

**22 POLICY QUESTIONS
ABOUT
HEALTH CARE FINANCING
IN AFRICA**

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By:

**Charlotte Leighton, Ph.D.
Abt Associates Inc.**

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**ABT ASSOCIATES INC., Prime Contractor
4800 Montgomery Lane, Suite 600
Bethesda, MD 20814 USA
Tel: (301) 913-0500 Fax: (301) 652-3916
Telex: 312638**

**Management Sciences for Health, Subcontractor
The Urban Institute, Subcontractor**

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22 POLICY QUESTIONS ABOUT HEALTH CARE FINANCING IN AFRICA

INTRODUCTION

Financing health care is a prominent political issue and a priority for the health sector throughout the world. In industrial nations, reform has focused mainly on containing costs. In developing countries, reform has been motivated by growing demand for better health care at a time when government, faced with shrinking resources, can no longer honor its traditional commitment to provide "free" care for all.

In sub-Saharan Africa, debate revolves around ways of improving the sustainability, equity, and effectiveness of health care services. Also under discussion are the impact of health financing reforms on efficiency, quality of care, access by the poor, and the respective roles of public and private providers.

Five *Topics* group 22 policy questions that ministries of health (MOHs) in sub-Saharan Africa most commonly ask about health financing reform. The answers summarize what is known about the impact and effectiveness of reform, based on experience and research in African countries. Each *Topic* is intended to be a brief, non-technical reference on the "state of the art" for senior decision-makers, health care analysts, program planners, and facility managers. For readers who want more detail, each *Topic* closes with an alphabetically numbered list of *References*. Numbers enclosed in brackets at the end of paragraphs refer to one or several entries.

Each *Topic* begins with an overview of the theme covered, highlighting the relevance and context of the policy issue(s) addressed. Since the key policy questions and answers are arranged by theme, readers may select areas of greatest interest — in any order. Because goals, policy questions, and experience of health financing reform are interrelated, however, readers may wish to skim all of the topics for a full range of information on any issue.

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Support for Analysis and Research in Africa (SARA) Project

AED

1255 23rd Street NW

Washington DC 20037 USA

Tel: (202) 884-8700 Fax:(202) 884-8701

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Topic 1

HEALTH FINANCING REFORM POLICIES, GOALS, STRATEGIES

TOPIC 1. POLICIES, GOALS, STRATEGIES

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:

- ▲ 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 the table below 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 the desired impact — on ministry of health (MOH) goals for equity, access, efficiency, and quality. (See *Topics 3 and 4.*)

For example, MOHs usually want to raise revenue to make some kind of quality improvement. It could simply be to assure that a minimum complement of drugs and supplies are made available or that facilities are better maintained. Similarly, most fee and insurance reimbursement structures will affect: utilization of different kinds of health services (e.g., curative vs. preventive) at different levels of the system (e.g., hospital vs. health center); how efficiently providers use resources; and whether consumers spend their money for health in a cost-effective way. Furthermore, the introduction or increase in user fees or insurance reimbursement is likely to have different impacts on different population groups, hence on equity of financial and geographical access.

Table 1-1: Health Sector Financing Reform: Goal, Purposes, Strategies		
<i>GOAL:IMPROVE HEALTH STATUS</i>		
STRATEGY (Technique)	PRIMARY PURPOSE	SECONDARY PURPOSE OR IMPACT
Raise revenue (e.g., user fees; insurance)	Financial sustainability	Equity Access Efficiency Quality
Reallocate resources (e.g.,increase MOH budget share for PHC; 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)	Efficiency	Access Financial sustainability

Predominant Financing Strategies

Faced with inadequate and declining government funding for ministry of health services, many African ministries have recognized they cannot meet their traditional commitment to provide a basic level of health care, free of charge, to the whole population. They also recognize limitations in their governments' ability to raise general tax revenue, as well as the unlikelihood of continued and substantial amounts of external donor assistance for health care.

Most sub-Saharan African countries have thus concentrated primarily on the first of the reform strategies that the chart lists—raising revenues from non-tax sources and modifying the way health services and medicines are funded. They have adopted policies to shift from full government funding by MOH budgets to partial cost recovery for publicly provided health services. The most common cost recovery technique that ministries have adopted is user fees for services, medicines, or both. Other techniques being explored or expanded include local government or community-based social financing, prepayment plans, and private insurance arrangements. Small-scale community-based financing efforts have been practiced extensively, especially for village health workers and "self-help" community projects to build or maintain health posts and clinics. But ministries have not widely promoted more elaborate social financing and insurance plans.

Complementary Strategies

Health financing reforms related to the other two main strategies — allocating, organizing, and managing health resources (health personnel, equipment, medicines, facilities, and funds) and developing alternative organizational forms, including expanded roles for private providers— are designed to improve the efficiency and effectiveness of a country's health system. These reforms 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 hospitals 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.

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. Financing reforms that would identify and foster appropriate roles for private for-profit health care are among the least developed.

It is important to keep in mind that other, broader organizational and institutional reforms and strategies are needed to complement and support the technical financing reforms that this brief addresses. These broader strategies — such as civil service reform, decentralization, strengthening management capacity, building political consensus on priorities, overcoming bureaucratic constraints — are needed to address the variety of organizational and political obstacles that health financing reform faces.

Common Financing Reform Issues

Considering the substantial shift that this array of financing reform strategies would entail for the public health systems of many African countries, ministries typically raise several issues:

- ▲ What financing reforms are needed?
- ▲ What approaches have been tried and been successful?
- ▲ How can financing reforms help achieve other goals of the public health system?

Topic 1 provides an overview of what is known about these issues. Other *Topics* give further details on country experience and specific aspects of overall health financing strategies and assess their impact on key ministry goals.

QUESTION 1: What health financing reforms are needed to improve the sustainability and performance of African health systems?

IN BRIEF: To address the multiple financing and related organizational issues confronting African health systems, a combination of measures is usually necessary to raise revenues, allocate resources more efficiently and effectively, consider alternative roles for the private sector, and target public resources more equitably.

What performance problems need to be addressed?

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, lack of incentives for health workers to provide quality care, inadequate regulation or inappropriate barriers to private 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. [4,5]

Governments in the highest income sub-Saharan African countries currently spend about 7 percent of their total budgets on health care; middle-income African countries, 5 percent; and the lowest income countries, 2.6 percent.[4] Irrespective of whether any of these governments could or should spend more, consensus has been growing that the traditional, complete reliance on government (general revenue) funding has not produced the quantity or quality of health services that African people and governments want. Neither can the system sustain or increase desired improvements in health status.[4,5]

What is the best way to approach these problems?

No single health financing strategy by itself can resolve these problems. Usually a combination of measures is necessary, including efforts to:

- ▲ raise revenues to improve quality and access
- ▲ develop effective targeting and means-testing policies and procedures to improve equity
- ▲ allocate resources more efficiently and effectively
- ▲ create incentives for more cost-effective use of health services and resources
- ▲ consider ways that private providers can help achieve public health goals

- ▲ adapt commonly proposed techniques to each country's specific set of performance problems, consumer preferences, configuration of public and private sectors, and priority health issues.

Each strategy includes a variety of techniques: various types of simple and complex fee structures; different combinations of fees to give consumers incentives to use services appropriately; various combinations of pricing mechanisms, cost-savings, and resource reallocation to expand resources for primary and preventive care services and make hospital services more efficient and effective; subsidies, tax incentives, and legal and regulatory codes to channel use of private health providers' services in the interests of public health goals. These techniques need to be adapted to each country's particular situation, and no single effective model exists for using them.

Details on country experience and options within each of these strategies are furnished elsewhere in this document. To be sure, technical strategies and techniques alone cannot guarantee sustainability or improved performance. Equally or more important are political, institutional, and management considerations related to consensus-building and implementation.

QUESTION 2: What approaches to health financing reform have countries tried? What has worked?

IN BRIEF: Cost recovery through user fees is the main financing reform attempted by ministries of health in Africa. Since cost recovery reforms rely on people's willingness to pay fees for health services, they are most likely to succeed when they also give people the improved quality, access, and equity they want. Satisfying clients and patients usually requires well-planned and managed implementation, avoiding common pitfalls, procedures to assure that fee revenues are used to improve quality and access, and mechanisms to protect the poor. Fee levels are important to the amount of revenues generated, but forging political and public consensus is as important as "getting the prices right."

How widespread is health financing reform in Africa?

Table 1-2 shows the 28 African countries that, as of 1994, had begun or put into effect national health sector cost recovery programs. Many of these countries (e.g., Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Zambia) have made revenue raising the primary objective. Others emphasize quality improvements for primary care, such as personnel incentives or assuring drug availability.[1]

TABLE 1-2 Countries in Africa that have begun or adopted national cost recovery reforms	
<i>Anglophone & Lusophone countries</i>	<i>Francophone countries</i>
The Gambia, Ghana, Kenya, Lesotho, Malawi, Namibia, Mozambique, Swaziland, Tanzania, Zimbabwe, Equatorial Guinea, Ethiopia, Guinea-Bissau, Nigeria, Sierra Leone, Sudan, Zambia	Benin, Burundi, Cameroon, Central African Republic, Côte d'Ivoire, Guinea, Mali, Senegal, Burkina Faso, Mauritania, Togo, Rwanda
<i>Source: [1,3].</i>	

A recent worldwide survey of cost recovery objectives in the health sector in 26 countries found that most countries had multiple objectives, but nearly all cited raising revenues as a primary objective. Nine countries (Cameroon, China, Honduras, Iran, Kenya, Mexico, Nepal, Thailand, Uganda) also cited improving the quality and extending the coverage of health care services. Seven other countries (Jordan, Iran, Kenya, Namibia, Papua New Guinea, South Africa, Sudan) sought to discourage unnecessary visits and prevent bypassing of lower level facilities.[2]

How do ministries actually begin reform?

Ministries usually need to begin by choosing an appropriate package of strategies and introducing them in some phased manner. Most African countries have started off with revenue-raising strategies through user fees for primary health care services and medicines at the health center and post level—as in the 13 countries implementing Bamako Initiative projects in one or more health districts. Others have begun reform with concerted cost recovery efforts for inpatient hospital services (e.g., Niger, Central African Republic, Burundi, Kenya, Malawi). Most countries have not attempted to engage simultaneously in strategies for cost recovery at every level of the health system, along with major changes in resource allocation, efficiency improvements, and increased involvement of private sector providers.

What have ministries of health learned about implementing reforms successfully?

Even when cost recovery is a ministry's main strategy, experience shows that these initiatives are complex and several components are needed for "success." Various measures of "success" can be used, but key indicators usually relate to amounts of revenue raised; use of revenues to achieve the intended goals (e.g., quality improvements, expanded access); and impact on use, especially for the poorest or high-risk groups. Cost recovery in sub-Saharan African countries shows that chances of success, as measured by these indicators, are improved by:

- ▲ introducing fees simultaneously with quality improvements, especially assuring drug availability and ploughing fee revenues back into quality improvements that satisfy patients and keep them coming back
- ▲ establishing clear cost recovery objectives, understanding the people's demand and use patterns, and planning the fee structure, exemption policy, and measures to cover costs of care to the indigent
- ▲ designing fee structures to encourage efficient use of services first at the lowest appropriate level, reinforce appropriate referral patterns, signal the cost of different kinds of health services, and promote use of cost-effective and preventive care
- ▲ avoiding common pitfall such as failing to keep fees up to date, allowing too many exemptions, failing to collect from government for services provided to beneficiaries of government health plans or social assistance programs (e.g., civil servants, students, the military, indigents)
- ▲ maintaining, rather than decreasing, the government's contribution to health facilities implementing cost recovery so that fee revenues are a net addition to resources
- ▲ providing workers responsible for fee collection with appropriate incentives

- ▲ allowing facilities to retain most or all of the collected fees for improvements at the collecting facility (e.g., to restock medicine supplies, pay for medical and office supplies, improve the building, pay personnel performance bonuses)
- ▲ providing some means of pooling a small portion of each facility's fee revenue at the district or regional level as a "solidarity" fund for common costs or redistribution to health facilities with the least viable cost recovery conditions
- ▲ conducting significant training and orientation for health workers and establishing appropriate financial management and accounting systems
- ▲ building political consensus and providing appropriate and extensive public information about fee levels, use of revenues, and goals of the cost recovery program.

These preliminary lessons have been culled from ongoing local or regional cost recovery experiments (e.g., Cameroon, Niger, Senegal, Swaziland, Ghana), from numerous Bamako Initiative projects (e.g., in Guinea, Benin, Nigeria), as well as from several national health financing reform efforts (e.g., the Central African Republic, Kenya, Zimbabwe). Many of these lessons have been learned the hard way: from having had to make mid-course corrections on initial efforts. No single country has developed a "model" for all, and every country is still learning and needs to make periodic adjustments.

QUESTION 3: How can health financing reforms help achieve other public health goals?

IN BRIEF: Health sector reforms designed to promote financial sustainability can also improve quality, access, equity, and effectiveness of health services. They can do this by making better use of existing government resources, assuring that additional revenues are used to maintain quality improvements, creating incentives for people to allocate their health spending more effectively, and targeting government subsidies to the poorest.

How can health financing reform improve health services?

Mobilizing additional resources to promote financial sustainability is a primary objective of health financing reforms. When well-designed, implemented, and including improved resource allocation and management, health financing reforms can also help African ministries of health to accomplish a variety of other important policy goals. Well-designed packages of health financing reforms can help to:

- ▲ improve quality of and access to public health services by making funds available to assure supplies of essential drugs, fuel for refrigerators to preserve medicines and vaccines, facility maintenance, and transportation for health worker supervision, outreach, and mobile services
- ▲ improve equity by asking individuals who can afford health services to pay for them, saving public monies for subsidies to people who cannot pay
- ▲ send price signals that encourage use of preventive and primary health care and generic drugs, thus helping households to get the best value and perhaps save money on health services
- ▲ increase efficiency and effective use of central government hospitals by improving cost recovery mechanisms, establishing health personnel performance incentives, and considering greater financial and managerial autonomy for hospitals to manage their resources better
- ▲ increase service availability and efficient use of government funds by encouraging a greater role for private health providers
- ▲ improve health status of the population by creating incentives for both governments and people to reallocate health spending to more cost-effective services.

What is the main rationale for financing reform?

Achieving these and related health policy goals, and promoting financial sustainability, is the primary rationale for health financing reforms. Financing reforms are most effective and best justified when designed to further health ministries' main public policy goals and health status improvements. This broader rationale is another reason that neither revenue raising goals nor cost recovery strategies should stand alone in financing reform efforts. User fee systems need to be designed to improve efficiency and equity and raising enough revenue for sustainability. And better resource allocation and targeting of government subsidies are needed in conjunction with cost recovery to realize the full benefit of improved financing strategies.

