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**STRATEGIES FOR ACHIEVING
HEALTH FINANCING REFORM IN AFRICA:
Synthesis of HFS Project Experience**

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1.0 INTRODUCTION

1.1 Background

The U.S. Agency for International Development's (USAID) Health and Human Resources Analysis for Africa (HHRAA) project, asked the Health Financing and Sustainability (HFS) project to prepare this document. The HHRAA project asked for a document that would synthesize lessons learned from sub-Saharan Africa experience with 1) strategies for adopting and implementing health financing policy reform, and 2) research and analytic techniques that support the reform process. The document was to use HFS technical assistance and field research experience in Africa as the base, along with review of secondary sources for selected other country experience.

This study is part of HHRAA's larger effort to provide practical guidance on ways in which health financing reform can be applied to improve availability and quality of health services for African populations, and hence to improve health status. In general, the HHRAA project focuses on bringing research findings to bear on important health policy questions facing African decision-makers. HHRAA objectives include developing and disseminating technical knowledge; improving the process through which that knowledge is used to bring about more effective policy; and improving analytic techniques and tools for applied research.

USAID's mandate for HFS is to provide technical assistance, conduct applied research, implement training activities, and disseminate information on health care financing throughout the developing world. Principal HFS activities have focused on: resource generation through cost recovery; risk-sharing mechanisms; public-private collaboration; resource allocation, use and management; and costing of health services. From 1989-1995, HFS was involved in health care financing activities in over 30 developing countries around the world, including 13 in sub-Saharan Africa. HFS experience with developing and applying a variety of research and analytic tools has produced over 30 data sets for countries in Africa, Latin America, and Asia.

In response to African countries' interest over the past several years, much of HFS's work in Africa focused on health financing reforms that the countries have planned or undertaken to improve quality, efficiency, access, equity, and sustainability of their health systems. In the course of this work, HFS has provided technical assistance for policy development and early implementation stages of health financing reform. The project has also applied and helped implement many research and analysis tools, including household surveys, health facility surveys, patient interviews, and focus group interviews, which ministries of health have used in their decision-making process. Collaboration with African countries to resolve strategic, implementation, and technical policy issues has yielded lessons learned for the many health financing reform efforts now emerging and underway in the region.

1.2 Purpose and Scope of This Paper

Many documents now exist that focus on technical policy issues related to health financing reform. These documents identify, for example, the advantages and disadvantages of various financing alternatives and the impacts these reforms have had on typical health sector goals for improved access, quality, and efficiency. (Shaw and Griffin 1995, Kutzin 1993, World Bank 1987, 1993, 1994, Griffin 1988.) HFS has also provided substantial technical assistance and research related to resolving these technical policy issues and has produced several cross-cutting documents that synthesize health financing policy issues, experience, and research findings from Africa (Bitran 1995; Setzer and Lindner 1995,

Leighton 1995a, Makinen and Leighton 1993, McLees 1994). This paper does not deal in depth with the technical issues, but is designed to round out the other analyses by focusing on strategic, operational, and research methodology issues related to health financing reform.

The purposes of this paper are to synthesize lessons learned 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 implementation of reform.

The HFS experience on which this document relies 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 and analytical assistance to one country (Senegal) in financing and economic issues related to reform, 3) short term technical assistance activities, as well as small and major applied research efforts in 10 other countries in the region (Burkina Faso, Congo, Mali, Kenya, Nigeria, Tanzania, Cameroon, Togo, Zaire, and Mozambique); and 4) two regional workshops on health financing, each attended by representatives of more than 10 African countries. In addition to using HFS experience in Africa as the base, the document reflects review of secondary sources for selected other country experience.

1.3 Organization of the Paper

To place the strategic and implementation issues in context, the next section, *Section 2*, provides a brief overview of the scope of health financing reform in Africa and the main policy and implementation issues that ministries have been discussing over the past decade. *Section 3* identifies some of the main obstacles that African countries face in adopting and implementing health financing reform and strategies they have used to overcome these obstacles. *Section 4* draws lessons learned from this review of experience. *PART II, Section 5* provides a summary of research and analysis tools that have been used to inform and facilitate health sector reform decisions and to monitor and evaluate its impact.

PART I DESIGN AND IMPLEMENTATION EXPERIENCE

2.0 HEALTH FINANCING REFORM IN AFRICA

2.1 Reform Experience

In sub-Saharan African countries discussions about health financing reform have centered on ways to improve the sustainability, equity, and access of health services. These discussions also include debate about the impact of health financing reforms and resource allocation on effectiveness, efficiency, and quality of health care, as well as on the respective roles of the public and private sectors.

Many ministries of health, service providers, and researchers have identified characteristics that lead to poor performance in African health systems. These characteristics include insufficient funding, inefficient use of available resources, inadequate allocation of health resources to cost-effective health services (especially insufficient funding for primary health care in favor of support for hospitals), lack of incentives for health workers to provide quality care, inadequate regulation or inappropriate barriers to private sector provision of health care, inequitable distribution of resources between urban and rural areas and between poor and better-off populations, and high household health expenditures even in the midst of "free care" systems.

To address these problems, most African governments have instituted cost recovery through user fees for health services or medicines in the past decade as one of the primary methods of health financing reform. The initial impetus for these reforms is usually recognition that government budgets have not been able, and will probably not be able in the short term, to support an adequate — or in some cases, a minimum — level of health services for the population. In addition to raising revenues to promote financial sustainability, ministries of health have also sought to use fees as a means to improve the availability and quality of care, and ultimately health status.

Exhibit 2-1 shows the 31 African countries that, as of 1995, had begun or adopted implementation of national health sector cost recovery programs.

Exhibit 2-1. Countries in Africa That Have Begun or Adopted National Cost Recovery Reforms	
Anglophone & Lusophone Countries: The Gambia, Ghana, Kenya, Lesotho, Malawi, Namibia, Mozambique, Nigeria, Sierre Leone, Sudan, Swaziland, Tanzania, Zambia, Zimbabwe, Equatorial Guinea, Ethiopia, Guinea-Bissau	Francophone countries: Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Rwanda, Senegal, Togo, Zaire
<i>Source: HFS experience and adapted from Shaw and Griffin 1995, Nolan and Turbat 1993.</i>	

In addition to user fees, other methods, such as private insurance or community-based social financing, also exist to mobilize and organize financial resources. Community-based financing efforts have been practiced extensively, especially for village level health workers and "self-help" community projects to build or maintain health posts and clinics. Other revenue-raising alternatives being explored

or expanded include local government or more elaborate community-based social financing, prepayment plans, and private insurance arrangements.

Along with these different ways to finance health service delivery, strategies for alternative ways to allocate and organize health resources are also available to help solve the performance problems that African health sectors face and reach goals for improving quality and access. For example, strategies to allocate more MOH resources to primary health care or to make better use of private sector health service providers may also help expand access to better quality health care. As the next section shows, however, African countries have not widely adopted or practiced these other reform strategies.

2.2 Reform Strategies and Goals

Health financing reform policies, broadly defined involve alternative arrangements for paying for, allocating, organizing, and managing health resources. In sub-Saharan Africa, health financing reforms are often grouped into three broad strategies related to:

- ▲ raising revenue through cost recovery techniques (e.g., user fees, various kinds of private or community-based social financing, and insurance plans)
- ▲ improving allocation and management of existing health resources
- ▲ increasing the role of the private sector in predominantly government-based health systems.

As *Exhibit 2-2*, on the following page shows, these strategies have both primary and secondary goals, or impacts. For example, raising revenues through user fees may be undertaken primarily with the goal of promoting financial sustainability. User fees also have an impact — and can be designed deliberately to have that impact in the desired directly — on MOH goals for equity, access, efficiency, and quality (Shaw and Griffin 1995, Leighton 1995a, World Bank 1994).

Of the 31 African countries now implementing cost recovery, about one-fourth (Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Zambia) have made revenue raising the primary goal. The others emphasize raising revenue to make quality improvements in primary health care, such as personnel incentives or assuring drug availability. (Nolan and Turbat 1993, Shaw and Griffin 1995)

A recent worldwide survey of cost recovery goals in the health sector in 26 countries found that most countries had multiple objectives, but nearly all cited raising revenues as a primary one. Nine countries (Cameroon, China, Honduras, Iran, Kenya, Mexico, Nepal, Thailand, Uganda) also cited improving service quality and extending service coverage. Seven other countries that responded to the survey (Jordan, Iran, Kenya, Namibia, Papua New Guinea, South Africa, Sudan) sought to discourage unnecessary visits and prevent bypassing of lower level facilities (Russell and Gilson, 1995). Zimbabwe is a notable example in Africa with similar reform goals related to the referral system.

Exhibit 2-2. Health Sector Financing Reform: Purpose, Goals, Strategies

OVERALL PURPOSE OF HEALTH FINANCING REFORM: Improve Health Status		
STRATEGY (Technique)	PRIMARY GOAL	SECONDARY GOAL OR IMPACT
RAISE REVENUE (e.g., user fees; insurance plans and prepayment schemes to pool risk and make it easier to mobilize resources for health)	Financial sustainability	Equity Access Efficiency Quality
REALLOCATE RESOURCES (e.g., increase MOH budget share for PHC and cost-effective service packages; reduce government subsidies for hospitals; shift HIV/AIDS treatment out of hospitals)	Efficiency and Cost-effectiveness	Equity Quality Financial Sustainability
DEVELOP ALTERNATIVE ORGANIZATION of service delivery resources (e.g., increase role of private providers; establish HMOs; involve employer-based health providers; decentralize MOH responsibilities for health services to regional or district level)	Efficiency and Cost-effectiveness	Access Financial sustainability

Health financing reform strategies related to reallocating resources (health personnel, equipment, medicines, facilities, and funds), as well as those related to alternative organization of service delivery, are designed to improve the efficiency and effectiveness of a country's health system. They also can help increase access and financial sustainability — by encouraging non-profit health providers to increase coverage, for example. These strategies complement and support revenue-raising efforts by helping to make the best use of scarce resources, thereby reducing the need for new resources. These complementary reforms have been less widespread than cost recovery reforms and are just recently receiving strong attention.

For example, some ministries have tried to find more cost-effective ways to deliver individual priority services (e.g., immunization; malaria prevention and control; management of acute respiratory infections (ARI)) but few have attempted to implement systemwide efficiencies. Some efforts to reallocate funds from hospital to primary health care have been made, but little attention has been given to targeting resources directly to the poor and high risk groups, instead of making all government health resources equally available to the entire population. Several African countries (e.g., Ghana, Tanzania, Zambia) have begun to identify cost-effective service packages along the lines recently recommended by the World Bank (World Bank 1993) and one (Zambia) has put in place a budgeting system based on the results.

Non-profit health providers flourish in some countries with little or no government assistance and receive large government financial subsidies in others, while legal and other constraints inhibit their operation in still others. Legal, regulatory, and credit constraints particularly tend to present obstacles to growth of for-profit private sector providers, though traditional health providers continue to flourish and provide substantial percentages of health care to the population in many African countries. Financing reforms that would identify and foster appropriate roles for private for-profit and traditional practitioner-based health care are among the least developed.

2.3 Common Strategic and Implementation Issues

Considering the substantial shift that this array of financing reform strategies entails for the public health systems of many African countries, ministries have typically faced several issues about how to proceed. In addition to technical questions about financing policy reforms (e.g., what fee structures exist, how can the poor be protected, are insurance mechanisms appropriate in rural Africa, how can hospitals be financed), ministries face a variety of strategic, institutional, management, and procedural issues that this paper addresses:

- ▲ What are the main strategies ministries need to employ to address obstacles to health financing reform?
- ▲ What decision strategies have been used effectively for adopting reform?
- ▲ What phasing strategies have been tried and been successful for implementing reforms?
- ▲ How have ministries resolved specific design and implementation issues? What are the common problems and conditions for success?
- ▲ What information is needed for decisions about financing reform?
- ▲ What tools and methodologies have been used effectively to develop, monitor, and evaluate health financing reform?

