

# Resource Allocation and Purchasing in Africa:

*What is effective in improving  
the health of the poor?*

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# List of Acronyms

AfDB	African Development Bank
AIDS	Acquired Immuno-Deficiency Syndrome
ARI	Acute Respiratory Infection
CBHI	Community-based Health Insurance
CFW	Cry for the World Foundation
CHF	Community Health Funds
CIMAS	Commercial/Industrial Medical Aid Societies
ESA	Eastern and Southern Africa
GDP	Gross Domestic Product
HIPC	Heavily Indebted Poor Country Initiative
HIV	Human Immuno-Deficiency Virus
ITN	Insecticide Treated nets
KHHS	The Kisiizi Hospital Health Society
MBB	Marginal Budgeting for Bottlenecks
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-governmental Organization
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund (Kenya)
OECD	Organization for Economic Cooperation and Development
ORT	Oral Rehydration Therapy
PCP	Primary Care Physician
RAP	Resource Allocation and Purchasing
SSA	Sub-Saharan Africa
SWAP	Sector Wide Approach Program
UN	United Nations
USAID	United States Agency for International Development
WDR	World Development Report published by the World Bank
WHO	World Health Organization

# Executive Summary

**T**he primary objective of this paper is to assess how Resource Allocation and Purchasing (RAP) is being implemented in Africa, and to consolidate some of the lessons that have been learned. This objective is accomplished by reviewing trends and specific cases in Africa where RAP strategies have increased the effectiveness of a health system, in terms of efficiency, equity, quality, ownership or a combination of these factors. The selection of case studies is solely based on the availability of empirical evidence to show that the arrangement had improved health out-

comes. This review is not exhaustive, but gives a clear idea of the current situation in Africa, putting forth information and insight into what approaches have worked and what current trends in this area are today. Further, this paper highlights a number of promising efforts that have been implemented or are currently underway that could provide direction useful to decision makers who should take action on these issues. Although these findings are not new — their organization and presentation is — and they are worth repeating.

### Ten key findings emerge from this review:

- 1) The public sector finances less than half of total expenditure on health. The remaining costs are financed with out-of-pocket funds, that go primarily to purchasing private sector services. The private sector herein comprises formal or informal service providers as well as Non-governmental Organizations (NGOs). Since money spent on private providers is unpooled, it provides little bargaining power for individual purchasers of commodities, resulting in inefficiency and inequity. Those issues must be addressed by governments.
- 2) The private sector plays a more significant role than the government in most African countries compared to the Organization for Economic Cooperation and Development (OECD) countries.
- 3) Social health insurance is an existing trend for the formal as well as for the informal sectors. Community-based health insurance (CBHI) mutuals are created in a rapidly increasing rate in Africa. The problem of re-insurance for the sake of sustainability needs to be addressed.
- 4) Some governments depend primarily on donors to cover health costs, and some even rely on donors to cover recurrent costs as well, which is of serious concern.
- 5) Although there is a need to increase funding for health in Africa, there is also a need to improve the utilization of existing funding as a large portion of available funding is not being disbursed.
- 6) Large funding allocations earmarked for addressing and treating specific diseases have the potential to skew key health sector priorities if attention is not paid to the long-term strengthening of health systems in Africa. This is a growing problem as donors have adopted a trend of increasingly financing vertical initiatives, rather than focusing on the health system as a whole.
- 7) Most governments in Africa have not yet assumed their stewardship function and are still struggling with service delivery issues rather than focusing on outcomes and performance.
- 8) Donors are part of the existing problem, adding to the fragmentation and the lack of ownership.
- 9) Decentralization in the health sector is often undertaken in parallel with others moves toward decentralization in and by the government. To date, the health sector has only achieved minimal decentralization, and health expenditure tracking surveys show that funds have had difficulties reaching the base.
- 10) Primary health care has permitted great strides in improving health outcomes, but more targeting is needed now to ensure that resources actually reach the poor and to improve health indicators.

## Nine main messages to guide future interventions:

*On the policy-side of RAP arrangements, there is need for African governments to:*

- (i) pay much more attention to equity of health services and systems. This can be achieved through risk pooling mechanisms, targeted subsidies to the poor, and marginal budgeting for bottlenecks, in addition to other targeted interventions.
- (ii) decrease dependency on donors for selected activities;
- (iii) develop policies to work with the private sector in order a) to alleviate the burden of financing health services by the poor who already purchase services from the private sector; and b) to harness those resources to achieve public health goals;
- (iv) implement public health policies that have a large impact and are cost-effective, for example in nutrition, immunizations, smoking. In the same line, an effort must be made to build on successes and go to scale.

*On the organizational-side of RAP arrangements, the primary messages are:*

- (v) develop a culture of results rather than process, by using performance-based contracts with lower level authorities as well as with the private sector. Governments might integrate this approach into the governments' overall decentralization process;
- (vi) less fragmentation in the financing and delivery of health services must be ensured, wherein the Sector Wide Approach Programs (SWAPS) might be a good start;
- (vii) provide subsidies to the poor so that they are able to pool resources, increased attention to the potential capacity and contribution of health mutuals is one way to achieve this.

*On the institutional-side of RAP arrangements, African Ministries of Health need to:*

- (viii) assume a stronger role as stewards, that is provide regulation, supervision, monitoring and competitive arrangements. Develop mechanisms, guidelines, and ensure adequate training to work with the private sector;
- (ix) separate financing from provision of services in order to help with governance problems which might be associated to RAP arrangements in public bureaucracies.

## Introduction

**S**trategic Resource Allocation and Purchasing (RAP) is a health system function and process where pooled resources are allocated to health service providers, and the providers, whether public or private, receive a coherent set of incentives to encourage them to deliver priority health services efficiently. This function involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom (WHO, 2000). Figure 1 below illustrates how RAP arrangements complement the stewardship function of government.

In order to assess whether health systems are adequately serving the poor, let's begin by examining the flow of funds. Generally, the flow of funds undergoes three phases: 1) collection, 2) pooling of revenues, and 3) use of these revenues to compensate public and private providers. (Preker et al., 2000). In all African countries these three functions co-exist under different organizational configurations and not all funding is required to pass through all three phases. For example, public health expenditure is typically pooled and then allocated through RAP arrangements, whereas out-of-pocket payments bypass the pooling phase and go directly to providers.

**Figure 1: Sharing Decision Rights Between Stewardship Function and RAP Arrangement**

Decisions	Stewardship Function	RAP sub-function
How much?	Defining resource level	Collecting and managing money
Who to buy for?	Defining beneficiaries	Identifying and targeting patients
What to buy?	Defining strategic benefit coverage	Deciding which services to purchase from providers
Who to buy from?	Setting rules of the game	Selecting providers
How to pay?		Choosing payment mechanisms

*Source:* Preker et al., 2002

## Current Practices and Trends in Resource Generation

In a worldwide comparison based on an index of performance which reports how efficiently health systems translate expenditures into health as measured by disability-adjusted life expectancy (DALE), The World Health Organization (WHO, 2000) ranks most African health systems within the bottom quarter. There are several possible explanations for this state of affairs; one could be the fact that most African countries do not have adequate resources to establish any functioning health systems. For example, Sub-Saharan African (SSA) countries have total per capita health expenditures ranging from US\$ 4 in Ethiopia to US\$ 230 in South Africa, with a median situated at US\$ 18, an average at US\$ 30 if South Africa is not included, and US\$ 40 if it is included (World Bank, 2002). In 1997, in absolute per capita terms South Africa, Namibia, Gabon, Botswana and Mauritius spent the largest amounts on health care (more than US\$ 100 per capita per year) (WHO, 2000). All the other countries spend less, with 19 countries spending less than US\$ 25 per capita. (McLaughlin, 2004).

Total health expenditure in SSA, as a percentage of Gross Domestic Product (GDP), is on average 4.9 percent, which compares to the 5 percent of all lower-middle income countries,

but is less than the 6.2% of upper-middle income countries (World Bank, 2002a). Out of 44 countries with data, only 10 spent more than 5 percent of GDP on health services (WHO, 2000). Several countries have been able to significantly increase their public health spending per capita in the last decade. For example between 1990 and 1998, Senegal increased it by 19 percent, Ethiopia by 10 percent, Burkina Faso by 6.4 percent. On the other hand, a number of countries saw a decrease in those percentages, the worst being Burundi with -11 percent, Gambia and Tanzania followed with -3 percent. (Wagstaff, 2002)

A report by the WHO Commission on Macroeconomics and Health (2002) therefore concludes that significant increases in donor funding are needed to provide basic health services in Africa. (WHO, 2002a) However, care is required when pretending to increase expenditures at the country level on the basis of donor financing. Increased financing may not translate into larger expenditures at the country level as will be seen later in this paper. Moreover, increases in expenditures may not be efficient or directed to those determinants that have the largest impact or outcome. (Gotret & Preker, 2003) Other possible explanations and solutions can be found in this paper.

The following is a review of existing practices and issues with accompanying suggestions that provide guidance in addressing these limitations.