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TOPIC 2

FINANCIAL SUSTAINABILITY

TOPIC 2. FINANCIAL SUSTAINABILITY

Raising revenues through cost recovery, with the primary goal of improving financial sustainability of health care systems, has been the focal point of financing reform in Africa. Severe budget constraints have forced ministries of health (MOHs) to find needed funds outside their normal budgets, funded with central government tax revenues. The likelihood that external donor assistance will dry up, leaving a sizable funding gap also motivates financing reform. Funding in many countries already falls short of amounts needed for adequate health care, even with their government budgets and donor assistance. Health ministries in those countries cannot maintain improvements in the health status, much less expand those improvements.

Financial Sustainability Goals

Ministries' primary goals for cost recovery in relation to financial sustainability have thus been to:

- ▲ help fill the gap between government resources and funds needed to maintain or improve health services
- ▲ establish a cost-sharing principle whereby the national government continues to pay health worker salaries and fixed infrastructure costs and users of the health care system pay for at least part of the medicines and services they receive directly
- ▲ assure the long-run financial sustainability of health services by becoming more independent from external donor assistance.

Financial and Other Aspects of Sustainability

Financial sustainability in African health systems means having enough reliable funding to maintain current health services for a growing population and to cover the costs of raising quality and expanding availability to acceptable levels. Usually the financial sustainability goal also means achieving these funding levels with a country's own resources.

So far, ministries have concentrated their financing reform efforts on raising revenues through user fees, but:

- ▲ There are many other ways of mobilizing new resources such as: insurance, broadly based social financing, changes in government budget priorities to increase health care allocations, improvements in the central government's tax capacity.

- ▲ Institutional, political, organizational, behavioral, medical, and clinical reforms are equally important for sustainability.

Both points must be kept in mind when discussing sustainability, although a detailed discussion of the second point would exceed the scope of this presentation.

Policy Issues for Cost Recovery and Financial Sustainability

Raising revenue through user fees is not entirely new for government health systems in Africa. For quite some time, many countries have officially had fees for inpatient hospital services. And church missions and other private, non-profit health care providers have a long tradition of charging fees, even in the poorest rural areas. Traditional healers and birth attendants have required payment in cash or in kind, and market vendors have sold traditional and western medications to urban and rural African populations.

Many of these experiences have been limited in scope, sporadically implemented, poorly documented or publicized, and the results, often contradictory or incomplete. Therefore, ministries of health facing major policy change are often uncertain about whether user fees can provide a steady, adequate source of funding for health care. Some often-asked questions about the impact of cost recovery on financial sustainability are addressed below.

QUESTION 4: Are people willing to pay for health services?

IN BRIEF: Yes. Willingness to pay should no longer be an issue for health care financing reform in sub-Saharan Africa. A large majority of the population, at every income level, expresses a willingness to pay for health care, especially the modest fees ministries usually propose for health services and medicines. Other factors than willingness to pay fees can as strongly influence an individual's decision to use health care.

What evidence is there that people will pay for health care?

Evidence abounds that consumers in sub-Saharan African countries already spend large sums for health care services and medicines, even in the absence of official government cost recovery policies.[10,22,39,51] People also say they would pay more to improve care at public health facilities.

- ▲ In the Central African Republic, household surveys revealed that people at every income level would pay more than they already spend for medicines to treat priority diseases (e.g., malaria, sexually transmitted diseases [STDs], intestinal ailments). They would also pay gladly for quality improvements at health facilities (e.g., better maintenance). Mothers said they would help to pay for immunizations if their contribution assured availability of vaccines.[19,47]
- ▲ In Niger, household surveys showed people at every income level willing to pay higher fees for service and higher local taxes than currently to assure availability of drugs at local dispensaries. But the extent of their willingness varied with income. Better-off rural households were more likely to be willing to pay more than poorer households.[9,50]
- ▲ In Tanzania, household surveys similarly showed people at every income level willing to pay fees if that would guarantee availability of drugs and reduce waiting time at government health facilities.[1]

African households are most willing to pay for drugs that treat common adult and childhood ailments and for care that saves them and their infants and children from dying. Once they see the benefit of health care, they are likely to be willing to pay. Often they visit several health providers for the same illness episode to accomplish these objectives.

Is willingness to pay fees the only influence on a person's choice of health care?

No. Fear that unwillingness, or inability, to pay fees will curtail use of health care is a main reason for policy concern about user fees, but other factors are equally important in a person's decision to seek health services or to use a particular provider.

Use of health services is also influenced by perceived quality of care, type of service (preventive or curative), and type of provider (traditional practitioner, church mission clinic, government health post). The costs of waiting and travel time as well as travel costs figure in a person's choice of health care services. These other costs can easily exceed modest user fees and can play a stronger role in the decision to seek care. Cultural factors, too, are often more important than fees. And both distance from a health facility and perceived quality are often more important determinants than fees, especially for the poor. [2,6,10,15,17,18,54] (*See Questions 12 and 13*)

QUESTION 5: Can people afford to pay for health services?

IN BRIEF: African households spend substantial amounts of money for health services and medicines, regardless of government fee-sharing policies. Many different factors affect the "affordability" of these expenditures. Some households find them harder to pay than do others, and a few may not be able to pay even a modest cost recovery fee. Health ministries need to build into their cost recovery policies mechanisms for evaluating and accommodating variations in ability to pay and in factors affecting the affordability of health care in relation to other household needs.

What criteria govern "ability to pay?"

A \$10 expenditure on medicines is a bigger piece of a poor household's income than a better-off household's, but there is no consensus on criteria for "ability to pay" for health care. In the absence of standard criteria, many MOHs take what people now pay for health care as a first indicator of what they can pay.

Most households in Africa spend between 2 percent and 5 percent of their income out-of-pocket for health services and medicines. The poorest households often spend 5 percent or more—even in the absence of user fees for public health care. [19,30,47,51]

People often have to borrow to make these expenditures. Evidence from Tanzania in the early 1990s, when government health services were officially free, shows that 60 percent of respondents in a large household survey said that they had to borrow (36 percent) or make special sales (14 percent) to pay for health care in the previous year, while others (10 percent) of *all* income quintiles said they were completely unable to pay for health care. The rural population, who were on average poorer and faced higher transport costs, reported the greatest difficulties in paying for health care. [1]

As true worldwide, wealthy people in Africa spend more on health care than poorer people do, but these amounts are a much smaller part of the wealthier household's income.

- ▲ In rural Kenya, the poorest groups spent 6 percent of their income on health care, while the wealthiest group spent 2 percent.[8]
- ▲ In Kenya, Nigeria, and Malawi, households can spend as much as 8 percent of their annual income for malaria treatment alone. These costs are a higher burden for the poor. In Kenya, the estimated burden of malaria health costs is twice as high for rural small farm households (4 percent of annual income) than for urban middle income households (2 percent of annual

income). In Nigeria, the poorest households spend 8 percent of income on malaria treatment compared with 3 percent for middle income families. [12,20]

- ▲ In the Central African Republic before the official introduction of fees for services and medicines at government health facilities, the poorest rural families said they were spending an average of F CFA 1,200 (0.6 percent of income, equivalent to US\$4.00) for one outpatient illness episode. Middle-income urban households reported average spending of F CFA 4,100 (also 0.6 percent of household income, equivalent in this instance to \$13.76). Upper income families in Bangui, the capital, were spending F CFA 9,000 (0.3 percent of household income, equivalent to \$30) for an average outpatient illness episode.[10]

What are some of the factors that affect ability to pay?

What people can afford to pay for health care depends on many different factors. They include:

- ▲ Total family income and family size
- ▲ The specific fee for each type of health service
- ▲ How many family members get sick in a year
- ▲ How much they must also pay for education, water, and other services
- ▲ Their spending for other basic needs in relation to total household income.

Ability to pay may also vary by season, especially for rural agricultural populations, and with national economic changes such as currency devaluations. Ability- to-pay assessments have to take into account not only the price of one medication or service but also the cost of a series of services and medications a household will likely need in a year.

What type of research is needed to assure that fees are affordable and sustainable under cost recovery reforms?

Net savings over spending for health care prior to reforms may be one of cost recovery's main benefits to households, making health care clearly more affordable. [10,21,53] (*See Questions 12, 13, and 17*) Nevertheless, little research has been done to determine what range of spending or proportions of income is "affordable," and hence sustainable by the population. Some empirical

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measure would help to protect equity needs and assure that patients can pay the fees charged. Research should be done to:

- ▲ define criteria for determining "ability to pay"
- ▲ develop monitoring indicators
- ▲ incorporate means of accommodating variations in ability to pay into the design of cost recovery initiatives tailored to local conditions (e.g., seasonal payment mechanisms where needed; effective indicators of income for means testing; administratively feasible sliding fee scales).

QUESTION 6: Can cost recovery initiatives raise enough revenue to make a difference for financial sustainability in countries where most people are poor?

IN BRIEF: Theoretically, yes. User fees can contribute modestly to total government recurrent costs for health care and more toward recovery of non-salary recurrent costs. A variety of implementation factors have kept cost recovery rates below their potential. These factors have often been a bigger obstacle than people's willingness or ability to pay. If cost recovery is to help with financial sustainability, legal and management safeguards need to be in place to assure that revenues are used to sustain the service improvements.

How much do user fees contribute to paying government's total recurrent costs of health care?

Little is known about how much cost recovery based on user fees contributes to funding total government costs for health care. The few estimates that have been made are based on data collected in the 1980s before the most vigorous cost recovery initiatives had been implemented. Table 2-1 summarizes data most often cited regarding the contribution of fee revenues to total government spending for recurrent costs (e.g., salaries, medicines, supplies, transport, utilities, and other annual operating costs) of health services. As the data indicate, cost recovery rates are usually under 10 percent when calculated as percentage of total MOH recurrent costs.

TABLE 2-1 Cost recovery in sub-Saharan African countries, 1980s <i>(percentage of total government health care spending)</i>	
<i>Costs recovered</i>	<i>Countries</i>
1–5 percent	Botswana, Burkina Faso, Burundi, Côte d'Ivoire, Kenya, Malawi, Mali, Senegal, Swaziland, Zimbabwe
6–8 percent	Lesotho, Mozambique, Rwanda
12 percent	Ethiopia, Ghana, Mauritania
<i>Source:</i> Compiled from Vogel 1988 and 1989. [44,45]	

At facility level, how much of recurrent costs are recovered?

Few health financing reforms involving user fees in sub-Saharan Africa attempt to recover salary costs, which often amount to between 60 percent and 80 percent of total recurrent costs. Instead, they are designed to contribute to the much smaller proportion of recurrent costs absorbed by medicines, supplies, transport, and other non-salary operating costs. Estimates using this measure are most often made at the facility level.

By this measure, user fees generate between 30 percent and 40 percent (occasionally over 50 percent) of non-salary recurrent costs at outpatient health facilities in sub-Saharan African countries. When costs of medicines alone are used as the indicator, cost recovery can be as high as 100 percent. Fee revenues from cost recovery initiatives sometimes equal or exceed the amounts governments previously allocated to health care facilities for non-salary recurrent costs, especially for drugs. [10,19,33,49,52] (*See Questions 7 and 11*)

Do cost recovery rates increase over time?

Often. For example, cost recovery in Ethiopia rose from 12 percent of total government health care spending in the early 1980s to 20 percent by the mid-1980s. Cost recovery rates also improved in Ghana (from 5 percent in 1984 to 12 percent in 1987), Lesotho (from 6 percent in 1984 to 9 percent in 1991), Côte d'Ivoire (from 3 percent in 1986 to 7 percent in 1993), and Zimbabwe (from 2 percent in 1986 to 4 percent in 1991). Recovery rates in other regions also rise over time. In China, for example, cost recovery as a percentage of all health care spending rose from 78 percent in 1985 to 85 percent in 1987. [31,39,45,51]

Increases and decreases over time can occur for many reasons and have to be assessed in the specific situation. Among the main reasons for increased cost recovery rates are: stronger cost recovery policies, improved experience and enforcement of fee collection, a rise in fees to account for inflation, or a drop in government funding, which effectively raises the cost recovery rate even though fee collection performance does not improve. Rates have also declined in countries such as Ethiopia during war or political turmoil. Hospital rates have declined where fees are not updated to keep pace with inflation (e.g., Turkey, Botswana, Jamaica, Lesotho, Zimbabwe). [3]

As cost recovery rates improve, do revenues further financial sustainability of the system?

It all depends. There is little documented long-term evidence that fee revenues are used to enhance financial sustainability of the health care system or services in specific public health facilities. Some drug revolving funds have managed to channel fee revenues back into operations, but many other small-scale efforts have failed. More time is needed for a longer term evaluation of

cost recovery efforts, and national level assessments will be necessary after smaller initiatives and phased programs have had time to expand and become institutionalized throughout the country.

The cost recovery potential of user fees depends on such factors as fee levels charged, corresponding utilization changes, health worker incentives for collection, fee exemption policies and practices, implementation system procedures, and how well good practices are institutionalized. [14,16,22,23,26,27,35,39,45,51] Evidence about people's willingness to pay for health care services suggests that higher than token prices could be charged, bringing in more revenue without causing hardship for most people.[22] Financing mechanisms such as prepayment or insurance may raise more revenues than straight fee-for-service systems. [10] (*See Questions 8 and 22*)

User fees' contribution to financial sustainability of health services, especially to quality improvements, depends on whether or not fee revenues are channeled back into the health care system, and into the specific health facilities raising the revenues, to pay for the costs associated with improved service delivery. Although fee levels and fee collection/exemption practices do affect how much revenue is raised, implementation details and legal and management safeguards are key to assuring that the revenue is used to sustain the system. [52]

QUESTION 7: What is the impact of cost recovery on financial sustainability at primary care facilities and hospitals?

IN BRIEF: Total cost recovery rates for individual public health facilities in Africa are generally modest. Measured against goals of covering non-salary recurrent costs, especially costs of drug supplies, cost recovery rates are higher. Even when cost recovery rates are low, user fees often fill important funding gaps that have prevented quality improvements at government health facilities.

How much has cost recovery contributed to funding at primary and secondary facilities?

Cost recovery at health centers, health posts, and dispensaries has been modest but has filled important gaps. (See Table 2-2) In many sub-Saharan African countries, the major share of MOH budgets goes to hospitals, leaving primary and secondary providers relatively underfunded.

Many financing reform initiatives have focused on recovering the non-salary portion of recurrent costs of outpatient services and medicines at these primary and secondary care facilities.