Experience has shown that a broad array of institutional reforms and management processes — such as, civil service reform, decentralization, strengthened management capacity, building political consensus on priorities, overcoming bureaucratic constraints — are needed to complement and support the more technical solutions to implementing health financing reforms. (Walt 1994; Leighton 1995a) To address the multiple technical and institutional issues confronting African health systems, a combination of strategies is usually necessary to achieve consensus on health financing reform policies and then to implement them.

3.0 STRATEGIES FOR ACHIEVING HEALTH FINANCING POLICY REFORM

3.1 Obstacles to Reform

Any country attempting major changes in financing and organizing their health sector faces a number of formidable obstacles. While each country faces its own particular array, in sub-Saharan Africa principal obstacles have included several political and institutional obstacles — policy conflicts, political instability, weak institutional capacity. They also include several economic, health sector and financing-specific obstacles — economic decline and slowed development, incomplete health sector development, and limited data on which to base informed decisions about likely outcomes of alternatives that might be adopted. Often, erratic donor funding assistance and conflicting donor policy pressures compound these problems.

Some of the obstacles for health financing reform are similar to policy reform in any sector that seeks to generate new revenues and change the allocation and organization of public resources. Many of the obstacles and related strategies, however, are more general and exist for any major policy reform countries may have been attempting, whether in financing or program policy, in the health or another sector. While lessons learned about these obstacles are thus not original to health financing reform, it is worthwhile to review this range of obstacles briefly to illustrate the combination of approaches needed and to emphasize that non-economic factors are as important as economic and financial ones to achieving health financing reform.

The following discusses six of the most prominent obstacles.

3.1.1 Conflicting Policy Goals

Policy conflicts in health financing debates have emerged on two levels. One has existed between African governments and donors. A second exists among the various health financing goals themselves. These conflicts are among the principal reasons that discussing, adopting, and then starting national implementation of, health financing reform has been an extended process lasting at least five, and frequently ten, years in many countries.

At the broadest level, key policy differences between donors and African governments and ministries of health have contributed to difficulties in reaching consensus on reform objectives and strategies. For example, donors tend to emphasize and fund primary and environmental health care services and activities, while Ministries of Health must respond to evident demands of their populations for hospital-based services. Some international donors (e.g., WHO and UNICEF initially in the 1978 Alma Ata Declaration and then explicitly in the 1987 Bamako Initiative) have consistently stressed community-level financing for primary health care and related medicines. Others (e.g., the World Bank and some bilateral donors) have also argued for overall financing reforms across the health sector — for hospital inpatient services as well as outpatient primary health care — with emphasis on the economic rationale for user fees, health insurance, expanding the role of private sector providers, and improving resource allocation (e.g., World Bank 1987 and 1994a; USAID, 1980, 1982, and 1988).

Until recently (especially with adoption of the Bamako Initiative) most African governments, on the other hand, have generally resisted adopting any of these reform approaches at the national level. They have generally affirmed policies in place since Independence that health care should be "free of charge" and provided by the government. Although many countries had policies that required some payment for inpatient hospital services, these were erratically or weakly enforced in most cases. Only after prolonged experience throughout the 1980s with declining MOH budget resources and seriously deteriorating health services did most begin, officially, to sanction or implement fee-charging policies at government health facilities in the late 1980s and 1990s as a way to raise revenues for health care in the public sector.

Having thus adopted cost recovery reforms primarily to resolve budget constraints, the reform objectives have tended to be limited to raising revenues, usually to improve primary care or the availability of drugs. Similarly, 6 of the 17 Anglophone and 11 of the 14 Francophone countries with national cost recovery policies officially require that fee revenues be reserved for drug repurchase. Only four Anglophone (Kenya, Lesotho, Malawi, Zimbabwe) and none of the Francophone countries also have "efficiency" objectives (e.g. appropriate use of services) or "equity" as an explicit objective. (Nolan and Turbat, 1993). Only a few African countries (e.g., Ghana, Kenya, Tanzania, Zimbabwe, Zambia) have seriously officially considered or begun other kinds of health financing reform initiatives in, for example, resource reallocation, insurance or private sector development that would expand the cost recovery activities and goals.

With respect to the second type of policy conflict, health financing reform goals can also conflict with each other, or cause disruptive adjustments in another part of the health system. These conflicts make domestic consensus on trade-offs especially difficult. For example, attempts to raise revenues from user fees may improve financial sustainability, but can hurt equity or create disincentives to use needed services if offsetting measures are not taken. Goals to provide health services for widely dispersed populations can improve access for underserved groups, but conflict with goals to improve efficiency in cost per person served.

Alternative financing methods also involve significant political considerations and trade-offs. Attempts to reallocate government funding toward more cost-effective health services can conflict with employment expectations of health workers who are civil servants. Ministries of Finance traditionally resist retention of fee revenues at the local health facility. Health personnel who are benefitting from informal fee collection procedures resist more standardized and monitored arrangements.

Equity goals can also conflict with each other. Using public funds to subsidize important employment or other interest groups (e.g., civil servants, military, students) drains resources that might be directed toward subsidies for the poorest. One of the overarching policy trade-offs confronts ministry officials with decisions to balance 1) the need for additional revenue to improve quality and access with 2) government's longstanding commitment to the "entitlement" of the whole population to health services provided free-of-charge.

3.1.2 Political Instability

Political instability makes it difficult to achieve the consensus needed, to mobilize political and public opinion, and to bring together the disparate interests (e.g., doctors and nurses, pharmacists, key Ministries, central and local authorities, NGOs) that need to be accommodated. In Niger, for instance,

health workers were on strike for 95 days in 1994. In the Central African Republic, civil servants did not receive their salaries for nearly a year in 1994. Ministers of Health are often in their posts for less than 2 years, with corresponding changes in their top staff. Parliaments or National Assemblies can be disbanded, holding hostage any needed legislative reform.

3.1.3 Weak Institutional Capacity

Weak institutional capacity restricts the country's ability to assess current performance, identify options, project likely impacts, formulate and implement plans, administer complex insurance reimbursement mechanisms or reliable means testing procedures to protect the poor. It also restricts ministry of health's ability to collect and analyze needed information. Financial, management and health status and utilization information systems are not in place or do not produce routinely reliable data. Frequent turnover of top ministry officials and of mid level staff with requisite skills eliminates institutional memory and capacity to carry out the job. Frequent lack of rural banking facilities makes it difficult for local health facilities and community health committees to manage revenues from health service and medicine fees. Independent auditing capabilities and firms are weak to non-existent.

3.1.4 Poor Economic Conditions

For most African countries, poor and declining economic conditions have been perhaps the major factor forcing them to consider making significant changes in financing and organization of government health services. These conditions have eroded the resources needed for the government to live up to its commitment to provide minimally acceptable health care for all. Economic decline has not only limited the government's taxing capacity, it also limits the population's ability to pay for health services under cost recovery schemes. MOH concern that people would not be able to pay for health care and that fees would inhibit the populations use of needed services has been one of the major obstacles to adopting official charges in government health facilities. In addition, slow development of financial institutions and formal wage sector employment has limited the potential for health insurance to grow or for credit availability for start-up of private health providers. In some countries foreign exchange constraints and balance of payment deficits put pressure on drug importation, while trade ties limit purchasing options in others.

3.1.5 Incomplete Health Sector Development

Many different degrees of health sector capacity and development exist across all the countries of Africa, and across geographic regions in any single country. But in general, where it exists incomplete health sector development means, to varying degrees, that primary, secondary and tertiary care services are not well-differentiated or linked in referral networks. The geographic distribution of health services is highly uneven: reliable quality assurance mechanisms for health services, products, and medicines are virtually non-existent. The private sector for health service delivery is often rudimentary, either because of economic or legal constraints. Pharmacies are usually not widely available or well-regulated; informal, unregulated sellers of medicines and injections abound. And communication channels do not exist for coordination, record keeping, and dialogue between the public sector and the private sector providers and suppliers that do exist. Private health insurance is rare or unable to operate on an actuarially sound basis. Social insurance and health insurance plans for civil servants may exist formally, but frequently do not reimburse providers for health services delivered to covered populations. Financial management skills and systems are not in place in health facilities or at the central Ministry level to implement either fee-for-

service or insurance reimbursement reforms. Drug distribution and inventory infrastructure is often weak to non-existent.

3.1.6 Information Constraints

Data are limited on several aspects of the health care system that are essential for informed decision making for health financing reform. Data on costs of current health care services at hospitals, health centers, and health posts are not reliable or unavailable. Little is known about what people are now spending on health services and medicines or how that spending would change if prices, quality, and access were different. Little information exists to help evaluate the use of health services by different socio-economic and demographic groups. Much of the available data on the success of small-scale experiments with cost recovery and revolving drug funds is out-of-date, scattered, and not comparable.

In spite of the recognition of the potential advantages of user fees and related reforms, many Ministries of Health and health providers have been concerned that people will not be willing or able to pay for health services, that changing from systems where services are officially free of charge will create barriers for the poor, or that private or public sector fees will discourage utilization of high priority preventive and primary care services. Yet typically, little information exists on the local situation in the country considering the reform to help answer these questions. Ministries of Health have also been concerned that fees will not raise adequate revenue to justify implementation costs or to improve quality. Too little information has been available about the effectiveness of various methods to protect the poor or about the efficiency and quality of private sector providers. Lacking data on these issues, policy makers often delay making socially and politically difficult decisions.

In part because of these information constraints, many "myths" about health financing reform exist that make policy change difficult. For example, in the absence of information to the contrary, people tend to believe that the poor are unwilling to pay for health services, that there is no role for the private sector in achieving the public health agenda, or that insurance or pre-payment mechanisms will not work in the poorest rural areas. Ministry officials and others may believe that providing services "free of charge" promotes equity, makes health care affordable, and promotes appropriate utilization of needed health care. Data collected on the actual situation in many African countries, however, frequently dispels these beliefs and encourages officials to adopt reforms that may achieve these goals more effectively.

3.2 Overcoming the Main Obstacles

3.2.1 General Strategies

Ministries of health that have designed, adopted, and are implementing national reforms have at least partially overcome these obstacles. To address them requires several general strategies, as applicable to health financing reform as to any other sector reform. Some of the most important of these strategies include:

- ▲ Build consensus domestically and among donors
- ▲ Exercise and maintain Ministry of Health leadership of the effort
- ▲ Strengthen institutional capacity and personnel skills
- ▲ Adapt and update reforms to economic conditions

- ▲ Develop health organizational and financing infrastructure
- ▲ Collect, analyze, disseminate data and information

Exhibit 3-1. provides examples of strategies ministries have used to address the major obstacles to health financing reform.

