

Developing and Implementing a Resource Mobilization Strategy

Mukesh Chawla

Research Associate
Data for Decision Making Project
Department of Population and International Health
Harvard School of Public Health

Peter Berman

Associate Professor of International Health Economics
Department of Population and International Health
Harvard School of Public Health

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1. Introduction

As part of the overall strategy of US Agency for International Development (USAID) to conduct research into matters of critical importance to policy makers in developing countries, the Data for Decision Making (DDM) project at Harvard University was commissioned by the Health and Human Resources Analysis for Africa (HHRAA) project of the Africa Bureau to conduct five case-studies on resource mobilization. These studies were conducted in Cote d'Ivoire, Senegal and Zimbabwe within sub-Saharan Africa, and in Bolivia and Sri Lanka outside Africa.

At the onset of the project, a provisional conceptual framework was proposed by the principal investigators at Harvard University. This framework was intended to guide the assessment of the resource mobilization effort in each participating country, and assist in organizing the presentation of the data and results (see Chawla and Berman, 1995). The evaluation framework suggested a combination of qualitative and quantitative analyses of the experience of resource mobilization. The research methodology employed in undertaking the studies included secondary data collection and analysis, direct observation by the study teams, interviews, and field surveys.

These studies provide a systematic review of different experiences with specific resource mobilization strategies in terms of the major objectives of these efforts. The country case studies emphasize a country focus in contrast to a method focus, and assess national strategies and experience with generating resources for the health sector, both public and private. Overall, four general questions were examined in each case:

- What was the overall impact on health care resources of the strategies adopted?
- What was the relative effect on government and non-government sources of finance?
- Can the contributions of specific resource mobilization strategies be identified?
- What was the effect on resources for public goods and primary health care services, if any?

The impact of various strategies was assessed in terms of the various objectives of these efforts. Specifically, the quantitative aspect of the study focused on the effect on (a) resource mobilization; and (b) sustainability, while the qualitative aspect of

the study examined, to the extent possible, the effects on equity, quality of service and patient satisfaction, and private sector development.

The results, conclusions, and recommendations of each study were then collated in a synthesis document (Chawla and Rannan-Eliya, 1996). The synthesis paper presents the summary findings of the five studies and draws on them to derive broader lessons on resource mobilization strategies in developing countries. One conclusion of the five case-studies undertaken as part of this project is that currently few countries have a comprehensive resource mobilization strategy, and most reforms have been experimental and at the margin. Another finding is that tax revenues and direct out-of-pocket spending by consumers of health care are the most significant sources of finance for the health sector, while user fees is probably the least significant source. In most cases we find that insurance benefits only the rich and formal sector employees, and does not reach the poorer sections of the society. Nongovernment initiatives, in the form of community insurance and private insurance, are seen to be fairly successful in mobilizing additional resources.

The findings of the five country studies point to the need of improved conceptual and implementation protocols for decision makers in developing countries wishing to adopt a comprehensive strategy to mobilize additional resources for the health sector. These implementation guidelines are a step in that direction.

The guidelines are designed to help policy makers design and implement effective strategies for mobilizing resources for the health sector. Though the guidelines are organized in a way that reading and using it alone would be sufficient in most cases, interested users are strongly encouraged to read and refer to the two companion documents: *Resource Mobilization: Methodological Guidelines* (Chawla and Berman, 1996) and *Experiences of Five Developing Countries with Resource Mobilization: What can we Learn* (Chawla and Rannan-Eliya, 1996).

It is also useful to understand what the guidelines are *not*. The guidelines do not concentrate on specific resource mobilization methods, and as such, do not go into any details regarding design and implementation of any particular method. There are many comprehensive guidebooks on user fees and insurance, and interested readers are encouraged to refer to them after a specific method of mobilizing resources is chosen as part of the overall strategy.

The rest of the guidelines are organized as follows. Our definition of resource mobilization strategy is discussed in section 2. The first step in formulating a strategy for resource mobilization is assessing and understanding current and past patterns of resource mobilization, and this is discussed in section 3. Issues related to estimating resource needs are discussed in section 4. Feasibility assessment of different methods of resource mobilization form the content of section 5, and section 6 deals with the political assessment of different methods and the process of consensus building and decision making. An end note is placed in section 7.

A checklist is placed at the end of each section, indicating the kind of information collected and the activities completed by the end of the section.

2. What Is a Resource Mobilization Strategy?

Strategy formulation comprises the articulation of a mission, a set of long term objectives to be achieved within the stated mission, and an action plan specifying how the mission and objectives will be realized. In the context of health care, a mission common to governments of most countries is to provide, or cause to provide, health care for all citizens of the country. Long term objectives include efficient provision of quality health care that is accessible and equitable, in a manner that is socially and ethically acceptable. One of the principal components of an action plan for achieving these objectives is finding ways and means to finance the provision of health care.