### Emergence of untapped opportunities upon closer study of who finances health care

Analyzing public expenditures gives only half the picture since at least one-half of all health expenditure is financed by the private sector. This figure is 58 percent for the whole SSA according to the 2003 World Development Indicators (World Bank, 2003) and 43 percent according to data from 9 National Health Accounts (NHA) in Eastern and Southern Africa (ESA) (see Graph 1 below). Graph 1 also shows that 84 percent of private expenditures come from out-of-pocket in those nine countries of ESA. Out-of-pocket spending represents more than 65 percent of total health expenditures in seven other countries of Western Africa: Burkina (69 percent), Mauritania (70 percent), Nigeria (72 percent), Sudan (79 percent), Cameroon (80 percent), Sierra Leone and Democratic Republic of Congo (90 percent). Most of the out-of-pocket expenditures

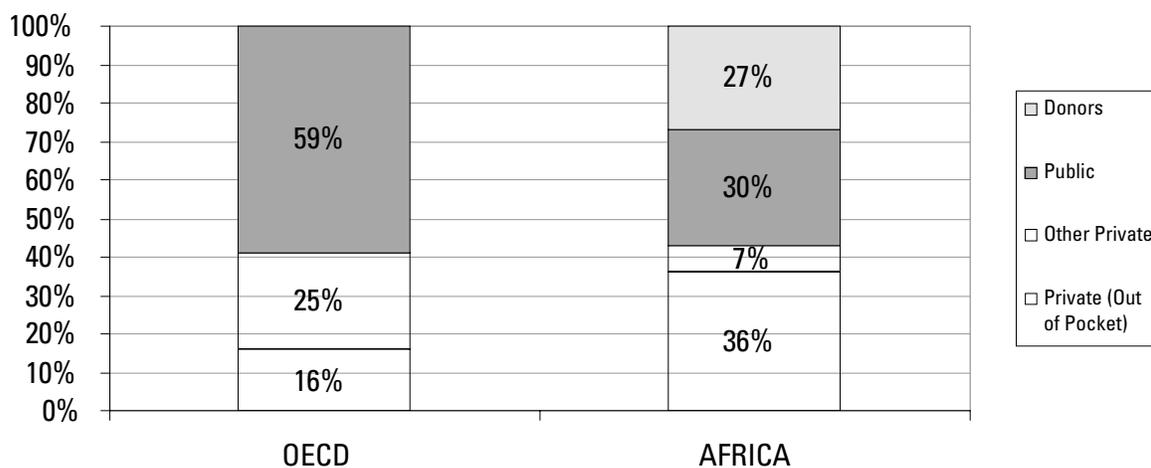
pay for service fees and for mostly unregulated over the counter medicines (WHO, *World Health Report 2000*) Since those out-of-pocket expenditures are unpooled, they tend to be inefficiently spent and highly inequitable (ESA NHA, 2000).

In Guinea, total health expenditures were US\$ 34 per capita in 2001, of which only US\$ 3 came from the public sector (including donors), and the rest was provided by mainly out-of-pocket. (Schwabe et al., 2003)

Residents of the more industrialized OECD countries spend relatively much less out-of-pocket on health, 16 percent versus 36 percent in Eastern and Southern African countries, as private insurance companies' contribution is higher in industrialized countries. Since in Africa, most of out-of-pocket for health is spent buying services from the private sector, one can say that the private sector plays a more significant role than the government in less industrialized countries than in OECD countries.

Although health is still underfunded by governments in Africa, the potential for generating large resources is there, if out-of-pocket expenditures could be channeled to more efficient and equitable health services. This could be done in part by working with the service

Graph 1: Sources of Total Health Expenditures in 24 OECD and 10 ESA Countries



Sources: for OECD: WHO, 2002c Annex 5; World Bank 2002a; ESA NHA 2000.

providers used by the population, namely the private sector.

### **Funding health services through tax and social health insurance schemes**

Tax-funded health expenditure is around 14 percent of GDP for 16 African countries with available data (World Bank, 2003). In most African countries, adequate revenue collection through public taxes has proven difficult because a large proportion of the population works in the informal sector and tax collection mechanisms are weak. Since most public health expenditure is tax-funded, overall public spending on health services is very low. The prospects for increased public funding in the medium term are thus slim.

Several African countries complement tax revenues by mandating participation by government workers and/or formal sector workers in social health insurance. In 1993, a World Bank Survey identified 14 African countries which have some form of social health insurance. The population covered ranged between 0.1 percent (Ethiopia) and 25 percent (Kenya) (Shaw and Griffin 1995). However, WHO estimates that Kenya was the only country where social security contributions exceeded one percent of public health expenditure. (WHO, 2000) Social insurance has not been a major contributor to the generation of resources in SSA. Details of social health insurance and lessons for SSA are presented in section IV that covers risk pooling, drawing on lessons from the Kenya National Hospital Insurance Fund (NHIF).

### **Charging user fees**

It is generally believed that cost-recovery schemes administered locally (i) ensure a steady cash flow at the local level; (ii) promote more efficient drug use; and (iii) provide the community with more flexibility in financing necessary

recurrent expenditures (Shaw and Griffin, 1995). Experiences from Ghana (Nyonator and Kutzin, 2000), Uganda (Konde-Lule and Okello, 1998), Mauritania (Audibert and Mathonnat, 2000) and Zambia (Bossert et al., 2000) have shown that user fees have a positive impact on drug availability and service quality. A study in Nigeria showed that although Bamako Initiative facilities had a better availability of essential drugs than non-Bamako Initiative centers (35 drugs available versus 15), the Bamako Initiative gave rise to higher rates of drug prescribing, which, in turn, calls for promoting the rational use of drugs as part of strengthening the Bamako Initiative scheme (Uzochukwu et al. 2002). Thus, cost recovery has, in many cases, improved access to and the quality of health care. This has benefited the population at large, including the poor.

However, since the introduction of cost recovery schemes, there has been a debate as to their impact on very poor people. For the poorest of the poor even small fees are too high to afford. Exemption schemes designed to protect poor people from user fees have usually failed to do so. In Ghana in 1999, only one out of 1,000 patients was granted an exemption (Nyonator and Kutzin, 2000) while 45% of the population lives with less than US\$ 1 per day (World Bank, WDR 2003, p. 58). In rural Ethiopia, 52 percent of all patients were exempted from paying user fees but a survey found no relation between exemption status and income (Engida and Mariam, 2000). These results render it difficult to estimate the real impact of cost recovery on poor people. Essentially, we do not know the counterfactual — How accessible would health services be for poor people in the absence of cost recovery schemes? While there might be no fees for poor people, at the same time, there might not be any services either.

For example, Mauritania's public health services charge very low user fees. However, there are significant shortages in essential drugs and equipment. A study showed that the

availability of syringes in primary care infrastructures was between 1.4 percent and 74.2 percent with the majority of regions being at the lower end (Hahmed and Soucat, 2004). Another source (Audibert & Mathonnat, 2000) suggests that the introduction of user fees in Mauritania, *with its accompanying strategies* (better running of facilities) might have positive effects on the effective ability of the poor to access health care. Another instance is found in the Malawi context — Malawi's public sector does not charge for services, while the NGO sector, which provides about 35% of health services does charge for services and 32 % of the NGOs' income comes from user fees (Picazo, 2002). Uganda abolished user fees in March 2001, and recent evidence suggests that this policy change increased utilization of health services by the different income groups. At the same time the Government improved health sector funding with increased amounts for pharmaceuticals and health workers' emoluments (Tashobya et al., 2003), so it is difficult to know if the increased utilization should be attributed to the abolition of user fees or to the increased funding.

In response to these problems, the Government of Ghana, for example, intends to phase out the system of requiring front payments for drugs and supplies (the "cash and carry" system) and it will improve and extend the exemption scheme while also further developing health insurance schemes (World Bank Ghana PAD 2002). This policy stems from the widely growing consensus that out-of-pocket payments reduce equity since they impose a burden on those least able to pay (Chawla et al., 1996).

Thus, there seems to be evidence that any change in the existing user fees policies (either adding user fees or getting rid of them), brings about some positive changes in terms of utilization of health services. This is probably due to several factors, among which the most prominent are a political commitment to

change and the introduction of new measures to improve services. More research is needed in this area.

## **Implementing employer-based insurance**

According to NHAs, in 1998 five African countries (Botswana, Cote d'Ivoire, Namibia, South Africa, and Zimbabwe) had forms of private insurance that accounted for more than 5 percent of total private health expenditure (WHO, 2000).

The term "employer-based" insurance is a scheme that is financed by payroll-deductions and sometimes by employer contributions — and is exclusive to the formal sector. The resources mobilized through employer-based insurance and thus the contributions to generating resources for the health systems are relatively small (Shaw and Griffin, 1995). An exception to this is Zimbabwe, where medical aid societies provide private insurance to people employed in the public and the private sector that represents roughly 8 percent of the total population. Medical aid societies are non-profit organizations that collect premiums from businesses and government and use these resources to pay health care providers for services provided to beneficiaries. Details of medical aid societies and lessons for SSA are presented in Section IV which covers risk pooling.

