Kingsdale

67 pages • Order No. TR10/VOL4

This report focuses on the potential for developing in Pakistan private health insurance programs based on managed-care principles. Fostering such programs would benefit the Government of Pakistan because encouraging private coverage of health care costs would reduce the burden that the government currently bears in financing health services. At the same time, promoting the development of a private-sector insurance industry with the managed-care approach would contain the costs of health services while improving the quality of care provided. This study surveys employers in Karachi and Islamabad to ascertain the market potential for private insurance programs and makes recommendations about developing these markets. It also presents the basic elements of a model managed-care health insurance program for Pakistan.

Volume V. Organizing and Financing Rural Health Services

Richard Yoder, Sikandar Lalani, and Marty Makinen

91 pages • Order No. TR10/VOL5

The purpose of this report is to explore an alternative approach to organizing and financing rural health services in Pakistan. The proposed model calls for the government to assign directly to rural communities the financial resources currently allocated to their local health facilities. The communities would then take responsibility for managing a contracting process whereby providers would compete to offer them a basic package of health services using existing government facilities and equipment. At the option of the community, additional services could be asked of the contractor in return for giving the provider the right to charge limited user fees. This report addresses the financing of different packages of services, including the provision of financial support for the needy; development of a medical referral system, definition of the contractual and oversight roles of the community, steps to attract providers to bid, and implementation, monitoring, and evaluation of the proposed approach. Also included are a sample Request for Proposal and contract form that could be used in carrying out this alternative approach to the management of rural health services.

The Potential for Sustained Provision of Health Services by Sector PVOs in the Dominican Republic

Technical Report 9

Gerard La Forgia and Stephen Heinig

54 pages (January 1992) • Order No. TR 9

This is an economic and institutional analysis of the potential for sustained provision of health services by sector private voluntary organizations (PVOs) in the Dominican Republic. A sample of 12 Dominican PVOs—chosen to illustrate variations in size, mission, and scope—were assessed to determine the extent, effectiveness, and efficiency with which they provide maternal and child health care and family planning services to the community. Unlike earlier investigations of PVOs and their roles in society, this report viewed PVOs as possible alternatives to governmental units, due to the shortcomings of the current Ministry of Health delivery system (SESPAS).

The authors interviewed the PVOs and examined internal records to determine their strategies, administration, programs, services and beneficiaries. They also examined the management capacities of the PVOs and the success rate of their incentive systems to improve the effectiveness of semi-volunteer workers. PVO methodologies, institutional capacities (including information management systems), and coordination are also addressed. The report proposes options to expand or sustain the capability of the PVOs to continue their services in terms of financing and efficiency.

The Ecuadorian Social Security Institute (IESS) Economic Evaluation and Options for Reform, Ecuador Technical Report 8

Carmelo Mesa-Lago

91 pages (September 1992) • Order No. TR 8

Available in Spanish: Instituto Ecuatoriano de Seguridad Social: Evaluación Económica y Opciones para Reforma (Order No. TR 8S)

This report analyzes the current economic-financial situation of the Ecuadorian Institute of Social Insurance (IESS), including its organization, population coverage, financing, expenditures, and financial equilibrium, and advances policy recommendations and options for future reform. Although all IESS programs are covered herein, the report concentrates on the two most important: pensions and maternal health care. The final section of the report provides policy guidelines for the future reform of social security, as well as a research agenda for the future. The study recommends reform of the IESS through the creation of a mixed system combining a reformed IESS, that would provide basic benefits, with private sector participation.

Health Financing in Fiji The Role of and Potential for Cost Recovery Technical Report 7

Holly Wong and Salik Govind

June 1992 (80 pages) • Order No. TR 7

This paper examines the existing cost recovery system in Fiji's health sector and evaluates its potential for policy reform. The study analyzes the costs of providing services at government hospitals, assesses current fee structure and revenue generated at the hospitals, and lays out various options for improving the cost recovery system. Some cost recovery improvement options laid out in this report include charging fees only at hospitals rather than at all facilities; charging all-inclusive fees rather than for individual services; and using the fee structure to encourage patients to lower levels of health care facilities. The paper also outlines additional factors that need to be considered, including the need for policy reform in the area of fee retention, strengthening the means testing system, simultaneously increasing the quality of care in government health facilities, and developing an effective health insurance system.

El Régimen Legal de los Servicios de Salud en el Ecuador Technical Report 6

Alberto Wray, Ivette Haboud, Elizabeth Garcia, and Lucia Cordero

106 pages (March 1992) • Order No. TR 6S • Available in Spanish only

This report examines Ecuadorian law and the regulation of health services. The report outlines user fees for health services provided by the public health sector; health services as an obligation of the state; collaborative agreements between the Ministry of Health (MOH), municipalities, and nongovernmental organizations (NGOs); the legal framework for financial assistance from the government to private health insurance; free choice between private health insurance or the Ecuadorian Institute of Social Security (IESS) scheme; the laws and regulations related to the practice of private medicine.

The first chapter discusses the juridical context of charges for health services provided by the public sector and examines the administration and use of collected funds. Chapter two analyzes the legal administration of medical care in hospitals and health centers and the obligations of the government to provide these services. Chapter three addresses the juridical environment which applies to agreements between the MOH and other institutions. The purpose is to analyze the context of the agreements and legal possibilities for the MOH to enter into agreements with nongovernmental organizations to manage the health services. Chapter four refers to the legal implications and obstacles to the Government of Ecuador in providing financial assistance for health insurance. Chapter five reports the legal obstacles for the IESS to use contributions as a payment for private health insurance. Chapter six analyzes the legal environment for the private practice of medicine in Ecuador. It includes the Ecuadorian tax code, regulations, and salary levels. This chapter also presents: an inventory listing the requirements and licenses necessary to operate hospitals and clinics; an evaluation of the legal aspects of pharmaceutical importing; a procedural explanation on custom duties for imported equipment and medical supplies; and finally pharmaceutical trade and price controls.

Cost Recovery in Public Hospitals in Belize

Technical Report 5

Gerard La Forgia and Charles Griffin

65 pages (June 1992) • Order No. TR 5

This study examines options for improving the cost recovery system. Although user fee policy implementation is legally mandated, it has not been a priority of the Ministry of Health (MOH). Pressure from the government to improve efficiency and reduce budget deficits in Belize's health care system initiated the MOH search for a workable cost recovery program. This document provides the Government of Belize with a method for choosing the level of cost recovery. The study finds that simple adaptations of the current fee schedule could be used to develop partial and full cost-recovery simulations that assist policymakers in deciding which changes in fee structure and total revenue estimates would work best in the system.