Production and delivery of health care is financed either directly by consumers of health care or by the government on behalf of the consumers. Direct financing by consumers takes many forms, such as user charges in public or private facilities, contributions to private or government insurance funds, private donations, and purchase of drugs and other medical supplies from pharmacies. Similarly, government financing of health services uses resources generated from various sources, such as through increased allocations from general government revenue; specially targeted public revenue-raising efforts; public sector user fees; social health insurance; and foreign assistance. A resource mobilization strategy, therefore, comprises the mix of mechanisms the government employs in order to directly finance its own production and delivery of health care (and indirectly ensure nongovernment provision of health care) in a manner that is efficient, equitable, sustainable, transparent and improves quality of care.

The direct tools available to the government for mobilizing resources for the health sector are tax revenues, public sector user fees, insurance and donor funding, and the government may employ any one or a combination of many to meet its requirements of funds.

End-of-Section Checklist

- √ Check that the following is done by the end of this section:
- √ Government has a mission statement relating to health care
- √ Short and long term objectives related to resource mobilization are specified
- √ An inventory is made of all resource mobilization mechanisms available with the government

3. Understanding and Analyzing Current and Past Resource Mobilization: the use of National Health Accounts¹

Policy makers and planners in the health sector must understand the potential as well as the limitations of resource mobilization strategies if they are to be effective in achieving their financing goals (Rannan-Eliya and Berman, 1993). Accurate information about the current availability and distribution of resources in the sector and their directions of flow, as well as their previous patterns, are vital to this process. Such estimates should cover both formal and, so far as practicable, informal health care, in both the public and private sectors. Expenditure estimates can be used for a variety of purposes connected with policy formulation, planning and management. Broad estimates of national totals are generally useful at the policy level, and detailed disaggregation by sector, program, institution, or problem at the level of operational planning and management.

In most low income countries, the estimation of national health expenditures is still at a preliminary stage. Both historical reasons and the difficulties involved in making estimates have prevented most countries from going further with current and retrospective accounts. However, recent work has shown that the National Health Accounts (NHA) methods, using a detailed breakdown of sources and uses of expenditure, can be used feasibly, affordably, and usefully in developing countries.

NHA are one tool to assess health expenditures in a rigorous and timely manner. NHA describe the expenditure flows -- both public and private -- within the health sector of a country. They describe the sources, uses and flow of funds within the health system, and are a basic requirement for optimal management of the allocation and mobilization of health sector resources (Rannan-Eliya and Berman, 1993).

In particular, the method employs a "sources and uses" matrix to illustrate the allocation and flow of funds from the ultimate sources of financing, through financing intermediaries, to providers of health services. "Sources" of financing might include the Ministry of Finance, donors, employers, and households. Financing intermediaries might include the Ministry of Health, the Ministry of Education, donors, other ministries, social insurance funds, firms, private insurers, and households. "Uses" categories have included a combination of types of services (acute hospital care, physicians' services) and types of providers (psychiatric hospitals, nursing homes) (Berman, 1996).

1/ This section draws extensively from Rannan-Eliya and Berman (1993) and Berman (1996), and compiled by Amanda Glassman

NHA provides the best value when it is carried out periodically and used to track changes in the financing of the health care system (Berman, 1996).

There are five steps in the development of NHA:

Step 1: *Define the scope of NHA.* The scope of the NHA must be determined prior to commencing the collection of data. The most commonly used definition of health expenditure has been "expenditure on activities whose *primary* purpose is health improvement" (Griffiths and Mills, 1983). This excludes large programs which have health effects, but whose primary goal is not health: for example, general food subsidies, housing improvements, and large urban water supply projects (Berman, 1996). Other definitions may be used as needed by the analyst or policy-maker. A narrow definition may be used initially that would focus NHA on expenditure on health care and related *services* and subsequently expand the analysis to other ancillary expenditures whose primary purpose is health improvement separately.

Step 2: *Define categories.* Mutually exclusive categories should be determined according to policy priorities, with precise definitions of each category and sub-category, in order to ensure relevance to policy-making. However, this imperative should be balanced with an effort to create comparable categories within geographical regions.

Step 3: *Plan for and conduct data collection.* Existing sources of data on expenditures should be carefully reviewed for quality, consistency, and applicability. Those sources meeting minimum criteria should be used and compiled. A process of data collection should then be set in motion that would collect missing information, perhaps through other routine data collection systems or provider and household surveys.

Step 4: *Plan for and conduct data analysis.* Basic NHA analyses should present the "sources and uses" matrix, with detail on definitional categories and other methodological notes. If estimates and projections are used, these should be made explicit. Further analyses can be conducted to model the effects of various resource mobilization schemes or, in a time series, to evaluate the impact of different resource mobilization packages. More detailed disaggregation allows for program or problem level analyses.