African countries planning to promote employer-based health insurance must be careful to assess the equity impact of such schemes. Private insurance can mobilize additional resources for health needs and has the potential to improve health access by stimulating the health industry. However, in countries with severe human resources shortages, such schemes might actually pull scarce clinicians away from serving the poor in favor of serving the insured population. At least in the short run, this would have negative equity implications for the system.

**Table 1: Informal Sector Employment as a Percentage of Employment**

Country (year)	Informal sector employment as % of employment
Uganda (1993)	84
Zambia (1993)	81
Ghana (1997)	79
Gambia (1993)	72
Mali (1996)	71
Tanzania (1995)	67
Kenya (1995)	58
Madagascar (1995)	58
Cote d'Ivoire (1996)	53
Benin (1992)	48
Mauritius (1992)	24
Botswana (1996)	19
South Africa (1995)	17

Source: ILO, 2002a

Considering that many people in Africa are employed in the informal sector (see Table 1), the adoption of employer-based insurance needs to be complemented with other means and schemes to reach informal workers.

### The rise of community-based health insurance (CBHI)

Community-Based Health Insurance provides financial protection through local level risk pooling to the informal sector. Households contribute premiums to a risk pool that provides coverage for a package of benefits that can range from primarily ambulatory care to a comprehensive package that includes hospitalization. In Western and Central Africa the number of CBHIs has risen from 67 to approximately 827 from 1997 to 2000 (Abt Associates, 2000a). Details of CBHI schemes and lessons for SSA are presented in Section III that covers risk pooling.

The impact of the aforementioned schemes on equity is not yet fully understood. CBHIs have the potential to improve welfare and health access for the poor. However, the extent to which they have done so in the past is uncer-

tain. Moreover, these schemes have to deal with adverse selection, moral hazard, small risk pools, and the need for additional resources to protect against catastrophic risk. Given these challenges and the important role that such schemes might play, more operational research in Africa is needed to understand the design features that best achieve social priorities including the equity impact of CBHIs.

### The role of external development assistance

#### External aid

Although the real value of development assistance to Africa has declined since the mid-1990s, the importance of external aid for the health sector is remarkable. About US\$ 1.2 billion or 10 percent of total health expenditure, in SSA is externally financed. Thus, this region receives the largest proportion (38.5 percent) and the highest per capita share (US\$ 2.45) of global development assistance for health (McLaughlin, 2000). Donor assistance for health care varies considerably from country to country. In 1998, in 23 African countries more than 20 percent of public health expenditure was financed by donors. In six countries foreign aid provides more than 40 percent of total health expenditure (WHO, 2000).

For example, 84 percent of Chad's public expenditure on health in 2000 was financed by external grants and loans, 12 percent by the Government's own resources, and 4 percent by communities (Hahmed and Soucat, 2004). In Mauritania in 1999, donors contributed 53 percent to the overall health budget (Soucat, 2004). In ESA, donors on average contributed 27 percent of total health expenditures.

In some countries, even the recurrent budget is mainly covered by external money. This was the case in Chad in 2000 where 81 percent of recurrent expenditures were funded by

external sources and only 19 percent by the Government's own funds (Hahmed and Soucat, 2004). In Guinea in 2001, external financing paid for 32 percent of recurrent costs, which included 93 percent of vaccines, 91 percent of training, and 84 percent of vehicles maintenance paid by the outside (Schwabe et al., 2003). In Mozambique in 1997, 47% of recurrent costs were financed by donors, and donors also covered 92% of drugs and medical equipment (S. Chao and K. Kostermans, 2002).

The World Bank and other multilateral donors have supported health expenditures with the *Debt Initiative for Heavily Indebted Poor Countries* (HIPC). The HIPC initiative was launched in 1996 with the goal of reducing unsustainable levels of debt. As of July 2003, 27 of the 38 countries that potentially qualify for assistance under HIPC had used this initiative which resulted in the freeing of about US\$1.0 billion in annual debt-service savings. As a result of the HIPC debt relief, debt stocks for those 27 countries are expected to decline by two-thirds in net present value terms. Part of the debt relief initiative is a poverty reduction strategy, which includes programs to improve health care services for poor people. In the 27 countries, poverty-reducing expenditures, including those for health, have increased from about US\$6.1 billion in 1999 to US\$8.4 billion in 2002, and are projected to increase to US\$11.9 billion in 2005 (IMF, Sept. 12, 2003. HIPC Initiative: Status of Implementation).

The high dependency on donor funding in a number of countries is a serious concern. Any country's health system should aim at having enough reliable funding within the country's own resources to maintain basic health services for a growing population (ESA NHA, 2000).

### The paradigm of undisbursed aid

Despite the growing need for additional resources, there is the problem of non-dis-

bursement of available funds. For example, in the period from 1994 to 1999, the World Bank approved 27 International Development Association (IDA) loans in Africa with a total commitment of US\$ 751 million. However, by June 2000 only 53 percent had been actually disbursed. The undisbursed balance amounted to US\$ 353 million. (World Bank, 2002d) Other donors like the United Nations (UN), the African Development Bank (AfDB) and bilateral donors experience slow disbursement as well. In Malawi, between 1994 and 1998 only 61 percent of the donors' health allocation was disbursed (Picazo, 2002).

African countries experience implementation constraints which limit the ability to utilize funds effectively. Among those, severe shortages of human resources represent a major challenge to health systems in Africa. Another reason for slow disbursement is the complexity involved in coordinating different donors' priorities with local health strategies. Administrating and coordinating donors consumes scarce local government administrative resources. A recent study in Rwanda lists 27 international donors contributing to the health budget, each donating amounts ranging from US\$ 100,000 to US\$ 4 million (Schneider et al., 2000). Another problem with donor assistance is that it is often not tracked in a consistent manner, and is often maintained "off budget", which makes proper planning and management by the government more difficult.

### Multiplicity of initiatives

An additional challenge facing SSA is the pressure placed on African health systems by the spread of the HIV/AIDS epidemic. It is estimated that in SSA alone, more than 55 million people will die from AIDS within the next twenty years. In Botswana, life expectancy has dropped below 40 years, a level not seen since 1950 (Joint UN Program on HIV/AIDS, 2002). Therefore, several initiatives to increase resources to fund programs that address the

challenges of prevention, and care of the infected and affected people have been undertaken to react to this new threat in Africa. The most prominent initiative is *The Global Fund to Fight AIDS, Malaria and Tuberculosis* which has collected US\$ 2.1 billion from industrialized countries prior to May 2002. The World Bank also launched the *Multi-Sectoral AIDS Program* (MAP) which up until May 2003 had funded 21 HIV/AIDS Projects with a net commitment of US\$ 722 million. (World Bank, 2002b) Other recent initiatives also aim to increase funds for HIV/AIDS as well as for other health conditions. While a strong commitment from the international community for funding programs to address, treat and prevent HIV/AIDS and other health problems are needed, limited attention has been given to ensuring that local governments have the adequate capacity to effectively manage these new funds. Large funding allocations targeted specifically for specific diseases have the potential to skew priorities if attention is not paid to the long-term strengthening of African health systems.

Some of the problems that plague governments at the central level also find their way to local levels of government. This is the case in Tanzania, where the health office in Dar Es Salaam, the country's capital city, has to manage 12 different financing sources (Dar Es Salaam City Medical Office of Health, 2003), thus stretching its management capacity.

## Foreign aid and ownership

Another important constraint faced by countries in the context of external development assistance is the need for ownership by local governments in order to ensure a program's success. Recent evidence suggests that external aid does not help to improve health indicators if a government is not committed to the programs. Even the conditionality of loans or grants will have little effect on a country's health outcomes if the local government does not fully support the project(s) (Devarajan et al., 2001).

Most African governments have not yet assumed their stewardship function and are still struggling with delivering services themselves, rather than embarking on strategic reforms of the existing service delivery system. Africa could benefit from Latin America's lessons on health reform strategies, where it was found that a major factor in the success of reforms was that a relatively stable and coherent "change team" was formed, supported by the President and other major political actors, and included members drawn from the Ministries of Planning and of Finance. This change team was isolated from the broader political process until it had developed a significant, technically defined package of reforms (HSPH, 2000).

## Current Practices and Trends in Resource Pooling

### Establishing Social Health Insurance

**T**hrough social health insurance schemes, governments can provide financial protection to households by aggregating contributions and pooling risk. Social insurance agencies have the potential to drive improvements in the performance of the delivery system by active and strategic purchasing. There are few examples of government-managed social insurance in SSA. Tanzania is in the early stages of implementation of a program for civil servants, and Mozambique has begun withholding wage contributions for a future social insurance program (Conversation with Daniel Kraushaar, 2002). Other countries in SSA have considered introducing social health insurance for civil servants and employees of formal sector companies (Ghana, Nigeria, Uganda, South Africa, Zimbabwe) but little progress has been made. Only Kenya has a long history of experience with social insurance through its NHIF.