Exhibit 3-1. Strategies to Overcome Obstacles to Health Financing Reform	
OBSTACLES	STRATEGIES
POLITICAL & INSTITUTIONAL FACTORS	
Policy conflicts	<p>Build consensus and negotiate with relevant ministries and international donors, public and private sector health providers, and interest groups so that all "buy into" the process and negotiated goals.</p> <p>Set clear goals and establish balance among competing objectives.</p> <p>Evaluate periodically and make adjustments needed to achieve intended goals.</p>
Political instability	<p>Exercise consistent MOH leadership, commitment, perseverance below the political appointee level.</p> <p>Inform and brief new political appointees.</p>
Weak institutional capacity	<p>Strengthen institutional capacity through training and identifying organizational focal points and responsible individuals.</p> <p>Conduct implementation in phases.</p> <p>Avoid overly complex approaches and attempting multiple reforms simultaneously.</p> <p>Expect reform process and results to take time.</p>
HEALTH SECTOR & FINANCING-SPECIFIC FACTORS	
Poor economic conditions	<p>Take advantage of openness to change.</p> <p>Adapt financing strategies and techniques to current income distribution, tax capacity, economic cycles, and employment structure with built-in flexibility to change as economic conditions change.</p>
Incomplete health sector development	<p>Develop infrastructure for medicine purchase and supply, financial management, quality assurance, private sector provision of health care, and information/monitoring systems.</p> <p>Adapt financing mechanisms to organizational capacity and infrastructure, urban-rural differences, population preferences, and public-private mix.</p> <p>Implement reform in phases; monitor, evaluate, and disseminate results to policy-makers, program & facility managers, and other stakeholders frequently.</p>
Information constraints	<p>Collect and analyze locally relevant data and experience.</p> <p>Assess experience of other countries.</p> <p>Disseminate information to relevant central and local MCH and other government officials and interest groups.</p> <p>Conduct public information campaigns.</p>

These strategies are all required in the beginning of reform consideration, while debates are proceeding, and throughout implementation. The specific subject matter will shift and the emphasis will be different in different countries. But the strategies and mechanisms for resolving policy conflicts and addressing political, institutional, economic, health infrastructure, and information constraints need to be in place for the duration.

Countries such as the Central African Republic and Niger have followed these strategies over an extended period and are both now introducing implementation of national cost recovery reforms. Other countries, such as Kenya, have followed some of these strategies and omitted others, such as adequate consensus-building and public information, suffered setbacks, and adjusted course. The following sections provide examples of country experience with these strategies during the design and implementation phases of financing reform.

3.2.2 Decision Strategies During Design Phase

Three obstacles tend to dominate during the design phase, prior to adopting health financing policy reforms: policy conflicts, information constraints, and institutional weakness. During the design phase MOH officials want to know whether various reform options are likely to be effective in their country or not. They need to identify more specifically what the problems are and quantify their dimensions. They need to resolve the concerns of all those who need to agree with the decision at the national level. And they usually want to minimize the uncertainty and risk they face in deciding to adopt major policy change.

Ministries that have successfully adopted national reform programs have chosen a variety of approaches to addressing these constraints. *Exhibit 3-2* illustrates three of the main strategies African countries have followed for informing and facilitating decision-making during the design phase, along with country examples. Given the emphasis ministries of health have placed on cost recovery as the principal reform, the examples refer primarily to decisions to adopt some form of user fee for government-provided health services, but they are applicable to broader reform packages as well. The three main strategies leading up to decisions to adopt national cost recovery reforms include:

- ▲ *Analysis of multiple, "natural" experiments* in the country, assessing lessons learned and identifying options that are evident in the cost recovery experience of church missions, other NGOs, small donor projects, and private sector experience with fees
- ▲ *Official pilot test(s)* in one or more regions or districts to demonstrate the feasibility of one or more of the main options under consideration (sometimes including options derived from multiple, small informal experiments), with the explicit purpose of using the information as a prototype for national reform
- ▲ *National planning effort* by experts involving assessment of international experience and baseline data collection in-country to develop a well-designed national plan for reform

Exhibit 3-2. Strategies for Designing Health Financing Reform: Illustrative African Countries		
Multiple Experiments	Official Pilot Tests	National Planning
Central African Republic Cameroon	Niger Senegal Zambia	Kenya Ghana Zimbabwe

3.2.2.1 *Multiple experiments.*

The Central African Republic used multiple experiments as their information base for decision-making. The Ministry of Health was unwilling to establish deliberate pilot tests because of the inequities they might create between the test district(s) that would have an apparent advantage over non-test districts. Instead, they assessed and compared the variety of informal cost recovery "experiments" that were taking place among NGO health facilities, some donor-assisted sites, and a few public sector health facilities. They also conducted legal studies, provider interviews, facility cost studies, and a large nationwide household survey to assess willingness and ability to pay for health care. In all, more than ten studies were conducted to collect and analyze local data from 1986 through 1993 (McInnes 1993, Leighton, Becker, Derriennic, and Laurin 1994, Nguembi et al. 1992).

Many of the studies were conducted between 1986 and 1989, leading up to National Assembly passage of legislation needed to establish the principle of paying for services in public health facilities. Several others were conducted from 1990-1993 for purposes of developing information needed for details of implementing the new law. The MOH established a focal unit at the central level to coordinate and conduct the analyses.

The Ministry held two interministerial workshops: one in 1989 to define specific goals and objectives of cost recovery under the new legislation, the other in 1994 to debate and reach consensus on implementation details for the fee structure, services for which fees would apply, fee exemptions for various target population groups, and an implementation strategy. Availability and analysis of findings from household and provider surveys conducted in the country were key elements in convincing workshop participants and decision-makers of the feasibility and benefits CAR would likely achieve from full implementation of their 1989 law. (Leighton, 1994)

In Cameroon, the MOH established a National Primary Health Care Coordinating Committee to assess the community-based financing system adopted in 1982 in accordance with the 1978 Alma Ata principles. Based on findings of many community-based experiences, the study commission recommended a Reorientation policy in 1989 and the Legislature enacted relevant laws to revise the current structure (c.g. laws needed for village level management and sale of drugs) in 1990. The MOH carried out subsequent analyses of donor-supported projects in several regions, adopted a final revised strategy for district-based cost recovery with Provincial Health Funds in 1992, and several Presidential decrees officially authorized the new procedures in 1993. (Owona-Essomba, Bryant and Bodart 1990; Gellar and Ndonko 1993, Litvak and Bodart 1993, Sauerborn, Bodart, and Owona-Essomba 1995.)

3.2.2.2 *Official pilot tests.*

In the early 1990s, Niger designed a pilot test of two alternative health financing methods: 1) a simple fee per episode, and 2) a form of social financing consisting of a locally administered annual tax, plus a small fee per episode at the time of using a health service. Although a variety of small-scale experiments had operated for years in Niger and hospital sector financing reform had been proceeding slowly, the Ministry of Health remained uncertain about the feasibility and impact that cost recovery would have if officially introduced for primary health care in rural areas. To resolve disagreement and uncertainty, they designed a deliberate, controlled experiment to produce information they needed. They also established a small monitoring unit in the central MOH to follow and evaluate the pilot results.

Debate leading up to the pilot and decision-making delays related to political transition to multi-party democracy took over three years. But the MOH quickly made their decision to adopt nationwide cost recovery for primary care after one year's operation of the pilot, which had produced results indicating feasibility of cost recovery and positive impacts on utilization, including for the poorest. A workshop with wide government and central and local MOH representation was held for both the decision to implement the pilot tests and to adopt nationwide cost recovery based on the pilot findings. The implementation strategy Niger adopted built directly on pilot test findings by offering each region a choice between the two alternatives that had been tested. Before deciding, each region will be given a detailed briefing on the results and operational details of the two options. (Diop, Bitran and Makinen 1994)

In Senegal, the success of an urban pilot project (in the Pikine community on the outskirts of Dakar) for cost recovery in primary health care, along with early promise showed in rural community-based pilot efforts (in Sine-Saloum Region), led to the adoption in 1980 of a policy to extend community financing throughout the country at the lowest level of the official MOH system, the health post. The MOH permitted pilot tests of expanded cost recovery at the hospital level for three regional hospitals in 1982 and three more in 1986 and 1987. In 1989, the government issued a National Health Policy reaffirming cost recovery at all levels of the health system, issued tightened regulations for using fee revenues to improve health services, and upgraded the legal status for Community Health Organizations and NGOs. (Vogel 1988, Osmanski et al 1991, World Bank 1992)

In Zambia, the success of a 1991-1992 pilot project in three districts to test the feasibility of a fully decentralized planning and budgeting system resulted in the adoption of a district-level budgeting policy nationwide. (Lagerstedt, 1993; Government of Zambia 1994a, 1994b)

3.2.2.3 *National planning.*

In 1987, Kenya assembled a large study team of central MOH staff and local Kenyan economists to develop a master plan for health financing reform. The team began with in depth analysis of the central referral hospital, Kenyatta National Hospital, and other public and private hospital facilities in Nairobi, followed by a survey of selected provincial and district health facilities. They conducted these intensive studies over a two year period before implementation. The initial implementation included simultaneous introduction of fees for outpatient and inpatient care, lab tests, and X-rays, (with exemptions for preventive services, family planning, MCH) at all health centers and hospitals in the country (Collins and Hussein 1993, Overholt et al. 1989, Makinen et al. 1989, Setzer, Leighton, and Emrey 1992)

Ghana followed a similarly centralized planning process for revisions of an existing cost recovery system. The MOH revised existing fees for outpatient and inpatient care and drugs sharply upward in

1985 following a central analysis of an underfunded health system in the midst of economic decline and donor emphasis on policy change. Recent design efforts that have addressed plans for greater decentralization and allocation of national budget funds for more cost-effective service packages are also national planning efforts. (Republic of Ghana 1995; Waddington and Enyimayew 1989 and 1990, Vogel 1988).

Zimbabwe has had a multi-layered fee system in place for inpatient and outpatient services at health centers, district, provincial and central hospitals since independence in 1980. The MOH published a revised fee schedule, and a revised sliding-income scale for fee exemptions in 1985, but had not otherwise emphasized vigorous cost recovery implementation for health services. Under increasingly severe economic constraints in the late 1980s, the MOH assembled a team of local and international experts to conduct a comprehensive review of health financing in Zimbabwe, and a detailed study of the cost recovery system in 1990. Based on technical weaknesses uncovered in the current system, the MOH adopted several of the study team's recommendations in 1991 (e.g., setting facility-level cost recovery targets, providing fee collection training to health workers) but delayed action on several others (e.g. adjusting fees and exemption levels for inflation) until 1994. After 15 months experience with the new fee schedule, the MOH revised the fee structure again in March 1995 based on findings that it was not meeting its referral or equity objectives. (ARA-Tehtop 1995, Hecht et al. 1993, World Bank 1992b)

3.2.3 Strategies for Implementing Cost Recovery

Several obstacles tend to dominate implementation considerations: institutional weakness, incomplete health sector development, and remaining policy conflicts about specific design details. With respect to cost recovery, some countries that have designed and adopted a national program have used phasing strategies to overcome these obstacles.

Phasing is particularly important where institutional capacity and key aspects of the health infrastructure (e.g., drug distribution systems, systems for financial management, monitoring, supervision, quality assurance) need to be strengthened. These features mean that it is not possible to implement cost recovery simultaneously at all levels of the health system in all parts of the country. Phasing allows time for the necessary preparation and permits lessons and skills learned in each stage to be applied to the next.

In addition, although legislatures may have passed laws authorizing fee collection for public sector health services, policy conflicts may still emerge in drafting of regulations that may block implementation of some aspects of the program (e.g. type of fee to charge for outpatient care, what the mark-up should be on the price of drugs). Alternatively, consensus may have been reached on adopting one aspect of financing policy change (e.g., cost recovery for hospital services, cost recovery for drugs at the primary care level), but not on another (e.g., private sector development, insurance). Phasing allows time to resolve these additional policy issues.

Although often phrased as primarily technical policy questions, phasing issues that Ministries of health face usually involve political and management considerations, as well as technical ones. Typical phasing issues include:

- ▲ Should financing reform start with cost recovery at the hospital level, for inpatient care only or at lower levels of the system, for primary health care (PHC) only?