The report concludes that enforcing the current fee schedule would recover ten percent of the costs, and the MOH should grant autonomy to the health facility managers as an incentive for fee collection. In addition, the study recommends that means testing should be transferred to the Social Development Department of the Ministry of Social Services and Community Development.

Tools for Break-Even Analysis and Financial Control at Mirebalais Hospital, Haiti

Technical Report 4

Kirsten Frederiksen and Serge Fernandez

84 pages (April 1991) • Order No. TR 4

Available in French: Instruments d'Analyse de Point Mort et de Contrôle Financier à l'Hôpital Mirebalais, Haiti (Order No. TR 4F)

To achieve financial self-sufficiency, Mirebalais Hospital, a rural facility in Haiti run by the private voluntary organization Eye Care Management and Resources for Community Health (MARCH), instituted a cost recovery system. However, fees charged do not generate sufficient revenues to cover costs, and collection of fees is not strictly enforced. A break-even analysis shows that if fees for most services (excluding surgery, deliveries, and maternity care) were increased by 25 percent in real terms, the hospital could break even in six years. This assumes fee collection rates are 100 percent and a 50 percent increase over current rates.

Fee collection and financial administration can be improved by: assigning fee collection tasks to specific individuals, separate from patient registration responsibilities; improving reporting forms and the chain of reporting cross-checks; improving patient tracking through a numerical reporting system, instituting accountability for fees collected; and using a one-book accounting system and revised chart of accounts. To improve monitoring and financial control, regular reports on financial status can be utilized.

Assessment of Health Systems, Financing and Policy Options in Arequipa Region, Peru

Technical Report 3

Josh Coburn

115 pages (September 1991) • Order No. TR 3

Available in Spanish: Evaluación de los Sistemas de Salud, Financiación y Opciones de Política en la Región de Arequipa, Peru (Order No. TR 3S)

This report presents the results of an assessment of health systems and health financing in the Arequipa Region of Peru. Detailed quantitative and qualitative information is presented on the structure, utilization, operating costs and financing systems of public (Ministry of Health), quasi-public (Social Security) and private health services in the Arequipa region. Also presented are the results of a household survey, carried out to obtain information on health service utilization patterns. The information, which serves as a baseline for development of sound health resource allocation and financing policy, generates recommendations for ways in which the regional government can take a more active leadership role in health policy formulation, more effectively generate revenue within MOH facilities, and more appropriately allocate scarce public health resources to the region's population.

Health Services for Low-Income Families
Extending Coverage through Prepayment Plans in Santo Domingo, Dominican Republic
Technical Report 2

Gerard La Forgia

39 pages (December 1990) • Order No. TR 2

This study explores the potential for extending health services to low-income families in Santo Domingo through private, prepaid HMO-type health plans known as *Igualas Médicas*. Since their founding in the late 1960s and early 1970s, the *Igualas* have demonstrated impressive growth and increasing market share. The growth has occurred in the lower-end market of minimum wage employees in small and mid-size firms and parastatals. Based on a sample of eight *Igualas*, this report examines the strengths and weaknesses of these prepayment plans as extension mechanisms. Several features of these plans are reviewed: ownership, organization, provider arrangements, benefit packages, premium structures, membership characteristics and cost containment procedures.

Lending associations that provide loans to informal sector microenterprises are another major focus. The report identifies two associations which could serve as grouping mechanisms for microenterprise owners, workers, and dependents. Through an analysis of *Iguala* and lending association operations, this report explains the financial and administrative arrangement whereby the *Igualas* can be matched with this large yet specific segment of the informal work force. These groups receive what is widely regarded as inadequate health care at state health facilities or pay high-priced, fee-for-service practitioners.

Kenya Ministry of Health Preventive and Primary Health Care Resource Gap Study
Technical Report 1

Larry Forgy and Mutsempi Manundu

119 pages (October 1990) • Order No. TR 1

This study examines the gap in resources used to provide preventive and primary health care (P/PHC) at Ministry of Health (MOH) facilities in Kenya. The study, performed in collaboration with other donor organizations, determines the current expenditures for P/PHC services, estimates the costs of offering P/PHC services at facilities operating at full capacity, and calculates the resource gap. MOH facilities do not provide P/PHC services at full capacity because of a lack of staff, drugs, supplies, transportation and maintenance. The annual recurrent expenditure gap (approximately 423 million Kenyan shillings, or US\$20 million) represents 37 percent of current expenditures for P/PHC services and 20 percent of the entire MOH budget. An additional capital outlay of 326 million Kenyan shillings would be required to upgrade facilities and equipment to conditions required to provide P/PHC at full capacity.

TECHNICAL NOTES

Demand for Curative Health Services in Rural Ecuador

Technical Note 41

James C. Knowles

35 pages (September 1995) • Order No. TN 41

This study uses multivariate and econometric analysis to examine the demand for modern health care in rural Ecuador, as part of a larger assessment of the Seguridad Social Campesino (SSC), the government's voluntary social insurance and health care system for the nation's rural population. The analysis uses the results of a household survey of 1,017 rural households and a survey of nine SSC clinics to determine the potential effect of policy options, such as improving the quality of health care, increasing the rate of referrals to higher level facilities, and increasing user fees on SSC's three major goals: 1) to increase utilization of SSC health facilities, 2) to expand membership, 3) to promote the financial sustainability of the SSC. The overall conclusion of the study is that investing in improved quality of care, especially by increasing the availability of drugs in the clinics, and having user fees cover the full costs of these quality improvements would simultaneously promote all three of the SSC's goals.

Protecting the Poor in Africa

Impact of Means Testing on Equity in the Health Sector in Burkina Faso, Niger, and Senegal

Technical Note 40

Charlotte Leighton and François Diop

25 pages (August 1995) • Order No. TN 40

This paper examines the effect of informal methods of means testing in health facilities that are carrying out cost recovery activities. Using data from large household surveys, this analysis shows 1) the proportion of all people seeking health care who paid and who were given waivers, 2) the proportion of poorest individuals (in the lowest 25 percent of households according to income) and of the non-poor (the remaining 75 percent of households) who were given waivers, and 3) the proportion of all waivers that were given to the poorest and to the non-poor. The data from Senegal revealed that church-run facilities had developed more effective practices in protecting the poor and granted twice the percentage of waivers to the poor as did MOH health facilities. The Burkina Faso data revealed that the non-poor were just as likely to receive fee exemptions as the poor. The data from Niger, collected both before and during pilot tests on cost recovery, showed that a substantial proportion of people paid under the "free care" system and helped draw conclusions about the impact of official cost recovery on fee charging and waiver practices, specifically on how cost recovery affected waivers for the poorest 25 percent of patients.