When evaluating the performance of the NHIF in Kenya and aiming to determine whether this is a model that can be adapted to other countries in the region, it is important to look at both the system's successes, failures and problems. The biggest strength of the system is

that a large portion of the population, in both the formal and informal sectors, is receiving some financial protection from high cost health events. The NHIF has increased revenue for both private and public providers raising the total amount of resources available for health. This availability of funds seems to have also stimulated the development of the private sector which has enabled consumers to have choices (See Box 2 below). Weaknesses of the NHIF include its limited capacity that extends to most aspects of insurance design, implementation, management and ongoing monitoring. Moreover, poor design features, such as perverse incentives in the reimbursement system and weak monitoring of fraud and abuse, have led to some unintended negative consequences. Individuals with the technical skills needed to effectively run health insurance schemes are in short supply in Africa. An additional factor that must be well thought out when considering social insurance is the impact of the AIDS epidemic which is a catastrophic risk that can render broke nascent insurance schemes in populations with high prevalence of the disease.

If other African countries plan to implement or expand similar schemes, they would have to analyze the supply side of health services to adequately assess its impact on equity. Social

### Box 1: The Kenya National Hospital Insurance Fund (NHIF): a model for Africa?

The Kenya National Hospital Insurance Fund (NHIF) was established in 1967 to finance improved access to private hospitals, nursing and maternity homes to middle and upper class Kenyans (Kraushaar 1997). By law, all Kenyans earning over the equivalent of US\$ 19 per month must contribute to the NHIF. In the early phases of the program, this included primarily formal sector workers and civil servants. In recent years, because of inflation, informal sector workers and agricultural workers have also been included. Those formally employed contribute through payroll deductions and this is considered “standard”. Others can voluntarily enroll for a flat amount per month. Membership has grown considerably from roughly 60,000 in 1967 to roughly 1.4 million members in 1985/1986. Assuming an average of five dependents per member, this translates to coverage of roughly seven million people.

NHIF members and dependents receive coverage for inpatient care and the cost of drugs at certified inpatient facilities but do not receive coverage for hotel services. Outpatient and preventive services are not included in the benefits package. Only “hospitals”, which includes government, mission and private hospitals, nursing homes and maternity homes, are eligible to receive reimbursement. The NHIF pays a fixed per diem fee. Substantial balance billing occurs in private higher cost hospitals while the NHIF fee is accepted to fully cover costs in other hospitals.

In 1992, the law on contributions was changed from requiring a fixed sum contribution to requiring one equal to 2 percent of income for standard members. Voluntary members, or those in the informal sector, continue to pay the same fixed sum of roughly US\$ 1.14 per month as was stipulated in the original 1967 law. Contrary to expectations, this approach to financing does not seem to provide subsidies from wealthy to poor, from healthy to sick, or from smaller to larger families. Table 2 below shows findings that cast considerable doubt as to the equity enhancing effect of the NHIF. In 1990/1991 low-income individuals contributed 18 percent of resources to the fund but the facilities they frequented only received 3 percent of total paid claims. The reason for this is that individuals with low-income are unable to pay the large additional fees they would need to pay out-of-pocket to seek care from more expensive private facilities (balance billing). In effect, low-income individuals are subsidizing the middle and high-income members of the NHIF.

**Table 2: NHIF Contributions Received and Claims Paid by Member Income Category**

Member income	FY 1989/1990		FY 1990/1991	
	Contributions rec'd (%)	Claims paid (%)	Contributions rec'd. (%)	Claims paid (%)
Low	23	1.4	18	3
Middle and High	27	98.6	32	97

Source: Akumu, 1992.

*(continued on next page)*

**Box 1** (*continued*)

Assessment of both the strengths and considerable weaknesses of the NHIF system generates lessons for RAP arrangements for the rest of the region. By providing insurance coverage for hospitalization, NHIF provides a degree of financial protection for households. Increasing voluntary enrollment of the informal sector indicates that households are willing to pay for this type of risk coverage.

The NHIF, as a predominant purchaser of health services in Kenya, exerts significant influence on both government and private provision of hospital services. Allowing multiple competing providers to receive reimbursement has stimulated an expansion in the number of providers who can service beneficiaries leading to increased access in Kenya's urban areas. The purchasing power of the NHIF has the potential to be used strategically to influence appropriate growth of the private sector.

A major weakness of the NHIF is that poorly developed compliance and monitoring systems have enabled fraud and abuse by both providers and the covered population. In some cases, providers have been known to overcharge clients and members are known to share NHIF membership cards with non-members. Weak capacity to manage these insurance systems is a considerable impediment to effective implementation and ongoing management of the NHIF. The per diem reimbursement system provides incentives to providers to increase lengths of stay while basing reimbursement rates on facility characteristics such as the number of beds does not encourage quality care. The NHIF should take advantage of its considerable purchasing power to drive improvements in efficiency and quality by implementing stronger systems to monitor fraud and abuse, to control utilization, and to reward quality of care.

**Box 2: The link between health insurance and the existence of private for-profit providers**

Evidence seems to indicate that health insurance encourages the development of private providers. For example, in Kenya the private sector has grown from a few private providers at independence in 1963 to about 1,500 providers in 1993. Currently, the private sector accounts for 50 percent of all hospitals and provides 36 percent of all hospital beds. Approximately 21 percent of all health centres and 51 percent of all other outpatient treatment facilities are privately owned. New facilities offering routine hospital services are mostly privately owned and for-profit. This rapid development of private, for-profit hospitals is unique in SSA (Shaw & Griffin, 1995).

The most plausible explanation for these developments is the existence of national health insurance, supplemented by private insurance schemes. Kenya established an NHIF in 1967 which covers more than 25 percent of the population. Contrary to volatile public subsidies, payments by public and private insurance schemes provide a stable source of income for private providers. Although this evidence is not conclusive it provides support for the argument that health insurance encourages the development of private providers.

health insurance provides financial incentives to providers to serve insured individuals, who are typically wealthier than uninsured individuals. If a government wants to mobilize more resources through a social insurance scheme and the sector has an upward sloping supply curve for medical services you would expect an increase in the size of the health industry and improved health access as a consequence of such improved financial incentives for providers. This was the case in Kenya and is a possible scenario for other African countries.

However, most African countries do not have an elastic supply for medical services, at least not in the short-run. A number of SSA countries continuously suffer from chronic shortages of medical personnel. In 2000, a World Bank study reported that the shortage of human resources is the single most important problem in African health care (McLaughlin, 2000). Under these circumstances, the introduction of public insurance schemes would shift resources towards the insured rather than increasing overall access to the health system. In this case, the introduction or expansion of social insurance would have a negative impact on equity, at least in the short-run.

### **Setting up Medical Aid Societies**

As previously mentioned, medical aid societies are generally private non-profit entities organized to provide health insurance, or prepayment schemes, to a particular industry or population (Quigley 1997). In Africa, medical aid societies primarily collect and pool resources and provide financial protection to formal sector working populations. Usually they are governed by a Board of Directors comprised of member firms and sometimes with representatives of the covered population. When membership is employment based, members contribute through wage deductions that are sometimes supplemented by employer contributions. Some governments have chosen to

stimulate the development of medical aid societies through tax incentives. This is the case in Zimbabwe (see Box 3). They function as a form of social insurance in that premium contributions are income based or flat fees and not based on the risk characteristics of individuals or households. Premium contributions from members of a given plan are pooled to provide financial coverage for the benefits included in the package. Medical aid societies also have the potential to stimulate innovation in the insurance market by encouraging competition among competing funds.

As implemented in Zimbabwe, medical aid societies have not explicitly targeted the poor. The concept of medical aid societies, however, is similar to some of the CBHI schemes that are being introduced for the informal sector in SSA. Lessons from the development of risk pooling schemes in the region include that it is important to implement sound systems to monitor fraud and abuse and that well designed provider payment mechanisms can provide powerful incentives to both improve quality and overall costs.

### **Promoting risk pooling schemes for the informal sector**

Poor people not only face financial barriers to access proper health care but they are also very vulnerable to high cost health events which may force them into further poverty. This requires solutions to protect such households against financial risk. In SSA the majority of public systems have failed to provide financial protection for the poor. The previous sections described schemes that pool resources and protect primarily formal sector households against financial risk. This section will present three prepayment schemes that pool resources and provide some degree of financial protection for the informal sector.

It should be noted that traditional solidarity schemes have existed for a long time in most

**Box 3: Medical aid societies in Zimbabwe**

In Zimbabwe, health insurance is provided to 7 percent of the population, or approximately 800,000 people, by 25 medical aid societies (Quigley 1997). The market is dominated by Commercial/Industrial Medical Aid Societies (CIMAS), organized to serve the commercial and industrial sector and by the public service sector, organized to serve government workers. Other medical aid societies focus on small groups, railway workers, or specific geographic areas. In the past, there was little competition among medical aid societies but this is changing as employers search for lower cost solutions to providing financial coverage for their employees.

While the majority of enrollees are from the formally employed sector, voluntary enrollment is also possible. Generally, participating employers choose one medical aid society to be its health insurance carrier and offer different insurance packages to employees based on their income. Employers, as such, pay a significant share of the contribution. Packages vary from the most basic services that entitle beneficiaries to coverage for services in the public sector to the most extensive services that provide access to the full range of care including tertiary care through the private sector. Additionally, members have free choice of providers covered within their package and providers are paid fee-for-service by CIMAS and bill patients for the uncovered balance. Medical aid societies have the potential to use their purchasing power to implement cost-saving strategies such as negotiated low rates and payment mechanisms that transfer financial risk to providers but CIMAS and the other medical aid societies in Zimbabwe have not done so. They are essentially passive payers.