Step 5: *Disseminate results.* NHA results should be clearly and concisely presented to decision-makers at relevant levels of government.

End-of-Section Checklist

- √ Define the scope of National Health Accounts
- √ Define mutually exclusive categories for sources and uses of funds
- √ Plan and implement data collection
- √ Plan and implement data analysis
- √ Provide policy relevant information for formulation of a resource mobilization strategy

4. Estimating Resource Needs for the Health Sector

One of the critical elements in formulating a resource mobilization strategy is estimating the resource needs for the health sector. In most countries health sector budgets are determined historically, with adjustments for inflation and epidemiological changes. It is often useful to depart from this routine, and assess resource requirements based on actual needs and supply potential.

The process of computing resources for the health sector involves six steps:

Step 1: Assess the current situation

Step 2: Estimate the demand for health care

Step 3: Determine supply capability

Step 4: Calculate the unit cost of health care services

Step 5: Compute the requirement of total funds, adjust for available resources and estimate the balance requirement

Step 6: Repeat, for five, ten and twenty year projections

Assess the Current Situation

The first step is the description of current strategies of health care finance in the country:

- description of the methods of resource mobilization adopted in the country
- assessment of the contribution of these methods to resource mobilization
- assessment of the levels of human resources, managerial skills and systems support that are available in the health sector for the purposes of resource mobilization.
- evaluation of the impact of these methods on government and nongovernment sources of finance; on resources for public goods and primary health care, services; on utilization levels and accessibility, quality of care and patient satisfaction, efficiency in allocation of resources, and equity.

- evaluation of the main implementation issues, in terms of preconditions, sequencing, design, and complementary policy.

Demand for Health Care

Various factors affect the demand for health services. These include:

- demographic factors: the total demand for health services in the economy would depend on both, the size and the demographic structure of the population. As would be expected, larger the population of the country, higher will be the aggregate demand for health care. At the same time, the aging structure also influences aggregate demand, since the very young and the old are likely to have a higher demand for health care as compared to other age groups.
- income-related factors: of the socioeconomic factors affecting demand for health services, probably the most important are income, distribution of income in the population, and source and regularity of income. Individual demand for health care is known to rise with income, and formal sector employees are likely to have a higher demand for health services.
- educational factors: demand for health care is likely to rise as general awareness and literacy levels rise.
- price of health services: demand for health services is likely to fall as prices rise.
- urbanization: demand of health care is likely to rise with urbanization
- cultural and behavioral factors: cultural and behavioral factors often play an important role in treatment seeking behavior
- epidemiological factors: the burden of disease pattern affects demand for certain types of health services

Estimation of demand for health care is often difficult in most countries because the appropriate information and data is not readily available. Still, an assessment of demand is critical to the analysis of requirement of funds for the health sector, and all efforts should be made to arrive at plausible estimates.

Supply of Health Care

Health services are provided by governments at various levels, nongovernment organizations, private sector and employers of major industrial and service undertakings. An assessment of supply of health services can be undertaken by doing a census of all the providers and obtaining estimates on:

- distribution of health facilities
- size of health facilities
- staffing in health facilities, of medical personnel, nursing staff, technicians and laboratory staff, public health staff, etc.
- availability of equipment and other supplies affecting the scope, nature and extent of services a facility can provide
- availability and distribution of pharmacies
- annual production of physicians and paramedical staff
- distribution of services in urban and rural areas

If supply of health services is less than the demand, then the system is supply constrained and can provide only that level of services as determined by the supply conditions.

Costing of Health Services

The cost of outpatient and inpatient health services can be determined empirically, using data on unit costs at primary and inpatient level.² Computation of unit costs will vary according to utilization, and these figures can also be collected at the primary and inpatient levels. Total cost of delivering a service can be calculated by multiplying the utilization and unit cost. Dividing this by the number of users gives the cost per user.

One problem with the above methodology is that unit costs and cost per user depend on the utilization levels. A method of costing often suggested to overcome this problem is the calculation of the cost of an ideal hypothetical package at an average size clinic with a known catchment area population. Costs calculated in this manner can include administrative, personnel, depreciation, drugs and other supplies costs. This cost can be corroborated with empirically calculated costs, and appropriate adjustments can be made to arrive at a final figure.

Computing the Requirement of Funds

The total cost of health services that can be supplied by the capabilities of the existing health system is the amount of resources that are required to fund the health sector, if the system is supply constrained. Similarly, if supply is more than demand, then the amount of resources required to finance the health sector is given by the cost of the services demanded.