A Proposed Fee Structure and Prices for a National Program of Cost Recovery for Health Services in the Central African Republic

Technical Note 39

Charlotte Leighton

54 pages (October 1994) • Order No. TN 39

Available in French: Structure Proposée de Paiements et de Prix pour un Programme National de Recouvrement des Coûts à L'Intention des Services de Santé en République Centrafricaine (Order No. TN 39F)

This study describes a proposed fee structure and fee prices in the Central African Republic (CAR) that would require patients to pay a flat daily fee for inpatient services, depending on the type of accommodation, and eliminate separate fees for medical procedures with two exceptions (minor outpatient surgery and childbirth). It would introduce a fee for outpatient consultations and for medicines. The study focuses on the impact of alternative fee options on household income and on what activities and improvements could be funded from the revenues. The study recommends that fee revenues be retained by the health facilities and that the MOH require that they be used to: 1) resupply medicines and support the medicine distribution and stock system, and 2) to pay for quality improvements.

Evaluation de la Qualité des Soins dans les Districts Sanitaires de Boboye, Illéla, et Say

Technical Note 38

François Diop

80 pages (May 1994) • Order No. TN 38F • Available in French only

Le rapport présente la méthodologie et les principaux résultats d'une étude de la qualité des soins de santé réalisée dans le cadre des tests pilotes de recouvrement des coûts dans le secteur non-hospitalier au Niger en 1994. Le rapport discute de l'adaptation au système de prestation des soins de santé primaires du Niger d'une méthodologie générale de l'évaluation de la qualité des soins aux niveaux de la structure, du processus, et du résultat de la prestation des soins. La mise en oeuvre de la méthodologie dans les établissements de soins de trois districts sanitaires du Niger révèle des fossés dans la disponibilité des ressources nécessaires à une intégration plus effective des activités de soins de santé primaires aux niveaux des districts sanitaires. L'étude révèle, par ailleurs, que des efforts devraient être faits pour améliorer l'accueil, l'approche et l'écoute des malades au niveau du processus de la prestation des soins. Par ailleurs, les échanges entre infirmier et patients devraient être intensifiés afin de présenter des alternatives de traitement aux malades et, si nécessaire, de les orienter vers d'autres soins du paquet minimum d'activités afin de renforcer l'intégration des soins. Enfin, l'étude suggère que du point de vue des patients, la disponibilité des médicaments, l'accueil des malades et la permanence des soins sont des éléments essentiels pour stimuler la demande des soins de santé.

Pilot Tests on Cost Recovery in the Primary Care Sector

Patterns in the Use of Health Care: Comparative Analyses of the Household Survey on the Demand for Healthcare — Boboye, Illéla, and Say Districts, Niger

Technical Note 37

François Diop

177 pages (May 1994) • Order No. TN 37

Available in French: Tests Pilotes de Recouvrement des Coûts dans le Secteur Non-Hospitalier: Enquête Ménage sur la Demande des Soins de Santé, Arrondissements de Boboye, Illéla, et Say, Niger: Schemas d'Utilisation des Soins de Santé: Analyses Comparatives (Order No. TN 37F)

This paper presents the descriptive analysis of the changes in the demand for health care resulting from the introduction of two cost recovery mechanisms which began in two districts in Niger in May 1993 during pilot tests in the non-hospital health sector. This paper presents the results of the analyses comparing the baseline survey carried out in October to December 1992 with the final survey, conducted in October to December 1993. The issues examined in these surveys include self-care, the utilization of public health facilities, illness-related expenses, and the willingness and ability of the population living in the two test districts to pay for the improvements in the quality of care which took place during the first six months of the pilot tests.

The introduction of fees, coupled with improvements in the quality of health care resulted in cost savings to households in the test districts seeking medical care, as well as in an increase in the utilization of health care in public health facilities. This result is consistent with the population's strong willingness to pay for quality of care improvements in public health facilities. The population surveyed expressed a clear preference for a payment mechanism based on an annual head tax versus one based on user fees, since from their point of view, the indirect (tax) payment method is easier for households to finance.

Cost-Effectiveness of Safe Motherhood Services in Indonesia

Framework for Analysis, Research Design, and Methodology

Technical Note 36

François Diop and Charlotte Leighton

25 pages (July 1995) • Order No. TN 36

Prepared at the request of USAID's MotherCare project, this study is intended to provide assistance in developing a research design and methodology for assessing the cost-effectiveness of maternal health program improvements that the Ministry of Health (MOH) of Indonesia is planning with MotherCare's assistance in three districts of South Kalimantan, Indonesia. The study provides options and recommendations to help develop 1) a framework for identifying the costs of safe motherhood services at the different levels of the district health system in South Kalimantan, as well as costs for pregnant women and their families; and 2) selected aspects of a research design

for the cost-effectiveness analysis to help integrate data collection for the cost and the effectiveness measures of safe motherhood interventions in South Kalimantan province.

This study also incorporates suggestions that would permit analysis of a second and equally important issue in the Indonesian context: the financial sustainability of MOH plans to ensure that recently trained community-based midwives make a transition from MOH salary support to self-financing service delivery at the village level.

Demand Side Impacts

Experiment in Health Care Cost Recovery in Niger

Technical Note 35

Randall P. Ellis and Mukesh Chawla

37 pages (September 1994) • Order No. TN 35

Direct user charges and indirect insurance payments are two systems of cost recovery that have been advocated and implemented in many countries. This report assesses the demand-side impacts of a 1993 pilot study in Niger under which these two cost recovery methods were implemented in different parts of the country. The experiment included three components: training and implementation of diagnostic and treatment protocols using essential drugs; improved management system capabilities; and new forms of cost recovery. Extensive household and individual survey data were collected six months before and six months after the cost recovery experiments. Using the survey data, this report assesses whether differences in the initial demographic, health, or treatment patterns affected the outcome of the cost recovery reforms; how cost recovery and quality enhancements affected the demand for treatment from public sector providers and from informal providers; whether reported rates of illness changed; and whether the policy reforms had a disproportionate impact on lower-income households.