Medical aid societies are facing many challenges. Currency devaluations have increased the cost of imported goods, most importantly from pharmaceuticals. The HIV/AIDS epidemic has caused an increase in demand for services for opportunistic infections, though antiretroviral therapy is not covered. Providers are mounting pressure for increased fees and there is a significant level of fraud and abuse by both providers (false billing and over-utilization) and patients (sharing membership cards with non-members). Recent estimates are that fraud and abuse amount to up to 33 percent of all claims expenses. The result of these factors altogether is that insurance premiums have been rising faster than inflation and employers are increasingly concerned that they will no longer be able to afford to provide coverage for their employees.

To control costs associated with fraud and excessive use, CIMAS management considered a range of strategies employed by managed care organizations in the U.S. (Campbell et al., 2000) that focused on: the role of the primary care provider; incentives for providers and patients; composition of the enrolled population; selective contracting with a network of providers; active care management strategies; communications and education; and continuous measurement and improvement. CIMAS management decided to introduce a pilot project named Health Guard that focused on the relationship between primary care providers (PCP) and patients. In this pilot, the PCP is responsible for coordinating medical care (including specialty and inpatient care) for CIMAS members in his/her panel. CIMAS was able to select the PCPs that are part of the network. All care reimbursed by CIMAS had to be based on a referral from the PCP. To participate in the pilot study, patients receive extended drug benefits and PCPs receive additional payment to compensate for additional responsibilities. CIMAS management did not choose to change payment to PCPs from fee-for-service to capitation (as is the practice in many models of managed care). Instead, they chose to introduce gradual reforms that included extensive monitoring of utilization and referral patterns. Results are not yet available.

African countries. They are prepayment schemes which are often used to help during a catastrophic event, such as burial.

In a government-stimulated community health fund (CHF) model, the government, often with donor resources, provides matching funds to community-managed prepayment schemes that offer access to a limited package of ambulatory care services. This was the case in Tanzania. In the provider-initiated model, health providers offer prepayment schemes to households in the communities they serve that provide access to a wide range of services, as occurred in Uganda. In the CBHI model, households prepay into a community-managed fund for coverage for a defined package of services delivered by a range of local providers. This model was utilized in Rwanda.

For most participants in such schemes it is the first time that they had access to health insurance. Such risk-sharing agreements represent a significant welfare gain for the insured population, since individuals who take out voluntary insurance prefer to pay monthly premiums rather than being exposed to the risk of a major health expenditure. It is, however, unclear whether these schemes improve overall health access for poor people. A survey of 258 CBHIs in developing countries, including 131 CBHIs in Africa, shows that little is known about the health impact of CBHIs. The study concludes that there is no evidence that CBHIs positively impact health status and financial protection, particularly of poor people (ILO, 2002).

However, another study, undertaken in rural Senegal arrives at a more favourable conclusion. The study analyzes four CBHIs which have been operating between three to ten years. Using household survey data, the study shows that insured members have higher utilization rates than non-members. Furthermore, members report “less personal worries” as a result of having health insurance. Without CBHIs they would have been forced to rely on their social network or money lenders in the

case of illness or disability. These results seem to indicate that CBHIs increase health access (higher utilization) and welfare (risk-sharing) for its members. However, the study also concludes that CBHIs fail to protect the poorest of the poor because they cannot afford the premiums. Furthermore, CBHIs typically suffer from a relatively small risk pool (500 to 2,000 members) and lack funds to cover catastrophic risk (Jutting, 2001).

The experience of CHFs in Tanzania (see Box 4) contain lessons for the design and implementation of similar schemes for the informal sector in SSA. From household surveys in Kilosa, it appears that the population is willing to prepay for participation in a pool for coverage of a range of services if the services they will have access to are perceived to be of adequate quality (Kihombo, 2002). Suggestions to improve the functioning of the CHF which have the potential of making similar approaches more attractive to households include: expanding coverage to include higher cost services such as hospitalizations; allowing choice of provider, and introducing incentives to improve service quality as perceived by patients.

It is obvious that CHFs include only those people who can pay the premium, not the poorest people. To reach the poorest, government subsidies would be necessary. In Tanzania, the Government’s matching grant program helps reach those that can still pay, not the poorest.

CHFs are also interesting in that they create a local collective power, and it has purchasing capacity.

The design and implementation of provider based prepayment schemes in Uganda (see Box 5) provides lessons for the rest of SSA. These schemes provide coverage for both outpatient and inpatient services and provide financial protection against catastrophic costs for those households that can afford to and choose to enroll. The restriction that only groups can enroll controls adverse selection and co-payments mitigate moral hazard. Schemes begin

**Box 4: Community Health Funds in Tanzania: a government stimulated health insurance scheme that covers primary health care for the informal sector**

As a response to growing concern about the financial burden user fees impose on poor households and the potential barriers to access care they create, the Government of Tanzania began implementing CHF in 1996. By December 2001 CHFs were established in 20 districts (Kihombo 2002). In exchange for an annual prepayment fee (equivalent to US\$ 5 per year), households who choose to enroll in a CHF are entitled to access ambulatory care services in participating public facilities without paying customary user fees. The Government provides matching funds equivalent to the amount the CHF collects from households as an incentive to community members to enroll in the program and as a mechanism to increase financial resources for health services in public facilities. CHFs are managed by District Boards that include representatives from communities, district councils, and the MOH. Stakeholder management and oversight of CHFs was supposed to improve responsiveness of health providers to households by increasing accountability. Overall goals of the CHF are to improve health outcomes through better access to quality services, improved financial protection through pooled prepayment of premiums, and improved responsiveness of providers to clients through changed incentives (Shaw, 2002).

The initial design phase of the CHF envisioned paying providers based on a capitation payment and enabling both public and private providers to participate. Because of concern that this approach may jeopardize funding for public hospitals making it impossible to cover salaries of civil servants, the CHF chose a different model to pay providers. Instead, CHF funds were used to improve the physical condition of facilities and to improve availability of equipment, drugs, and medical supplies. Shaw indicates that these improvements enhanced worker motivation and therefore contributed to improved quality of services. More recently, CHF funds have been used to provide bonuses to staff (Shaw, 2002).

When initially designed, CHFs were expected to attract approximately 30 percent of households with hopes that eventually up to 70 percent would enroll (Shaw 2002). Enrollment rates have fallen far short of these expectations and many households that initially enrolled have dropped out (see Table 3 below).

**Table 3: Enrollment and Dropout Rates in the CHF in Kilosa District by August 2001**

Total # households	Enrollment rate 1999-2000	Dropout rate
56,519	4.3	77.7

*Source: Kihombo, 2002.*

with little knowledge of the expected utilization of their covered population making it difficult to price premiums to cover actual costs in the first years of implementation. There is a need for better marketing of the advantages of

the prepayment schemes to the general population. In addition, it clearly shows that poor people are familiar with the way insurance schemes operate, appreciate their value, and are willing to pay for financial protection

**Box 4** (*continued*)

Researchers (Shaw, 2002; Kihombo, 2002) have hypothesized that there are a number of reasons households have been slow to enroll and have decided to drop out after participating. Since CHF do not cover inpatient services, they are not providing households with financial protection for catastrophic health events when people need to be hospitalized. Since user fees for ambulatory care services in public facilities are relatively low, CHF insurance coverage does not necessarily provide expected benefits that exceed the cost of joining. A recent survey of households in Kilosa district shows insignificant differences in satisfaction with perceived quality of providers between non-joiners, drop-outs, and those currently enrolled. However, households enrolled in the scheme report more satisfaction with availability of drugs than the other two groups who cite unreliable access to drugs as a primary reason for not joining or dropping out. Of households surveyed, those currently enrolled in the CHF report an average of 8.21 outpatient visits per household in comparison with an average of 2.93 visits among non-joiners and 3.89 visits among drop-outs (Kihombo 2002).

If enrolled households had paid user fees, annual expenditures would have exceeded the amount paid to enroll in the CHF. In contrast, both those households that had never joined and those that had dropped out would have paid less than the value of the annual premium. One explanation for these differences in utilization rates is adverse selection, which means that households that know that they will use more health services than the average household, choose to join. A second explanation is moral hazard – that the presence of insurance coverage stimulates households to use more services than they would if they were paying full fees. A third and important explanation is that the availability of health insurance coverage through the CHF removes a financial barrier to access and enables households to obtain the care they need.

Evidence from Kilosa indicates that household wealth, measured as total household expenditure, is a determinant of whether households decide to join the CHF scheme. Average income of enrolled households is Tsh 59,023, in comparison with Tsh 46,273 for drop-outs and Tsh 33,102 for non-joiners (Kihombo 2002). These data indicate that the lowest income households may face financial barriers to paying the annual premium and that the decision to drop out may also be determined by resources available to households. These data indicate that the poorest households in Kilosa are not being served by the CHF, though it is also important to note that the majority of households in Kilosa are considered poor.

against uncertain events if they can be assured of access to good quality services.

