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16. Abstract (Limit: 200 words) The major findings: 1) It is highly unlikely that consumers will be willing to bear the full recurrent cost of modern care. The highest proportion reported was one third, at a tightly managed missionary health center in Bong County. 2) No reliable data exist on the cost of providing primary health care. 3) Most (at least 65%) health care in Liberia is delivered by other than modern practitioners on a loosely defined fee for cure, not service. 4) Although 80% of the population lives in villages of 500 or fewer and only 6% of all the roads are paved, rural populations throughout the country are reached on an irregular basis by providers with supplies - the so-called "Black Baggers." 5) Consumers sort themselves out, with regard to the type of care (modern v. traditional) they will seek by the type of disease they believe they have and their economic status. 6) There are numerous formal and informal groups to which financing plans can be attached, including employee groups, agricultural coops, and credit unions. 7) There are resources, both real and potential, which may be available and in Liberia now or soon. For example, a national 10% sample survey was conducted by UNFPA in 1982. It included some health expenditure information; analysis of it is beginning. Also, a US Dept. of Agriculture Household Consumption Survey (1978) included health variables.			
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PLEASE NOTE

This paper is one of a series by the author on the topic of **private sector financing of primary health services in Africa.**

The titles in the series are the following:

"Private Sector Research Retrieval and Analysis Project: Somalia," October 18, 1983, NTIS Accession Number JDMCG/TR-83/1

"Private Sector Research Retrieval and Analysis Project: Liberia," November 29, 1983, NTIS Accession Number JDMCG/TR-83/2

"Private Sector Research Retrieval and Analysis Project: Upper Volta," December 20, 1983, NTIS Accession Number JDMCG/TR-83/3

"Private Sector Research Retrieval and Analysis Project: Niger," January 22, 1984, NTIS Accession Number JDMCG/TR-84/1

"Private Sector Research Retrieval and Analysis Project: Zimbabwe and Lesotho: Bibliographies," February 16, 1984, NTIS Accession Number JDMCG/TR-84/2

"Private Sector Research Retrieval and Analysis Project: Rwanda," February 22, 1984, NTIS Accession Number JDMCG/TR-84/3

"Private Sector Research Retrieval and Analysis Project: Swaziland," March 8, 1984, NTIS Accession Number JDMCG/TR-84/4

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"Private Sector Research Retrieval and Analysis Project: Sierra Leone," June 2, 1984, NTIS Accession Number JDMCG/TR-84/6

"Private Sector Research Retrieval and Analysis Project: Overview and Recommendation - Household Expenditure Survey," June 2, 1984, NTIS Accession Number JDMCG/TR-84/7

I. Introduction

The problem of securing private sector payment for health care is the focus of this paper. It is not a new problem, though the circumstances surrounding it have made it appear new. The worldwide recession has affected health services financing in Liberia by reducing:

- A. Liberia's tax revenues (Liberian public sector's ability to pay),
- B. Incomes of Liberian (Liberian private sector's ability to pay),
- C. Donor countries' tax revenues (donor countries ability to provide aid),
- D. Donor countries' individual and corporate incomes (donor private sector's ability to contribute to PVOs).

While most agree that "Health for All by the Year 2000" will not be achieved unless major innovations and commitments are undertaken, little agreement exists concerning the nature of those innovations nor with whom those commitments shall rest.

This paper consists of the results of a search for and analysis of previous work on these issues. First, a context is established, concepts are defined, and major findings are discussed. The final section contains a discussion of the policy implications and opportunities for further work.

II. Context, Concepts, and Findings

Growth of the Liberian economy has been slow in the past ten years. The economy consists generally of two parts - the modern, concession economy, largely foreign and engaged in iron mining, rubber, and timber, and the traditional economy, primarily subsistence agriculture. While the corporations in the concession economy have enjoyed the benefits of a favorable tax policy and a liberal profit repatriation policy ("open door" to investment), they have also, voluntarily, contributed to the social and physical infrastructure. Agriculture contributes over 30% of the GDP, but much of that is the modern sector. Seventy percent of the total labor force is involved in agriculture, 90% of which is the traditional, slash and burn method. (USAID, 1983, page 2)

There was great hope for Liberia in the years following World War II as worldwide demand for two of its primary export products, rubber and iron ore, expanded. It could not fulfill the world's expectations, and by 1974, per capita income started a decline which has persisted until today. A persistent, corollary problem to real growth has been the population growth in Liberia, currently about 3.4% per year.