Survey on Willingness and Ability of Households to Pay for Health Care in Three Provinces of Burkina Faso

Technical Note 34

Boubacar Sow

60 pages (August 1994) • Order No. TN 34

Available in French: Enquête sur la Volonté et la Capacité des Ménages à Payer pour les Soins de Santé dans Trois des Provinces du Burkina Faso (Order No. TN 34F)

This report summarizes the findings of a household survey conducted in early 1994 in the provinces of Bazéga, Gourma, and Séno in Burkina Faso. The document presents the results of descriptive analyses relating to the demand for health care and its determining factors. It also discusses the results of a contingency analysis of the willingness and ability to pay for health care. The survey data point to a high incidence of self-medication in the three provinces, compared with poor use of public health facilities. At the same time, households spend substantial sums on the treatment of illness in general, in particular, on buying drugs. The households indicated a marked willingness to share in the cost of improving the quality of care at health facilities in general. In particular, this willingness to pay is greater when it comes to financing improvements in equipment, maintenance, and pharmaceutical products than it is for contraceptive products.

Impact Evaluation Proposal

Proposal for Development of an Impact Evaluation System for Implementation of Cost Recovery in the Public Health System of the Central African Republic

Technical Note 33

Amy Pine

9 pages (September 1994) • Order No. TN 33

Available in French: Proposition d'Évaluation de L'Impact: Proposition d'Élaboration d'un Système d'Évaluation de l'Impact pour la Mise en Place du Recouvrement des Coûts dans le Système de Santé Publique en République Centrafricaine (Order No. TN 33F)

This paper offers a brief review of the fee structure proposed in 1994 for cost recovery for provision of inpatient and outpatient health services and medicines in the Central African Republic (CAR). It proposes a system to evaluate the impact of the proposed fee structure, particularly in two key areas: the financial impact of civil servants on the health care system, and the effects of the fees on indigents' utilization of the health care system.

**Cost Analysis for Hospital Care
The Case of Embaba Hospital
Technical Note 32**

Samir Zaman

200 pages (May 1993) • Order No. TN 32

This study was undertaken primarily to help Embaba Hospital in Cairo to establish fees for services once it converts to a cost recovery system. The main objectives of the study were to estimate the actual cost of a service delivered by each medical department of the hospital, to develop a clear and appropriate methodology for calculating the service cost at the other hospitals that will be the target of the Cost Recovery for Health Project, and to create a solid base for a pricing system for medical services delivered by hospitals run by the Ministry of Health in general and by Embaba Hospital in particular.

To achieve these objectives, the organizational structure of Embaba Hospital was studied; the jobs carried out in each hospital department were reviewed; the interrelationships among the departments were analyzed to determine patterns of resource utilization; and the use within the hospital of the services of individual departments was mapped. Five major categories of cost were examined to estimate the total expenditure of the hospital: buildings and permanent structures, equipment, personnel, utilities, and materials and supplies. All costs of operating the hospital were allocated to the departments, which were identified as either overhead, intermediate service, or final service departments.

**Pilot Tests on Cost Recovery in the Primary Care Sector
Data from the Public Health Facilities in Niger
Technical Note 31**

François Diop, Midou Kailou, and Ousmane Oumarou

89 pages (May 1994) • Order No. TN 31

Available in French: Tests Pilotes de Recouvrement des Coûts dans le Secteur Non-Hospitalier: Données des Formations Sanitaires Publiques au Niger (Order No. TN 31F)

This report assesses the preliminary results of the Pilot Tests Project on Cost Recovery in the Primary Care Sector, run by the Ministry of Public Health (MSP) of Niger to assess the performance of two payment methods for health care. The report covers the first ten months of the test year (May 1993–February 1994). It assesses cost recovery in the two test districts of Boboye and Say in terms of the impact on use of public health facilities, continuity of treatment, amount of medicines used, receipts generated by cost recovery, and both the amount spent on medicines and administration and the amount recovered for these expenditures. The findings are evaluated by comparing them with results for the health facilities of the Illéla district, the control area.

In Boboye, collection of a co-payment for services did not deter patients from visiting the health facilities, who instead were strongly attracted by the availability of medicines. The results were more mixed in Say, where the direct payment method was used. Despite the increased availability of medicines, the number of initial visits decreased slightly at most of the rural dispensaries in Say, although most public health facilities experienced an increase in the number of return visits. As a result of the heavy demand for services at the public health facilities in the test districts, a large quantity of medicines was used. In fact, the monthly usage of medicines in the two test districts indicates that current allocations for medicines to the medical districts is far below the amount needed.

The indirect payment method (used in Boboye) generated revenue at twice the rate of the direct payment method (used in Say). However, under the indirect payment method, those who live far from a health facility are penalized since the primary users of a health facility are those who live nearby. This finding and the exemption system used raise questions of equity.

A Survey of Costs, Revenues, and Staffing at PHC Health Facilities in Three Provinces of Burkina Faso

Technical Note 30

Suzanne McLees

30 pages (August 1994) • Order No. TN 30

Available in French: Une Enquête des Coûts, des Recettes, et des Effectifs dans les Etablissements de Soins de Santé Primaires de Trois Provinces du Burkina Faso (Order No. TN 30F)

This study summarizes the findings of a survey conducted in March 1994 of primary health care facilities in the provinces of Bazéga, Gourma, and Séno in Burkina Faso. The survey finds that all public health centers in Burkina Faso suffer from a variety of weaknesses that pose significant obstacles to their effective functioning. Shortages of health personnel, essential drugs, and equipment, and irregular supervision have the effect of reducing the already low demand for care at public health centers. In addition, the lack of accurate data on financial operations, including the level of expenditures and revenues, makes it difficult to determine the most appropriate policies to maximize the effectiveness and efficiency of cost recovery measures. It is particularly disconcerting to realize the health facilities studied were selected by provincial health directors based on the criteria that they be as fully staffed and functioning as possible. In the absence of complementary changes in staffing, medicine supply, and financial management, it is likely that construction and upgrading of health facilities, as was proposed in the 1991–95 National Development Plan, will accomplish very little.

A Supply-Demand Model of Health Financing

An Application to the Ambulatory Health System of Burkina Faso

Technical Note 29

James Knowles

51 pages (August 1994) • Order No. TN 29

This paper describes a quantitative tool, or supply-demand model (SDM) of health care financing, which is intended to serve as an aid in setting fee levels within the ambulatory health system of Burkina Faso. The typical situation that the model is designed to address involves a health facility that covers a fraction of its recurrent costs from self-generated revenues. The model allows the user to explore alternative financing options designed to reduce the facility's dependency on external financing while maintaining (or improving) the facility's utilization and quality of care. The SDM can also be used to trace the impact of a variety of other policies on the financial status of health facilities. The main body of the paper provides a brief overview of the model, describes the base scenario, presents the results of a series of policy simulations, and provides conclusions and suggested additional applications of the model.