The experience of CBHI schemes in Rwanda (see Box 6) indicates that low income individuals will prepay for services if they can be assured of quality services, can trust scheme managers with their contributions, and can afford the premiums and co-payments.

Expanding membership beyond the current level remains a challenge.

The sustainability of community risk-pooling schemes needs to be tackled by governments, especially in countries with high HIV prevalence. Re-insurance might need to be introduced to ensure the sustainability of those schemes. Governments also need to

### Box 5: Provider based prepayment schemes in Uganda offer access to ambulatory and inpatient care.

The MOH Health in Uganda acknowledged that it could not provide access to an acceptable and affordable level of health care services to the entire population and led a process to search for new sources and mechanisms to finance care. The National Health Policy and Health Services Strategic Plan for 2000/2001 through 2004/2005 emphasizes broadening the financing base for the sector and providing support for strategies to promote increased efficiency, fairness, risk pooling and protection for poor and vulnerable groups (Matsiko et al., 2001). In 1996, Government and donors helped establish the first provider-based prepayment scheme in Kisiizi hospital, a NGO in the western district of Rukungiri. By 2001, eleven provider-based prepayment schemes had been established with varying degrees of success (Matsiko et al., 2001). The Kisiizi Hospital Health Society (KHHS) is considered one of Uganda's success stories.

Kisiizi has a 200 bed hospital and a community based health care program funded largely by user fees (70 percent) with some support from donors and from national government programs such as immunizations and TB control (Walford et al., 1997). In 1996, the KHHS was established to offer households the opportunity to prepay for access to health services. To manage potential problems with adverse selection, the KHHS scheme is only available to Engozi societies (all residents of the region of KHHS belong to Engozi societies which, in exchange for prepayment, finance transportation to hospitals, fund funerals, and offer small loans). In exchange for a premium that varies by size of household and a co-payment at each visit, implemented to control moral hazard, members of the KHHS have access to a wide range of outpatient and inpatient services with a few exclusions (eye glasses, normal deliveries, and self inflicted injuries). Of the 87 Engozi societies in the region, 36 were able to convince at least 60 percent of households to join in the first year (Walford et al., 1997). By 2000, 13.3 percent of the total catchment area population of 60,000 was enrolled in the scheme (Matsiko et al 2001). Table 4 presents a progression of enrollment from 1996 through 2000.

consider providing targeted subsidies to the very poor so they can benefit from the schemes.

### **Building on the Bamako Initiative: A pooling mechanism with local ownership**

As a result of the *Bamako Initiative* implemented in 1988, which promoted community financing and management of recurrent costs, 27 African countries had introduced a cost recovery scheme by the mid-1990s (Shaw and Griffin, 1995).

The *Bamako Initiative's* main principles are that (i) it is a financial contribution to a self-managed system which includes the community; (ii) the money is kept at the local level; and (iii) it is used to replenish the local drugs revolving fund, and for local maintenance of the health infrastructure. The *Bamako Initiative* has been implemented differently in various countries, most countries applied it only as a cost-recovery scheme with the implementation of user fees for health services and medicines, while other countries also stressed community management of the money. Every country kept the money at the local level and

## Box 5 (continued)

**Table 4: Individuals covered by KHHS**

Year	Number of Individuals Covered
1996	1,536
1997	5,768
2000	~ 8,000

Sources: Walford et al 1997; Matsiko et al 2001.

The chairman of the Engozi group collects and delivers premiums to KHHS each quarter. Premiums were priced at below the cost of services expected to be utilized by members with a commitment by donors to fund the difference during the initiation phase of the scheme. After one year of experience with the scheme, members were found to utilize fewer outpatient visits (almost half) but more than double the number of inpatient admissions than predicted (Walford et al., 1997). KHHS interpreted this increase in admissions over what was expected as evidence that the customary user fees were a barrier to access and that membership in the KHHS reduced this barrier. KHHS intends to increase premiums to cover expected costs once membership increases and the population grows to appreciate the value of the scheme.

In early 2001, focus groups and interviews were conducted with households who live in regions of Uganda where prepayment schemes are available (Matsiko et al 2001). This investigation included the area served by Kisiizi and can give some insights into whether prepayment schemes were being accessed by the poorest households. Of the 201 households interviewed, 53 were members of schemes. The most common form of income for households was agriculture (48 percent), the majority owned a radio and or cassette player (87 percent), and over half of households owned a bicycle (52 percent). Of the households not enrolled, 30 percent stated that the primary reason was that they could not afford the premiums. Among the 148 households not enrolled in any scheme, 71 said that they did not have the cash needed to pay for services when a family member last visited a health facility. This evidence indicates that it is probable that lowest income families are excluded from participation because of the costs of the premiums. It also indicates that customary user fees needed to pay for services pose a barrier to accessing care.

benefited from the pooling of funds to buy drugs and equipment.

Implementation of the *Bamako Initiative* in Benin, Guinea and Mali for example, helped the MOHs focus on defining the primary health care package, its costs and on improving the accessibility of primary care. Since the early 1980s the Bamako Initiative helped cover more than 20 million people in those three countries, under-five mortality declined significantly, even among the poorest, and immunization levels increased (World Bank, WDR 2004, pp.

76–77). Some of the problems were that local management committees typically valued investment over redistribution, and exemptions did not reach the poorest.

The community financing of key operational costs bought communities a seat at the table. Governments had to systematically negotiate new activities with community organizations. However, all three countries need to establish mechanisms to subsidize and protect the poor better and this is a priority in those countries' reform process (WDR 2004).

**Box 6: Community-Based Health Insurance (CBHI) Funds in Rwanda increase utilization and reduce financial barriers to access health care**

As part of the national effort to rebuild the country, the Government of Rwanda was interested in promoting innovative strategies to generate additional resources to fund health care services. In Rwanda, public health centers and hospitals earn the majority of their revenues from user fees which imposes a financial burden on patients at the time of need. As a result, utilization of formal health services is low and people delay obtaining care until they are very ill (Schneider et al., 2001). An additional result is that there are insufficient funds to operate health services which results in drug stock outs and unmotivated staff. CBHI was the strategy tried in Rwanda to address the issues of low utilization, lack of financial protection, and insufficient resources to fund health services. The MOH chose to test community based prepayment schemes in three districts using an approach that involved community members in design, management, and oversight. This experience has been well documented and evaluated by Pia Schneider and colleagues using study and control districts and before and after comparisons and contains valuable lessons for design, implementation, and management of community based prepayment schemes in resource poor settings.

In the first year of the pilot study, starting July 1999, 54 prepayment schemes were initiated that enrolled 88,303 members representing 8 percent of the population of the three districts (Schneider et al., 2001). In exchange for an annual premium, families could obtain access to all preventive and curative services and drugs offered in their chosen public health center and to a limited package of inpatient services from the district hospital. Hospital services were covered only if the patient had a referral from the health center. By prepaying for services at a time that households had income, and after a one month waiting period, families were able to insure themselves against large out-of-pocket payments for services throughout the year. One result was that new case consultations for members were up to five times higher than for non-members. Strong improvements in the utilization of preventive services were also a result. Immunization rates increased 50 percent, prenatal care 25 percent, and there were 45 percent more assisted deliveries among the covered population. Rather than being interpreted as a moral hazard effect of insurance leading to excessive utilization, these results were interpreted as eliminating the gap between needed and obtained health services that existed before the introduction of community based health insurance (Schneider et al., 2001).

**Box 6** *(continued)*

With the introduction of CBHI, each of the 54 health centers in the three pilot districts became a partner that offers one prepayment scheme. Families that enroll choose their preferred participating public health center. Each month, scheme managers retain 4 percent of premiums for administration; send 4 percent to the district hospital fund that pools risks for the district and manages funds to cover hospital services for members; send 49 percent to health centers to cover capitation payments; and retain 43 percent in bank assets to cover future payments. Health centers receive a monthly capitation payment for each member who enrolls with them. Hospitals are paid by the district federation per episode for cesarean sections, malaria treatment and non-surgical pediatric cases and fee-for-services for consultations and overnight stays. By the end of a year, 7 percent of premiums were spent on administration, 7 percent on hospital services, and 86 percent on health center level care (Schneider et al., 2001).

As part of the evaluation of the impact of the pilots, the MOH wanted to understand what population groups chose to enroll in the community based insurance schemes and whether membership improved financial access without increasing the overall burden of out-of-pocket spending. To answer these questions Pia Schneider and colleagues estimated three demand models using household data (Schneider and Diop, 2001a).

Results indicated that the probability of purchasing insurance was not determined by health need or economic factors but by the level of education of the head of the household, family size, district of residence, distance to the health center, and radio ownership. The income quartile of families was not shown to be significant and cattle ownership, an indication of household wealth, was also insignificant. The second model looked at the determinant of use of services and found that members used up to five times the number of curative and preventive services than non-members. The probability of a visit decreased with distance to the health center and increased with severity of illness, but those with coverage sought care when less sick. Results from the third model found that annual per capita contributions of member are up to five times greater than payments by non-members but payments at the time of service are significantly lower for members. This indicates that the presence of insurance changed care seeking behavior of members causing them to access care more frequently and sooner.