Constraints to a reversal of this decline include a heavy foreign debt burden, especially since 1975, and a scarcity of trained and experienced administrators. There

were few experienced administrators before the coup in 1980; many of them left Liberia after it. At present, about 40% of all managerial and technical positions are filled by non-Liberians. (USAID, 1983, page 23) Beyond that constraint, there is the continuing problem of tribal social friction. National values are not shared to the extent that tribal values, which are often divergent, are shared. In the end, investment is the key. Restoring fiscal and economic stability and evidence of sound GOL financial management are the sine qua non for rekindling private sector confidence. (USAID, 1983, page 35)

It may be quite some time before economic stability and sound financial management are established in Liberia; such conditions are certainly well beyond the scope of this health project. The issue then reduces to what can be done under present circumstances to enhance private sector involvement in paying for health care?

Before presenting any of the initial findings, it is essential to define some of the major concepts of this paper. The first is private sector financing. The private sector, as distinguished from the public sector, is that portion of an economy which is non-governmental. The funds which flow through the private sector do so because either private individuals or groups have chosen to spend or invest them that way. The funds which flow through the public sector have arrived there either through taxes, public

borrowing, user fees, or external assistance. Unless public funds are earmarked for a specific use, "health funds" must compete with all other uses to which public funds can be put in arriving at the public budget. In Liberia, foreign investment is being directed, to the extent GOL and donors can agree, to those projects which have significant production, income, and employment effects (USAID, 1983, page 28). Thus, funds are being shifted from health activities to other activities in public investment.

In the private, non-governmental sector, people pay for health services in a variety of ways. First, there are the private and voluntary organizations (PVOs) which operate to deliver services. The people who pay for such services are the contributors to these organizations, generally non-Liberians, and including USAID. In the case in which PVOs are funded by public entities, like USAID, they may be considered hybrid public/private financing sources. Second, there are employment and cooperative related payment plans for health services, such as those provided by Firestone Rubber or LAMCO. These services are paid for collectively by the employees and coop members in a risk sharing mode, not unlike standard prepayment plans. Finally, there is the ad hoc, out of pocket payment made directly to the provider by the consumer. Generally, services provided by PVOs and traditional practitioners are paid for this way, with an increased use of this method employed by publicly organized

rural health projects. We shall be interested in the latter two categories of private expenditures, those which involve the user paying for his services.

The major findings of this research into private payment for health in Liberia consists of the following:

- 1) It is highly unlikely that consumers will be willing to bear the full recurrent cost of modern care. The highest proportion reported was one third, at a tightly managed missionary health center in Bong County.
- 2) No reliable data exist on the cost of providing primary health care.
- 3) Most (at least 65%) health care in Liberia is delivered by other than modern practitioners on a loosely defined fee for cure, not service.
- 4) Although 80% of the population lives in villages of 500 or fewer and only 6% of all the roads are paved, rural populations throughout the country are reached on an irregular basis by providers with supplies - the "Black Baggers."
- 5) Consumers sort themselves out, with regard to the type of care (modern

- versus traditional) they will seek by the type of disease they believe they have and their economic status.
- 6) There are numerous formal and informal groups to which financing plans can be attached, including employee groups, agricultural co-ops, and credit unions.
 - 7) There are resources, both real and potential, which may be available and in Liberia now or soon. For example:
 - A. A national 10% sample survey was conducted by UNFPA in 1982. It included some health expenditure information. Analysis of it is beginning.
 - B. An anthropologist with Liberia experience may be in country for work with the Agriculture people in early 1984.
 - C. A US Dept. of Agriculture Household Consumption Survey (1978) included health variables.

III. Discussion of Policy Implications and Opportunities

The following material consists of a discussion of the major findings, a consideration of the policy implications therein, and consideration of opportunities for further

work.