Cost Recovery in Public Sector Hospitals in Ecuador

Technical Note 28

Gerard LaForgia and Mercy Balarezo

91 pages (August 1994) • Order No. TN 28

Available in Spanish: Recuperación de Costos en Los Hospitales del Sector Público en Ecuador (Order No. TN 28S)

This document assesses the present cost recovery practices in the public health facilities of Ecuador, poses price simulations as an aid in determining potential revenue, and recommends the administrative changes needed to reach the government's target for cost recovery. The study includes brief background notes explaining the current financial difficulties the public health sector faces: for example, legal restrictions on fee collection, fees that do not reflect market realities, and flawed means testing and billing systems. The simulations offer a solution by updating the prices, while proposing policy and administrative changes to improve financial management.

Specifically, the authors recommend revenue sharing and increased autonomy for the facilities. Individual performance would be subject to review and determine future government subsidies for each facility. Such incentives would provide the impetus for quality improvements. Finally, the authors recommend more localized means testing programs to protect the poor and eliminate prevalent leakage.

**Cost Recovery Pilot Tests in the Primary Care Sector
Household Survey of the Demand for Health Care in Three Districts of Niger
Technical Note 27**

François Diop

90 pages (May 1993) • Order No. TN 27

Available in French: Tests Pilotes de Recouvrement des Coûts dans le Secteur Non-Hospitalier: Enquête auprès des Ménages sur la Demande de Soins de Santé (Order No. TN 27F)

The Ministry of Public Health of Niger has been implementing cost recovery pilot tests within the non-hospital sector since April 1992. Through applied research activities, two cost recovery systems for non-hospital services are being tested. This report contains the initial results of the baseline survey conducted between October and December 1992 in the framework of the cost recovery pilot tests. It describes the methodology used for the baseline survey and the types of demand for health care in the three districts of Boboye, Say, and Illela.

Some 600 households were surveyed in each district. The information obtained on what 2,800 sick persons did to get over their illness constitutes the basis for the analysis contained in this report. Analysis of types of demand for health care reveals that in the period prior to the start of cost recovery and before the improvement in the availability of medicine in public health facilities, the inhabitants of the Say, Boboye, and Illela districts mainly relied on household remedies to get over their illness at home.

The informal market, represented largely by street vendors, has become the main source of medicine for the poorest households in rural areas. The frequency with which health care is administered at home and the large sums spent on it suggest that poor households in the three districts of Boboye, Illela, and Say devote a large share of income to health. The little use made of public health facilities suggests that people have lost confidence in non-hospital health centers. Given the lack of organized private sector health care in the rural areas where 80 percent of the population live, rehabilitation of public health facilities in the non-hospital sector is a prerequisite for any effort to improve the health of the majority of the people of Niger.

**Expansion of Private Health Insurance in Papua New Guinea
Technical Note 26**

Zohair Ashir

80 pages (January 1994) • Order No. TN 26

The expansion of private health insurance in Papua New Guinea is supported by the country's National Department of Health and believed by that agency to be an important prospective method of financing health services. As the budget for and quality of health services in the public sector continues to decline, it is believed that expanding private health insurance resources and then transferring additional financial burden to them would assist the survival of the public health sector, as well as provide better services for the uninsured.

Introduction of user fees and expansion of the health insurance market are believed to best be accomplished using managed care principles—payment of a fixed premium providing access to a predefined set of health services for a specific group of people.

To conduct the health insurance assessment and provide recommendations, numerous methods were used, including interviews with insurers, health care providers, and public and private employers. Results were divided into near-term and long-term actions and included direction on conducting workshops and technical training to improve the current state of health care and assist personnel in making the transition to a larger, private insurance-based system. Development of quality assurance mechanisms to arrest further deterioration of government health facilities; enacting exemptions on employee premium taxes for employers; and the eventual development of a more sophisticated, full-scale social security system are just a few of a wide variety of recommendations discussed in this paper. The study illustrated wide support for the managed care insurance project from employers, insurers, and health providers in Papua New Guinea.

Summary of Technical Assistance Reports (1986–1993)
Health Financing and Cost Recovery Systems in the Central African Republic
Technical Note 25

Keith McInnes

64 pages (September 1993) • Order No. TN 25

Available in French: Compte Rendus des Rapports sur l'Assistance Technique: Financement des Soins de Santé et Systèmes de Recouvrement des Coûts en République Centrafricaine (Order No. TN25F)

For the last decade the government and Ministry of Health (MOH) of the Central African Republic have pursued reforms in health care financing for health services. With the primary goal of improving the quality and coverage of health care services, policy makers have sought to increase resources for the health sector. This document summarizes ten reports on the CAR written by health finance specialists for the HFS project and the USAID-funded Resources for Child Health (REACH) project. They encompass broad assessments of the health care sector, descriptions of ongoing cost recovery programs and experiments, and results of a nationwide willingness to pay survey.

Review of Cost Recovery Experience in the Central African Republic
Technical Note 24

Charlotte Leighton, Gregory Becker, Yann Derricnic, and Evelyne Laurin

60 pages (January 1994) • Order No. TN 24

Available in French: Examen de l'Experience de Recouvrements des Coûts en République Centrafricaine (Order No. TN 24F)

This paper covers the findings from a field review of the cost recovery experience at all levels of the health system in the Central African Republic (CAR). It supplements and updates an earlier study undertaken in 1991 to assist the CAR develop a national cost recovery program. This paper documents the different types of cost recovery being practiced in the CAR, including those at village pharmacies, and notes the lessons learned from a variety of managerial and operational experiences. Conclusions based on this and the previous study suggest that a nationwide cost recovery program is feasible because the population of the CAR is both willing and able to pay for some essential services, the government has made the fundamental policy commitment, and necessary management systems exist that could be adapted for national use.

Means Testing in Cost Recovery
A Review of Experiences

Technical Note 23

Ruth Levine, Charles Griffin, and Timothy Brown

25 pages (January 1992) • Order No. TN 23

The HFS Project provides technical assistance and training, conducts applied research, and disseminates information to developing countries in health economics, health sector policy development, and health services management. The applied research work is to increase knowledge of the complex issues underlying health financing problems in the following policy areas: cost recovery, productive efficiency, social financing, and the private sector. As part of the project's studies on cost recovery, one activity examines means testing as a method of protecting the poor under cost recovery systems. This document presents a review of experiences with targeting and means testing worldwide and contributes to the HFS applied research on this topic.