^{2/} Interested readers are referred to "Social Health Insurance Study" in Zimbabwe done by Peat Marwick, draft version (1996). In costing health services in a primary care package in Zimbabwe, Peat Marwick allocate the costs of personnel, drugs, medical supplies, stationery, laundry, utilities, maintenance, vehicles, and food to outpatient, antenatal, post-natal, family planning, immunization, inpatients, and environmental health services. This study is done at various facilities, and median costs are taken to be representative. These costs are then adjusted upward to cover the costs of transport, annualized capital costs, and costs of improvements in staff, drugs, etc.

Future Projections

The entire exercise can be repeated to arrive at future projections of resources required to fund the health sector. On the demand side, besides changes in income, aging, urbanization, epidemiology, etc., changes in treatment seeking behavior are also critical in determining future demand for health services. On the supply side, costs, inflation adjustments, and availability of medical personnel are some of the important factors.

End-of-Section Checklist

Check that the following information is collected by the end of this section:

- √ Assessment of the current situation is done, and policy makers have information regarding the methods, contribution and impact of resource mobilization currently adopted in the country, and the levels of human resources, managerial skills and systems support that are available in the health sector for the purposes of resource mobilization,
- √ Some estimates of demand for health care are made.
- √ An assessment is made of the current and potential supply of health care.
- √ Cost estimates are made of health care packages at primary and hospital levels.
- √ An estimate is made of the current and future requirement of resources for the health sector.

5. Feasibility Assessment of Resource Mobilization Methods

The principal methods of resource mobilization are:

- increased allocations from general government revenue;
- specially targeted public revenue-raising efforts;
- user fees;
- social health insurance;
- private health insurance; and
- contributions from private donors, and foreign assistance.

We discuss the relative merits and demerits of taxes, user fees and insurance in the first section, and the implementation issues in the second section.

A. Relative Merits of Various Methods of Resource Mobilization

Tax Revenues

Virtually every country in the world uses general tax revenues to finance various components in the health sector. This tax support ranges from total public financing of all health services to financing only specific services for specific segments of the population. In most countries with a tax-based health care system, the allocation of funds to the health sector depends on the explicit decisions of the finance ministry, and on the availability of funds. The health ministry competes for funds along with other ministries, and the allocation of funds to the health sector directly affects, and is affected by, some other ministry's allocation. Allocation of funds to the health sector is therefore likely to grow and shrink as total tax revenue grows and shrinks.

Public Sector User Charges

Consumers of health care are accustomed to user fees in most countries round the

world where the private sector participates in health care provision. User charges in public facilities is less common, though almost every country has considered this option some time or the other. The impact of user fees can be analyzed in terms of its effect on revenue mobilization, sustainability, efficiency, and equity.

(a) Raising Revenue

While user fees have the potential to mobilize resources for the health sector, the net contribution of user fees to total recurrent costs will be low if:

- the fees set are very low compared to the operating costs;
- the recurrent costs of operation are very high, so that even if the absolute amount of user fees collected is high, its contribution to total recurrent costs would be low;
- billing and collection procedures are poor and lead to losses in revenue;
- exemption and waiver policies are not carefully drawn up and strictly enforced;
- consumers of health care are either unable to pay or unwilling to pay, or both.

(b) Sustainability

In the context of user fees, sustainability depends on the contribution of user fees to revenue and costs associated with its implementation, as well as on the institutional capability it develops and sustains. Contributions to net revenue can be sustained over time if:

- the costs of billing and collection are contained;
- there is no substantial fall in the utilization of health services; and
- user fees are periodically adjusted for inflation and changes in costs.

User fees can improve sustainability of the health system if:

- user fees contribution reduces the government's burden of financing the health system;
- the system of user fees leads to the development of a system of accountability, reporting, and responsible management;
- user fees improve allocative efficiency

(c) Improvements in Efficiency

User fees can improve allocative efficiency in at least two ways:

- user fees provide price-signals that inform consumers of health care of costs of services, and suppliers of health care of the services that are being demanded (though actual improvements in efficiency would depend on the extent to which these lead to desired changes in behavior of consumers and providers); and
- in absence of user fees, allocation of medical care is effectively decided by travel time and waiting time, both of which are inefficient in that “time-price” can neither be traded, borrowed, nor stored.

(d) Improvements in Equity

The general opinion about fees is that they reduce equity³, since they impose a burden on those least able to pay. On the other hand, a free care system is also not equitable, since persons with better connections, better knowledge of the system, etc. get more attention, and possibly superior care.

(e) Quality of Care

Implementation of user fees may bring about an improvement in quality of health care, particularly if the revenue so generated is reinvested in the facilities that collect it.

Health Insurance

Health insurance is characterized by a group of persons who contribute funds to a common pool, usually held by a third party. These funds are then used to pay for the health care costs of the members of the pool. The third party can either be a governmental social security, a public insurance fund pool, employer-sponsored pool, or a private insurance fund pool. Depending upon who owns the third party fund pool, insurance can be categorized as “government” or “private”. Insurance plans may be further characterized by groups covered, type of management, size of the group (number of enrollees), services covered (inpatient care, outpatient care, preventive care, drugs, etc), annual premium, copayments, deductibles, restrictions on use (like requirement of referrals), etc.