- ▲ In Benin, user fees under the Bamako Initiative in the early 1990s produced 43 percent of total facility recurrent costs, including salaries, and 100 percent or more of all medicine costs. Cost recovery revenues in Guinea's Bamako Initiative covered on average 47 percent of non-salary recurrent costs, while 52 of 95 health centers covered at least 100 percent of their non-salary operating costs in 1990.[33,43]
- ▲ In Senegal, Bamako Initiative sites in 7 districts recovered, on average, over 100 percent of drug and related administrative costs.[7,53]
- ▲ In Niger, revenues from user fees in 1993 produced revenues equal to 52 percent of drug costs and 35 percent of the costs of both the medicines and pharmacy administration in one district. In another district, which instituted a health tax in addition to user fees, revenues covered 149 percent of drug costs and 89 percent of drugs plus administration.[10]

Even when fee revenues are just a fraction of total spending on government-provided services, they can help individual facilities to alleviate shortages of basic medicines and other critical supplies (e.g., bandages, alcohol, gloves, and anesthetics). In many countries or regions where facilities receive limited supplies of drugs, or none, from the health ministry, drug revolving funds financed by user fees have been solely responsible for drug availability. User fee revenues are often

the only source of funds for any operating cost other than salaries and drugs (e.g., fuel for refrigerators and vehicles, office supplies, routine maintenance).

TABLE 2-2 Recovery of non-salary recurrent costs by user fees at ambulatory health facilities in Africa	
<i>Percentage covered</i>	<i>Selected health centers and health posts</i>
< 15 percent	1980s: Rwanda, Burkina Faso
30-40 percent	1980s: Benin, Niger, Sudan 1990s: Benin, Cameroon, Guinea
50-80 percent	1980s: Mali, Zaire, Senegal 1990s: Cameroon, Zaire, Niger
<i>Sources:</i> Bekele and Lewis 1986 [4]; Bitran et al 1986 [7]; Diop et al 1994 [10]; Knippenberg et al 1990 [16]; N'Diaye 1989 [32]; Reveillon 1987 [34]; Sauerborn et al 1993 [36]; Sékou et al 1991 [37]; Unger 1990 [42]; Willis 1993a [49].	

Like overall cost recovery rates, recovery rates at the facility level can fluctuate over time.

- ▲ In Cameroon, revenues as a percentage of non-salary recurrent costs in a project encompassing rural health centers increased from 34 percent in 1991 to 51 percent in 1992.[36]
- ▲ In Benin, average cost recovery rates at rural health centers rose from 31 percent in the late 1980s to 43 percent in 1990.[16]
- ▲ In Zaire, revenues from seven semi-autonomous health zones declined from an average rate of 80 percent of non-salary recurrent costs in 1986 to between 60 percent and 70 percent in 1991.[7,49]

What about the cost recovery rate for medicines?

As much as 100 percent of the cost of drugs can be recovered through fees. Fee revenues that pay for improved drug supplies often equal or exceed by many times the amounts that governments have historically allocated to health facilities for medicines.[52] Drug revolving funds operate in at least 13 countries — Benin, Cameroon, the Central African Republic, Chad, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Sudan, Tanzania, and Zaire. About half the funds in those countries were able to cover the full costs of drugs with fee revenues from medicines and services, and between half and 80 percent of the funds made a profit.[39]

How much of their costs do hospitals recover with fees?

Several analysts have made extensive efforts to compile data on hospital cost recovery rates, but sources are difficult to locate, and data are not systematically collected. Nor do they always reflect comparable methods of estimating cost recovery rates. Table 2-3 nevertheless suggests the range of experience with hospital cost recovery.

Few public hospitals in Africa or elsewhere raise much of their operating costs from user fees. A variety of managerial weaknesses are to blame for keeping hospital fee revenue below potential, including failure to update fees and to claim insurance reimbursements and lack of incentives for fee collectors.[3]

TABLE 2-3 Recurrent costs covered by user fees in public hospitals, 1980s	
<i>Percentage of total recurrent costs recovered</i>	<i>Selected public hospitals, various countries</i>
10 percent or less	<ul style="list-style-type: none"> ▲ Sub-Saharan Africa: Botswana, Central African Republic, Lesotho, Swaziland, Senegal, Zambia ▲ Other regions: Jamaica, Honduras
15-25 percent	<ul style="list-style-type: none"> ▲ Sub-Saharan Africa: Ethiopia, Ghana, Niger, Zaire ▲ Other regions: <ul style="list-style-type: none"> □ Turkey, Indonesia
38 percent	<ul style="list-style-type: none"> □ Bolivia
80-100 percent	<ul style="list-style-type: none"> ▲ Sub-Saharan Africa: Nigeria ▲ Other regions: China
<i>Source: Compiled from Barnum and Kutzin 1993, using latest date in 1980 where multiple dates listed. [3]</i>	

With concerted efforts, user fees have covered increasing shares of hospital recurrent costs. Insurance reimbursement is usually needed, however, to provide substantial cost recovery at the hospital level. (*See Question 8*)

- ▲ In the Central African Republic, a revised fee structure in 1995 will make central hospitals more affordable for most patients and strengthen reimbursement procedures for civil servants and the indigent. These reforms are expected to produce enough revenue to cover all inpatient medicine, laboratory, and supply costs and a share of other non-salary hospital operating costs. These revenues are expected to exceed the non-salary operating funds currently received from MOH.[19,48]
- ▲ In Niger in 1991, cost recovery rates from user fees at the national hospital ranged from under 4 percent for inpatient care to over 150 percent for medicines. With a strengthened commitment from MOH and reinforcing legislation to support greater hospital financial and managerial autonomy in 1992–94, the national hospital increased revenue collection by 5 percent, in the midst of a particularly turbulent period. Among district hospitals, one increased collection by 110 percent and another by 5 percent during the same period.[11,37]

QUESTION 8: What else could be done to tap potential sources of finance for public health facilities?

IN BRIEF: Insurance reimbursement for public health facilities could be expanded and "best practices" could be adopted from nongovernmental organizations (NGOs) that have been successful with cost recovery through user fees. Weaknesses in implementation, large numbers of fee exemptions, and failure to collect unpaid bills and reimbursement from insurance and government health plans and social assistance programs have kept cost recovery rates low, especially in public hospitals. If cost recovery or insurance reimbursements are to help with financial sustainability, revenues cannot be used in the short run to replace, or reduce, government funding for health services.

What potential does insurance reimbursement have for government health facilities in Africa?

Financing through health insurance, especially for public hospitals, is least developed in sub-Saharan Africa, although it is not widespread in any developing country region. Generally, it is the countries with a large population employed in the formal sector—such as Argentina, Brazil, Jordan, Korea, Turkey, and Uruguay—that tend to have significant public or quasi-public health insurance programs that cover hospital services. In general, reviews of hospital financing experience conclude that hospitals in most countries have not generated more than a small fraction of their revenues from non-government financing sources. The general reasons for this pattern tend to be due to various administrative failures and scope of formal employment, but not to level of per capita income or prevailing government ideology.[3]

In most African countries, government health plans for civil servants and their families are the predominant source of health insurance. National or local government social assistance programs also often exist to pay for health services for the indigent. In many cases, however, these plans have not worked well to reimburse health facilities for providing services to the eligible people.

- ▲ In the Central African Republic, government has been in arrears in its reimbursements to central hospitals for treating civil servants and their families, which often make up 40 percent of their patient load. Reimbursements (80 percent of charges for the patient's care) are to resume in 1995. Under the government's renewed commitment to health financing reform, the President of the Republic signed a decree establishing a line item in the national budget for reimbursing services under the government's health plan for civil servants.[19,48]
- ▲ In Mali, a single ministry's reimbursements for services to its employees and their dependents raised one hospital's revenues 7 percent in one year.[51]
- ▲ In Ghana, exemptions for MOH employees and their families cost government health facilities 21 percent of their potential fee revenue.[46]

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Where privately funded health insurance exists, hospitals can be the major beneficiaries of the additional source of funding. In other instances, private insurance represents an untapped source for public hospitals.

- ▲ Less than 5 percent of private health insurance claims in Jamaica and in Zimbabwe went to public hospitals. In contrast, hospital financing through prepaid capitation plans covers about 43 percent of the population in Uruguay.[3]
- ▲ A community-based health insurance plan in Bwamanda, Zaire, covers 80 percent of the district hospital's costs from user fees and insurance reimbursement, while 90 percent of the insurance plan's income goes to pay hospital charges. Hospital cost recovery rates increased from 48 percent of operating costs in 1985 to 79 percent in 1988.[7]
- ▲ In Kenya, after reforms to improve fee structures, fee collection, insurance claiming procedures, reimbursement rates, and management systems at government health facilities, total monthly revenue tripled at provincial, district and sub-district hospitals. When these reforms reach their full potential, income from fees and insurance is expected to provide revenues equal to 39 percent of the government allocation to hospitals, after deducting the revenue share that the government re-allocates to health centers and dispensaries for preventive and primary health care.[9]
- ▲ In China, all health institutions were instructed in 1981 to cover all non-salary recurrent costs through user fees. In addition, about 20 percent of the population is covered by health insurance plans that cover 100 percent of hospital charges and another 15 percent of the population has more limited hospital coverage. These reforms have helped health facilities generate revenues that cover large shares of recurrent costs (85 percent on average). However, they have led to rapid inflation in health care costs, growing at average annual rate of 17 percent in real terms between 1980 and 1988, primarily due to patients paying user fees and to insurance reimbursements.[3]

What does NGO experience have to offer?

Health facilities operated by church missions and other non-governmental organizations often cover a large part of operating costs through user fees, while serving the poorest population groups. Countries that have substantial experience with NGO health facilities might adapt their cost recovery lessons for public providers.

- ▲ In Senegal, user fees charged by church mission health posts represented 95 percent of all their revenues.[5]
- ▲ In Tanzania, between 50 percent and 80 percent of mission health posts' total recurrent costs including salaries came from user fees. In Uganda and Zaire, NGO hospitals have recovered between 75 percent and 95 percent of annual operating costs through user fees.[7,28,51]

- ▲ Church mission hospitals recovered 13 percent of costs in Swaziland, 46 percent in the Central African Republic, 56 percent in Tanzania, and 72 percent in Uganda in the late 1980s and early 1990s.[39]

NGO project experience among relatively poor populations in countries in other regions (e.g., Bolivia, Peru and Haiti) show similar patterns to those found in sub-Saharan African countries.[13,24,38] In Haiti, health facilities run by one non-governmental organization raised 92 percent of non-salary recurrent costs for outpatient services, and in Bolivia, a non-governmental organization, PROSALUD, covered 80 percent of outpatient costs from user fees in one site and 59 percent in another.[38,41]

Do any of these options lessen the need for government funding?

Probably not in the short run. Revenues from fees neither cover—nor are expected to cover—salaries, which make up the bulk of recurrent costs for government health services, nor do they always cover non-salary recurrent costs. Even with improved performance, cost recovery revenues are not likely to reach levels that could offset government spending in the near future. Insurance mechanisms, while promising, take time to establish, are administratively complex, and require careful planning and monitoring to safeguard efficiency, cost containment, and equity.(See *Question 22*)

People might be willing and able to pay more. Fees affordable for most people, but higher than token fees, could more than cover the cost of collecting fees and bolster financial sustainability and quality improvements, according to the general consensus among MOH personnel in Africa.[22]

Households, in fact, already contributed more than government to overall health care financing in sub-Saharan Africa in 1985–90, especially in the lowest income countries. Private spending was 52 percent of total health spending in high-income African countries, 58 percent in middle-income countries, and between 69 percent and 78 percent in low-income African countries.[51]

This pattern suggests that households can be counted on for a substantial share of financing for health services and medicines they use. It is evidence that established MOH cost sharing goals are feasible. Nevertheless, ministries will have to find ways to tap current spending levels for use in the public sector health system and will have to stay within the bounds of affordability for patients. While ministries improve and refine the fee system, government will probably have to continue funding health care services at least at current levels to allow cost recovery to contribute to improvements in public health care.

In other parts of the world, governments have reduced MOH budgets once fee revenues materialized (e.g., Cambodia, Chile, China, Iran, Jordan, Nepal, and Thailand), sometimes by explicit agreement between ministries of health and finance.[35] Acknowledging the possibility of such reductions, some African countries have instituted explicit agreements to prevent them. In the Central African Republic, MOH officials have sought assurances that the MOH budget contribution would be maintained as the national cost recovery program proceeds.[19] In Kenya, where an agreement between MOH and the ministry of finance guaranteed that fee revenues would not be used to reduce the MOH budget allocation, health care's share of all government expenditure rose, from 7.6 percent in 1988 to 8.5 percent in 1991.[25]

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TOPIC 3

COST RECOVERY'S IMPACT ON QUALITY, ACCESS AND EQUITY

TOPIC 3. COST RECOVERY'S IMPACT ON QUALITY, ACCESS AND EQUITY

An ample supply of essential medicines for common illnesses and vaccines for childhood immunizable diseases is one of the first quality improvements sought by Africans and their ministries of health (MOHs). They also want reliable stocks of other medical supplies and equipment — and well-trained, skilled, and understanding health workers to dispense them — in neat, clean health facilities, with vehicles for emergency and outreach transportation.

The term *access*, used to refer broadly to *availability* of health services, has both financial and geographic aspects. The term *equity* also has several dimensions but usually refers to *comparable access* to health services for all population groups.

Policy goals for equity and access are often linked. They involve efforts not only to make health services available to the whole population, but also to remove barriers that may prevent the poor in cities and isolated rural areas, and high-risk groups, from using health services they need. Public health policies in sub-Saharan African countries thus usually include goals for expanding access to basic health services to make them equally available for everyone. Accessibility is often measured by the presence of at least primary health care services within 5 kilometers of people's homes. Mobile or outreach health services are often used to reach this goal.

Policies for improving access often emphasize availability of health services that cut illness and death among high-risk groups such as women and children and people constantly exposed to malaria and communicable diseases such as tuberculosis. Similarly, policies for improving equity commonly focus on removing financial or geographic handicaps in access between urban and rural areas, for example, and between poor and wealthy households.

Cost recovery has been the main policy reform chosen by African ministries of health for financing quality, access, and equity improvements in health service delivery. Cost recovery reforms can capture new funds to:

- ▲ pay for quality improvements such as assuring reliable supplies of therapeutic drugs and medical necessities
- ▲ improve geographic access to health care services by providing villages with additional outreach services, mobile vaccination teams, or health workers
- ▲ improve equity by asking patients who can pay for health services at the time they use them to do so, thus reserving public funds for paying part or all of the cost of services for patients less able to pay
- ▲ improve financial access with fee exemptions or reductions for selected health services or for poor or high-risk population groups.

Complementary financing reforms that reallocate resources and encourage private sector participation can multiply cost recovery's contribution to quality, access, and equity. These complementary efforts can help make more cost-effective services available to more people, especially the underserved rural and urban poor. Because African ministries of health have focused on user fees and related cost recovery initiatives, whether these reforms live up to their promise can be judged from their experience and a body of research. Less is known about the relatively untested potential of resource reallocation or private sector development activities for improving quality, access, and equity.