## Current Practices and Trends in Resource Allocation

### Utilizing budget mechanisms to ensure better resource allocation

**M**ost African countries use *historical budgeting* to distribute their resources. Under this process, the current year's budget is based on last year's allocation, typically with minor modifications. Historical budgeting ensures that existing capacity is funded but it does not necessarily ensure that the optimal mix of services is funded, that priority population groups receive services, or that funds are used efficiently and effectively. Moreover, historical budgeting provides no incentives for outputs or outcomes.

If health facilities are poorly distributed in the first place, such a resource allocation arrangement will continue to lead to severe inequity. To improve allocation, some countries have started to allocate funds on a needs basis rather than on the basis of what was needed in the past. A needs-based approach requires a country to develop a new resource allocation formula, one that is typically based on indicators such as population size, age and sex profile, and degrees of absolute and relative poverty. For example, in 1994, Zambia introduced a population-based resource allocation

formula to distribute funds. Two studies suggest this change resulted in a more equitable distribution of the government budget in all but two provinces. It also supported an increase in the average share of primary care expenditure from 39 to 54 percent by 1998. (Bossert et al., 2000; Gilson et al., 2000).

Efficiency improvements could result from a more rational approach to resource allocation. For example, in Malawi, budgetary allocations to hospitals are based on cost-per-bed. This creates a perverse incentive either to increase beds or to inflate costs; it does not provide incentive for hospitals to be resource-efficient (Picazo, 2002).

### Decentralization: an ongoing trend

A number of countries have begun to decentralize health services, although most achieved only some form of deconcentration to date. This move towards decentralization stems from the desire to increase local ownership, and to improve efficiency and equity of health services. Reform initiatives usually focus on giving more political and administrative autonomy to decentralized districts. They often also consist of raising local revenue for health serv-

ices through cost recovery schemes, integrating other health service providers, and introducing needs-based resource allocation (Bossert, 2000).

To date, most governments have not achieved significant improvements in efficiency and equity as a result of their move towards decentralization. For example, the Government of Uganda began in 1993 to undertake decentralization by devolving responsibilities for primary care from the central to the district level, including the provision of basic health services and control over health personnel. District funding was provided by three main sources: government grants (81 percent), donor assistance (12 percent), and local revenue (7 percent). Between unconditional grants, flexible donor funding, and local revenue districts are free to decide the allocation of between 25 and 60 percent of their total health revenue, which represents a considerable rise in local autonomy compared to the earlier system. However, studies suggest that districts have allocated fewer funds to public goods type activities, in particular to primary care, as they progress further into the decentralization process. On average, district spending on primary health care fell from 33 to 16 percent in the period from 1995 to 1998. (Akin et al, 2001) The utilization of maternal and child health services has also fallen significantly since the introduction of decentralization (Mwesigye, 1999). A World Bank study warns that poorly carried out decentralization runs the risk of recreating inefficient centralized systems within each district (Habte et al., 1999).

Other countries also reported difficulties in implementing decentralization. In Senegal, resources were allocated to local authorities, who were not accountable for health outcomes (Diop et al., 2001). In Chad, the Government granted 60 percent of its federal budget to the districts. However, the allocation process was not on a needs-basis and the wealthier districts received significantly higher shares of funding than the poorer provinces (Soucat, 2004). A

study on Zambia's decentralization is slightly more favorable. It concludes that Zambia's decentralization effort's probably improved overall efficiency since the activity levels have been maintained in face of declining funding (Bossert et al, 2000). More recent analysis (Bossert et al, 2003) however concludes that decentralization may not have had either a positive nor negative impact on services. In Rwanda less than 1% of public resources went to finance preventive and primary health care services in health centers in 1998, but in 2000, for the first time, almost one-third of the public health budget was decentralized and disbursed to the regional/prefecture level (Rwanda Health Accounts, 2000). While the experience of decentralization varies from country to country in Africa, it seems that it is more difficult to increase ownership and accountability through decentralization than initially expected.

A public expenditure tracking survey undertaken in Ghana in 2000 (Xiao Ye & Canagarajah, 2002) showed that only about 20 percent of non-salary public health expenditure reached the primary care sub-district facilities. A large proportion of the leakage occurred between line ministries and district offices, where public expenditures are usually turned into materials from cash flows. The study underscored the need to set up a consistent and transparent recording system all the way down to the service provision facilities. The following table (Table 5) shows the disconnect between the measurement of the resource flows at the central government and at the facility level. At the central level, the Government is committed to provide more resources to basic health care, however, clinics receive a large proportion, if not all, of public non-salary expenditures in kind, and thus don't have much control over it. Moreover, salaries are distributed directly to employees by a central government agency. Consequently, at the facility level, there is little knowledge about what public resources

**Table 5: Ghana: A comparison of Public Financing at Ministry and Facility level**

	Percent of Financial Resources from:		
	Government and donor pooled fund	Paid by patients	NGO's assistance
Based on MOH estimates for sub-district clinics	87	13	
Based on sub-district clinic estimates	39	54	7

exist for them. This leakage means that the patient bears a much higher proportion of the costs than intended by the central government.

Burkina Faso undertook an interesting experiment to make health districts more accountable for their results, with the help of the World Bank. It involved a performance-based contract between the central MOH and the District Health Office in one-half of the nation's districts. Because it was a project financed by an external agency, an exception was made to the regular flow of funds, and money was transferred directly to the district level. Indicators such as immunization seem to have improved (World Bank, 2003b), however, once the project terminated, the money did not reach decentralized units any longer, jeopardizing acquired results. The World Bank's Team Leader held that this was attributable to several factors: (i) transfers to district bank accounts had stopped, which had been the primary source of funding for the action plans; (ii) the planning and performance monitoring process that had been established and financed by the project also stopped; and (iii) the project management unit which played a key role in organizing and implementing the process was disbanded (BTO, 2003). This problem shows the difficulty projects have in scaling-up and integrating lessons learnt into national programs.

A diagnosis of the decentralization process in Guinea asserted that one of the main problems is that ministries were more preoccupied with issues related to administrative processes than with providing an enabling environment to nur-

ture local capacities (Cote, 2003). A health expenditures tracking survey undertaken in 2002 showed that only 30 percent of the public resources that were allocated to local health infrastructures actually reached those structures (Bah, 2003). The problem here again is mainly one of complex procedures for funds to be sent to the local level, lack of flexibility in deciding how to use those funds at the local level, delays in budget voting and allocation, and lack of transparency as mentioned before.

A recurrent problem is that most MOHs have not established a clear decentralization policy which is in harmony with the rest of the government's decentralization policy. Often, the health sector decentralizes in a vertical way, with no or little links to municipalities' offices. Such a policy is needed to identify clearly the lines of authority and the flow of funds. In Malawi for example, there are three uncoordinated systems which attempt to decentralize with varying degrees of success: the MOH system, the Ministry of Local Governments which funded health services through local authorities, and the Christian Hospital Association of Malawi. (Picazo, 2002)

Decentralization is a trend to support, but the ways and means for implementing this process must be improved in terms of: 1) better financial record keeping and information; 2) better flow of funds to the local level; and in terms of 3) a clear consolidated policy and strategy. In addition, alternative options for strengthening downward accountability should be considered (Ndegwa and Levy, 2003), such as contracting decentralized units with performance criteria.

## Better allocation through primary health care

Although a number of countries in Africa have made efforts to expand primary care to increase coverage of basic services to the rural population, since the Alma Ata Conference in the late 1970s countries have encountered several problems in this effort, three of the main ones being:

*a) Expansion:* Although as previously mentioned, Zambia increased its expenditures on primary care from 39 percent to 54 percent in the period from 1994 to 1998 (Bossert, 2000) a number of other countries had difficulties expanding primary care, especially to underserved areas. For example, the Government of South Africa aimed to redistribute resources from the relatively prosperous mostly urban Gauteng Province to poorer Northern provinces. Over a five-year period Gauteng's share was expected to decline from 25 to 17 percent, and the Northern provinces' share to increase from 6 to 15 percent. Thirty percent of this shift was expected during the first year but the plan proved impossible to implement. Gauteng Province received more funds than budgeted (Pearson, 2002). Studies from Uganda (Akin et al., 2001) and Mauritania (Hahmed and Soucat, 2004) also document sharp declines in the share devoted to primary care in the 1990s, contrary to efforts to achieve the opposite.

There are several reasons why the expansion of primary care proved difficult. First, some take advantage of external funding to support

primary care by decreasing their own primary care expenses. Second, governments planned the expansion of primary care without addressing the politically sensitive question of reducing funding for other health care facilities. Reducing funding for secondary and tertiary level care has proven to be difficult. As part of health reforms in Zambia funding for hospitals was reduced. After some time, there was a public outcry about deteriorating hospital conditions which caused the government of Zambia to reduce its reforms in scope (Blas and Limbambala, 2001). Third, most governments underestimate the timeframe required to achieve the desired redistribution. In the short run, 80 to 90 percent of the costs are fixed, making it hard to change the allocation of resources.