Government sponsored health insurance may be operated through national security funds. Social security systems consist of funds contributed by certain social classes for a specified set of health and welfare benefits. Based on the principle of social solidarity, the concept of social security insurance refers to defining medical care as

3/ Following Wagstaff and van Doorslaer (1993), equity can be defined in terms of finance and delivery of health care. Equity in the finance of health care refers to the requirement that “persons or families of unequal ability to pay make appropriately dissimilar payments” for health care (vertical equity), and the requirement that “persons or families with the same ability to pay make the same contribution” (horizontal equity). Equity in the delivery of health care refers to the requirement that “persons in unequal need be treated in an appropriately dissimilar way” (vertical equity), and the requirement that “persons in equal need be treated equally” (horizontal equity).

a social rather than a private risk. Another significant type of government sponsored insurance arrangement is community, or cooperative, financing. Community sponsored plans and cooperative based programs are characterized by a group of individuals, like in a cooperative, who identify projects which have strong public goods characteristics, and establish a mode of mobilizing resources toward meeting the objectives of the program.

Another form of insurance coverage is employer-sponsored insurance coverage. Under this system the employer provides health care to the employees and their families through either employer owned or employer contracted providers.

Finally, health insurance coverage is also provided by private ownership of the third-party pool.

Health insurance is essentially a risk-pooling mechanism, and the main objective of health insurance is to protect people from the financial risk of seeking medical care when they fall ill. Nonetheless, health insurance has significant implications for revenue mobilization, sustainability, efficiency, equity, and quality of care.

(a) Improvements in Revenue Mobilization

Compared to tax based revenues and user fees, insurance mechanisms have a greater potential to contribute to revenue collection:

- insurance usually involves the mandatory contribution of new funds (especially employer's contribution) as well as some mandatory contribution of some funds that are probably just moved from private to public (especially worker's contributions);
- in many developing countries tax avoidance is high, whereas since the insurance contributions are an "earmarked" contribution, they are kept separate and tied to specific benefits;
- consumers of health care often do not have funds readily available at the time of need to pay user charges;
- since ability to pay is low in times of illness, people would find it easier to make smaller contributions at periodic intervals than large contributions at the time of illness.

(b) Sustainability

Sustainability in the context of insurance depends on the contribution insurance mechanisms can make to net revenue as well as to the institutional capability that can be developed and sustained. Contributions to net revenue can be sustained over time if:

- the administrative costs of management of insurance systems can be contained.
- there is no decline in quality of service
- individual contributions are periodically adjusted to take into account inflation and changes in costs.

As far as sustainability of the health system is concerned, insurance systems have the potential to improve sustainability in a number of ways:

- increased revenue contribution may reduce the government's burden of financing the health system;
- management of insurance systems entails a complex system of billing and collection, accounting, book-keeping, maintaining individual records, keeping detailed accounts of various charges, and is likely to lead to the development of a group of trained accountants and professionals, which is likely to lead over time to better management of the health system;
- insurance mechanism has significant implications for equity and efficiency, which contribute to sustainability of the health system over time?
- to the extent that insurance systems can lead to growth of the private sector, sustainability of the system improves as the pressures on government budgets decrease.

(c) Improvements in Efficiency

Health insurance can lead to improvements in economic and social efficiency. Most purchasers of insurance are risk averse, and are therefore willing to pay for risk coverage. Provision of risk coverage, therefore, is an efficient use of scarce resources. Further, the insurance system can potentially encourage providers to contain costs, and the consumers to make least cost choices of type and sources of health care. These represent the economic efficiency objective.

Health insurance can potentially improve social welfare by setting in place a mechanism for spreading costs over the unwell and the healthy. Moreover, insurance mechanisms can be designed to permit income redistribution in favor of the poor. These represent the social efficiency objective.

However, the welfare-enhancing potential of insurance can be reduced by several risks which are associated with third party insurance.

- introduction of third party insurance may lead to an increase in the utilization of health services. When the unit price of health care is very low,

there will be a tendency among consumers to overuse health care. This has the potential of increasing costs.

- the introduction of insurance may lead to an increase in the supply of services, for in certain payment systems (like fee per service) providers face incentives to over supply services. This also has the potential of increasing costs.
- insurance systems can face significant cost overrun risks and have a negative impact on welfare if risks are not spread across broad segments of the population. This may happen if only the unwell seek insurance (demand side adverse selection) and/or the unwell are not encouraged to participate in the insurance plan (supply side adverse selection).

(d) Improvements in Equity

Insurance, whether it be social insurance or private insurance, has a direct equity-enhancing impact. Within the risk pool, i.e., the group of persons who have insurance, the system of insurance takes care of equity in terms of delivery of health care. Benefits are provided on the basis of need rather than on the basis of income.