- ▲ If the reform program calls for cost recovery for both PHC and inpatient hospital care, should cost recovery be phased in by facility level (e.g., all hospitals, followed by all health centers) or for all facilities in each region, moving progressively region by region?
- ▲ Should hospital insurance be introduced before initiating hospital cost recovery reform?
- ▲ Where hospital insurance coverage exists, should hospital reimbursement procedures be strengthened before charging fees for services for uninsured patients?
- ▲ Where a diverse array of private sector health services (e.g., provided by church missions, other NGOs, employers, and health practitioners) exist in independent practice, when should efforts be made to develop collaborative arrangements, new laws, regulatory capacity and other actions needed to involve the private sector in helping achieve the public sector's reform goals?
- ▲ Should new fee exemption rules and systems be put in place simultaneously with new cost recovery programs or after evaluation of the new system's impact?
- ▲ Should the public sector drug procurement and distribution system be strengthened, altered immediately, or a private distribution network phased in?
- ▲ How can Ministries develop feasible plans for the series of training, systems development, public information, and regulatory changes needed for effective implementation of national cost recovery programs?

Countries have used four broad phasing strategies to implement national cost recovery programs over periods ranging from 12-24 months to 3-5 years. *Exhibit 3-3* shows these strategies, with illustrative countries.

Exhibit 3-3. Strategies for Implementing National Cost Recovery Reforms: Illustrative African Countries			
Hospitals first	Primary health care first	Hospitals & PHC on separate tracks	All health facilities, district by district
Kenya	Senegal Many Bamako Initiative countries	Central African Republic Niger	Cameroon Zambia

3.2.3.1 *Hospitals first.*

Kenya is one of the few African countries that has successfully completed a systematically phased implementation plan that resulted in extending cost recovery in public health facilities throughout the country from 1992-1994. The reform plan called for inpatient and outpatient fees at all facility levels, as well as strengthened insurance reimbursement for hospital care covered under the National Hospital Insurance Fund. The Kenyan MOH began with establishing necessary management systems, health worker training, and public information in the large central referral hospital, proceeded to the provincial hospitals, then the district hospitals, whose managers trained health centers staff they supervised. Once

systems, manuals and procedures had been designed and tested, the process took 3 months at the central hospital, eight months at eight provincial hospitals, and six months at the 72 district hospitals. (Collins and Hussein 1993.)

3.2.3.2 *Primary health care first.*

Many of the 22 countries implementing the Bamako Initiative have followed this pattern, expanding cost recovery from region to region with an emphasis on PHC outpatient care and drugs in district level networks. In these cases, fees at the hospital level either do not exist, are not well-enforced, or have been allowed to languish without updating for many years. Variations on this model include Senegal's introduction of fees at the district health post level, along with encouragement of village-level self-financing schemes, in the early 1980s as part of a broader government decentralization effort. During this phase of Senegal's reform, health services at hospitals remained free of charge.

One of the main risks of this strategy is that people will use free services at the hospital level instead of paying fees for primary care at lower level health facilities. The main factor that serves as a counterbalance to this tendency is improving quality of PHC sufficiently at lower level health facilities that using services at usually more distant hospitals will be unattractive for most people.

3.2.3.3. *Central hospitals and PHC on separate tracks.*

Under this strategy, Ministries introduce cost recovery at the hospital level and primary health care levels under separate timetables, then integrate the two cost recovery systems later into coordinated national programs. Both Niger and CAR have followed this approach, with cost recovery beginning at central hospitals under a national reform plan in both countries for several years, while final policy decisions were being made about cost recovery for primary care and outpatient care at all other facilities in rural areas. Both countries are now in the process of incorporating non-hospital cost recovery with hospital efforts.

3.2.3.4 *District by district implementation for facilities at all levels in the district.*

Cameroon has adopted a carefully designed plan for carrying out over several years, district-by-district, the numerous activities needed to lay the base for effective implementation of the MOH cost recovery program e.g., training of health workers and management committees, public information campaigns, establishing of drug funds and financial management systems. The CAR plans to send MOH training teams to each of five Regions to prepare and train regional personnel, who will then prepare district health personnel and communities, to implement final cost recovery regulations for inpatient and outpatient services and medicines at all health facility levels. Plans call for completing the process nationwide in 12 months. In Zambia each district is responsible for setting fees and implementing cost recovery for all public health facilities, in the context of the decentralized district responsibilities for planning and budgeting.

3.2.3.5 *General Strategies*

Not all countries have adopted phasing strategies. Some have proceeded with simultaneous national implementation by decree and issuing of circulars. This approach is particularly common for making revisions to already-established cost recovery programs. Ghana and Zimbabwe, for example, followed this strategy for revisions they made in the 1980s, announcing new fees that all public health

facilities should follow. While Ghana's announced changes involved sharp fee increases and a strong intent to raise revenues, Zimbabwe's were modest. For its reforms in the 1990's, Zimbabwe's approach remained simultaneous across the whole public health system. Phasing has taken the form of adopting changes in the fee level and structure change incrementally, so that the impact could be monitored, changed as needed, and people would have time to adjust to gradually increased fees.

In spite of certain broadly distinguishable phasing strategies that some countries have adopted, in practice, design and implementation are not always clearly separate phases. Implementation of national policies does not always follow immediately official adoption of cost recovery, the demonstration of successful pilots, or lessons learned about weaknesses that need to be corrected. The opposite pattern is also common: health personnel often begin informal fee charging practices before laws or regulations are officially changed. Household surveys in Niger in 1992, for example, showed that 34 percent of the people who sought care at government health facilities paid for those services in one district and 39 percent in another, while services were officially free. (Willis and Leighton 1995)

One of the main implementation tasks that MOHs have had is to bring coordination to all the disparate cost recovery efforts that have existed in the public, private non-profit (e.g., church missions), and community sectors or to decide officially to have a highly decentralized system. For example, in many countries numerous village-level self-financing initiatives were conducted and government health workers were implementing their own informal cost recovery reforms, all during the 1980s and 1990s, while national policies were still in the formative stage.

Similarly, the degree of cost recovery implementation in public health facilities in Africa ranges from implementation in scattered facilities and communities, to a minimal national system that is not enforced systematically, to a national system of officially sanctioned user charges at all health facility levels. Two recent World Bank studies identify 17 countries in this latter category: ten anglophone countries (The Gambia, Ghana, Kenya, Lesotho, Malawi, Namibia, Mozambique, Swaziland, Tanzania, and Zimbabwe) and seven francophone countries (Benin, Burundi, Cameroon, Cote d'Ivoire, Guinea, Mali, Senegal). (Shaw and Griffin 1995; Nolan and Turbat 1993.) Even among these cases, countries differ in the extent to which the official national cost recovery system is uniformly practiced, how long it has existed, and the scope and type of reforms it represents.

3.2.4 Implementing a Broad Package of Reforms

As *Section 2* of this paper indicated, 31 countries have cost recovery initiatives. Of these 31, some have included other financing, resource allocation, and organizational initiatives and are implementing broader reform packages. For example, in countries where other financing arrangements exist (e.g., private insurance, employer-mandated insurance) and/or where private sector providers (e.g., church mission health facilities, other non-profit providers, for-profit traditional and western-medicine practitioners) deliver a significant portion of health care, reform efforts have been more complex to accommodate these other features (e.g., Kenya). Some countries have also considered, or begun to implement, initiatives to generate these additional financing mechanisms and expanded private provider coverage, along with cost recovery initiatives in the public sector (e.g., Tanzania). Some have adopted cost recovery reforms in the context of broader organizational change in the form of partial or full-scale decentralization of financing, management, and planning responsibilities to the district or regional level (e.g., Zambia).

Exhibit 2-2. of this paper identified three broad health sector reform strategies: raising revenues, reallocating resources, and organizational change. In principle, these strategies represent phases of increasingly complex reforms — from introducing user fees in the public sector, to supporting expansion of third party reimbursement in the public sector and private insurance more generally, to broad organizational changes that affect overall resource allocation in the health sector between public and private providers and between central and local MOH authorities. In principle, one would expect that countries with greater institutional capacity and higher income would be more likely to undertake the more complex reforms than countries with less developed health infrastructures.

But, as the following examples show, the implementation process for these broader reform packages has not followed these patterns as closely as might have been expected. Countries considering, or in early stages of, the broader reform strategies have adopted various combinations of initiatives. Since reform initiatives in the areas of insurance, the private sector, resource reallocation and financial decentralization are relatively new, or in the planning and design stage, it is too soon to identify clear phasing patterns or implementation strategies that have been clearly successful.

- ▲ Most of the lowest income countries have attempted only to implement cost recovery in public facilities and have not yet embarked on major efforts to encourage the development of insurance or to strengthen the operation of existing health benefit plans for civil servants.
- ▲ Some lower income countries such as Tanzania, have adopted vigorous private sector expansion policies along with cost recovery; they have not yet adopted policies to expand private insurance or mandate employer health plans.
- ▲ Some higher income countries, such as Cameroon, have mandated employer insurance coverage, but have concentrated their health financing reform on cost recovery and fee-for-service mechanisms. Others, such as Senegal, have had health benefit coverage under social security programs and some private insurance for some time, but are just beginning to move beyond an emphasis on user fees in government health facilities to implement insurance-based reimbursement initiatives to strengthen health financing in the public and private sectors.
- ▲ Some higher income countries, such as Zimbabwe, have maintained central control over fee revenues (requiring most or all to be returned to the Treasury) while mid-income countries, such as Zambia, has fully decentralized financial responsibilities to districts and health facilities, along with ambitious, broad-scale financing reforms.
- ▲ A few countries have plans for comprehensive changes they hope to make within a 3-5 year period. The MOH in Ghana has plans to improve cost recovery performance at public health facilities, to decentralize financial management to the district level, to grant autonomy to tertiary hospitals, and to develop a national health insurance scheme. Zambia has plans to implement insurance and prepayment schemes, along with the graduated cost recovery now in place at all public health facilities based on a cost-effective package of health services — all in the context of a comprehensive decentraliza-

tion plan under which districts have full responsibility for planning, budgeting, and setting user fees.

- ▲ Several countries have implemented initiatives to reallocate resources to cost-effective health services. Kenya, for example, explicitly requires a portion of hospital fee revenues to be applied to primary health care services. Zambia has recently implemented a district budgeting system based on estimates of the cost of a cost-effective package of health care, and Ghana has been studying similar reallocation measures.

4.0 LESSONS LEARNED ABOUT DESIGN AND IMPLEMENTATION STRATEGIES

4.1 Policy Development and Implementation

Several general lessons emerge from sub-Saharan African experience with developing and implementing health financing reform.

- ▲ It takes time. The scope of reform often envisioned entails substantial changes in behavior of health providers and patients; changing attitudes; instituting new management procedures and systems, making new information systems functional; shifting priorities, incentives and decision-making from long-established to unfamiliar requirements; and balancing the demands of competing interest groups.
- ▲ Broad political, economic, and institutional obstacles are likely to be as important as technical and economic ones, such as "getting the prices right." Similarly, it is just as important for ministries of health to develop political, institutional, and management skills and methods as it is to develop the technical capacity for health financing and economic analysis — or to invite international experts to bridge that gap temporarily. The political and bureaucratic strategies are needed to create the environment for technical strategies and solutions to work.
- ▲ Practice often differs widely from official policy. Developing monitoring, enforcement, regulatory and public information capacities is critical to ensuring that reform policies are implemented as planned to achieve the goals Ministries seek.
- ▲ Design and implementation of national health financing reform are usually not a linear process. Setbacks are to be expected.
 - Senegal was in the forefront in Africa with cost recovery pilot projects in urban (Pikine) and rural (Sine-Saloum) areas, as well as decentralization reforms, in the late 1970s and early 1980s. Nevertheless, policy change stagnated for most of the 1980s such that only in 1989 did Senegal adopt a National Policy that called for Bamako-type initiatives throughout the country. Senegal has also been one of the few African countries with mandated employer insurance, but various obstacles have prevented the MOH from using insurance effectively to promote hospital autonomy or a strengthened financing system more generally.
 - CAR began exploring options for health financing reform using health cards in 1974, quickly dropped the scheme due to misappropriation of funds, did not take up consideration of reforms again until 1986, passed national legislation authorizing cost recovery in 1989, revised regulations for hospitals in 1990, implemented revised regulations in central hospitals in 1991, had drafted final regulations for outpatient and primary health care by early 1995, but the third

change in Ministers in three years delayed signing of those final regulations, preventing cost recovery from proceeding officially.