1) It is highly unlikely that consumers will be willing to bear the full recurrent cost of modern care. The basis of that speculation consists of the absence of any reported experience to the contrary, in light of many attempts to have consumers pay the full recurrent cost. Specifically regarding the Lofa County Rural Health Project (LCRHP), a physician from Lofa County described (Cole, 1983, pp. 6-7) some of the adverse effects of the project following the withdrawal of external support. He asserted the following:

A) The people continued to expect free drugs after external financing was withdrawn.

B) The communities were unwilling to purchase the kerosene needed to power refrigerators even though the government provided the vaccine (measles, in this case) for free. Similar lack of support was evidenced for the mobile teams, which lacked gasoline. The effects were felt through a measles epidemic (described by this physician as devastating).

More recently, in 1983, a primary health care project in Maryland County, Liberia collapsed after (and presumably because) the Dutch Government failed to renew the grant.

In studying the market place for health services, emphasis needs to be placed on studying demand, especially for factors. It appears as if there is effective demand for health services, as witnessed by the preponderance of

alternatives (MH&SW services, PVO services, "Black Baggers," traditional healers, and medicine vendors). What fails in the case of modern services is the induced demand for factors.

It would be essential to conduct estimations of demand for service before any project relying on consumer willingness to pay is developed. Such estimations can be performed simply, if not rigorously, and provide good baseline information regarding the willingness to pay for new services or medicines.

2) No reliable data exist on the cost of providing primary health care. To date, the most carefully researched primary health care project in Liberia is the LCRHP. The following is from Lashman's Evaluation: "No reliable data exist to document Liberian expenditures to date for recurrent costs of operating the LCRH system. Constraints to determining actual project costs include: 1) the cost of personal services provided by MH&SW employees assigned to Lofa County cannot be ascertained since the centralized Ministry of Finance payroll information has eliminated information on geographic location of employees from its data bank. Thus, it is impossible to identify the portion of total MH&SW salaries and wages expended in this project's facilities; 2) no basis exists to determine the maintenance and repair costs of Lofa County buildings, despite the fact that such information is urgently needed to justify an

anticipated need for a budgetary increase to cover this operating cost, and extend the coverage to include medical and other equipment not currently included; and 3) one of the two county hospitals - Tellewoyan in Voinjama - had its subsistence budget moved from direct MH&SW control to the centralized Ministry of Finance. This action impedes effective and efficient hospital management since the administrator has no means to trace actual outlays against budgeted expenditures and, thus, rapidly identify and redress problem areas for cost control.

Given the data limitations, the following distribution of the MH&SW financial expenditures on LCRH by category are at least illustrative of major cost categories:

<u>ITEM</u>	<u>PERCENT</u>
Personal Services	57
Drugs and Medical Supplies	24
Curran Lutheran Hospital	6
Maintenance, Operation, and Repair of Transport Equipment	5
Training	2
Other	<u>6</u>
Total	100"

(Lashman, p.95)

The following fee structures were reported (Lashman, p. 94) for Lofa County (L\$1 = US\$1):

- 1) Physician's Assistant (fees are unevenly applied)

Adult - initial visit	\$0.50
- subsequent visits	0.25
Pre-natal care and delivery	5.00
Children - initial visit	0.25
- subsequent visits (under 2 yr)	free
- subsequent visits (over 2 yr)	0.10
2) Zowo (Traditional Practitioner, General Practice)	
Undifferentiated visit	0.50 to 1.00
3) Untrained Midwife	
Pre-natal care and delivery	3.00 to 4.00
4) Bone Doctor (Bonesetter)	
Undifferentiated fracture	up to 40. to 50.00

Better data than the above would be necessary to determine the feasibility of producing services within the range of consumers' willingness to pay for them. Unless it is known that people will pay for services at the price it takes to bring them to market, one does not know if the market can survive without subsidy. Experimenting with the size of the subsidy (if required) would be benefitted by knowledge of the cost of delivering care.