The impact of insurance system on equity in the finance of health care is less clear. Clearly, tax-based insurance can be designed in a manner that ensures vertical equity (persons or families of unequal ability to pay make appropriately dissimilar payments) and horizontal equity (persons or families with the same ability to pay make the same contribution).

In this situation of "partial insurance", equity may in fact be increased in several ways:

- the insured switch to private providers, or if they remain in the public sector, charges recover at least the full cost of services;
- the amount of freed government funds exceed the amount of insurance subsidy;
- these freed resources are targeted to the poor.

B. Design and Implementation Issues

There are several design and implementation issues that need to be considered in order to raise the level of resources through any of the methods discussed in the earlier chapter. Interested readers are encouraged to refer to Normand and Weber (1994): *Social Health Insurance. A Guidebook for Planning*, WHO; Day (1992): "Designing a Family Planning User Fee System", Service Expansion and Technical

Support Project; and Chawla and Berman (1996): *Resource Mobilization: Methodological Guidelines*. In this section, we revisit some of the key issues briefly.

Design and Implementation of User Fees

There are several steps in the design of a user-fee system.

- Step 1: Set targets for cost recovery.
- Step 2: Determine the structure of user charges.
- Step 3: Set user fees.
- Step 4: Formulate a policy on exemption and waivers.
- Step 5: Design and operationalize a system for managing fee-collection

We discuss each in turn.

Targets for Cost Recovery

Targets of cost recovery can be set along a no-recovery-cost-plus continuum. At one extreme is no cost recovery and all products and services are offered free of charge. At the other extreme is full (or more than full) cost recovery and all recurrent and capital costs are fully recovered. There are several advantages and disadvantages associated with each level of cost recovery. For instance, the biggest advantage of free care is that it imposes no administrative burden on the provider. However, this advantage is overcome by the disadvantages associated with free care, like lack of revenue, lack of a signaling system to improve allocative efficiency, etc. Similarly, the main advantage of full recovery is that it provides for the required resources for provision of goods and services. The associated disadvantages include the possible exclusion of some segments of the population.

Structure of User Fees

There are several ways in which fees can be structured:

- Fee per visit.
- Fee per episode.
- Fee per service.
- Capitation fees.

An important issue in selecting a type of user fees, other than its potential in raising funds, is the effect it is likely to have on provider and consumer behavior in health care consumption. For example, consumers in a fee-per-visit system are likely to be more sensitive to the number of visits they make as compared to a capitation system. Similarly, providers under a fee-per-service system are more likely to oversupply as compared to fee-per-episode system.

Setting Prices

Prices may be determined in a number of ways. These include

- Market prices.
- Actual costs.
- Fixed price

Exemptions and Waivers

Regardless of the average ability and willingness to pay in the population, there are always those who are unable to pay all or part of the fees at any price. An effective system of waivers and exemptions requires determination of;

- criteria for eligibility, i.e., those who are eligible for exemptions from payment of user fees, such as the poor, disabled, old, those suffering from communicable illnesses, etc.
- criterion weight, i.e., if one criterion for exemptions is low income level, it is necessary to decide what constitutes a low level of income.
- extent of exemption, i.e., whether patients should pay part of the fees, and if so, what part.
- authority to grant waivers, i.e., designated persons in the facility authorized to grant waivers on the basis of the criteria and extent established above.

Management of Revenue Collected

The final step in the designing and implementation of a user fee system is management of the user fees collected. Management of revenue includes all the activities from billing to collection to depositing collected fees to accounting.

Design and Implementation of Insurance Systems

There are several issues in the design of an insurance system⁴. These include

4/ Interested readers are referred to Normand and Weber (1994): "Social Health Insurance: A Guidebook for Planning", WHO.

- ownership of funds;
- identification of the target group;
- enrolment: mandatory or optional;
- contribution rates;
- frequency of payment;
- types of benefits;
- payment to providers;
- administrative arrangements;
- strategies to minimize losses from insurance; and
- legislation.

We discuss each of these in turn.

Ownership of Funds

Health insurance systems are distinguished by, among other things, the ownership of funds. Insurance funds may be owned by :

- Government
- Public bodies
- Employers
- Non-government not-for-profit organizations
- Private for-profit organizations

Identification of Target Groups

Another distinguishing feature of health insurance schemes is the different segments of the population targeted by the scheme. These include the entire population (as in tax based social insurance schemes); employees (as in government insurance for public employees, and employer based insurance); self-employed (as in government insurance and community plans); members of a cooperative (as in community and cooperative based programs); and special demographic or socio-economic groups (as in some government schemes).

Enrollment

Enrollment can be optional (as in most private insurance) or compulsory (as in some forms of social insurance, and employer based insurance).