- Zimbabwe considered for several years a proposed update and revision for an already existing cost recovery program, then implemented a new policy in 1994, and annulled part of that reform within one year due to perceived lack of success.

- Zambia's ambitious reforms have only just begun with one aspect (decentralized budget planning) in place in 61 districts, a second aspect (a prepayment plan) tried then suspended until it can be revised, while several other proposed insurance and community financing changes are still on the books.

4.2 Elements Needed for Successful Design and Implementation

Several features have contributed to successful design and implementation, regardless of the particular technical approach adopted.

- ▲ Although ministries of health differ in the extent to which they have involved regional and facility level managers in the decision process, the central MOH necessarily plays the leading role in designing national-level reform. In cases of political change and turnover of top decision-makers during the design period (e.g., Niger, the CAR, and Kenya), several key individuals below the political level at the central technical level of the MOH maintained a commitment to reform and kept the dialogue open.
- ▲ The design and implementation strategies this paper has reviewed have all included some degree of international technical assistance throughout the discussion, design, planning and implementation periods. Technical assistance can contribute to counterpart training, institution building, and bridging gaps in technical knowledge.
- ▲ Countries that have successfully adopted reform and moved to implementation have all used information from both their own and other country experience to help solve technical issues and develop policy options. They have usually done this throughout a study period of at least two years, gathering and analyzing information on consumer demand, provider behavior, quality, costs, and institutional and systems capabilities.
- ▲ Most countries that have successfully adopted national reform and moved on to implementation have emphasized consensus-building, especially through workshops, and involved several ministries and local, as well as central, MOH staff at key points in the decision-making process. Under the central planning approach countries may tend to skip this element, or limit it to developing a consensus among the experts. But this approach has risks, especially at the implementation stage.
 - In Kenya, political consensus was not as strongly established as technical consensus and the first attempt to implement planned reforms was soon stopped by public protest, lack of understanding by health workers in the field, and

Presidential intervention. Only after more than an additional year of laying the political groundwork and working out implementation details was reform again initiated, this time successfully. (Collins and Hussein 1993)

- In Ghana, the sudden fee increases that central policy makers and experts agreed to without sufficient consultation with the public or health facility workers resulted in sharp declines in utilization. (Waddington and Enyimayew 1989 and 1990, Shaw and Griffin 1995.)

- In Zimbabwe, health workers were not well informed about procedures for implementing the 1994 fee schedule revision and cost recovery revenues were minimal. Patients were not well informed about the revised fee schedule that established incentives for appropriate referral patterns and disincentives for bypassing appropriate lower levels of care. As a result hospital congestion declined only marginally. (ARA-Tehtop 1995)

4.3 Resolving Specific Design and Implementation Issues

Most countries that have designed and implemented health financing reform over the past 10 to 15 years have faced a number of common issues. The accumulated experience has produced lessons learned about the main actions, decisions, and information that are needed, about conditions for success, and common problems. While much of this experience has been gained in the course of cost recovery reforms, many of the lessons are applicable to broader reform packages as well.

Exhibit 4-1. illustrates these lessons.

Exhibit 4-1. Lessons Learned about Design and Implementation of Health Financing Reform in African Countries

Action Areas	Actions/Decisions Needed	Information needed	Conditions for success	Common Problems
DESIGN				
Goals and objectives	Establish consensus among relevant ministries, health personnel, interest groups, & the public.	Main actors, actions needed for decision; financial, utilization, quality etc data showing need for reform and likely impact of reform options.	Clear goals, objectives adapted to country circumstances & developed with full participation of relevant decision-makers & implementers.	Lack of consensus; no forum for deciding goals; unclear or contradictory goals; medical personnel resistance; conflicting donor pressures; unrealistic time frames.
Laws and regulations	Revise all relevant laws and regulations.	Existing laws, regulations; current practice vis-a vis changes; "political mapping" of stakeholders' positions.	Interministerial consensus; parliamentary cooperation; political stability.	Long delays; Details in law instead of laws with basic framework and details delegated to line ministries.
Price structure and fee levels	Decide or update: how much to charge for which services using what method (fee for service, episode, visit, etc).	Consumer demand data (willingness, ability to pay; use of services, etc, for various income, demographic, geographic groups); cost data.	Administratively simple fee structure; price signals for efficient/effective use of services & resources; fee levels affordable for majority (not 100 percent) of population; fees cover significant share of non-salary recurrent costs; willingness to try policy, monitor, evaluate, and revise.	No hierarchy in fee structure for lower/higher levels of care or different patient income levels; hospital fee systems too complex; drug fees too low; tendency to over-study before acting.
Fee exemption rules	Decide/update fee exemption categories for target groups (e.g., civil servants, students, military, the poor, children); and services (e.g. preventive, chronic).	Effectiveness and impact on costs and service use of current or planned exemption categories & practices; demographic, income, health status information about groups who would benefit from the exemptions.	Clear, easily administered eligibility criteria; simple means testing methods; special emphasis on improving operation of exemptions for the poorest; periodic evaluation of effectiveness.	Too many groups exempt; unclear exemption rules; difficulties identifying income levels accurately; high share of exemptions given to non-poor.
Fee retention	Decide distribution of fee revenue (e.g. health facility keeps all; share goes to district; all goes to Treasury; all goes for medicines, share goes to personnel).	Current law re distribution of fees collected in public sector; extent of need for redistribution to facilities not in financially viable catchment areas; resource gap that fee revenue should fill; cost for service package to be provided.	Significant portion of fees retained at facility level as incentive for collection; MOH subsidy raised or portion of fee revenues redistributed for equity across catchment areas; MOH funding maintained so that fee revenues are a net addition to resources.	Lack of incentives for health personnel to collect fees; unclear or unenforced rules; lack of banking facilities in rural areas; low revenue potential for facilities in poorest or underpopulated areas; poor financial management supervision, safeguarding of funds

Exhibit 4-1. Lessons Learned about Design and Implementation of Health Financing Reform in African Countries

Action Areas	Actions/Decisions Needed	Information needed	Conditions for success	Common Problems
Use of fee revenues	Develop national guidelines; allow partial or full facility discretion.	Current needs, costs for quality improvements; expected revenue percent of non-salary costs.	Fee revenues used for quality improvements visible to patients and for personnel performance incentives; central guidance, monitoring provided.	Fees not used to improve health services; no staff incentives to offset low salaries or informal charging practices.
Drug policy and procurement practice	Establish generic drug policy; decide whether central or local procurement; public or private distribution.	Pharmaceutical prices, bidding mechanisms; private pharmacy and NGO drug procurement & distribution practices, capacities; consumer awareness & prescription practices.	Adequate stock of essential, affordable medicines routinely available at/near all health facilities.	Non-generic drugs unaffordable for patients; distribution delays, drug stockouts, inadequate safeguarding of drug supplies; inefficient or non-existent public distribution systems; inadequate private pharmacy supply in rural areas.
Insurance Coverage	Decide whether to extend, encourage private or social insurance coverage.	Current insurance coverage; consumer demand for insurance; financial risk of illness; assessment of management, actuarial, financial sector capacities.	Insurance available once hospital fees reach full cost recovery; infrastructure conditions and demand for insurance exist; consumers have choice of providers.	Weak insurance reimbursement mechanisms, unclear rules; failure to collect existing insurance & civil servants' health benefit coverage.
Private provider role	Develop policy for private sector role; establish public-private collaboration; decide policy for private practice by public sector health personnel.	Size, distribution, of private sector providers; effect of current laws, taxes, credit, public sector salaries on private practice, type and quality of private providers' services.	Collaborative public-private relationships; incentives that promote beneficial market competition, quality standards, affordable prices.	Public-private sector mistrust; no collaborative mechanisms exist; public sector perceived to have lower quality than private; private providers unevenly distributed, high priced; inadequate public regulatory & quality assurance capacity; private practice of public health employees not managed effectively, weakens public services.

Exhibit 4-1. Lessons Learned about Design and Implementation of Health Financing Reform in African Countries

Action Areas	Actions/Decisions Needed	Information needed	Conditions for success	Common Problems
IMPLEMENTATION				
Phasing	Decide phasing by type of facility, service, and/or geographic area; decide how many major reforms to implement at once.	Assessment of administrative feasibility, costs, equity, effectiveness, technical appropriateness of different options.	Phasing sequence adhered to for linked implementation actions; facility or geographic area starting point not as important as having all of the linked components present in the start-up point(s).	Management systems not in place before fees introduced; public not sufficiently informed before fees introduced; drugs made available before fee schedule is official; availability of required inputs (e.g., training, accounting forms) not synchronized with implementation schedule.
Drug procurement, supply and distribution	Establish new or revised drug supply & distribution system for public facilities.	Assess public and private drug supply & distribution capacities; cost-effectiveness of public, private and mixed alternatives.	Adequate stock of essential, affordable medicines routinely available at/near health facilities; rational drug prescription practices; supervision, controls exist to safeguard drug supply.	Frequent drug stockouts at public facilities; high travel costs for patient to obtain drugs; inefficient central drug procurement & distribution systems; ineffective & inefficient patient spending for drugs.
Public Information	Conduct information campaign for public, all health personnel & key interest groups and stakeholders.	Variety of informational materials and media to explain purposes and operation of new fee or insurance systems; cost estimates for materials, distribution, related campaign activities.	Public well-informed about fees, exemptions, and other changes affecting their use of services; health workers well-informed about procedures, cost recovery goals, changes affecting job performance.	Public protest, distrust or misunderstanding; lack of information, or misinformation prevents people from seeking care at public facilities, limits opportunity for health status improvement.
Monitoring & evaluation	Establish systems to assess impact of reforms on population, health facilities, health sector and goals for equity, access, quality, sustainability; provide training to evaluate findings.	Health facility and consumer data on impact of reform (e.g., fees, insurance, more private providers) on people's spending, use of health care, public sector health resources; cost estimates for system start-up, maintenance, related training.	Simple monitoring & evaluation system available & used for periodic update and problem-solving; relevant analytic capacity available.	Relevant data not available routinely to assess impact or need for revision; available data not used or not used well; assessments not followed up with action to make improvements; data not formatted and presented to decision makers and opinion leaders.
Financial management	Revise financial management systems for facilities; strengthen insurance billing & reimbursement systems; provide training in financial management, billing; add specialized staff.	Assessment of need for system update, revision; training needs assessment information; cost estimates for system development, operation, and related training.	Easily administered, transparent financial management system functioning to assure that revenues are safeguarded and used for intended purposes.	Resources not used for intended purposes; inadequate & infrequent monitoring, supervision; lack of clear accountability; staff too busy or unable to do financial management.

Exhibit 4-1. Lessons Learned about Design and Implementation of Health Financing Reform In African Countries

Action Areas	Actions/Decisions Needed	Information needed	Conditions for success	Common Problems
Management oversight at local level	Establish and train community committees and hospital boards with community representation.	Assessment of current committee experience; needs assessment for training; cost estimates for start-up & training.	Organizational focal point & mechanisms in place to assure that reform goals are achieved & sustained at the local & facility level; committees and boards trained in their roles, not overburdened with details.	Training not reinforced; incentives for oversight not present; patients & communities not well-represented; committees and boards dominated by local elites, one(few) interest groups; committees asked to manage, rather than oversee, operations.
Quality Improvement	Training to improve health worker skills, practices & drug prescription; assure supply of essential drugs; establish performance incentives for health workers; establish quality assurance mechanisms.	Assessment of drug supply & prescription practices, of health worker diagnostic & treatment skills for prevalent health problems & cost-effective prevention & treatment interventions; evaluate quality assurance mechanisms for public & private providers.	Fees used for quality improvement; patients perceive they are "getting their money's worth" for payments made; routine monitoring followed by corrective action.	Fees not used to improve quality; patients see no benefit from their fees; means to sustain quality improvements not in place; inefficient/inappropriate drug prescription habits persist.