3) Most health care is delivered by other than modern practitioners. For 65% of the population of Liberia, health care is limited to that provided by traditional practitioners. The remaining 35% with access to modern care finds it primarily in Monrovia and in the coastal areas, but often finds it lacking supplies and medicines. When medicines are

unavailable at clinics, the patient is often sent to a local dispenser to buy what he needs. Since the patient sometimes knows the clinic will not have a supply of that which he needs, he skips the clinic visit (foregoing the primary diagnostic step and its attendant cost) and pursues the medicine directly in the marketplace. A research question worth asking in a formal way could be, "If the medicine can be bought down the street, why can't it be bought in the clinic?"

Opportunities exist currently to learn more about the single most effective component of the private sector for health, the traditional sector. Sample surveys throughout the region can be conducted which provide information on the type, amount, and expenditures for care within the traditional sector. It is hypothesized that this sector is where much of the "health dollar" is spent. Influencing that sector, even marginally, would have a major impact on the bulk of the care that is delivered.

4) Rural populations are reached on an irregular basis by providers with supplies - "Black Baggers." Considering that 80% of the population lives in villages of 500 persons or fewer, and that less than 6% of the miles of roads considered "all-weather" are paved, and these are eroding fast due to lack of maintenance, it is quite surprising that the rural populations are reached with supplies at all. These providers, untrained, illegal, and thoroughly outside

any recognized system of health care delivery, travel to villages with syringes and medicines in their black bags. They sell injections to all takers, and are, apparently, quite successful at what they do. The one system that they are not outside of, however, is the supply and transport system. They are a very interesting brand of private sector provider, true entrepreneurs. While their care is deplorable at times, they are able to surmount the very obstacles which constrain the modern sector rural providers. And yet, the "Black Baggers" are not completely outside the modern sector; they rely on its supplies.

It is unlikely that they can be kept from practicing in rural areas. But, without the approval of the GOL, they will always be a renegade force. However, after a little training, possibly some supervision, and attention to their supply of medicines, it is conceivable that the "Black Baggers'" quality of care can be improved. Alternatively, public sector involvement may exacerbate the problem with them. It may bring in more incompetent or illiterate practitioners, resulting in more inappropriate care, not less. Finally, and not cynically, it is possible that tampering with their system (which may be barely viable) would cause it to fail. Whatever the intention, an attempt to integrate the "Black Baggers" into the system may be their undoing. This final outcome may be viewed differently, depending on the interests of the viewer. Those who

feel the "Black Baggers" can be integrated successfully may view it negatively; undoubtedly it would be viewed positively in the MH&SW. To paraphrase Theodore Sorenson, "Where you stand on an issue depends first on where you sit."

Just as there was terrible opposition to the integration of the Traditional Birth Attendant (TBA) into the modern sector at first, there may be similar opposition to the integration of the "Black Baggers." They should be investigated for insight into their abilities to keep their costs low and their access to supplies unimpeded. Minimally, the WHO/UNFPA report on "Black Baggers" in Grand Cape Mount County should be evaluated for relevance to this work.

5) Consumers sort themselves out with regard to the type of care they will seek by disease and economics.

Villagers have identified a whole set of diseases and conditions for which traditional healers are felt to be more appropriate than modern medicine including: leprosy, epilepsy, mental disorders, abscesses, and bonesetting. In the latter case it is common for the patient to seek diagnosis from the hospital, e.g., X-ray with wound treatment as required, but to have the actual fracture set by the community bone-setter. (Lashman, page 142)

Anecdotal reference (Cole, 1982, p. 4) to a consumer survey (N=1118) conducted in Zambia by Leeson and Leeson

provides insight into apparently perverse behavior. That behavior, investigated specifically in Zambia, exists throughout Africa. It is, simply, the apparent preference among consumers for more costly, less effective health care (traditional health services) when less costly (sometimes free) more effective care (modern health services) is available. Leeson and Leeson surveyed 1,118 patients and 22 traditional healers, and used Government of Zambia clinic and hospital data. They concluded that some of the reasons traditional practitioners were used much more prevalently than modern practitioners were:

- 1) Traditional practitioners did more than heal the sick. They dispensed advice about future or otherwise unknown events (finding lost objects or people), they offered protection against future misfortune (illness and "bad luck" events), and they offered an explanation for the patient's current problem in non-abstract terms he could easily understand.