Topic 3 attempts to answer some of the questions policy makers and program managers most commonly ask about controversial aspects of cost recovery and its potential effects on policies to improve quality, access, and equity of health care delivery.

QUESTION 9: What role does quality play in health financing reform?

IN BRIEF: Improving quality is a two-way street. People will pay reasonable fees for recognizably high-quality health care, and their fees generate revenues to help cover the costs of quality improvements. Cost recovery reforms are most likely to work when fee revenues are ploughed back into the delivery system to improve quality. Thus, the link works both ways: quality improvements generate support for financing reform and financing reform can generate the revenues to sustain quality improvements.

Are fees the main influence on people's willingness to pay for health services?

No. Time and travel costs, perceived quality and benefit of a health service, income, and education all enter into a person's decision to pay for health care through a particular provider, or to do without. (*See Question 4*) Perceived quality, however, often predominates over every other factor.[2,6,9,10,18,19,21,22]

Perceived quality, the quality of health care as patients see it, has many dimensions, including health workers' attitude, waiting time, and the appearance of the health facility. In sub-Saharan Africa, patients consider medicine availability the touchstone of health service quality, and they are overwhelmingly willing to pay for medicines.[1,9,21,33,38,42] Thus, ministries of health have frequently concentrated cost recovery initiatives on introducing fees for drugs. Those fees go into revolving drug funds to assure availability of medicines, thereby improving a key indicator of quality from the patient's point of view.

How do quality and fees affect use of health care services?

The positive effects of quality can offset the negative effects of price, according to a growing body of evidence on the impact of fees on people's use of health services in Africa — and elsewhere. These studies show that assessments of fee impact on use are likely to be misleading or inconclusive if they do not take into account whether or not quality is simultaneously improved when fees are introduced or increased.

- ▲ Use decreases when quality worsens and increases when quality improves, with few exceptions, as shown in a recent survey of more than 50 user fee experiences in Africa.[36] In Ghana, Zaire, and Mozambique, for example, utilization dropped in rural health units after fees were increased. However, a major part of the revenue collected went to the central treasury, and little improvement was made in local services.[27]
- ▲ In Cameroon, Gambia, Niger, Sierra Leone, Sudan, and Zaire, expanded supply and improved quality more than offset price effects of user fees, resulting in net increases in utilization of health services.[5,7,9,21,28,29]

- ▲ In Niger, quality outweighs price in decisions to seek or forego health care, according to a pilot test of health financing reforms. Moreover, the poor respond more strongly than the better-off to quality improvements. [8,9,44]

- ▲ In Ghana, quality improvements in drug availability, services, and infrastructure could raise attendance at public facilities and lower self-treatment by 15 percent. Fee increases deter consumers from seeking care less than either quality or distance from a health facility.[18]

- ▲ In Nigeria, quality influences people's use of health services more strongly than price, and the negative effect of price increases can be offset by higher quality. Public facilities could raise outpatient fees to the private level and still increase use if they offered comparable drug availability and physical surroundings.[39]

QUESTION 10: Have fee revenues been used to pay for quality improvements?

IN BRIEF: User fee revenues retained at the facility level have been widely used to make several kinds of quality improvements. How consistently or well this is done depends on a variety of implementation factors, but especially on the extent to which health personnel are given the authority and the motivation to make improvements.

How have fee revenues been used?

While there are both successes and failures, cost recovery can generate enough money to improve both quality and overall financial sustainability.

- ▲ In Benin, user fee revenues have been used to improve drug stocks and to hire new village health workers to extend services to people with limited access to health care.[15]
- ▲ In 15 countries, that allow revenue retention at the facility level, fee revenues were used to improve drug supply (9 countries), staff morale (8 countries), equipment (5 countries), and maintenance (7 countries), and to reduce patient waiting time (5 countries), according to a recent worldwide cost recovery survey of ministries of health.[26]
- ▲ Under the Bamako Initiative in Nigeria, the Congo, Kenya, and Guinea, health center fee revenues are being used for drugs (37–53 percent), supplies (2–12 percent), personnel incentives (12–48 percent), miscellaneous operating costs (2–12 percent), and savings (8–26 percent).[30]

How important to quality improvement is local management of funds?

There is a general consensus that cost recovery initiatives are more likely to lead to quality improvements when the ability and the incentive to make improvements are given to the health facilities that collect the fees. These conditions are usually achieved when revenues are retained at the facility level, not turned over entirely to the national treasury, and are managed in some decentralized fashion.[4,13,26,27,31,38] Local control of cost recovery revenues becomes more and more a possibility with increasing efforts to decentralize planning, budgeting and service delivery decisions across the continent. Decentralization efforts are in progress in the health sectors in Botswana, Ghana, Lesotho, Tanzania, Zaire, and Zimbabwe, have begun in Benin, Guinea, Mali, and Nigeria, and are being tested in Burundi and Senegal.[27]

- ▲ Health facilities in 18 out of 26 countries recently surveyed were allowed to keep revenues from fees, although retention was not always permitted at every level of the health system, and not all of it could always be kept at the facility level. Of the 18 where fee retention was permitted, 7 are in Africa (Cameroon, Ghana, Kenya, Sudan, Tanzania, Uganda, and Zambia), 2 in the Middle East, 5 in Latin America, and 4 in South Asia.[26]

- ▲ In another survey, 9 out of 10 cases where improvements were cited, at least part of the user fee revenue was retained and managed locally. On the other hand, in 3 out of 10 cases where fee revenues were managed by facilities or by local health committees, quality was reported as staying the same.[36]

The latter finding suggests that decentralized local management is one but not the only condition for quality improvement. Local management of revenues can be subject to abuse without appropriate community, legal, and other safeguards. In addition, health facilities in the poorest areas or serving dispersed populations may not be able to raise enough revenue to improve quality. In these cases, it may be necessary to establish a mechanism at the district level, such as a *solidarity fund*, to which a portion of each facility's fee revenue is allocated for redistribution to the less well-off health facilities. More experience and country-specific adaptations will be necessary to determine which local level (e.g., health facility, district, province) is appropriate for what responsibility under cost recovery programs.

QUESTION 11: How do quality improvements affect costs and financing policy?

IN BRIEF: Quality improvements increase utilization, willingness to pay fees, and revenues—but they also increase costs. The net effect depends on specific local circumstances. Appropriate financing and cost-containment policies can help to keep the lid on costs. With the current focus on medicine availability as a prime indicator of quality in Africa, the interactions between quality improvements and cost bear watching.

How are quality, cost, and financing linked?

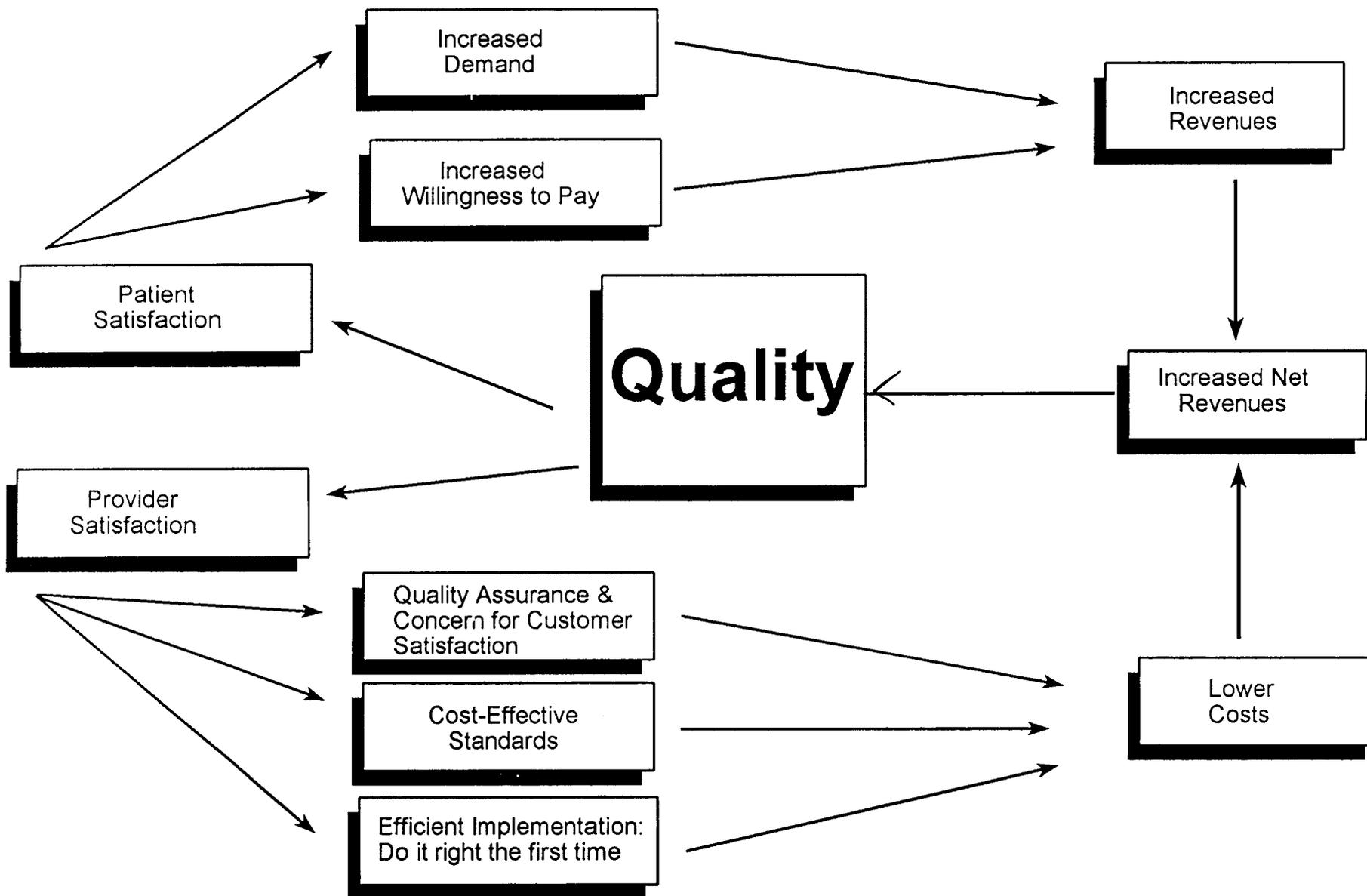
Few African health ministries adequately fund the costs of essential drug supplies or other needed quality improvements (e.g., health worker training in drug prescription protocols, protocol development, drug distribution networks and inventory systems, health worker supervision and in-service training in diagnostic and treatment practices.) Filling these funding gaps has inspired many cost recovery efforts in African health systems. But little research to guide reform has been done into the complex interactions between quality and costs and effective approaches to financing the costs.

Quality improvements may help to generate additional revenues, but their effects on costs, hence net revenues, are not well known. The cost recovery and quality flowchart (*Figure 3-1*) illustrates some of the important interrelations between quality, costs, and financing. Net revenues depend on two financial flows:

1. costs to providers of quality improvements (*the bottom path*)
2. revenues generated from patients' willingness to pay for quality improvements (*the upper path*).

The combination of increased revenues and controlled costs generates an increase in net revenues which can be channeled back into further improvements. Not all quality improvements lead to increased net revenues, but this model can be used to test the connections between different approaches to cost recovery and quality improvement.[40]

THE FLOWCHART OF COST RECOVERY



Source: Adapted from Wouters, A. and Velhuyzen van Zanten, T. 1994. "Helping Health Managers to Optimize Resources." Q.A. Brief 3(2). Center for Human Services, Quality Assurance Project, Bethesda.

What implications do quality improvements have for financing policy?

The costs of quality improvements have at least two implications for cost recovery reforms and financing policy. First, because increased use due to quality improvements raises total costs, plans must be made to meet costs of a larger drug supply and other medical supply and administrative expenses directly associated with increased utilization. These variable costs must either be recovered through user fees or government must plan on budget increases to cover them.

If revenues from user fees do cover variable costs, then MOH budgets can be redirected to paying for quality improvement expenses that remain constant regardless of volume (fixed costs), especially those that enhance the cost effectiveness of the health sector.

Second, the costs associated with improving quality and utilization must be controlled to yield a net increase in revenues. A surplus from user fees can be spent to make further improvements or to reduce the need for public subsidies. Current emphasis on drug availability as the prime quality improvement illustrates this point. *(See the box below)*

QUALITY IMPROVEMENTS, DRUG AVAILABILITY, AND COST CONTAINMENT

With the current emphasis in Africa on medicine availability as the prime quality indicator, ministries of health could easily have to double or triple their spending on medicines. As drugs become available, utilization usually increases, and more drugs than ever are needed. This cycle could tax MOH budgets *unless* drug and related inventory and distribution costs are recovered through user fees. Some initiatives in Africa have recovered 100 percent of these costs.[38] In other cases, full cost retrieval may require higher fees than government wants to charge.

One way of improving quality and containing drug costs is to improve efficiency in drug-prescribing practices. Also, assuring an adequate stock of essential, generic drugs simultaneously reduces costs relative to brand name drugs, improves effectiveness of health personnel, attracts patients to the facility, increases their willingness to pay for services, and improves worker productivity by increasing the number of patients treated. Thus, appropriate drug policies are likely to be among the single most important policy actions that could simultaneously improve quality, efficiency, effectiveness, and financial sustainability of health care in Africa.

To tap peoples' willingness to pay for health services, ministries of health need reliable ways of measuring patient satisfaction with specific aspects of quality. At the same time, these ministries need to expand popular notions about what constitutes quality and their capacity to assess other dimensions. Sophisticated consumers are one of the best protections against a drug-skewed, financially strapped health system.

QUESTION 12: How do fees affect access to health care?

IN BRIEF: Fees play a less important role than once thought in determining people's use of health care under cost recovery programs in sub-Saharan Africa. When other factors affecting demand for health services are taken into account, the modest fees usually charged create much less of a barrier to utilization than may have been expected, especially in the case of primary and preventive care services. Equally and sometimes more significant obstacles are distance and poor quality. People accustomed to paying private sector fees may save money under public cost recovery programs.

Do fees deter people from using needed health care services?

Introducing or increasing fees at government facilities represents a price increase and, unless other changes are made, is likely to reduce the number of government services patients seek. But price is only one of several important factors that determine whether or not people seek health care and whether they seek care from government or other health providers. Time and travel costs, perceived quality, perceived benefit, income, education and cultural factors also influence their decisions.