PART II. TOOLS FOR DESIGNING AND EVALUATING HEALTH FINANCING REFORM

5.0 RESEARCH, ANALYSIS, AND TRACKING TOOLS FOR HEALTH FINANCING REFORM

This section describes research and analysis methodologies and tools that ministries of health in Africa have used with assistance from the HFS project to address major policy issues they have faced in the design of health financing reform. It presents the research methods, some of their strengths and weaknesses, and the type of results obtained for five policy issues: assessing willingness and ability to pay for health services, measuring quality of care, evaluating equity and means testing, estimating costs, and assessing the role of private providers and health insurance. Country-specific research examples are given for each of these five policy areas. These examples concentrate on work done in Africa on these issues, though it includes selected references to countries in other regions where HFS assisted with similar studies.

The final part of this section discusses how these tools can be used to track progress toward meeting the goals of financing reform and identifies indicators and data sources that have been useful for monitoring and evaluating impact.

5.1 Assessing Willingness and Ability to Pay for Health Services

5.1.1 Policy Issues

In designing policies to supplement public budgets with private financing in the form of user fees, ministries of health have been concerned with the effects on utilization of services. They have encouraged investigation of patient willingness and ability to pay for inpatient and outpatient services under a variety of payment methods, with and without accompanying quality improvements.

5.1.2 Research Methods and Results

Five basic quantitative methods are available for studying the relationship between price increases, quality improvements and utilization patterns (Wouters, Adeyi and Morrow 1993):

- ▲ facility-based studies
- ▲ health care demand studies
- ▲ intervention studies
- ▲ willingness to pay studies using contingent valuation
- ▲ hedonic pricing studies.

Facility-based studies:Congo. In most cases, facility-based studies look at a sample of facilities and their utilization records before and after the implementation of the user fee system to determine whether the number of patient contacts was affected by the introduction of cost recovery. Although such

studies are relatively easy to conduct, the results they generate about relationships between price changes and utilization are quite inconclusive because they cannot control for a variety of other factors which may be influencing utilization patterns during the study period. HFS did not conduct this kind of study. It did, however, conduct more qualitative analyses using facility-based data.

In the Congo, patient exit interviews were conducted at a sample of no-charge government and for-charge PVO health facilities to determine patient satisfaction with services rendered, prices paid, and perceptions of quality (Tsongo, Willis, Deal and Wong 1993). Such interviews provided useful information about the socioeconomic status of people who use each type of health facility, but they could not identify the characteristics of non-users, nor reasons why certain providers were chosen.

Demand studies: Burkina Faso, Central African Republic, Niger. In contrast to facility-based studies, econometric health care demand studies based on household surveys are able to offer clearer results about factors affecting the choice of provider, including price. Demand studies, however, require conducting large household surveys, such as those HFS conducted or analyzed in Egypt, Burkina Faso, the Central African Republic, Ecuador, Niger, and Senegal (McInnes 1993, Diop, Bitran and Makinen 1994, Ellis and Chawla 1994, Yazbeck and Wenner 1994, Wouters and Kouzis 1994, Sow 1994, Weaver et al 1993, Knowles 1995, Sadio and Diop 1995). This data can be analyzed using both simple descriptive statistics and more sophisticated statistical techniques, the latter more clearly identifying relationships between key variables and choice of provider, but often producing quite similar general conclusions to the more simple descriptive statistics.

For example, in Egypt, the econometric study revealed that increasing insurance coverage would increase utilization of private providers for inpatient care and that at Embaba hospital, outpatient care was more sensitive to price increases than inpatient care. The findings of health care demand studies in most countries all tend to confirm the finding that quality of health care is an important factor in choosing health providers and that patients are willing to pay for quality improvements.

HFS has used the concepts underlying health care demand studies in combination with other concepts about provider behavior to simulate, using computer models, the impacts of various cost recovery packages on items such as utilization and revenue generation. In Burkina Faso, HFS used such a computer model in conjunction with other information on a variety of institutional factors to demonstrate hypothetical effects of various cost recovery packages (Knowles 1994).

Intervention studies: Niger. A third method for assessing willingness and ability to pay for health care is to measure changes that occur in the course of a specific field intervention. In particular, use of health care demand studies can be enhanced if incorporated into the monitoring and evaluation component of an actual demonstration of cost recovery. In this context, effects on utilization from price increases and quality changes can be observed directly, rather than simulated through the demand model.

For example in Niger, HFS conducted household surveys before and after the implementation of cost recovery in pilot areas and a control site (Diop, Bitran and Makinen 1994; Ellis and Chawla 1994, Yazbeck and Wenner 1994, Wouters and Kouzis 1994). The studies found that, compared with the pre-existing situation, utilization increased substantially for all population groups: children, the elderly, women, the poor, and those living farthest from the health facilities. Qualitative questions at the end of the household survey found that an overwhelming majority of the population preferred cost recovery and the associated quality improvements over the previous free public health system, that there was strong willingness to pay for quality improvements, that there was a perception that social financing was less

costly, and that social financing provided a more convenient form of payment than straight fee-for-service at the time of illness.

Experimental design studies provide the most convincing evidence to test hypotheses establishing cause-and-effect relationships between price and use of services. They are often not feasible, however, because of the substantial resources they require, the long-term commitments required from governments and donors, the specific timing and phasing requirements of interventions, and the difficulty in controlling for a variety of confounding factors that may contaminate the research design. The HFS experience in Niger was unique and generated a substantial amount of important information, but is not easily replicable. Many of the results from Niger, however, can be generalized to other, similar countries.

Willingness to pay studies (contingent valuation):Central African Republic. An alternative method for indirectly assessing willingness to pay for quality improvements is contingent valuation. Through household surveys, these studies attempt to elicit preferences from respondents about various quality improvements by describing hypothetical quality improvements. In general, researchers using contingent valuation method studies have acknowledged the experimental nature of the technique and have interpreted the findings with caution. Particularly troubling is the lack of data to validate the hypothetical nature of the results.

HFS tested contingent valuation methods in the Central African Republic (Weaver et al. 1993). The results showed that patients intended to pay for quality improvements, especially for pharmaceuticals and that these amounts were quite substantial. Strikingly, rural populations exhibited strong intentions to pay for improved services. It was difficult, however, to determine the extent to which these results might have been artifacts of the methodology. For example, rural populations might be less able to deal with the hypothetical nature of contingent valuation studies.

Hedonic pricing. The fifth quantitative method, hedonic pricing, also assesses willingness to pay for health care services indirectly by comparing price levels associated with different attributes of quality. The statistical analyses underlying such studies require strong assumptions that may be unreasonable for data usually available in developing countries. Hedonic pricing methods are unlikely to be feasible to determine willingness to pay for selected health service quality improvements in developing countries. The HFS project did not conduct any such studies in Africa, but did conduct a small applied research activity on this topic in the Philippines (Hotchkiss 1993).

5.2 Measuring Quality of Care

5.2.1 Policy Issues

The increased need for and use of cost recovery to generate additional resources for the public sector and new interest in enhancing public-private sector collaboration has resulted in heightened attention to issues of quality of care. Patients want value for their money and will pay more for services if they perceive that quality of care has improved. Although improvements in quality of care may encourage patients to contribute revenues to pay for the health care services they receive and thus increase the revenues of the health facility, the effect on net revenues will depend on to what extent increased revenues offset the cost consequences of the quality improvements implemented. Understanding the economic implications of quality improvements requires developing better definitions and measures of quality which can be used for assessments in the public and private sector.

5.2.2 Research Methods and Results

Methods for measuring quality depend on the dimension of quality which is being measured. Experts in quality assurance generally agree that there are three measures of quality including structure, process and outcome (Wouters, Adeyi and Morrow, 1993).

- ▲ Structure assessments evaluate the quality of health care through a study of the physical and administrative setting in which care takes place. Collecting data on the structural attributes of quality generally requires taking inventories of critical resources needed to implement diagnostic and treatment protocols.
- ▲ Process measures of quality assume not only that medical technology exists to achieve results, but also whether what is known to be good medical care has been applied. Data collection on the process of care is more revealing, but more complex and potentially more costly. A variety of methods exist including interviewing staff about their practices, role playing or simulating care rendered, and actual observation of patient-provider contacts. The latter method is probably the most valid, although not without some problems.
- ▲ Outcome measures would ideally measure quality by looking at whether health outcomes had actually improved. However, because there are frequently multiple factors which in addition to the treatment protocol affect health outcomes, it is not easy to attribute good health backwards to good procedures. Examples of other determinants of health might include education, income, environment, and nutrition. Alternatively, one could look at patient perceptions of outcomes, that is, whether they are satisfied with the services rendered.

Structure and process studies: Niger, Senegal. In Niger and Senegal, HFS conducted facility surveys to inventory items important for quality such as staff size and training, availability of essential drugs and medical supplies, presence of diagnostic and treatment protocols, and supply of management and financial records (Wouters 1995, Diop 1995, Bitran 1995b, Bitran, Brewster, and Ba 1994). Both countries had similar problems showing severely deteriorated infrastructure with frequent stockouts of drugs, supplies and equipment.

HFS also assessed the process aspects of quality of care in Niger and Senegal by conducting task observations on a sample of patient visits for selected treatment practices. Health professionals were hired to observe compliance of medical staff with expected standards related to welcoming the patient, history taking, monitoring vital signs, conducting the diagnostic exams and implementing treatment. Observations of the process showed that significant gaps in implementation existed, especially in monitoring vital signs, diagnostic examination and provider-patient communications.

Outcome studies: Niger, Senegal, and Congo. In Niger, Senegal and the Congo, HFS assessed one quality outcome by recording patient satisfaction with care through exit interviews. In Senegal, information on staff perceptions of the quality of care they rendered was collected through interviews. In other countries, HFS has used focus groups as an alternative method. Although most patient satisfaction information in the U.S. is collected through patient exit interviews, there is concern that this

technique does not produce valid results in the sub-Saharan African context, where interview results frequently show little variation: almost all people express satisfaction with services received. Further research is needed to quantify these suspicions.

5.3 Evaluating Equity and Means Testing

5.3.1 Policy Issues

Increased focus on cost recovery has led policy makers to be concerned about the impact of fees on use of health services by the poor. One of the most persistent debates about health financing reforms in Africa concerns the feasibility and effectiveness of methods that might be used to protect the poor and high risk groups from the potentially negative impact of user fees. Many ministries of health rely on informal systems, along with traditions of "community solidarity," to protect the poor under cost recovery initiatives. Little documented evidence exists, however, on the extent to which these informal means testing mechanisms meet their objectives. Some of the key policy issues include questions about the effectiveness of informal means testing systems in protecting the rural poor, the cost-effectiveness and feasibility of more formal income-testing procedures, about how the poorest fare compared with better off people under informal means testing, and about the costs of granting fee waivers to those able to pay.

5.3.2 Research Methods and Results

Several methods are available for gathering data to assess the impact of means testing procedures in protecting the poor:

- ▲ household surveys, with questions that identify household income, whether sick household members paid for care received, by source of care
- ▲ facility records of patients who paid, and of fee waivers granted by income and other waiver eligibility classification
- ▲ patient exit interviews about payment for health services.