- 2) People used traditional and modern services as (personally perceived) appropriate. Those health problems slow in onset or non-serious in symptoms were often routed to modern practitioners who were expected to provide rapid cures. Other health problems, quick in onset, or with insidious symptoms, or coincident with other seemingly unrelated problems, were seen by traditional practitioners.

Although the specifics differed in some respects, the

work on demand by Akin et al (Akin, et al, 1982) reached very similar conclusions. "The introduction of modern medical installations is usually undertaken on the assumption that they will be filling medical service vacuums. No such vacuums exist, however, since in every community there are well-established patterns of health-related behavior. New medical services are simply used as another alternative in what appears in most cases to be a pragmatic and unprejudiced search for a cure." (Akin, et al, page 53)

6) There are numerous formal and informal groups to which financing plans can be attached. A persistent problem associated with self-financing plans is the organization. It is often safer to align the plan with an extant group. In Liberia, there are no such shortages. Some are permanent, such as employee groups, tribal organizations, the Liberian Marketing Board, and agricultural co-operatives. Others are temporary, formed as needed. A study of rural finance in Africa by Von Pischke and Rouse (1983) described one such informal organization, the Rotating Savings and Credit Association. "RoSCAs consist of people closely associated on a village, family, or employment basis. Each member of the group undertakes to make a contribution of a specified amount at each regularly scheduled RoSCA meeting. Contributions are pooled, and awarded to each member in turn. The order in which members

receive the pool or "hand" is usually determined by lot, or by the organizer, either at each meeting in response to need, or at the start of the cycle on the basis of age, social standing, or order of enlistment. When each member has received a hand, the cycle is complete and the group may disband or agree to begin anew." (Von Pischke and Rouse, p. 33)

Their conclusions follow:

A. Illiterate and semi-literate farmers having some contact with the cash economy are capable of devising informal means of financial intermediation which are socially useful as demonstrated by their popularity and ability to survive and prosper with changing economic and social conditions.

B. Traditional rural institutions, such as the extended family and village, provide a basis for organizing financial services to participants in these institutions. Participation tends to ensure responsible performance.

C. Systems of rural financial services which are relatively simple to operate can succeed in reaching large numbers of people without intensive outside assistance if they serve a real demand.

D. Saving facilities have much greater potential than credit programs for reaching large numbers of rural people and for achieving rapid institutional growth.

E. Scale is important to the design of successful

financial services for rural people. While loans which are too large easily jeopardize the integrity of rural credit institutions, loans and savings services aimed at the scale of typical or routine rural transaction sizes can attract many customers.

F. Generally favorable economic circumstances in rural areas promote the establishment and survival of rural financial institutions. (Von Pischke and Rouse, pp. 35-36)

Based on the experience of Von Pischke and Rouse, it appears as if there is a large untapped reservoir of organizational resources in rural areas. The key to such organizations working for financing health is that it serve a real demand. Thus, the demand estimation work described above should be performed in light of the presence of organizational structures about which to build the services. As a concrete example, one may wish to measure the demand for "modern medicines" in a rural area, as measured by the willingness to pay for them through an organized offshoot of the Village Council.

7) There are resources which may be available in Liberia now or soon which are valuable. Confirmation by field personnel is essential in this section. The following was only thought to be available. The national 10% sample survey done in 1982 was a housing survey done by UNFPA and may be available through the Ministry of Planning, Census Division, or the University Demography Department.

Questions regarding source of care and expenditures on health were thought to be included, in some aggregate form, in the study.

Regarding the anthropologist, insofar as private sector activities depend on consumer behavior, and anthropologists study local, customary behavior, it is logical that they, as a group, would know about consumers' use of traditional care. An anthropologist, W. Penn Handwerker, of Humboldt State U. (Arcata CA 95521), is making arrangements with the Ag people in Monrovia to spend 3-4 months in Liberia beginning January. He may be useful to you in framing the issues pertinent to surveying the population regarding their sources and expenditures on traditional care. Some of his work includes investigations of food consumption, of marketing institutions, and price support programs.

Nothing more is known about the USDA Household Consumption Survey than that it was conducted in 1978.