Kenya National Hospital Insurance Fund Unit Costing and Quality Assessment Report
Technical Note 21

Richard Siegrist and Stephen Musau

186 pages (May 1993) • Order No. TN 21

When the National Health Insurance Fund in Kenya updated its reimbursement design to expand its provider base to include outpatient services, this report helped to estimate the daily total cost per inpatient day for various levels and types of health care facilities. It describes unit costing and quality assessment methodologies that can be applied to determine realistic reimbursement schedules for specific services based on the standard cost appropriate for the quality range in which the provider facility falls. The report is based on a survey of 14 hospitals.

Health Insurance in Fiji **Technical Note 20**

Deborah McFarland

103 pages (October 1993) • Order No. TN 20

This document examines the role that health insurance may play in the Government of Fiji's efforts to reform the way health care services are financed and delivered. Health insurance in Fiji is limited to the private sector; there is currently no comprehensive social insurance mechanism designed to ensure the availability of affordable health care services. Examination of existing group plans and data collected on insurance participants can provide guidance in making policy decisions about financing future health care systems in Fiji.

Mozambique Public Sector Budgetary Resource Needs and Allocations in Health **Technical Note 19**

Keith McInnes, Estrela Polonia, and Francisco Ramos

62 pages (January 1993) • Order No. TN 19

This report details a technical assistance effort in Mozambique with the objective of establishing a health budget and allocation process. It documents expenditures on health by the Government of Mozambique (GOM) and donors, current MOH budgeting and planning procedures, and existing financial information systems. In a recently completed postwar plan analyzing Mozambique's health financing situation, it was found that, compared to other sub-Saharan African countries, Mozambique had relatively low per capita spending on health; a relatively small percentage of GOM spending; and a high percentage of spending from donors. Funds are unevenly allocated to health facilities, with about 60 percent of combined donor and GOM capital directed to high-level facilities, such as central hospitals, while lower level facilities, such as rural hospitals, receive about 40 percent. In addition, some provinces are economically favored. Resources for health programs are not defined, and health expenditure programs are not properly monitored or evaluated. Budgeting is not conducted by the same sources that develop health programs.

To correct these imbalances, the MOH has created a plan that will gradually lessen dependence on external donors and reallocate existing resources to develop primary and secondary care services. In addition, the authors recommend installation of a financial management information system and training of MOH personnel in accounting and financial management systems.

The Expansion of Health Services Outside the Public Sector in Mozambique **Technical Note 18**

Keith McInnes, Antonio Jorge Cabral, and Jorge Almeida Simoes

80 pages (August 1992) • Order No. TN 18

This report examines the potential for expansion of nonprofit and for-profit private sector healthcare delivery in order to increase coverage for the population. The legal and regulatory environment for private sector collaboration is examined and necessary legislative reforms conducive to this participation are cited. The authors find that there is sufficient demand, willingness to pay, and ability to pay to support private medical practice in Mozambique. The National Health System (NHS), the major provider, would be buttressed by for-profit providers mainly in urban areas and not-for-profit providers in rural areas.

Financing Health Care in Kenya **Background and Framework for Strategic Planning** **Technical Note 17**

Charles Griffin, T. N. Kibua, Mary Kilonzo, B. Obonyo, and J. K. Wangombe

58 pages (October 1992) • Order No. TN 17

The authors adapt the strategic planning process to the public sector, specifically the health sector, to provide advisory policy support to the Government of Kenya on health care financing reform. It is not a strategic plan, but rather a description of the process whose final product is to be a strategic ten-year plan. The authors describe a framework for the process based on four main points: 1) set goals in terms of the ultimate beneficiaries; 2) focus on economic issues; 3) separate financing and service delivery issues as much as possible; 4) remember people pay for the health system, directly or indirectly; "nothing is for free" and therefore the efficiency and equity of

expenditures are important. The paper concludes with a proposal for institutionalizing the process in the Ministry of Health and an action plan for carrying out the planning process.

The Effects of Cost Recovery on Demand for Health Care at Cairo's Embaba Hospital, Egypt

Technical Note 16

Keith McInnes

17 pages (February 1993) • Order No. TN 16

This report summarizes two surveys conducted to understand how utilization at Embaba Hospital would be affected by the upgrading of the facility and an increase in prices. Under the hospital conversion component of the Cost Recovery for Health Project in Egypt, five public facilities, including Embaba Hospital, will be given autonomy in a pilot experiment to increase the efficiency and the quality of services. Econometric results of a household survey indicate that outpatient price increases will result in a significant reduction in utilization, but have a minimal effect on inpatient utilization. An alternate provider survey identifies existing competition to Embaba Hospital. Fees range widely and the extent to which other providers refer patients to Embaba is also assessed. The overall analysis of the surveys suggests that upgrading the quality of care at Embaba, through improvements in the infrastructure, the equipment, and the management, along with a general increase in user fees is unlikely to reduce utilization of the hospital; in fact, it is likely to increase. Differential fees are recommended to protect the poorest segments of the population who could not afford the increases.

Current Health Care Cost Recovery Systems in the Central African Republic

Technical Note 15

Nguembi, Senwara-Defiobona, Vuomo, Weaver, Setzer, and Ngueretia

34 pages (February 1992) • Order No. TN 15

Available in French: Les Systèmes de Recouvrement des Coûts de Santé en Cours en République Centrafricaine (Order No. TN 15F)

This study was performed to analyze cost recovery systems currently in use in the Central African Republic (CAR) and to provide decision makers with recommendations for the system which is best suited to the population's health needs, in preparation for possible implementation of a nationwide system. The study focused on systems which recover a significant amount of facilities' recurrent costs; cost recovery systems were considered financially effective if they recovered at least 45 percent of operating expenses. The study looked at 35 health facilities (28 public, seven private), including hospitals, health centers, maternity centers, and dispensaries.

Of the four types of cost recovery systems studied, two are recommended for nationwide implementation: fee for service and payment per illness episode. Constraints to implementation of a national cost recovery system include widespread indigence and the difficulty of identifying those who are unable to pay fees; the fact that relatives of civil servants and others who are required to pay for care currently do not pay at all or receive highly subsidized care; and the fact that government ministries do not pay for their employees who use health services. The authors recommend steps to be taken in preparation for a nationwide cost recovery system.