Contribution Rates

Contribution rates can be determined such that

- Total funds are determined actuarially; individual contributions based on ability to pay (as in government social security schemes, social insurance, not-for-profit private insurance, employer based insurance, community insurance)
- Individual contributions determined actuarially (as in private insurance).

Frequency of Payment

Contributions can be collected in each pay check (as in some forms of government insurance, employer based insurance), monthly (as in private insurance) or seasonally (as in some community and cooperative based plans).

Benefits Covered

Benefits offered would depend on a host of factors, including types of illness, cause of illness, length of illness, epidemiological profile of the community, burden of disease profile of the community, income, premium contributions, cost-effectiveness of delivery, etc, and could include preventive care, curative care, dentistry, drugs and tests, family planning needs, ambulance services, etc.

Payment to Providers

There are several different ways of reimbursing the provider. In most insurance the provider bills the insurance that pays according to some agreed criteria, such as fee for service, fee per episode, fee per visit, capitation, etc. In some insurance, the consumer pays and claims reimbursement from the insurance. And finally, in some cases where the insurance company is also the provider, the patient receives treatment from salaried physicians employed by the insurance.

Administrative Setup

Administrative setup varies with the type of insurance and the population covered, and include:

- establishing fee schedules, price lists, etc.
- establishing premiums and contributions
- establishing copayments, deductibles, ceilings, etc.
- registering members and maintaining record of individual members
- billing and collection, for premiums as well as for other charges in the use of services, like copayments, etc.
- advising members about entitlement and procedures for claims
- processing claims
- reimbursing providers in accordance with the established agreements
- maintaining accounts, records, statistical updates, etc.
- periodic training.

Strategies to Minimize Losses

One potential disadvantage associated with an insurance system is cost escalation. Cost escalation may be due to over-utilization and/or over-prescription. The problems of over-utilization can potentially be addressed by copayments, deductibles, ceilings, and referral requirements. Over-prescription is usually avoided by having specific agreements with providers and requiring patients to seek pre-approval of many procedures.

Legislation

For the system of insurance to function effectively, an appropriate legislation has to be in place. Laws and legislation usually cover issues like eligibility, coverage, premiums and contributions, benefits, reimbursements to providers and consumers, and enforcement of contracts.

End-of-Section Checklist

Check that the following is done by the end of this section:

- √ A feasibility assessment is made for all available methods of resource mobilization.
- √ Design and implementation issues relating to all methods are known and evaluated.

6. Political Feasibility and Consensus Building

There are two elements in the assessment of the political feasibility in relation to resource mobilization strategies. The first relates to the feasibility of the decision processes surrounding the choice and commitment to the various methods of resource mobilization available to the government. The second relates to the political aspects of popular acceptability of policies relating to making payments for a service largely considered an entitlement.

Stakeholders within government are likely to respond differently to various methods of resource mobilization, insofar as they impinge their organizational and individual interests. For example, organized interests within the government may find it difficult to assume a regulatory role as opposed to a direct service provision role, which may follow a shift to social insurance.

Public reaction to resource mobilization strategies will likely occur only after the effects of the strategies are felt. In particular, it may be difficult to implement user fees without concurrent improvements in quality of health services. Similarly, while it may be easy to introduce social insurance in the formal sector, it will likely require an extra effort to reach the rural, self-employed, and poorer sections of society.

The importance of consensus-building can not be underestimated. An understanding of stakeholder interests, openness to negotiation, and frequent information-sharing, are critical to the success of any combination of resource mobilization methods. Experience worldwide indicates that the best of policies fail without adequate attention to consensus-building and public comprehension and reaction to policy reforms.

End-of-Section Checklist

- √ Identify and assess interests of stakeholders within the government and among the public.
- √ Formulate strategies to ensure consensus building and public acceptance.
- √ Ensure widespread popular acceptance before implementation of policy reforms.

7. End Note

These guidelines discuss some broad issues regarding formulation of strategy for resource mobilization. Needless to say, there will be many differences between country situations, and within a country, at different times. Guidelines such as these cannot hope to identify in advance all the various issues, and that is not the intention either. The objective is to highlight some of the key issues and to provide a relevant framework that can be easily adapted and built upon to take into account country specific situations. Within this caveat, we hope that these guidelines will be useful for policy makers trying to find new and innovative ways of mobilizing resources for the health sector.