Empirical evidence on the impact of fees under cost recovery reforms is hard to sort out because of the complex interaction of all these factors and methodological difficulties. But evidence is building up from Africa's experience with cost recovery that suggests that factors other than fees — especially perceived quality and geographic access (as measured by distance from the health facility) — have a stronger impact on utilization.[6,9,10,21,27] (*See Questions 4 and 9*)

- ▲ In six African countries (Cameroon, Gambia, Niger, Sierra Leone, Sudan, and Zaire), improved quality has more than offset price effects of user fees, resulting in net increases in utilization of health services. [5,7,9,21,28,29]
- ▲ In a project in Cameroon, the probability that a sick person would visit a government clinic was 25 percent higher when fees were charged and quality improvements were also made.[21]
- ▲ In a pilot test of cost recovery in Niger, initial visits increased 40 percent overall, and initial plus follow-up visits increased by 70 percent in one district. Among the poor, the utilization rate doubled. In another pilot test district, utilization held constant, but it declined in the control district where no cost recovery or quality improvements were made. In both test districts, geographic access was more important than fee levels in determining people's use of services. [8,44]

What do decreases in use mean?

After an initial decline, utilization sometimes regains previous levels. For example, in Lesotho after a fee increase and declines of between 40 percent and 51 percent in use, patient traffic regained pre-fee increase levels in most areas. Similar rebounds in utilization were reported in the Gambia, Ghana, Swaziland, and Zaire, although it is not known if utilization regained previous levels.[7,29,32,36,45]

Decreases in traffic at government health facilities after the introduction of user fees does not always signal an absolute drop in use of health services. Some patients may switch to private providers. In Lesotho, for example, an initial decline at government facilities was accompanied by a utilization increase of between 19 percent and 35 percent at private facilities. In Swaziland, a drop in utilization was partially offset by increased use of mission facilities which reportedly lowered their prices.[27,45]

User fees are sometimes deliberately used to redirect patients from over-utilized hospital-based services to appropriate and less costly services at lower levels.(See *Question 17*) Excessive use of medicines can be deliberately curtailed for quality reasons.[3,4,27]

How can a fee system cost users less than a "free care" system?

Not all "free care" is without cost to users.[1,9] People often spend large sums for travel to health facilities and for food for relatives who are hospitalized. "Free" government services are costly if low quality prompts patients to forego treatment or resort to expensive, sometimes distant private health providers or pharmacies. In Cameroon and Niger, for example, user fee systems save people money, especially the poor. People spent less of their own money on health care at government facilities than they had under the official "free care" system. In Cameroon, the most savings came from reduced time and travel costs. In Niger, households that used the improved services at government health facilities saved 50 percent over what they had previously spent on each episode of illness.[9,21,40]

Do fees discourage use of preventive services?

This is an important question, but there is too little evidence to answer it conclusively. Sub-Saharan Africa offers few examples of cost recovery programs that impose fees for preventive services where this question has been evaluated. What evidence does exist, however, suggests that people are often willing to pay for some preventive services and that at least *token* fees may not inhibit use of these services. There is also evidence that people undervalue services provided free of charge.[13,23,27]

- ▲ In 1990, more than half of 79 countries surveyed had some method of raising revenue for immunizations under the Expanded Program on Immunization (EPI), and 15 percent reported that people sought vaccinations from private providers where they paid fees.[25]
- ▲ In a pilot test in Niger, use of prenatal care increased by 10 percent after the introduction of fees and quality improvements for curative care.[43]

- ▲ In Burkina Faso, cultural factors and distance from the health facility had a stronger impact on use of immunization than did fees.[2]

- ▲ Many programs for social marketing of contraceptives have demonstrated people's willingness to pay for family planning services.

QUESTION 13: Does cost recovery reduce equity? Do fees always hurt the poor?

IN BRIEF: Charging people who can afford to pay fees for health services and providing fee relief for the poorest people improves equity compared with "free care" health systems. When used to improve quality at public health facilities, user fees can save time and money for the poor compared with free-care policies that leave health facilities without sufficient funds for good care. In these cases, the poor benefit even more than the better-off who often already have access to a wider range of health care. Specific evidence about the impact of cost recovery on the poorest people is limited, however, since most studies do not distinguish adequately among socioeconomic groups.

Can user fees be reconciled with equity?

Compared with "free care" systems, cost recovery programs can improve equity by charging people who can afford health services and using public monies for subsidies to people who cannot afford to pay. When government provides health services free-of-charge to all, many non-poor households use services they could pay for and crowd out the poorest from care they could receive.

- ▲ In Tanzania, patients from highest income households represented 35 percent of the inpatient load and 37 percent of outpatients at "free" government-run hospitals. Patients from the poorest households represented only 16 percent of inpatients and 9 percent of outpatients at these hospitals. In a separate study, 60 percent of highest income households, expressed willingness to pay fees of Tsh200 (approximately \$1.00) or more if drugs would always be available at the public hospitals.[1,27]
- ▲ In Nigeria, half of the highest income households used free or highly subsidized public clinics and hospitals. Highest income households were also five times more likely to use private hospitals (25 percent) as were poorest households (5 percent), a clear indicator of willingness and ability to pay private fees.[27,39]

Inequities for the poor could often be redressed by improving the administration of fee collection and exemption systems. For example, civil servants and members of the military frequently receive exemptions from payments owed under their government employee health plans although they are better able to pay than many others. Students and friends and relatives of hospital personnel, whether or not better-off than paying patients, also receive fee exemptions. When government health plans do not reimburse public hospitals and health centers for services delivered to civil servants and similarly exempt groups — a common practice — the government, in effect, subsidizes these groups with general tax revenue that is designated for health services for the broader population. These practices also use up government resources that could be allocated to improve access for lower income households.

Do user fees hurt the poor more than the better-off?

The cost of health care is likely to be harder to absorb for the poor than the non-poor and may present the poor with an insurmountable obstacle to seeking services. Poor households not only have less cash than better-off households. They are less likely to be able to borrow funds to pay for health care and more likely to have to sell their assets to pay for a major illness.

Evidence about the impact of health service fees on the poor, and on the poorest compared with the better-off, is inconclusive, however. Many studies that look at the effect of fees on utilization neither distinguish among income groups nor take account of other changes that might affect use of health services. The few studies that have looked at these impacts by income level—for example, in Côte d'Ivoire, Kenya, Cameroon, and Niger—suggest that the poor are more sensitive than the non-poor to changes in the quality and the time-price of care, but not necessarily to prices as represented by user fee levels.[9,10,11,21,27]

Fees for health services are often among the smallest components of health care costs in African countries, especially for primary care. Even when health services in public facilities are nominally free, people spend substantial sums for health care. These other costs can be higher for the poor than the non-poor because of longer distances and higher travel costs to facilities, greater reluctance to miss work, and quality deficiencies at public health facilities that do not have user fees or reliable government funding. Poor patients are likely to suffer more than non-poor patients when clinics run out of drugs because they either go without medication or spend scarce time and money traveling to other, frequently expensive drug sources.

Modest user fees that make better and less costly services available than alternative private sources of health care can only benefit, and not harm, the poor. Policies that reduce travel or waiting time are more likely to raise utilization rates for the poor more than for the non-poor.

- ▲ In Cameroon and in Niger, after the introduction of health care fees, drug stocks improved. Not only did use rise more for the poor than the non-poor, but it also rose more for people living farthest from the health facilities.[9,21]
- ▲ In Tanzania, only 4 percent of the lowest income households said they would not pay fees for government health services if drugs were always available. Twice as high a proportion (8 percent) of highest income households were unwilling to pay fees for improved government services—perhaps because the better-off already have better access to alternative sources of care.[1]
- ▲ In Niger and the Central African Republic, the lowest income households were as willing to pay higher fees to maintain drug supplies in public health facilities as higher income households. In the Central African Republic, rural households were more willing to pay higher amounts to assure availability of medicines for priority diseases than were urban households, which had greater accessibility to health services and medicines.[9,34]

Does this mean that government need not be concerned about the impact of health care fees on the poorest households?

No. It means that ministries of health need to make greater efforts to distinguish among income groups in designing and evaluating cost recovery programs. Even in the world's poorest countries, there are differences among income groups that the national averages mask. User fees at the levels usually charged have not proven to be major barriers to use of health care for a large majority of the population in sub-Saharan Africa. But the poorest people will need protection against the additional impact of user fees, especially for inpatient hospital stays, on what are often already high costs of health care. *(See Questions 14 and 15)*

Protection against user fees will not alone solve problems of access for the poor. Improving equity of access to health care for the poor will also require removing or compensating for non-monetary barriers — distance, education, culture, quality perceptions — that pose an equal or greater obstacle than fees for service.

QUESTION 14: Are there effective and affordable ways to protect the poor when cost recovery reforms are introduced?

IN BRIEF: Policies that protect the poor and other target groups vary in both cost and likelihood that they can be administered effectively in African settings. Trade-offs exist in targeting programs between accuracy and cost. At some point, accuracy could be improved — but at greater cost — reducing the amounts available for providing services to the poor. More field experience and testing is needed to find cost-effective approaches to protecting the poor under cost recovery.

What is targeting and how does it work?

Targeting policies can be designed to protect the poor and other high-risk groups in systems where fees are charged. Targeting can take several forms, identifying people by:

- ▲ individual means testing based on income or indicators of income
- ▲ group characteristics (age, gender, occupation, infectious or chronic disease condition)
- ▲ geographic location (region, city or country, specific neighborhood)
- ▲ self-selection (everyone who goes to a specified place for a free service).

Individual means testing is the best way to identify who is "poor," and therefore eligible for reduced prices or free care, and who is not. Depending on how individual means testing is administered, however, it can also be the most costly targeting method. For example, means tests that require wage, earnings, income, or tax records are more expensive to administer than informal identification by a health worker in a small community. Both methods cost more to administer than geographic targeting, under which everyone in a certain area is automatically considered poor and therefore eligible for reduced-price or free care.

Can means testing be both accurate and affordable?

A trade-off has to be made between the cost of achieving accuracy in identifying the poor and the non-poor and the most effective methods of assuring that people are not excluded from care because of low income. The less accurate the targeting method, the more non-poor can capture the benefits or the more poor people are missed. On the other hand, money used for administrative costs of improving accuracy could be used to subsidize health services for the indigent, high-risk, or other target group. This trade-off means that the most accurate targeting mechanism is not necessarily the best. There is a point where the additional cost of administering a very accurate means testing system is higher than the cost of providing services free to some of the non-poor.[35]

What are some of the factors influencing the cost and accuracy of means testing?

Means testing costs and accuracy are influenced by a variety of factors, including population density, record-keeping capacity, and prevalence of formal employment, seasonal fluctuations in income, literacy, central registration of beneficiaries, measures to verify information, and administrative discretion in identifying applicants. Usually, it is easier to distinguish informally between people who can and cannot afford to pay user fees in small communities and at small health care facilities than in large urban areas and at large urban or district hospitals. At the same time, higher prices for hospital care than for primary health care make it more necessary to have a method for ensuring that the poorest people are not refused hospital care because of an inability to pay.

Some research has been conducted on methods that contribute to means testing accuracy and cost containment in Latin America, Africa, and Asia, but this information has not been combined to assess the relative cost-effectiveness of different approaches in any of these regions.[11,12,14,16,17,37] Other than cases in highly localized situations, models and best practices have not been documented (*See Question 15*). Developing and testing alternative means testing and other targeting procedures for the poor, estimating their costs, and assessing their effectiveness are among the top priorities for protecting the poor under cost recovery programs.

QUESTION 15: What policies and practices are used to protect the poor in Africa?

IN BRIEF: Means testing policies and practices in Africa are usually administered locally with informally applied eligibility criteria. Informal means testing and "community solidarity" — government's most commonly used methods of protecting the poor — may be less widespread than targeting groups by non-income related criteria (e.g. civil servants, students, the military, tuberculosis patients, the handicapped). Though scanty, the evidence on effectiveness of informal means testing in Africa suggests that fee waivers are often siphoned-off to the non-poor and that many of the poor fail to receive exemptions. Ministries face key policy trade-offs between exemptions for the poor, compared with other target groups, and between revenue raising goals, compared with the economic and political need to exempt the poor and other special groups from fees.

What national policies exist and how are they applied?

Many African countries have a national policy that supports exemption of the poor from fees for health services. These policies rarely specify criteria or procedures that should be used to identify poor patients, however. About half the countries in Africa appear to have no official national policy to protect the poor from health service fees.[24]

- ▲ Only 14 documented cases of health sector means testing in Africa were located out of 56 projects using means testing in a recent survey of developing countries.[35,37]
- ▲ Surveys have identified just two countries with means testing systems specifying income cut-off levels (Zimbabwe and Ethiopia), one (Lesotho) with specific, strict criteria related to land and livestock ownership, one (Malawi) using landholding structure, and more than a dozen other African countries with official general exemptions for "the indigent" but no clear criteria for the health facilities to follow.[11,24,27]

Most means tests and fee exemptions for the poor for government health services in Africa are applied loosely and informally at health facilities at the time a patient seeks care. Social assistance programs are also often administered locally and informally, relying on the word of the applicant or of a community leader. Many recent health financing initiatives in Africa rely extensively on these official and unofficial informal mechanisms to protect the poor.

Because of the potential for abuse of exemptions at the face-to-face, local level, "everyone must pay" is often the prevailing practice for health financing reforms that involve only modest fees for outpatient services and medications.[20,38] When all are required to pay, informal, ad hoc arrangements and community or family "solidarity" are frequently counted on to pay for the truly indigent.

How effective are current practices?

While informal means testing policies — both official and unofficial — are widespread in Africa in the public and the NGO health sectors, little documented evidence exists of the effectiveness of these policies in providing fee exemptions or reductions for the poor. Reviews of country practices have concluded that means testing in African countries is limited in scope (e.g., Nigeria, Burundi, and Kenya), ineffective in practice (e.g., Uganda), or non-existent. Many constraints undermine the development and implementation of effective means testing systems in developing countries in general. Rare in African countries are "ideal" conditions for effective means testing (e.g., formal wage records, high literacy, steady income, strong administrative and information system capacities).[11,24,35]

When both fee exemption and fee collection policies are loosely administered, few people are required to pay. In such cases, it is often the non-poor who receive the lion's share of exemptions.

- ▲ Civil servants and their families in the Central African Republic before reforms were adopted received care in the central hospitals without paying their share of the bill and without government's reimbursing the facility for its share of the bill. These exemptions represented 40 percent of the inpatient hospital caseload.[34]
- ▲ Hospital patients in Mali are supposed to show a certificate of indigence to obtain a fee waiver. In practice, facility workers often waive fees without certificates, and civil servants and their families typically receive care without paying their copayment under the government health plan. In one Malian hospital these exemptions represented 70 percent of the caseload. [31]
- ▲ In Ethiopia a country where a high proportion of patients pay, exempted patients are required to go through a formal, centrally administered application process in advance of needing care.[37]

In contrast to means testing for income-related exemptions, exemptions targeted to groups based on occupation or other characteristics (e.g., civil servants, students, handicapped) are easier to administer. They are also more prevalent in African countries and likely to be more effectively applied, judging from the high proportions of exemptions reportedly granted to such groups in government health facilities.