Household surveys can provide more accurate information by income level than the other methods, though they are more expensive to conduct. Frequently, however, existing surveys, whether or not designed to answer questions about means testing, contain the relevant data. Facility records provide information on categories of patients given waivers other than the poor (eg. civil servants, students, military, TB patients). This latter information is often not available in household surveys, unless occupation is clearly identified. Only representative household surveys can provide information to assess the impact on the whole population, including poor people who report illness but have not sought care because of fear that prices will be too high.

Household surveys: Niger, Senegal, Burkina Faso. Using household survey data from Niger, Senegal, and Burkina Faso, HFS examined the impact of informal means testing on use of health services by the poor. All these household surveys had been conducted for other reasons, but contained the relevant information. In Senegal's case, data was available for urban, as well as rural areas, and for use of public sector health services, as well as exemption practice of church missions and traditional healers. These analyses showed 1) the proportion of all people who sought health care who paid, and who were given waivers, 2) the proportion of poorest individuals (in the lowest 25 percent of all household incomes) and

of the non-poor (remaining 75 percent) who were given waivers, and 3) proportion of all waivers that were given to the poorest and to the non-poor.

In Niger, the data permitted a comparison of fee waiver practice according to these measures, both before and after the introduction of official cost recovery. This comparison 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, as well as specifically on how cost recovery affected waivers for the poorest 25 percent of patients. In Senegal, the data permitted a comparison of fee waiver practice in government and in mission health facilities. The comparison revealed that missions had developed more effective practices in protecting the poor and granted twice the percentage of waivers to the poor as did MOH health facilities. Traditional healers in Senegal functioned about the same as public health posts in terms of percent of all waivers given to the poorest, but gave a much higher percent of their poorest patients a fee exemption. (Leighton and Diop 1995, Willis and Leighton 1995)

Facility surveys: Niger. During the cost recovery pilot test conducted in Niger, health facilities kept records of patient payments and fee waivers granted. These records confirmed the data in the household surveys and showed, as well, that by far the largest portion of waivers were given to students, followed by the military and prisoners. Fee waivers in one district represented 18 percent of total fee revenues, and 3 percent in a second district. (Bitran 1995a, Diop 1994.)

5.4 Estimating Costs for Resource Allocation, Economic Impact, Pricing, and Sustainability

5.4.1 Policy Issues

In budget constrained environments, efficient use of resources is critical. Although many suspect that the private sector may be more efficient than the public sector, there is little empirical evidence to verify this. Understanding the costs of various health care services including fixed and variable cost components, personnel and non-personnel operating costs as well as the costs of proposed quality improvements is important not only for assessing efficiency, but also for determining the extent to which revenues generated from user fees can cover these costs and promote sustainability of the quality improvement.

Ministries also often use these cost estimates to help set prices for services and medicines under cost recovery programs. And they require cost estimates, along with other information, for helping to: make choices about the most cost-effective service delivery strategies; identify which services might bring the largest cost-benefit in reducing the disability burden or the economic impact of disease; and more recently, to identify cost-effective packages of health services. Similarly, given the large share of income that households in Africa spend for health, studies that identify how households are allocating their health spending helps ministries develop appropriate educational, pricing, and service delivery policies to improve the effectiveness of consumer spending for health.

5.4.2 Research Methods and Results

HFS has contributed to cost analysis for these purposes in several Sub-Saharan African countries using several methods:

- ▲ multi-facility sample of cost data
- ▲ cost accounting case studies of hospitals
- ▲ cost estimates of selected inputs to improve quality of primary care services
- ▲ estimates of national, sectoral and productivity losses related to economic impact of priority diseases (e.g, malaria)
- ▲ focus group studies of household spending for malaria treatment.

Multi-facility samples: Senegal and Burkina Faso. The first method involves collecting cost data from a sample of facilities along with other facility information such as utilization, quality, types of inputs and services, unit costs of inputs, and then estimating, using econometric techniques, cost functions which indicate levels of technical (production) and economic (cost) efficiency. Experience has shown that adequate cost data are often difficult to obtain given poor financial management information systems and that the statistical problems are quite challenging. In Senegal, econometric analysis was attempted, but because of data problems was ultimately not feasible (Bitran, Brewster, and Ba 1994).

Using more descriptive statistical methods, however, the data on costs, quality and utilization generated limited but interesting insights into the efficiency and quality of public and private facilities. Descriptive analysis included ratio analysis (input to output ratios, costs of inputs to output ratios), comparisons of unit costs per service and comparisons of cost components such as personnel, and non-personnel inputs. The limitation of descriptive analysis is that cost comparisons are not adjusted for differences in quality, case-mix, differences in input prices, and other factors which may influence costs.

In Burkina Faso, a simpler survey of facilities focusing on availability of inputs showed widespread shortages of critical resources even in those facilities which were presumed to be well-staffed and stocked (McLees 1994).

Cost accounting: Niger and the Central African Republic. The second method of cost analysis follows a case study approach where cost accounting techniques are used, to the extent possible, to calculate costs for selected units of service. HFS took this approach in hospital studies in Niger and the Central African Republic (Wong 1989, Weaver and Nguerita 1992). Again, collection of cost data is often inhibited by lack of financial management information systems in many developing country health facilities, but it still can provide fairly detailed cost estimates for a particular facility. Because this method requires close examination of the management processes and flow of resources within a particular facility, this approach also provides quite detailed suggestions on how to improve efficiency and quality of services within the facility.

Input cost estimates: Central African Republic. The third method of cost analysis focuses on estimating the costs of specific inputs required to improve the quality of services such as drugs, building maintenance and consumable materials for lab tests. In the Central African Republic, with information on drug and lab materials required for selected diagnostic treatment protocols in combination with

hypothetical utilization patterns of a typical facility in the pilot area, average expected costs were estimated for the purposes of setting user fees to finance these quality improvements (Barker 1992).

Economic impact and household spending for specific diseases: Kenya and Nigeria. HFS worked with MOH analysts and local experts in Kenya and Nigeria to develop estimates of the annual economic impacts of malaria in those countries. Study findings were intended for use by the Ministries of health and by international donor agencies in policy and programming decisions related to resource allocations for malaria and design of interventions to prevent or mitigate the economic impact of malaria. (Leighton et al. 1993)

The studies used general statistical sources, as well as employer and employee interviews, to estimate the economic impact in the agricultural, industrial and service sectors of the economy due to work time lost for workers suffering from malaria, as well as for caretaking of children suffering with malaria. The studies also used focus group interviews in an innovative way to estimate 1) lost household income due to missed work days because of malaria and 2) household spending for malaria treatment. Using these focus group findings, the studies estimated the impact of these factors on total household income for typical rural and urban households, and for women, compared with men. In general, estimates showed that the economic impacts of malaria in Kenya and in Nigeria were substantial for a single disease and that the impact was highest at the household level, and higher for women than for men.

5.5 Assessing the Private Sector's Scope and Role

5.5.1 Policy Issues

Ministries of health in Sub-Saharan African are seeking to complement limited public sector health budgets with additional revenues generated through cost recovery and in some cases through expanded roles for private health providers. In many of these countries, private sector practice is well underway, but its size and nature is not well understood. Private providers may offer useful lessons on how to implement user fee systems which attract patients and generate critical revenues. Private providers may also provide a means to expand access to health care services which are efficient and of acceptable quality.

5.5.2 Research Methods and Results

To inform policy design efforts by governments to enhance public-private sector collaboration, HFS participated in a variety of activities to improve understanding of the size and nature of the private sector. These activities covered three major topics including

- ▲ typologies, provider interviews, and secondary data sources to expand knowledge about private sector activities
- ▲ household surveys, patient and provider interviews to learn from private sector experiences in charging fees for services
- ▲ employer, insurer, and provider interviews to explore the potential for development of private health insurance.

Typologies and provider interviews: Senegal and Tanzania. The types of involvement by the private sector in health care can be clarified by distinguishing between the financing and provision of services. A typology of public-private sector collaboration based on this distinction was developed by HFS (Berman, Rannan-Eliya 1993). Based on this conceptual approach, HFS activities in Tanzania and Senegal focused on the private provision of services and identified several types of private providers such as non-profit voluntary agencies, for-profit, and employer-based providers (Knowles, Yazbeck and Brewster 1994, Munishi, Yazbeck, DeRoeck and Lionetti 1994).

Analysis of existing government records and in-depth interviews with government officials complemented by additional provider surveys generated qualitative and quantitative information including the geographic distribution of providers, capacity and types of services rendered, patient perceptions of quality and staff perceptions of working conditions. In Senegal, a detailed facility survey of private providers gave information on facility operating costs, types of patients seen, utilization trends and quality of services (Bitran, Brewster, Ba, 1994). For both Tanzania, these methods revealed a heterogeneous private sector; a greater private sector contribution to public sector health services than might have been expected; variations in quality and efficiency among different types of private sector providers; the importance of law, regulations, and credit in affecting the growth of the private sector. The studies identified specific opportunities for policy improvements in both countries and ways in which public-private collaboration and quality assurance could be improved.

Patient interviews and household surveys: Congo. In the Congo, patient exit interviews revealed what types of patients used private providers and what perceptions clients had about private practice, although such interviews could not reveal the reasons or characteristics of non-users (Tsongo, Willis, Deal, and Wong 1993). In-depth interviews with health officials and the providers themselves gave substantial insight into the legal, regulatory and financial strengths and weaknesses of the environment in which private providers had to function. In other countries, analysis of the Demographic and Health Surveys provided information on the extent to which private providers were used, although such data could not provide quantitative information on the reasons for these patterns.

In designing policies to promote cost recovery, it is important to determine what type of competition public facilities face. In Egypt, both household and provider surveys were conducted to determine the extent of competition faced by the Embaba public hospital (McInnes 1993). The household survey revealed that increasing insurance coverage would likely increase utilization of private providers. From the provider survey, it was found that private sector fees varied widely, but were generally higher than at Embaba hospital, such that the hospital still had a margin in which to increase its fees without seriously jeopardizing utilization. The provider survey also revealed information on the size and nature of the private sector, the extent to which it might actually compete with Embaba hospital or actually be a source of referrals for the hospital.

Provider and employer interviews: Kenya. The question of private health insurance becomes important in the context of cost recovery since, in some cases, patients might incur high financial costs. In Kenya, the potential for developing both public and private health insurance, especially for catastrophic illnesses, was explored using surveys of employers, insurers and health care providers (Mwabu et al. 1993).

The employer survey revealed the extent to which employers insured their employees, the types of financial contributions required and their general attitudes and recommendations for enhancing insurance coverage. The survey of insurers investigated items such as the types of policies offered,

methods for calculating premiums, numbers of policies sold, characteristics of clients (individuals and groups), use of insurance brokers, and constraints faced by insurance companies. The three surveys revealed great potential for the development of health insurance in Kenya for the formal and informal sectors and provided specific information on actions required to tap this potential.

5.6 Tracking the Impact of Financing Reform

5.6.1 Tracking Indicators

Many of the research tools that this section has reviewed can also be used to track progress toward meeting the goals of financing reform. As *Section 2* indicates, most African countries have five policy reform goals they are trying to achieve: improvements in equity, access, efficiency, quality, and sustainability. Relatively straightforward indicators can be used to measure progress toward each of these goals, or the specific targets that ministries may have set. A small group of indicators can be chosen to monitor key policy issues in which the ministry is interested. The data sources for these indicators are readily accessible and frequently already exist on a routine basis.

Exhibit 5-1. illustrates indicators and data sources that ministries have used to track the five typical health financing reform goals.