Beneficiary Analysis of Five Cost Recovery for Health Project (CRHP) Facilities, Egypt

Technical Note 14

Eltigani Eltahir Eltigani and Marty Makinen

23 pages (September 1992) • Order No. TN 14

This report offers a beneficiary analysis of five public-sector health facilities that are targeted in the first phase of the Egypt Cost Recovery for Health Project: Embaba Hospital in the Giza Governorate, 15 May Hospital in the Cairo Governorate, El Kantara Gharb Hospital in the Ismailia Governorate, Kafr El Dawar Polyclinic in the El Bahira Governorate, and Shark El Medina Hospital in the Alexandria Governorate. Profiles of the communities in the catchment areas of the five facilities are presented, as well as information on the currently operating facilities, including staffing, patient visits, common health problems served, and problems impacting the quality of care. Other health facilities in the four catchment areas are also briefly discussed.

The report attributes the decline in outpatient visits at the four currently operating facilities to inefficiency and poor quality of care. Greater autonomy of the management of each facility in the areas of staffing and procurement

of medicines and supplies is recommended, as is an improved system of subsidies for indigent patients. It is estimated that 40 to 65 percent of the population served by these facilities may require some form of subsidy. The report concludes by suggesting improvements to the current patient registration system in order to develop reliable profiles of the beneficiary populations and gather data on usage of the health services offered at each facility.

Cost Estimates with Accounting and Econometric Methods

Methodological Guide

Technical Note 13

Ricardo Bitrán

12 pages (July 1992) • Order No. TN 13

Available in Spanish: Estimación de Costos con los Métodos Contable y Económico: Guía Metodológico (Order No. TN 13S)

Available in French: Estimation des Coûts avec les Méthodes Comptable et Econométrique: Guide Méthodologique (Order No. TN 13F)

These brief notes were prepared for discussion with a team of enumerators and local researchers during the training stage of the HFS Project's work in Senegal. The notes are not intended to be an exhaustive explanation of cost measurement using the accounting and econometric methods. Rather, they are intended to illustrate the basic features of the two cost measurement methods to a group of enumerators and researchers who have little to no technical training in this area.

Selected Bibliography of Health Insurance Options in the USA

Technical Note 12

Basile Tsongo, with Cheryl Bailey

19 pages (July 1992) • Order No. TN 12

The researchers compiled literature on issues in the reform of health insurance in the United States between January 1990 and April 1992. A descriptive summary of the three major approaches for reducing the number of uninsured Americans introduces the bibliography. The proposals include: 1) "play or pay"—employment based coverage by private insurance, 2) "Bush Administration Proposal" for tax credits for the purchase of private insurance, and 3) a government health insurance system.

Operating Costs and Market Analysis for the Bon Repos Hospital, Haiti

Technical Note 11

Bradley Barker, Laurie Enrich, Ricardo Bitrán, Serge Fernandez, and Françoise Pean

35 pages, with IBM PC-compatible diskette (September 1992) • Order No. TN 11

Available in French: Analyse des Coûts d'Exploitation et du Marketing de l'Hôpital Bon Repos (Order No. TN 11F)

This report contains a financial analysis for a hospital, a marketing analysis for an insurance program, and a computerized menu-driven demand model. The cost projections were based on a relatively stable price index. The insurance program was based on a relatively stable level of urban employment. The financial viability of the Bon Repos hospital depends upon the government's continuing its support in terms of cash payments and provision of personnel; the poor not getting significantly poorer; and a willingness on the part of the wealthier population of the Bon Repos zone to use the upscale services that Bon Repos would offer.

Due to the military coup and the subsequent embargo, all socioeconomic and financial conditions upon which this analysis is based have changed. The report is still a useful resource for the general discussion of insurance principles and the computerized demand model that it contains.

Health Finance Policy Simulation Model

Technical Note 10

Developed by Larry Forgy and James Knowles

40 pages, IBM PC-compatible diskette and User Manual (1991) • Order No. TN 10 (specify diskette size)

This computer program is a planning tool that provides a method for a quantitative approach to health finance policy analysis. It simulates policy interventions and predicts the effect the proposed policy change will have on different areas of the health sector. The model operates by presenting the viewer with menus providing the projections of per capita expenditure and services and the financial condition of both the public and private sector. An additional set of menus allows input of data on the current health care situation and the proposed policy changes for the health care sector. The model simultaneously considers several relationships and influences on the health sector, useful for generating informed policy dialogue.

Assessment Report for the Central African Republic

Technical Note 8

James Setzer and Marcia Weaver

19 pages (June 1991) • Order No. TN 8

This paper provides an overview of the Central African Republic (CAR) and its health problems. Since independence in 1960, CAR's health policy has been based upon government provision of free health services to the population. The Ministry of Public Health and Social Affairs (MSPAS) is searching for alternative methods to generate resources for the sector. The paper includes an assessment of government laws and policy regarding alternative delivery and financing arrangements; an analysis of government expenditure trends in health service; an analysis of resource allocation trends; a study of social financing arrangements; a collection and study of documents, papers, and research on topics related to health financing; a summary of efficiency problems and gaps in knowledge; a draft workplan using data collection, analysis, research needs, and priorities; the willingness of CAR to affect change; and possible donor organizations and potential donor activities.

Economic Analysis of the "Strengthening Health Institutions Project" (SHIP) in Peru

Technical Note 6

Marty Makinen

28 pages (August 1991) • Order No. TN 6

This portion of the study of the Strengthening Health Institutes Project (SHIP) in Peru describes the costs and benefits of the project design; analyzes the cost-effectiveness of the project components; estimates recurrent costs and impact on the health budget of the Government of Peru; and analyzes the ability of the target populations to pay for the proposed costs of health services. To examine the affordability and sustainability of the project, the author uses cost-effectiveness analysis to evaluate the project design and its primary health care delivery system. The analysis reveals that the project design is economically sound, and the benefits of the project outweigh the costs. The author concludes that the beneficiaries are willing to pay for the majority of the recurrent costs, and the rest of the expenses can be covered by fundraising activities and regional government contributions.

Health Financing and Management in Belize

An Assessment for Policy Makers

Technical Note 5

A compendium in six volumes (July 1991) • Order No. TN 5

Volume I. Summary Diagnosis

Gerard LaForgia and Ruth Levine

10 pages • Order No. TN 5/VOL 1

This overview provides a synopsis of the six volumes that form a detailed and comprehensive study of health care financing and provisions in Belize. The paper cites the sources contributing to the deterioration of the public health care system and emphatically recommends, at the risk of political turmoil, a governmental shift away from "socialized medicine." Furthermore, this document summarizes the current issues facing Ministry of Health (MOH) policymakers and recommends changes in the health care system as well as the mechanisms for formulating and implementing health sector policy.