One of the main equity issues in relation to cost recovery programs in Africa is to develop effective, administratively feasible, and low-cost methods that work as well for the poor as they do for other target groups. In doing so, ministries are likely to face trade-offs in their goals for exempting the poorest in addition to special target groups, while also trying to achieve the revenue raising goals of cost recovery. Achieving both the revenue raising and equity potential of cost recovery in sub-Saharan Africa will require finding ways to improve both fee collection and exemption practices.

How could exemption systems for the poor be improved?

Experience from targeting programs around the world suggests that health ministries can enhance their accuracy in identifying people who cannot afford to pay fees for health services by designing exemption policies with the following features:

- ▲ incentives for the administrators of the policy to give exemptions only to the truly poor, (e.g, by allowing the facility to keep fees)
- ▲ clear, formal qualification criteria, leaving administrators little leeway for exemption abuse
- ▲ periodic renewal of exemptions, exemption criteria, and payment categories
- ▲ routine measures to verify information
- ▲ local or central government involvement in the screening, registration, or verification process (instead of putting the entire burden on facilities)
- ▲ sharing of information and administrative capacity with programs that provide exemptions in other sectors
- ▲ use of other targeting methods in combination with means testing
- ▲ determination of eligibility for exemptions in advance so that uncertainty about the fee will not discourage use of health services by the poor.

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TOPIC 4

ALLOCATION, EFFICIENCY, AND EFFECTIVENESS

TOPIC 4. ALLOCATION, EFFICIENCY, AND EFFECTIVENESS

Governments everywhere, pressed for cash, have to rethink priorities to get the best value for their resources as they try to satisfy many competing demands. To stretch their budgets, as a complement to financing reform, governments could devote more of the public health care budget to basic services and less to hospital care. This reallocation could make a big difference in a nation's health, according to many analysts, at the same time improving both efficiency and effectiveness of public health spending.

Basic services include immunizations, prenatal and delivery care, family planning, and curative care for acute respiratory infections, tuberculosis, sexually transmitted diseases (STDs,) and other common childhood and adult ailments. Health centers, health posts, or dispensaries could deliver most of these services. A basic package of health services for a year, covering 98 percent of the usual problems, would cost about \$8 per capita in low-income African countries and about \$11 per capita in higher income African countries. A full package of health, water, sanitation and institutional support services would cost \$13 per capita in low-income countries and \$16 in wealthier countries. [19,20]

Central to a good primary care system are supplies of generic essential drugs, community support, quality controls, effective management of personnel, medicines, and supplies, and a network of primary care facilities and first referral hospitals. This would entail financing and resource allocation reforms to achieve:

- ▲ increased support for the primary care and district hospital networks
- ▲ reduced government and increased private funding for central hospitals and other tertiary care referral hospitals
- ▲ broadened financial autonomy for public health facilities.

Major inefficiencies could be addressed by ending medicine and supply shortages, combining multiple outreach trips for special services, curtailing overstaffing at urban and hospital facilities, and improving quality at rural public health facilities to attract more patients. [3,19,22] Poor quality care, especially inadequate supplies of medicines, can lead to inefficient health care services as disgruntled patients seek attention elsewhere, reducing overall cost-effectiveness of services and health worker productivity at the clinic perceived to be deficient.

Individuals, too, could learn to spend more wisely the money they already spend on health care. Well-designed health financing reforms, with appropriate incentives for informed use of the system, could help people save money and improve their health. [11,17,19]

Few African ministries of health (MOHs) have yet made an all-out effort to reallocate resources in ways that improve efficiency and effectiveness. For that reason, hard evidence is slim on the ability of the recommended reforms to achieve their goals. For now, health ministries are weighing the general merits and feasibility of reallocating public resources and using financing reforms to change the way people use health care services. *Topic 4* deals with questions about this course of action.

QUESTION 16: How can governments better use their budgets to improve their people's health?

IN BRIEF: Government has so many competing claims on its limited resources that it has to consider rechanneling its health care spending into services that will do the most good for the most people at the least cost. Management reforms and quality controls could also improve health worker productivity and general health care. These measures that complement financing reforms are particularly difficult and ministries need to build consensus for them.

Specifically, what can governments do? Where should they put their money?

To improve the return in good health from scarce resources, governments could:

- ▲ allocate more resources to primary and secondary levels of health care and less to tertiary levels, leaving more hospital costs to be covered by non-tax sources of financing [1,19,21]
- ▲ allocate more resources to cost-effective curative and preventive services [20]
- ▲ allocate more resources to health education. The education of parents, especially mothers, is the most important determinant of children's health, more important than income and other relevant factors. Good health education is a cost-effective way of fostering healthy practices among the less educated. [7]
- ▲ improve efficiency by allocating health personnel according to traffic and by making sure they have enough medications and supplies to do their jobs. In many countries, 60 percent of MOH health personnel, located in the capital, serve barely a quarter of the population. Because of overstaffing, these personnel are underutilized, while health workers in rural areas are underutilized for lack of adequate supplies and medications, and even proper maintenance of equipment. By appropriately reallocating resources, ministries confronted by these and similar inefficiencies could improve health services to the general population without any additional funding. [3,21]

- ▲ institute efficient drug procurement and distribution procedures and require use of generic medicines. Waste and inefficiencies in procurement, storage, prescription, and use of therapeutic drugs are so widespread in Africa that patients of public health facilities may be using only \$12 worth of drugs for every \$100 of MOH budget money spent. [19]
- ▲ increase capacities for quality control and related regulation of private providers and suppliers to help reduce delivery of ineffective, over-priced, or unnecessary treatment and drugs. [8,9,11,22]

Why does reallocating spending seem to be so difficult?

Many African health ministries recognize these inefficiencies but find significant steps toward change difficult to take. Many of the most important actions they could take — in areas such as employment, geographic assignment of health workers, making less expensive generic drugs available in public facilities, or favoring primary care over large hospitals — involve touchy political considerations and strong group interests. Health financing reforms such as cost recovery initiatives can help fill the gap in some areas where government has been unable to reallocate needed resources. Other aspects of cost recovery, such as using fee revenues to create different incentives for health workers, may also give ministries some of the additional leverage needed to allocate public resources efficiently.

"Technical" considerations, cost-effectiveness analyses, and efficiency calculations may all help make the difficult choices required in major reallocation decisions. But, for implementation, government administrators need to build consensus among public health personnel, mobilize political resources, and negotiate trade-offs among competing interests.

QUESTION 17: Can financing reforms help households to spend their money for health care more effectively?***In Brief:***

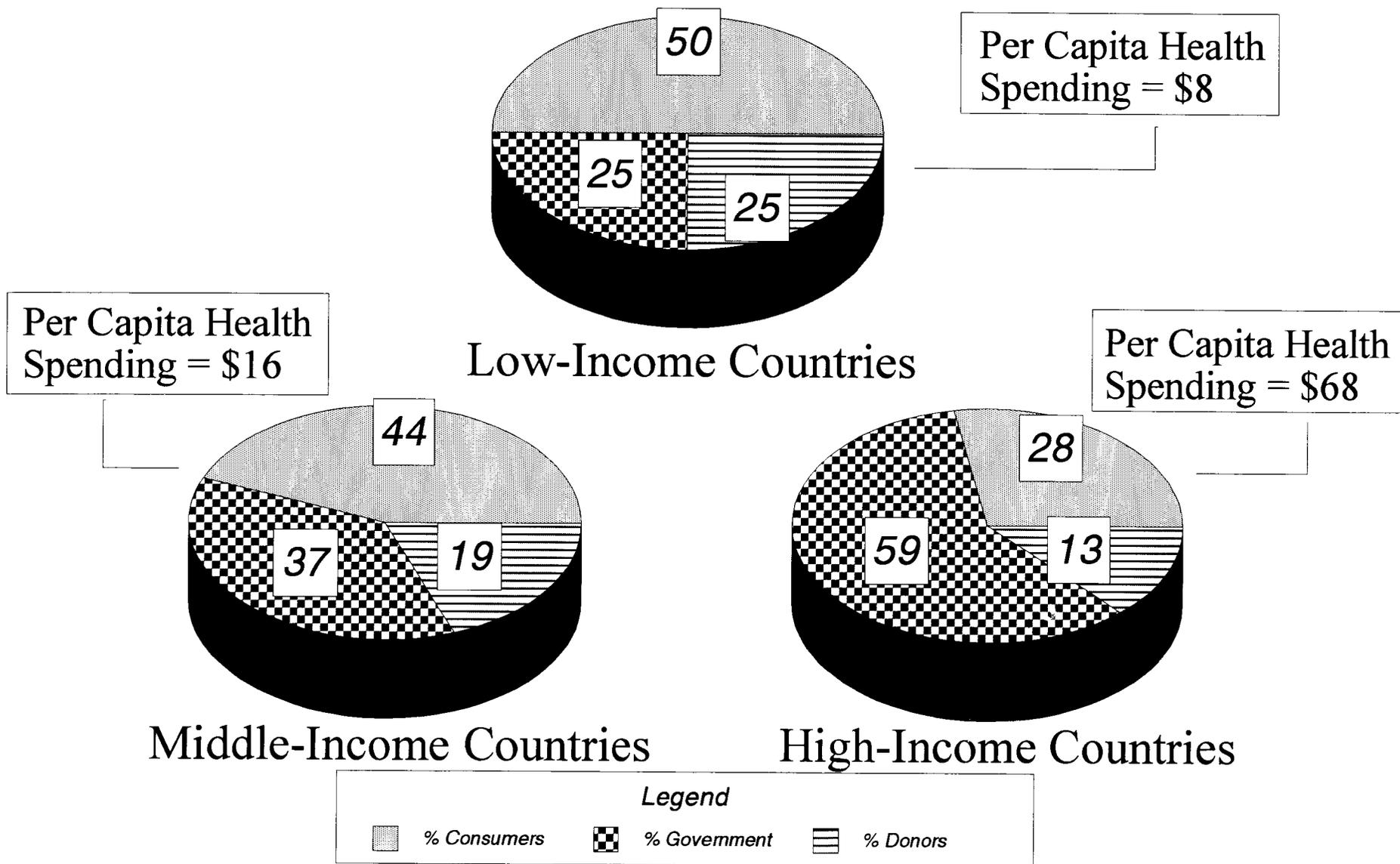
Yes. Most African households already spend a good part of their own budgets on health care, especially medicines, but much of this spending is likely to be ineffective. Through user fees and copayments, governments can use prices to influence consumer spending on health care, usually in ways that help people save money and make the health system more efficient at the same time.

How much do African households spend on health care?

Many households spend as much as government does per capita on health care, sometimes more. Among 23 countries in 1990, individuals in the eight lowest income African countries (\$225 a year per capita), spent \$4 per capita, while government and international donors each spent \$2 per capita on health annually. In the four highest income countries (average of \$757 per capita), on the other hand, consumer spending on health care amounted to \$19 per capita annually, against government's \$40. [19]

Private spending thus accounts for an important share of the spending on health care in sub-Saharan Africa (between 28 percent and 50 percent, depending on the country). Government's share is between 25 percent and 60 percent, and external donors fund the rest (between 13 percent and 25 percent). [19] (*Figure 4-1.*)

FIGURE 4-1. PUBLIC VS. PRIVATE SPENDING ON HEALTH CARE IN AFRICA, 1990



Data Source: World Bank 1994.

How do spending patterns differ between low and high-income African countries?

There are strikingly different spending patterns among countries at different income levels in Africa. Government's contribution to health care is smallest in the poorest countries. This means that household spending has the greatest impact on total health spending in the lowest income countries, where 66 percent of the continent's population live. Government represents the largest share of total health spending and has the largest impact in the highest income countries, covering about 5 percent of Africa's population.

In the short run, questions of allocating resources more efficiently rest equally with households and governments in the lowest income countries and largely with government in the middle-income and higher income countries. Low-income countries, spending \$8 per capita (including donor funding) on health annually, need to raise absolute levels of spending as well as spend current limited resources as wisely as possible. At \$6 per capita, the household and government share of this spending falls short of the World Bank's benchmark estimate of \$8 per capita for a package of cost-effective health services, and well below \$13 per capita for the full health package that crosses sectors and institutions.

Better-off African countries, spending \$68 per capita annually on health, probably need to concentrate strongly on allocating these substantially higher sums effectively. They may need to assess whether their higher spending really buys 17 times better health care than their poorest neighbors receive. Current per capita spending in the wealthier countries also far exceeds the estimated cost (\$16 per capita) of a basic package of health, water, sanitation and institutional support services. In these countries, consumer spending alone at \$19 per capita could cover the costs of the full basic package.

How do people spend their health care money?

People spend most of their health care money on medicines.

- ▲ In the Central African Republic, household spending on drugs alone was equivalent to 47 percent of combined government and donor health expenditure in 1990. [13]
- ▲ In Niger, the proportion of drugs bought privately rose from 70 percent in 1980 to 80 percent in 1989. Despite high prices and distance from drug outlets, Nigerien households bought drugs for 43 percent of illnesses. [15]
- ▲ In Mali, 90 percent of sales by the pharmaceutical-importing parastatal was to households, accounting for more than 50 percent of estimated expenditures on health services. [18]

People spend money on many other types of health care as well — and from many sources: for modern, traditional, ambulatory and inpatient care, delivered at private, mission, government, non-hospital, and hospital facilities. Payment for preventive services is also more widespread than commonly believed. (*See Question 12*)

Is this money well spent?

About 90 percent of household spending on medications in Africa is usually a waste of money, traceable to inefficient systems for buying, distributing, and prescribing drugs.[19] Government health facilities can typically sell generic drugs for 75 percent less than people pay private pharmacies for brand names. Households could do more for their health by putting money saved by purchasing generic drugs into basic preventive and curative services, whose timely use can reduce their chances of needing expensive hospitalizations. Using basic services at nearby health centers and health posts as the entry point to the health system can also cut the costs of time and travel for outpatient services.

How can financing reforms help households change their health care spending habits?

Health financing reforms based on user fees, public information campaigns, and health education, can motivate households to switch from costly treatments to equally beneficial but less costly treatments. Prices can also prompt people to choose generic drugs over brand names. Cost recovery initiatives that make low-cost, essential medicines available closer to home can save consumers large sums.