<i>Exhibit 5-1. Illustrative Indicators for Tracking Health Financing Reform</i>		
REFORM GOAL	INDICATOR	DATA SOURCE
EQUITY AND ACCESS	1. Utilization/Access	
	Percent of pop. and of target groups using services when sick: children under 5, women, people living far from health facilities	Household survey
	Percent change in number of total visits and visits by target groups	Facility utilization records
2. Financial protection of poor	Percent fee exemptions granted to poorest	Facility records
	Percent of poorest receiving fee exemptions	Household survey
	Percent fee exemptions (government subsidy) going to poor in relation to poor's proportion in the population	Facility records, census statistics, household survey

Exhibit 5-1. Illustrative Indicators for Tracking Health Financing Reform

REFORM GOAL	INDICATOR	DATA SOURCE
EFFICIENCY		
1. Financial resources	Percent spending allocated to non-salary expenses at target facilities and MOH national level	MOH budget; facility accounting records
	Percent change in spending for non-salary expenses at target facilities and MOH national level	MOH budget; facility accounting records
	Aver. cost per visit, per hospital s. y, per visit for a specific service	Facility accounting and utilization records
2. Human and material resources	Percent change in productivity: outpatient visits per day; inpatient visits per day	Facility utilization and staffing records
	Hospital occupancy rates	Facility records
QUALITY IMPROVEMENT		
1. Drugs	Essential drugs routinely available	Facility drug inventory records; patient exit interviews
	Unfilled prescriptions due to drug stockouts	Facility records
2. Services	Percent of visits for which health personnel follow treatment standards	Health personnel observational survey
	Essential medical supplies routinely available	Facility observational surveys; inventories
	Supervision visits routinely made	Facility management records
	Patient satisfaction	Patient exit interviews; focus groups
FINANCIAL SUSTAINABILITY		
1. Fee Revenues	Percent of facility, and MOH total, non-salary costs covered by fee revenues and/or insurance reimbursement	Facility accounting/bookkeeping records and MOH budgets
	Percent change in facility, and MOH total, annual revenues from fees and/or insurance reimbursement	Facility accounting records and MOH budgets
2. Non-fee sources of financing	Percent of MOH budget funding (authorizations and expenditures) represented by donor funding for health sector	Donor records, MOH and Ministry of Plan budgets
	Percent real change in government budget allocations to MOH	MOH and Government budgets
	Percent change in real per capita MOH budget expenditures	MOH budget and census data

5.6.2 Policy and Implementation Issues for Tracking

In addition to monitoring progress toward specific goals, it is also important to focus on goals that involve trade-offs that arise in the course of reform implementation. These trade offs often require watching the interaction of two or more of the indicators so that progress on the net effects of tradeoffs can be assessed.

For example, a trade-off often exists among goals for raising revenue, improving equity for the poor, and providing fee exemptions for selected other target groups (e.g., civil servant, students). How each health facility manages this revenue-equity-exemption trade-off can have important consequences. Categorical exemptions for target groups and fee waivers for the poorest can cover 60-80 percent of the patient load at some health facilities and cut drastically the revenue potential of user fees. Tracking both revenues and exemptions can help monitor the balance, or net effect, that is occurring between these two goals, thereby indicating policy decisions and adjustments that may be necessary. Tracking both fee exemptions given to the poor and to other target groups can show whether one of these groups is receiving a disproportionate share of exemptions, or whether the overall exemption policy may need to be modified in order to protect financial access for those who need it most.

Another common trade-off between health sector reform goals is that between efficiency and equity. For example, a ministry may decide to improve resource allocation by improving the cost-effectiveness of immunization services (or services to manage acute respiratory infections, reduce maternal mortality or other priority services) and may monitor the cost per immunization visit, or cost per fully immunized child, to evaluate progress in meeting that goal. At the same time, action to meet goals for equity by expanding access to those services through increased coverage for remote, harder-to-reach or widely dispersed populations, will, however, result in less efficient and less cost-effective measures (fewer people served by increased funding). In this case, tracking efficiency indicators separately for different target groups can help monitor progress in meeting equity goals and help a ministry to make necessary adjustments, avoid making undesirable ones, or set efficiency and equity targets that reflect the policy balance they wish to achieve.

5.6.3 Tracking Methods and Approaches

Most of the health financing indicators that ministries of health want to track can be collected from three sources: facility data, MCH budgets, and household surveys. Information systems that include most of the facility and MOH data are already in place — or need to be put in place to implement and manage the health financing reforms. Periodic reporting on a core set of tracking indicators need not take large additional time or other resources. But analyzing and evaluating the data, and providing feedback and corrective measures, does take a concerted effort on the part of staff with the necessary skills.

Facility level data. A carefully chosen, small sample of facilities — perhaps piggybacking on sentinel facilities used for health status monitoring — are likely to be the most flexible, efficient means of collecting key information on an ongoing basis for monitoring and tracking health financing reforms. A simple system under which sentinel facilities cumulate data by month and send monthly totals to the district or center quarterly would be adequate. Collecting data from all facilities should not be necessary on a routine basis and a nationally representative statistical samples need only be collected every so many years for major evaluations.

The Central African Republic is instituting such a system to monitor the impact of financing reforms to be implemented nationwide in 1995. The purpose of their impact evaluation system is to monitor the effect of user fees on revenue, equity, and quality of care. Their system will use several sentinel hospitals and health centers that will collect monthly data for 11 items of information related to: 1) revenue from fees for services, drugs, and from non-fee sources; 2) equity and access, as measured by utilization data for various demographic groups, the poor, and civil servants; and 3) quality improvements in drug availability and related costs. The central MOH Health Financing Unit will provide

feedback to health facilities regarding cost recovery updates, processes, problems, or successes. It is anticipated that the impact evaluation system would be incorporated after two years into the national health statistics system to ensure sustainability. (Pine 1994)

Household survey data. Because of their expense, household surveys are usually only conducted for major evaluations. The sample size should usually be established to provide statistically representative findings for target geographic, demographic, and socio-economic subgroups, as well as for population as a whole. Depending on the policy interest, samples could be drawn for one or two target regions, or be nationally representative.

The most typical use of household surveys for assessing the impact of health financing reform is a baseline survey before reform begins, then annual for first year or two of reform, then less often. It is important that follow-up surveys after the baseline survey be scheduled at time to allow the reform to have an effect and to allow people to have adjusted their health seeking behavior. Often, utilization fluctuates during the first six months to a year after reform is introduced while facilities and patients are learning new procedures. Both Niger and Cameroon have used the approach of baseline and follow-up household surveys for pilot experiments they conducted to test the impact of financing reform. The Central African Republic conducted a baseline survey for purposes of planning financing reform and is planning to conduct a follow-up household survey after reform has been in effect for a year.

MOH budget data. Depending on the degree of financial decentralization, it would be necessary to review MOH budget data at the central and regional or district level. Depending on the policy interest, it would be necessary to review both authorizations and actual expenditures for total or selected expenditure categories. For routine tracking in the first year or two of reform, it may be necessary to review these budget data every six months, then annual tracking is usually adequate thereafter.

GLOSSARY

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Access: The ability to obtain timely and financially acceptable health services. Access can be limited due to the location of facilities, relative high cost of transportation or user charges, or discrimination within families, communities or by providers.

Capital costs: An expenditure (chargeable to an asset account) for an asset acquired which has an estimated life in excess of one year and is not intended for sale in the ordinary course of business. In the health sector, capital costs include buildings, ambulances, and medical equipment.

Cost recovery: Using private financing (e.g., user fees, social financing) to recover all or a part of the cost of a service. In the health sector, "cost-recovery" usually refers to the introduction of user fees or insurance mechanisms for Ministry of Health services previously provided free-of-charge.

Copayment: An out-of-pocket charge paid by an insured individual at the point of services (in addition to the pre-paid premium).

Demand: The desire, ability, and willingness of an individual to purchase a good or service. Demand for health care is influenced by prices, education, quality of care, distance from facilities, income level, and religious and cultural factors.

Deductible: The amount paid by an insured individual before the insurer starts paying.

Efficiency: (technical and Economic) A procedure is technically efficient if production inputs (e.g., doctors, drugs, equipment) are combined in a way that yields the maximum feasible output (e.g., outpatient visits, hospitalization). A procedure is economically efficient if inputs are combined to produce a given level of output at minimum cost. In other words, one procedure would be more efficient than a second procedure if it can produce the same health outcome at a lower cost.

Equity: Fairness; the quality of being just or impartial. One dimension of equity in the health sector is that of equity of access of different population groups (sex, age, income, or ethnicity) to health care services.

Externality: An unexpected or unaccounted for outcome or cost. Pollution is usually thought of as an externality because its cost is born by society and not the producer causing it. An example of externalities in health is the spread of infectious diseases, where treating patients not only helps the patient but also decreases the risk of its spread to other.

Fee: Price charged to the user for a service. If the user is a patient, the fee is the price he or she pays for the care received.

Fee-for-service: A method of paying physicians (and other health care providers) in which each "service," for example, a doctor's office visit or operation, carries a fee. The physician's income under this system is made up from the fees she collects for services. Alternative methods of income for physicians are : (1) a salary, as from an HMO (health maintenance organization); and (2) a "capitation" payment system, in which the physician is paid a predetermined amount for each patient for which she assumes responsibility for a given period of time (rather than each service rendered).

Insurance: The opposite of gambling. Insurance reduces the risk of financial loss. Health insurance refers to the mechanisms for reducing the risk of financial loss due to medical care. Individuals and families uncertain about their health care needs in the future would seek to decrease the risk of expensive out-of-pocket payments for medical care by buying health insurance.

Marginal cost: Additional costs incurred when producing one additional unit of output. For example the marginal cost of vaccinating a child is the cost of the vaccine and that of the syringe if not used again. If the person who gives the vaccination was paid for each vaccine that he or she administers, then the amount paid to him or her would also be part of the marginal cost.

Means-testing: Targeting mechanism to identify individuals or households as eligible for benefits (exemptions from payment) based on established income-related criteria.

Operating costs: All the costs incurred by a health facility or the central office in their operations. It includes the costs of: salaries and bonuses paid to the personnel; drugs consumed; office supplies; fuel; supervision fees; maintenance of buildings and machinery. It includes neither investments nor depreciation.

Premium (for insurance): Amount of money paid to insurers on a regular basis in return for coverage (membership in an insurance plan). Premium rates for health insurance may be based on average costs of claims of the covered population or vary by socio-demographic characteristics such as age, sex, and occupational activity.

Private good: A good or service that is rival (consumed by one individual or group at a time) and easy to exclude people from its consumption. Examples of private goods and services are: a house, shoes, and a haircut. An example in the health sector is treatment for chronic illnesses.

Public good: A good or service that is non-rival (can be consumed by more than one individual or group at the same time) or difficult to exclude people from its consumption. Examples of public goods are: national defence, and public parks. An example in the health sector is health education campaigns.

Recurrent costs: Used in the text as a synonym for operating costs.

Reimbursement: The payment by an insurer to providers for services rendered to enrollees.

Social financing: A payment mechanism where individuals and/or households have to contribute to a central fund that finances health care delivery.

Subsidy: The opposite of a tax. One form of subsidization is lowering price to consumers below market levels. The difference between what consumers pay for a good or a service and the real price (if the difference is positive). A subsidy in the health sector is the provision of free or below cost health care services.

Sustainability: capable of continuing for a long time. A program is sustainable when consumer satisfaction and institutional capacity combine to ensure or increase the financial independence of the program. In the health sector, financial sustainability usually refers to a country's ability to maintain or improve a program using local resources (i.e., without contributions from external donors.)

Targeting: Method of identifying different groups (e.g., the poor, people at high risk of contracting a specific disease) to determine eligibility for benefits, e.g. exemption from payment, food supplements. Means-testing is one targeting mechanism.

Third party payor: An intermediate institution (e.g., insurance company) that modifies the transactions between consumers and providers of health care. Third party payers can be the government or private sector companies.

User fees: Same as fee.

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