Volume II. Cost Recovery

Charles Griffin and Gerard LaForgia

43 pages • Order No. TN 5/VOL 2

This report examines the current user fee system in Belize. Only 2 percent of recurrent costs are recovered through fee revenues. The authors suggest using simple adaptation of the current fee schedule to develop partial and full cost recovery simulations. They also conclude that autonomy for health facility managers is necessary, as a first step, for the development of a successful cost recovery policy. In addition, the same rates should be charged to all patients, public and private, although some accommodation should be made for people who are too poor to pay. Final suggestions include conducting a few large-scale experiments for a year or two.

Volume III. Social Security

Gerard LaForgia

44 pages • Order No. TN 5/VOL 3

To help facilitate an informed public debate on the constraints to Social Security Board (SSB) participation in health care financing, this report examines SSB coverage, benefits, financing, and claims during the scheme's first decade of operation and provides an in-depth analysis of the Social Security system. This study recommends a long-term strategy that prepares for a comprehensive health insurance system. For a short-term strategy, this report recommends three courses of action for Social Security: 1) establish a cost-based reimbursement system with the MOH to finance medical care provided to injured workers under the current regimen; 2) develop an occupational health program focusing on the agriculture sector; and 3) expand the purview of the recently initiated Social Security Development fund to include grants and loans for the expansion or improvement of public and private health services.

Volume IV. The Private Medical Sector

Gerard LaForgia, Harry Cross, and Ruth Levine

17 pages • Order No. TN 5/VOL 4

The authors analyze the factors constraining expansion in the private medical sector in Belize. The recommendations in this report focus on increasing the access of lower-income groups to private medicine. The private medical sector in Belize is limited in terms of the number of providers and range of services. The report identifies the factors contributing to the lack of growth in the supply of private medicine in Belize, including, among other things, licensing regulations that restrict the number of physicians authorized to practice privately, the proximity of higher-quality services in Mexico, and low population coverage of group medical insurance.

Volume V. Resource Allocation in the Public Health Sector

Ruth Levine and Gerard LaForgia

34 pages • Order No. TN 5/VOL 5

The distribution of human and financial resources in Belize's public health sector is analyzed here. The analysis provides information for planning health care reformations: current and projected health needs of the Belizean population; allocation of resources at the national level; supply of manpower; and demand and utilization of human and financial resources in public health services. The data analyses conclude that the need for health services in Belize will grow. The study concludes with recommendations to improve efficiency of health services delivery.

Volume VI. Pharmaceuticals and Supplies Procurement

James Rankin

125 pages • Order No. TN 5/ VOL 6

This report documents the major problems in public-sector drug management in Belize and presents options to resolve the problem. The author collected data on procurement, budgeting, distribution, and monitoring. Three major problems found in public-sector drug management include: 1) the annual budget is too low to cover the population's medical needs; 2) procurement is ineffective; and 3) the distribution system is sound in theory but dysfunctional in practice. The annual budgetary allocations are consistently insufficient to cover the costs of pharmaceuticals and supplies in Belize, and the budgeting process is haphazard.

The author provides a framework for forecasting the quantity and cost of necessary drugs and supplies to be used to estimate financial needs. The report also identifies several options to improve the procurement programs managed by the Pan American Health Organization/Fondo Rotario de Medicamentos Esenciales (PAHO/FORMED).

Cost Recovery in Ministry of Health Facilities, Egypt

Technical Note 4

Greg Becker

15 pages (February 1991) • Order No. TN 4

Technical assistance to the Egyptian Cost Recovery for Health Project (CRHP) led to the development of facility standards and a Facility Assessment Instrument. It is a tool to assess the condition of candidate facilities for conversion to cost recovery and measure needs. Specifically, the Facility Assessment Instrument provides project management with information to make resource allocation decisions based on the facilities prioritized needs.

Cost Recovery Programs in Hospitals (CRHP Project Component One, Egypt)

Some Issues in Project Design and Implementation

Technical Note 3

Carl M. Stevens

16 pages (December 1990) • Order No. TN 3

As candidate hospitals and health centers are selected for conversion to cost-recovery status, various problems arise. This study identifies these issues and suggests possible resolutions: 1) recent public finance and policy issues; 2) a pricing policy for pay beds in cost-recovery hospitals (CRHs); 3) possible objectives for a CRH's pricing policy; 4) additional factors for the success of cost recovery; 5) government subsidies for the CRHs, both existing Ministry of Health and Ministry of Finance budget policies for government facilities that earn revenues by marketing services and alternative policies favored by the CRHP Project; 6) the organizational status of CRHs because of their increased autonomy; 7) resource constraints on quality and efficiency; and 8) cost recovery implementation problems stemming from the lack of financial resources needed to initiate the cost recovery cycle.

Cost Recovery and Applied Research in Belize

Technical Note 2

Charles Griffin and Gerard La Forgia

29 pages (November 1990) • Order No. TN 2

This report examines cost recovery activities in Belize's hospitals and health centers. The cost recovery work done in Belize is applicable to cost recovery activities throughout the world. The report provides valuable information projecting potential revenue for the public health system, gathering prices for medical services in the public and private sectors, and discussing the main policy issues that must be resolved for cost recovery to progress. The report also details how supply-side and demand-side issues determine the success of cost recovery for public health service in Belize, using population-based surveys. On the supply side, cost recovery succeeds when the necessary administrative and legal arrangements are in place and work effectively. Demand-side issues, often overlooked, are important to the political and economic feasibility of cost recovery. From a political standpoint, facts about how fee structure changes could improve the allocation of government resources are essential.

Pharmaceutical and Medical Supplies System Assessment, Kenya Ministry of Health

Technical Note 1

Jonathan Quick and Francis Ndemo

82 pages (November 1990) • Order No. TN 1

This study is an assessment of Kenya's Ministry of Health (MOH) pharmaceutical and medical supply system. The team visited hospitals, supply depots, health centers, and dispensaries in two provinces. Finally, the team reviewed and incorporated into its work the results of more than 12 reports prepared over the last five years. Findings, actions, priorities, and timetables are described for 10 areas of drug policy management that are estimated to be critical to increasing current supplies of pharmaceuticals, perhaps by 50 percent or more.