One of the most important functions of cost recovery reforms is to establish user fees and copayments that signal the most appropriate level of care in choices among primary, secondary, and tertiary health facilities, and that encourage use of cost-effective services for improving health status (e.g., family planning, immunizations, prenatal care, and safe delivery services.) [1,5,17]

- ▲ In Senegal and Ghana when fees existed at the primary care level but not at hospitals, patients crowded into hospital outpatient units and left rural health facilities empty. In 1991, 11 government hospitals in Ghana saw twice as many outpatients as the entire rest of the government health network. [17]
- ▲ Malawi, Zimbabwe, Niger and the Central African Republic have all structured their fee systems with the highest user charges for outpatient care at central hospitals, medium charges at district hospitals, and lowest at primary care facilities. [6,10,12,17]
- ▲ In Kenya, after hospitals introduced fees, use of their outpatient services declined by 37 percent, while use of government dispensaries, which remained free-of-charge, increased about 10 percent. [1]
- ▲ In Sudan, after hospitals introduced user fees, former outpatients also sought less costly treatment lower in the system, and overcrowding eased at hospitals. [2]
- ▲ In Kasongo District in Zaire, user fees cut back use of the district hospital as a first point of service by 90 percent and quadrupled attendance at district health centers. [17]

- ▲ In Zambia, however, despite coordinated fees, hospitals are still flooded with outpatients, and health centers remain underused. [1]

Thus, though promising, coordinated pricing between various levels of the health system does not guarantee efficient use of health services. Buttressing measures such as quality control and improved referral procedures are usually needed.

Both households, with so many out-of-pocket expenditures for health care, and governments, with so many pressures on resources, have strong self-interest in getting the most for their money. The impact of user fees and copayments on health care use suggests that governments can play a major role in that quest by providing incentives through appropriate financing reforms and by making cost-effective services and low-cost generic medicines more widely available.

QUESTION 18: Can hospital autonomy help governments reduce hospitals' share of the public health budget in favor of primary health care?

In Brief: "Hospital autonomy" is one of the longer run goals of financing reforms that seek to increase cost recovery in hospitals. Several African ministries of health have begun to phase in partial financial and managerial autonomy for hospitals. Experience elsewhere in the world suggests that insurance is necessary for full autonomy to be a viable option. Autonomy largely based on health insurance may free the government from funding some public hospitals but brings with it possible trade-offs in efficiency and equity for the health system as a whole.

Why consider hospital autonomy?

Hospitals absorb between 40 percent and 80 percent of the public health budgets in sub-Saharan Africa. The predominance of hospitals in the funding picture reflects their heavy allocation of health personnel—and their salaries. Yet the same hospitals are underfunded for non-salary operating costs (e.g., medicines, X-ray and laboratory supplies, consumable equipment, laundry and food services). Public hospitals in most sub-Saharan African countries have long used inpatient fee systems, but often these fees are outdated, collected erratically, and not returned to hospital use. In any case, fees do not cover the shortfall between needed and available funds for minimum standards of care.

In addition to introducing user fees and cost recovery, many experts have suggested that hospitals should be given formal, legal status for financial and managerial autonomy, especially the large central referral hospitals. Under these proposals, hospitals could be fully autonomous or partially autonomous parastatals or could selectively privatize certain services (e.g., meals, laundry, laboratory testing). Hospitals receiving this status would be separated from the subsidized government health system in the hope of reducing government subsidies to hospitals. The public resources thus freed would be channeled into subsidies for preventive health care and services for the indigent.

Full management autonomy is thought to increase incentives for better use of resources by hospital staff. If freed from central MOH requirements, hospital administrators would have flexibility for hiring and firing employees, providing performance incentives, adjusting fee levels, and making efficient and timely purchases of medicines, other supplies, and equipment. Community or other public boards, perhaps with some MOH and local government members, would help to hold the hospital accountable.[1]

Have any African countries given large hospitals financial and managerial autonomy?

A few countries have begun to give government hospitals some legal and financial autonomy, but it is too soon to assess the results.

- ▲ Kenya, the Gambia, Niger, Côte d'Ivoire, and the Central African Republic have given partial financial and managerial autonomy to large central hospitals and district hospitals.[1,4,10,14,17]

- ▲ Burundi tested a phasing plan for granting full hospital autonomy by providing one 120-bed hospital a lump sum to cover the hospital's operating costs and reducing that grant by 20 percent each year thereafter. Given the success of the experiment, the MOH plans to use the same approach for its 600-bed central hospital. [19]
- ▲ Tanzania, Mozambique, and Kenya are privatizing selected services, beds, or wings in central government hospitals. [19]

The short-run goal of planned hospital autonomy in most African countries coincides with that of cost recovery in general: to cover non-salary operating costs and to improve quality with new revenue from user fees (and insurance reimbursement, where possible), while government continues to pay the salaries of hospital medical personnel. In the longer run, as hospital financing prospects improve with better cost recovery and possibly health insurance, these efforts may lead to full financial autonomy. (*See Question 7*)

What does worldwide experience say?

Financing reforms for public hospitals are too new in Africa to know if enough funds could be freed up to be reallocated to primary care and make a difference. Efforts in other parts of the world that have attempted full financial autonomy for hospitals through health insurance (e.g. Brazil, China, Korea, Thailand) provide some useful lessons. This other experience suggests that, with health insurance, hospital costs might be fully covered and relieve governments of funding responsibilities.

These efforts also raise several questions about whether this method can improve efficiency and equity for the health system as a whole. Health insurance can lead to skyrocketing costs and skew resources more toward tertiary level, high-technology care than before. It can create overuse by covered patients and inequities between the insured and non-insured, who are often less advantaged in the first place.[1,16] Few countries with widespread insurance have mastered these problems on a national level, even though a wide variety of utilization, quality, and reimbursement controls have been tried.

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Topic 5

NEW INITIATIVES: PRIVATE SECTOR AND SOCIAL FINANCING

TOPIC 5. NEW INITIATIVES: PRIVATE SECTOR AND SOCIAL FINANCING

Two additional possibilities for increasing access and expanding resources for health care are under scrutiny, as African ministries of health (MOHs) refine their cost recovery and resource allocation strategies:

- ▲ expanding the role of private providers in furthering public health goals (e.g., non-governmental health care providers, for-profit providers)
- ▲ finding alternative financing mechanisms for health care (e.g., private insurance, community-based social financing, employer-based insurance plans).

Both initiatives have a base in every sub-Saharan African country, but experience with expanding private services and health insurance is limited, and not every avenue has been exploited. *Topic 5* presents some of the most commonly asked questions and arguments for and against these initiatives.

QUESTION 19: Who are the private providers and what can they contribute to the public health agenda?

In Brief: Private health care in sub-Saharan Africa includes services provided by non-governmental organizations (NGOs), enterprises, for-profit medical personnel, and traditional practitioners. Depending on their size, scope, and nature of care provided in each country, these providers can help ministries meet goals for improving the availability, quality, and efficiency of health services and free the government of responsibility for people who can afford to pay. Ministries also need to take steps to avoid possible harmful effects.

What private sources already provide health care in Africa?

Private providers of health care in Africa include:

- ▲ non-governmental, non-profit providers of services who usually charge modest fees with exemptions for the poorest people. This group includes religious, community, and private voluntary providers.
- ▲ for-profit providers, who charge fees to cover costs plus profit. This group includes offices operated by individual physicians or nurses, privately operated clinics and hospitals, and traditional healers.
- ▲ employer-based health service providers, who provide selected services for employees and sometimes their families. This group includes company clinics and health personnel under company contracts.

What part do private providers play in the delivery of health care in Africa?

Non-governmental providers, especially church missions operating on a non-profit basis, are likely to be the largest private providers of western medical health care in most African countries. Usually, they serve rural and urban poor populations, providing curative and preventive care in both primary care and hospital settings.

- ▲ In Tanzania in 1991, for example, voluntary agencies were responsible for almost as much hospital capacity (11,341 beds) as the government (12,548 beds). [10]
- ▲ In Uganda, non-governmental organizations (NGOs) operate 36 of the 50 secondary and tertiary hospitals (72 percent, with 63 percent of the bed capacity). [13]
- ▲ In Zambia, mission bed capacity (6,358) is equal to 38 percent of MOH bed capacity and 25 percent of the country's total bed capacity.[2]

The number of *for-profit health service providers* and the complexity of services offered differs widely, within as well as between countries. *Traditional healers* are usually the largest group of individuals providing health care for a profit in sub-Saharan Africa.

Some countries have just recently authorized for-profit provision of western medicine (e.g., Tanzania, Mozambique), while others have had a for-profit western sector for many years (e.g., Kenya). In some countries, retired MOH personnel set up private practices. In others, ministries allow physicians to operate private practices outside their normal government working hours or to render services in private wings of public hospitals (e.g., Kenya).

- ▲ In Kenya, where private health care is perhaps the most developed, private for-profit providers own 25 percent of the health facilities, and church missions own 9 percent. MOH runs 61 percent of the health facilities, and municipalities run 5 percent. Nearly half of the tertiary level medical centers and hospitals are private or mission-operated. Maternity centers and nursing homes are almost entirely privately owned and operated for-profit. [4]
- ▲ In rural Zambia, traditional healers account for 12 percent of all health care visits; mission health facilities, 14 percent; and government facilities the rest. In urban Zambia, traditional healers account for 6 percent of visits; industrial and other private providers, 25 percent; and government, 69 percent. [2]

The importance of *employer-based health providers* depends on the number and type of industries in a country and the existence or not of insurance reimbursement mechanisms

BOX 5-1 QUALITY VS EFFICIENCY?

Many people insist that the private sector is more efficient than the public sector in providing health services. Others argue that the private sector sacrifices quality to efficiency. Actually, there is little evidence to confirm or deny either allegation.

- ▲ In Senegal, one study showed that—at about the same cost—non-governmental private providers (church mission facilities) were more efficient than public providers (as measured by number of visits per health worker). They also provided higher quality services (as measured by compliance with treatment protocols, other clinical factors, and patient and provider satisfaction). But the same study also found that for-profit providers and company-based clinics offered less efficient and lower quality care than the non-governmental providers.¹
- ▲ In Kenya, another study showed similarly mixed results. Using a quality ranking method, researchers found that of the top five overall quality scores, two were government and three mission facilities. The mean cost per outpatient visit was lower in government facilities than in mission facilities. The study concluded that generalizations about relative efficiency of government and mission health services could not be made and that management practices are more important than ownership in determining efficient provision of health services.²
- ▲ In Tanzania, less than half the church-based and other voluntary agency health facilities in Dar es Salaam followed acceptable clinical practice, a substantial percentage had potentially serious clinical errors, and many experienced stockouts of essential drugs.³

Sources:¹Bitran et al. 1994; ²Data for Decision Making Project,

as a substitute for directly provided employer health services.

- ▲ In Tanzania, where health insurance is in its infancy, half the 200 employers recently surveyed directly provide some kind of health services for employees through contracts with private or mission facilities or through their own clinics and hospitals. The rest of the employers had some kind of insurance or reimbursable arrangement. [10]
- ▲ In Nigeria, five large parastatals offer their employees and their families comprehensive health care at company facilities or under contracts with private hospitals and doctors. [16]

How can private providers contribute to public health goals?

An increase in the number and kind of private sector providers could help ministries of health to:

- ▲ improve overall availability and accessibility of health services and medicines, while relieving the government of having to provide that additional care directly
- ▲ increase availability of health services for the underserved, hardest to reach, and lowest income populations
- ▲ increase overall efficiency of health service delivery by permitting government to take advantage of efficiency gains by private providers
- ▲ reduce government funding for health services that people can and will buy with out-of-pocket or insurance-based payments.

Mission health providers, for example, could contribute to public health by maintaining and expanding their capacity for delivering high-quality services, especially priority preventive services, to poor and underserved populations at prices they can afford.

For-profit providers can contribute most by delivering care to people who could pay but who use free, or highly subsidized, public care. This would help to free public resources for people less able to pay.

- ▲ In Kenya, private health facilities provide about 20 percent of all childhood immunizations, about 16 percent of all maternal deliveries outside the home, and 24 percent of the diarrhea treatment in rural areas and 14 percent in urban areas. Mission health facilities treat between 20 percent and 30 percent of tuberculosis cases and diagnose and refer between 10 percent and 20 percent more. The high cost of TB medications in the private market has led to a reduction in the number of cases treated in the private for-profit sector. Missions, private hospitals and clinics, and private shops treat an estimated 27 percent of childhood fevers and coughs. [4]
- ▲ In Zambia, private health providers give 17 percent of all measles vaccinations in rural areas and 17 percent in urban areas. They also treat 22 percent of childhood diarrhea cases in rural areas and 24

percent of urban cases as well as 24 percent of the rural cases of childhood fevers and coughs and 38 percent of the urban cases. [2]

Traditional health care providers can contribute through their wide accessibility and users' confidence in them. Many African health ministries have furnished traditional health care providers with training and materials to upgrade the quality of their services. For example, retrained traditional birth attendants have long helped to widen rural and village access to safer childbirth services and to extend health education messages.

Employer-based clinics offer many people a range of quality health services and can make an important contribution to health services wherever they are prevalent.

How should ministries prepare for a large or expanding private health care sector?

Expanding private sectors can create public-private competition for patients and for health personnel. This competition can have beneficial or harmful effects depending on how it is handled. Government cost recovery initiatives and the financial sustainability of public health services could be jeopardized if for-profit providers draw most of the paying patients away from the public sector. Public health facilities with cost recovery underway need to be able to compete equally in price and quality with private providers.

In addition, increasing opportunities in the private sector and the prospect of larger incomes often attract health personnel away from the public sector. Employment conditions and incentives in the public sector need to improve in these cases. Many MOHs permit "moonlighting" to accommodate this situation, but few of them have yet found an ideal way to contain the abuses that can occur.

Many people argue that the private sector is always more efficient than the public sector and provides higher quality services. Given the wide diversity of private providers, however, such generalizations should be viewed with skepticism. Ministries generally need to increase their capacities for regulating quality, enforcing licensing and accreditation procedures, and monitoring facility health and safety standards as the private sector expands. (*See Box 5-1*)

QUESTION 20: How can government encourage private delivery of health care services?

In Brief: Laws, regulations, and funding arrangements have been government's main ways of encouraging or discouraging the growth of private health care providers. Permissive and supportive laws and regulations alone are often all that is needed for a private sector to begin to flourish. Ministries should undertake assessments to determine the cost-effectiveness of various public financial incentives for the private sector, compared with benefits that might come from spending the same sums to improve public providers.

What are the main options for support to the private sector?

Government can encourage private providers by offering them direct subsidies or contracts for specified services and/or services to target groups. They can also enact laws, regulations, and tax codes that create incentives or remove disincentives for the kinds of private services government wants.

Subsidies, paid in the form of bed grants, staff grants, equipment and basic operating grants, have been one of government's most common types of support to private providers. These subsidies have been offered almost exclusively to non-governmental health providers covering underserved populations.

Similar support could be given to company clinics or for-profit providers in underserved areas. Incentives can be created to expand coverage to the community with direct subsidization of important cost-effective health interventions. These providers can also be encouraged to add to their own service delivery base any services necessary to meet MOH priorities. A subsidy for the marginal cost of adding services may cost less than establishing or maintaining MOH capacity to serve that population.