Bibliography

- Akin, J., Nancy Birdsall, and DeFerranti. (1987): "Financing Health Services in Developing Countries: An Agenda for Reform", . A World Bank Policy Study, Washington D.C.
- Barnum H. and Joseph Kutzin. (1993): "Public Hospitals in Developing Countries: Resource Use, Cost, Financing". John Hopkins University Press, Baltimore.
- Berman, Peter (1996): "National Health Accounts in Developing Countries: Appropriate Methods and Recent Applications", Draft Manuscript, Harvard University, Boston.
- Brunnet-Jailly, J. (1991): "Health Financing in the Poor Countries: Cost Recovery or Cost Reduction?", PRE Working Paper Series 692, The World Bank, Washington DC.
- Carrin, Guy and Marc Vereecke (1992): "Main Lessons from the Practice of Community Financing Schemes" in Guy Carrin (ed.) Strategies for Health Care Finance in Developing Countries, 1992. St. Martin Press, New York.
- Chawla M. and P. Berman (1995): "Resource Mobilization: Methodological Guidelines", Data for Decision Making Project, Harvard University, Boston, MA.
- Chawla M. and R. Govindaraj, (1996): "Hospital Autonomy: Implementation Guidelines", Data for Decision Making Project, Harvard University, Boston, MA.
- Chawla M., R. Govindaraj, J. Needleman, and P. Berman (1996): "Evaluating Hospital Autonomy: Methodological Guidelines", Data for Decision Making Project, Harvard University, Boston, MA.
- Creese, Andrew and Joseph Kutzin. (1994): "Lessons From Cost-Recovery in Health", World Health Organization, Geneva.
- Creese, A.L. (1991): "User Charges for Health Care: A Review of Recent Experience", Health Policy and Planning, 6(4): 309-319.
- Day (1992): "Designing a Family Planning User Fee System", Service Expansion and Technical Support Project.
- Diop, Francios and Laurence Codjia (1996): "Etude Des Strategies De Mobilisation Des Ressources Dans Le Secteur De La Sante: Le Cas Du Senegal", Data for Decision Making Project, Harvard University, Boston, MA.

- Fuchs, Victor R. (1982): "Who Shall Live?" New York, Basic Books.
- Griffin, Charles C. (1988): "User Charges for Health Care in Principle and Practice", The World Bank, Washington, D.C.
- Griffiths A and A Mills (1983): "Health Sector Financing and Expenditure Surveys", in Lee K and Mills A (ed): "The Economics of Health in Developing Countries", Oxford, 1983, pp 43-63.
- Jimenez E. (1987): "Pricing Policy in the Social Sector", Baltimore and London: John Hopkins University Press.
- Kutzin, Joseph and Howard Barnum. (1992): "Institutional Features of Health Insurance Programs and Their effects on Developing Country Health Systems", International Journal of Health Planning and Management, Vol 7: 51-72.
- La Forgia, G.M. and Charles Griffin. (ed. 1993): "Health Insurance in Practice: Fifteen Case Studies From Developing Countries", HFS Small Applied Research Paper #4.
- McPake Barbara. (1993): "User Charges for Health Services in Developing Countries: A Review of the Economic Literature", Social Science and Medicine, Vol. 36 pp. 1397-1405.
- Newbrander, W., H. Barnum and J. Kutzin (1992): "Hospital Economics and Financing in Developing Countries", (1992): World Health Organization, Geneva.
- Nolan, B. and V. Turbat. (1993): "Cost Recovery in Public Health Services in Sub-Saharan Africa", Economic Development Institute, Draft.
- Normand, Charles, Glyn Chapman, Mukesh Chawla, Jack Needleman and Oliver Mudyarabikwa (1996): "Resource Mobilization in Zimbabwe's Health Sector", Data for Decision Making Project, Harvard University, Boston, MA.
- Rannan-Eliya, Ravi P and Nishan de Mel (1996): "Resource Mobilization in Sri Lanka's Health Sector", Data for Decision Making Project, Harvard University, Boston, MA.
- Rannan-Eliya R. and P. Berman (1993): "National Health Accounts in Developing Countries: Improving the Foundation", Data for Decision Making Project, Harvard University, Boston.
- Robles, Marina Cardenas, Jorge Munoz and Mukesh Chawla (1996): "Resource Mobilization in Bolivia's Health Sector", Data for Decision Making Project, Harvard University, Boston, MA.
- Vogel, R.J. (1991): "Cost Recovery in the Health Care Sector in Sub-Saharan Africa", International Journal of Health Planning and Management. 6: 260-281.

Vogel, Ronald J. (1993): "Financing Health Care in Sub-Saharan Africa"
Greenwood Press, Connecticut.

Wagstaff, Adam and Eddy Van Doorslaer (1993): "Equity in the Finance and Delivery of Health Care: Concepts and Definitions", in Eddy Van Doorslaer, Adam Wagstaff, and Frans Rutten ed: *Equity in the Finance and Delivery of Health Care*, 1993, Oxford Medical Publications, Oxford.

Yin, Robert K. (1994): "Case Study Research Design and Methods". Vol. 5. Sage Publications, London.

Yoder, R. A. (1989): "Are People Willing and Able to Pay for Health Services?" *Social Science and Medicine*. Vol 29, no. 1 pp. 35-42.