To be reasonably certain subsidizing private providers is more cost-effective than improving or expanding existing government health services, however, ministries must run the cost and effectiveness numbers before acting.

Where do laws, regulations, and tax codes come into the picture?

Laws, regulations, and tax codes are very important for for-profit private sector health providers. Together with tight credit, the absence of such laws can do more to keep private providers from expanding than limited demand from a poor population. Both credit and law-making are within government control.

- ▲ Tanzania exemplifies the effect of legalizing private medical practice. After the broad legalization of private for-profit health practice, the number of all private health providers in the capital, Dar es Salaam, almost doubled, from 136 in 1991 to 253 by 1993. [10]

What is government already doing to encourage private providers?

- ▲ Zimbabwe and Nigeria grant tax relief to private voluntary agencies. Mozambique has recently adopted legislation to allow private voluntary organizations to establish health care facilities and to allow private companies to establish and run clinics for employees. [16]
- ▲ The Tanzanian government has traditionally provided most of the staff and financial support (95 percent of total costs) to non-governmental, voluntary agency health providers to operate 17 district hospitals owned by voluntary agencies. These public-private facilities, known as *designated district hospitals*, serve as key health facilities in the public health system, providing free medical services for everyone. Government pays the remaining voluntary hospitals subsidies equivalent to between 4 percent and 9 percent of their revenues. [10]
- ▲ In Zimbabwe, the health ministry spends about 4 percent of its budget to subsidize church mission health care for indigents. This subsidy is about 85 percent of the mission's revenues for these services. Zimbabwe is also trying to contract out to private organizations functions related to equipment, maintenance, laundry services, and insurance reimbursement billings. [13]

QUESTION 21: What are the main ways of sharing the risks or easing the burden of paying for health care?

In Brief: Patients or clients can pay the full cost of health care when they use a service, or they can pay through a variety of other methods, often called *social financing*. Social financing helps people spread the risk and cost of medical care by pooling resources, usually through premiums or tax payments to central or local governments. In sub-Saharan Africa, individual financing predominates in traditional health care. Social financing predominates in western medical care, mainly in the form of government-provided, tax-financed health services for the whole population. Private insurance is limited but on the rise in several countries.

What forms do social financing risk-sharing arrangements take?

Three broad types of social financing arrangements for health care are prevalent in Africa:

- ▲ government health services for the whole population
- ▲ traditional, formal insurance arrangements for public and/or private sector employees
- ▲ community-based insurance and prepayment plans.

Specifically, social financing for health services in sub-Saharan Africa is provided in different ways, including:

- ▲ direct government health care financed by general tax revenues (e.g. all government-provided health services)
- ▲ government-mandated health insurance for all employed workers, financed by taxes on employee wages and on the employer payrolls, and government-financed health benefits for all civil servants (e.g., compulsory social security for the entire formal labor market in Senegal and Mali, government-mandated employer coverage of health care in Zaire; Kenya National Hospital Insurance Fund for employees in the formal sector; government programs for civil servants in most African countries)
- ▲ voluntarily provided employer-sponsored health insurance plans that provide services either directly through on-site health facilities or rely on contracts with outside providers (e.g., Zambia, Nigeria, Liberia, Senegal, Zaire, Kenya)
- ▲ community-sponsored prepayment and rural insurance plans, under which households or adults pay a fixed sum once or twice a year, and sometimes a copayment at the time of use, for services delivered at a local health facility (e.g., in Zaire, the Bwamanda rural hospital insurance program; in Guinea-Bissau, community-level prepayment funds for primary health

care and drugs at village health posts; drug revolving funds in many localities; in Kenya, Harambee Movement funds for catastrophic illnesses)

- ▲ group and individual private health insurance plans (e.g., in Côte d'Ivoire, Ghana, Kenya, Senegal, Zimbabwe). [8,9,11,13,14,15,16]

How important is government-sponsored social financing in sub-Saharan Africa?

Governmental, tax-supported health care is by far the predominant form of social financing in sub-Saharan Africa. Free government health care for every person is the equivalent of universal health insurance, with no copayments or deductibles. User fees for cost-sharing are the equivalent of copayments for services. Theoretically, universal government systems draw on the largest risk pool by spreading the costs of health care across the whole population. In progressive tax systems, this financing structure involves strong elements of equity.

How common is traditional health insurance coverage in Africa?

Insurance and prepayment plans are receiving more and more attention as governments introduce financing reforms in the public sector. Health insurance with third-party reimbursement (via social security, other public insurance, or private insurance) is most common for wage-earners in the formal economy. Coverage ranges from none in many countries to between 15 percent and 25 percent of the population in Burundi, Namibia, Senegal, and Kenya. Health insurance is available primarily to urban and middle-income or upper income households. [13,15] Insurance coverage for employees is growing in many countries and has doubled in some (e.g., Senegal and Kenya) since the mid-1980s. [16]

The number of sub-Saharan Africa countries with formal health insurance systems has doubled from 7 in 1990 to 14 in 1993. Seven countries have social security systems that provide medical benefits, 15 countries require employers to pay for certain medical services, 17 have no formal health insurance system, and 8 have no information available. [13,15]

What else is going on in the realm of health insurance in Africa?

A variety of community-based, rural insurance and prepayment plans have been developed. (*See Question 22*) Employers and other groups in several African countries have also developed some informal insurance, prepayment, and benefit plans to share the costs of health services.

Employer innovations in health insurance and health benefit plans seem to offer more potential for social financing than once imagined for use in health care financing reform.

- ▲ In Zaire, employer-organized insurance plans provide about 30 percent of revenue in Kasongo Health District, which has 30,000 urban and 165,000 rural residents. About 60 percent of the district hospital's revenue comes from insurance, compared with about 13 percent at health centers. [13]

- ▲ In Zimbabwe, private insurers covered less than 5 percent of the population in the late 1980s. Yet insurance payments made up almost 17 percent of all expenditures on health care, equivalent to a third of central government expenditures. [13]
- ▲ In Senegal, private insurance grew rapidly in 1987–90 as 15,000 people enrolled in plans offered by eight companies. Total insurance financing doubled over an eight-year period, from F CFA 4.4 billion in 1981 to F CFA 8.8 billion by 1989. Current transfers through health insurance amount to about 20 percent of total health expenditures. [16]
- ▲ In Tanzania, 193 out of 200 employers recently surveyed had some kind of health insurance, prepayment, or benefit plan for employees. About half of them had contracts with private or mission health facilities or ran their own clinics or hospitals; 20 percent reimbursed employees' medical expenses; the remaining 30 percent used other variations on these two approaches. About 90 percent of the plans were open to all employees, and most covered at least some dependents. Under all public and private employee health benefit plans, 13 percent of the population (employees and dependents) is covered. [10]
- ▲ In Kenya, there are three broad types of health insurance arrangements: the government-mandated hospital insurance and workmen's compensation for employed workers, community-based Harambee Movement funds, and private insurance funds offering individual, group, and employer-based health benefits. About a quarter of the 38 registered insurance companies sell medical insurance separately; the other companies package some health insurance with other insurance policies (e.g., for fire, theft, motor vehicles). Most insurance companies are located in the capital, Nairobi, but they use about 3,000 brokers and agents to market their policies countrywide. These health insurance policies most often cover hospitalization, therapeutic drugs, and surgery. The number of group health insurance policies increased by 265 percent in 1980–91.

Private employers in Kenya are the main purchasers of traditional health insurance. Small or unregistered businesses hold about 20 percent of the health insurance policies. Employers provide either formal group insurance or reimburse employees for their health expenses (22 percent) or provide health services directly in a company clinic or by reimbursing another provider directly (30 percent). [11]

QUESTION 22: Are insurance and other forms of social financing appropriate for low-income rural populations in Africa?

In Brief:

Cost recovery reforms in the public health system prompt consideration of other financing arrangements to help sustain user fee systems and make them affordable and equitable for patients— especially low-income and rural households. These other arrangements— such as traditional individual or group insurance, various forms of prepayment plans, or community-based funds earmarked for health care—can be run separately from, or in conjunction with, the government system. Many countries already use some of these alternatives, especially variations of community-based plans, but their use could be further encouraged. Insurance also brings disadvantages that must be guarded against. Some lessons have been learned about appropriate measures to include in the design and implementation of these plans so that they are effective for low-income african populations.

As governments in sub-Saharan Africa look more and more to user fees to cover costs, what advantages do insurance and prepayment plans offer?

Most countries in sub-Saharan Africa that have undertaken major health financing reforms have concentrated on changes within the framework of the long-established, predominant form of social financing — tax-financed, free services provided directly by government. The main change has been the introduction of user fees, a form of copayment covering part of the cost of care in government health facilities. Introduction of these changes has raised the importance of other social financing mechanisms— especially traditional health insurance or simpler prepayment schemes— to complement and support user fees.

Insurance and prepayment plans are an additional means to:

- ▲ improve access and equity by spreading the risks and costs of health services across a large group of users
- ▲ reinforce cost recovery efforts by allowing increases in user fees. This mobilizes additional revenues to help fund public health services and frees resources for important public health services not covered by insurance.
- ▲ relieve the government's budget of responsibility for subsidizing health care, especially expensive hospital care, for people who can afford to pay
- ▲ encourage diversification among public and private healthcare providers
- ▲ improve the likelihood that private and public health providers will receive payment for their services.

How do rural insurance and community-based social financing work?

Under *community-based social financing plans*, each year people pay a fixed sum of money per household or per adult. These arrangements are based on the premise that people pay in advance to (1) protect themselves from possibly high and unaffordable health care costs and (2) spread the cost of health services over the sick and the not sick. If premium or tax payments are graduated according to income, comfortable households would also help to pay for lower income community members.

A community health committee usually manages these funds to support health services at the local dispensary, health post, or health center. Local committees set fees for services and medicines and make rules for exemption from payment (e.g., for the indigent, chronically ill, or disabled). Benefits are usually limited to services available within the community. African communities have used this form of community financing for both primary and preventive health care as well as for hospital care.

Several African countries are using *rural social financing and insurance plans*.

- ▲ In Niger, the Ministry of Health recently experimented with a social financing plan in a rural district as part of a test of alternative cost recovery methods for improving quality and use of primary and preventive health care services at non-hospital health facilities. The plan involved payment of a local tax of FCFA 200 per adult (\$0.78 before the 1994 devaluation) and a fixed copayment per episode of illness, with preventive health services (e.g., immunizations, prenatal care) free of charge. The copayment, higher for adults (F CFA 50, \$0.20 before devaluation) than for children under age 5 (F CFA 25, \$0.10), entitled patients to whatever medicines were needed for treatment. [5] Based on success of this plan, the government has authorized extension of the system nationwide. (See Box 5-2.)
- ▲ In Zaire, the Bwamanda health zone instituted an insurance program as a means of generating revenue for its reference hospital and organizing service delivery. People pay a fixed premium per household member once a year. The plan covers only hospital services and chronic care treatment in health centers. It is managed by the health zone and enrollment is voluntary, but the whole family must enroll, if one member does. When using hospital services, plan participants pay 20 percent of the uninsured patient fee. Enrollment rose from an initial 30 percent of the community in 1986 to 60 percent in 1989. Since the second year of operation, income to the plan from premiums and interest has exceeded costs of covered health services

BOX 5-2 LOCAL TAX + COPAYMENT

In a poor rural district in Niger, a social financing method using a local tax plus copayment for each episode of illness was found effective and acceptable in a pilot test. This method worked better than a direct fee-for service by raising more revenue, covering a higher percentage of medicine costs, receiving higher community satisfaction ratings, and resulting in higher utilization rates. Both test districts preferred social financing to a straight fee for service because they thought it was easier and less expensive at the time of use. In addition, lower-income as well as higher-income residents said they would be willing to pay higher taxes if that assured ready supplies of medicines.

Source: Diop et al 1994. [5]

for members. Administrative costs are only 5.7 percent of premiums. Hospital charges are about 90 percent of the plan's costs, and health center charges for chronic care are about 5 percent. Drug stockouts are rare. [14]

- ▲ In Guinea-Bissau, village-based systems of prepayment started in 1980 after government introduced user fees in the national health system. The prepayment funds (*abotas*) help assure a supply of a limited number of drugs at village health posts because people do not have cash available for much of the year. Details of each of the village systems vary, but most adults contribute twice a year and are given receipts entitling them to free consultations and drugs and any necessary free referral to the next higher level of care. Each village committee sets its own prepayment rate (e.g., flat rate per adult or higher for men), decides whether to accept in-kind payments, and decides who pays (e.g., all adults, men only, or households), and who receives free services without any prepayment (e.g., very poor, disabled, visitors who have emergencies).

In the 450 villages that have adopted these plans, 90 percent of their residents participate in them. But success has varied in recovering costs, maintaining drug stocks, and assuring improved utilization and quality of village health workers. To purchase more drugs, village sites surveyed have raised their initial prepayment rates at least once (average amounts collected per adult male in 1988 was the equivalent of \$0.20). Of the villagers surveyed, those who could were willing to pay more. Community control has protected funds from misuse. [6,18]

What are the drawbacks to insurance?

Many employer-based plans are less efficient for employers and less effective for employees than they might be. [3,16] Health insurance arrangements, when not carefully designed, can also lead to excessive costs and inequities between the insured and the non-insured. (See box 5-3.) The potentially negative effects bear special watching in the case of insurance covering hospital care. (See Question 18)

What are some earmarks of successful rural insurance and prepayment plans?

The still-limited experience with rural insurance and prepayment arrangements in sub-Saharan Africa suggests that successful programs:

- ▲ ensure good access to quality care

BOX 5-3 PROS AND CONS OF INSURANCE

If health care services are to be affordable as countries introduce fees, more extensive use of health insurance or prepayment will probably become necessary in public health facilities. If user fees rise high enough to cover total recurrent costs, these or other forms of risk sharing will be needed, especially for inpatient care at major hospitals.

But to be of greatest benefit to reform efforts, insurance plans must be designed to avoid common problems: overuse of services by insured people, inequity between the insured and the uninsured, high administrative costs, and cost escalation stemming from inappropriate provider incentives.

Source: Shaw and Griffin 1995; Barnum and Kutzin 1993; LaForgia and Griffin 1993. [13,1,8]

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- ▲ limit benefits to keep premiums and prepayments affordable
- ▲ set rates carefully to reflect expected utilization patterns and the population's ability to pay
- ▲ encourage cost-effective utilization by including some form of copayment for services at the time of use
- ▲ provide for flexible and convenient premium payments
- ▲ target subsidies carefully to provide the maximum incentive to enroll in the plan
- ▲ establish simple administrative, accounting, and control systems
- ▲ market the plan aggressively so that consumers are well-informed about benefits, improved quality and potential savings from enrolling. [12,13,16]

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