*b) Recent benefit-incidence analysis challenges the conventional wisdom that public primary care expenditures mostly benefit the poor.* A study (see Table 6) conducted in seven African countries showed that on average, 23 percent of primary care expenditures benefit the richest quintile whereas only 15 percent go to the poorest ones (Gwatkin, 2002). Similar disparities have been reported with respect to certain cost-effective interventions which have been designed with the poor in mind. For example, an intervention like oral rehydration therapy (ORT) is considered a cost-effective treatment for diseases concentrated in poor areas (Gwatkin, 2001). However, recent research in SSA suggests the richest quintile (77 percent) is more likely to use ORT than the lowest quintile (58 percent) (World Bank, 2002a).

**Table 6: Inequities in 7 Government Health Care Expenditures**

	Percentage of total benefit gained by	
	Poorest 20% of the population	Richest 20% of the population
Total government health care expenditures	12	30
Government primary health care expenditures	15	23

Source: Gwatkin, 2002

*c) Hospitals are still used as primary care structures because the referral system operates inefficiently.* For example, in Malawi, tertiary hospitals devote most of their resources to basic or Level I health care, while only 10 to 15 percent of patients at these facilities receive Level II or III care (Picazo, 2002). This is very costly since basic care can be delivered much more cheaply by less fancy structures, such as health centres.

Those problems highlight once again three common institutional issues: (i) that of a lack of stewardship from the State, which means policies need to be taken and applied; still in the realm of lack of stewardship, there is inability to tap existing resources in the country, for example where the State is unable to self-finance some essential functions, such as immunizations, it could mobilize resources in the country, especially out-of-pocket payments and private delivery for such purposes; and (ii) that of weak governance where the separation of financing from provision of services is a shift not many governments are likely to want to make on a large scale.

Overall, the move towards primary care and cost-effective procedures is taking place in Africa and represents a clear step in the right direction. But the extent to which resources have been shifted towards primary care varies from country to country and some African countries still devote far too little towards primary care and cost-effective procedures. However, even in countries which have succeeded in increasing spending on primary care, it should be emphasized that a shift of resources is not enough to target poor people. The shift must be accompanied by other measures that will ensure that these expenditures actually reach poor people. The focus which, up to now has been on universal coverage, needs to shift toward targeted coverage to give priority to the poor.

## **Policy measures which have considerable public health impact**

All African countries have adopted a basic health care package based on cost-effectiveness analysis (World Bank, 1993a). This was useful in particular in defining what could be done at each level with limited resources. In Dar Es Salaam, the Tanzanian capital, for example, 10 activities can be undertaken at the community level, 35 at the dispensary, and so on. (Dar Es Salaam City Medical Office of Health, 2003) However, in spite of some progress, many cost-effective measures were not implemented to the extent that was expected. This is the case, in particular, for immunization, nutrition and tobacco control.

Nutrition benefited in the 1980s and 90s from large scale successes in Tanzania, Madagascar and Senegal (Marek et al., 1999) which shifted responsibility for service delivery to communities and the private sector, but most governments did not build on those successes, as it required a shift in paradigm from government service delivery to contracting out of services. Although 53 percent of all child deaths are attributed to malnutrition (Black et al., 2003), and that there are successes to build upon, there is still nothing being done on a grand scale in the continent.

Immunizations showed some progress but an analysis of 12 West African countries shows that on average, rates basically remained at the same levels they were in 1990 (see Table 7 below). This is in part due to the fact that in the 1980s, national immunization programs benefited largely from donor support, and this was not the case in the 1990s.

Less industrialized countries already account for half of all deaths attributable to tobacco. One of the most cost-effective measures to control tobacco smoking is to increase taxes on cigarettes, an action only South Africa has taken with success.

**Table 7: DTP3 coverage in 12 West African countries, 1990 vs. 2001**

Country	Coverage (WHO/UNICEF Best estimates)		% point change	Performance
	1990	2001		
Mauritania	33	61	+28	Medium-high
Guinea	17	43	+26	Medium-low
Ghana	58	80	+22	High
Mali	42	51	+9	Medium-low
Niger	22	31	+9	Low
Gambia	92	96	+4	High
Cote d'Ivoire	54	57	+3	Medium-low
Benin	74	76	+2	Medium-high
Senegal	51	52	+1	Medium-low
Togo	77	64	-13	Medium-low
Guinea-Bissau	61	47	-14	Low
Burkina Faso	66	41	-25	Low

Source: Naimoli, 2003

#### Box 7: Adoption of a Cost-effective measure to improve public health in South Africa

In 1999, the Tobacco Control Amendment Act gave the country some of the most progressive tobacco control policies in the world.

Today, all tobacco advertisements and sponsorships have been banned; smoking at work and in restaurants is illegal, except in clearly demarcated areas; and explicit health warnings are required on all cigarette packs. Excise taxes represent almost 50 percent of the total retail price of cigarettes. Around 80 percent of potential tax revenues from cigarettes are actually collected (excise and sales taxes combined), representing several billion rands a year.

As a result, cigarette consumption is on a downward spiral, it decreased from 1.9 billion packs in 1991 to about 1.3 billion packs in 2002. The rate of decline has accelerated especially since 1997, when large tax increases sharply increased the price of cigarettes. Between 1993 and 2000, total tobacco consumption decreased by about 26 percent, the percent of adults who smoke decreased from 33 percent to 27 percent, with the biggest decreases being seen in low income groups, and the percent of young people aged 16 to 24 who smoke has decreased significantly from 24 percent to 19 percent.

These gains are the result of decades of steadfast lobbying by the health community and antismoking groups and of the new South African government's commitment to public health. They have come in the face of vehement opposition from the tobacco industry, advertising agencies, hospitality associations, sporting organizations whose events were sponsored by tobacco companies, and, until the early 1990s, an apartheid government with extraordinary close links to the trade itself.

Source: de Beyer and Brigden, 2003.

Governments are thus missing opportunities to build on existing best practices and scale up, to harness existing resources to expand, and to implement policies which have great impact on public health. To do so, Governments would need to focus on their stewardship role to set and ensure that policies are implemented, to monitor progress, to set standards and ensure they are applied, to partner with service providers from the private sector, among other tasks.

### **Technicians overlook the importance of local politicians in allocating resources**

Most African governments have expressed their intention to focus scarce resources on providing health services to poor people. In practice, however, as mentioned before, funds are frequently spent disproportionately on facilities and services which primarily serve wealthier populations (Gwatkin, 2000). To understand this imbalance it is important to emphasize that decisions pertaining to resource allocation are made within a wider political context. Funding for health usually competes with other tax-funded government activities. Vocal interest groups, typically urban populations, and other vested interests influence allocation decisions (Pearson, 2002).

The difficulties in achieving commitment to large-scale health reform are analyzed in a recent study on the dynamics of policy change in South Africa and Zambia during the 1990s. In both countries, political transition brought a government to power which demanded speedy and visible health policy changes and created windows of opportunity for change. The study shows that reforms were heavily shaped by a few key actors, in particular the Minister of Health. Technical experts and analysts generally had less influence than politicians on the design of the health reform and its implementation. The study recommends that in order to

achieve their objectives, technicians and analysts have to pay more attention to “the art of politics”. Analytical techniques like stakeholder analysis or policy characteristics analysis can be used to gain a better understanding of the actors’ positions. Generally, the study suggests to balance strong political analysis with rigorous technical analysis (Gilson et al., 2000).

### **Some Trends to Better use external aid for resource allocation**

#### **The usefulness of conditionalities versus political commitment**

In order to ensure that health funding reaches poor people, external donors typically attach conditions to grants and loans. Recent research, however, suggests that conditionality has very little effect if the government is not fully committed. For example, the Democratic Republic of Congo received significant external aid, including six structural adjustment loans by the World Bank between 1965 and 1996 (Easterly, 2001). However, the lack of a coherent macroeconomic framework and endemic corruption under the Mobutu Government led to a three decade-long decline. In 1996, GDP per capita was estimated at US\$ 150, less than 40 percent of its 1958 level. Foreign aid probably has reduced the urgency for reform rather than promoted better economic policies (Devarajan et al., 2001). Thus, commitment by the government to reform is an essential component of any successful intervention.

#### **Sector Wide Approaches Programs (SWAPs): A Trend to Watch**

In order to deal with the challenge of ownership and coordination, some African countries have agreed on a SWAP to managing health funds. SWAPs focus attention on the perform-

ance of the entire health sector in contrast to performance of individual projects. The ultimate vision of SWAPs is to provide budgetary support, i.e. all sources of public financing would be disbursed against a comprehensive budget of the MOH in the respective country. In practice, many donors still provide earmarked funding to support specific components of the budget that are articulated as part of a national health strategy. This approach has required changes in standards and approaches by both donors and clients. Donors are assured a voice in the process of developing a national health strategy and countries are required to develop sound national health policies and secure their implementation (McLaughlin, 2000). The shortage of resources for the health sector has often frustrated the intentions of donor earmarked financing as Government resources will sometimes be reallocated away from the externally financed categories by the Government. This partly explains the preference for SWAPs in SSA by donors (McLaughlin, 2004).

Many countries, however, do not have a national health policy in place and their budgets often do not reflect stated priorities. Thus, a one-step transition to the new approach is not feasible as many donors are reluctant to channel their funds through existing systems. SWAPs, however, provide direction for future development work which both sides can agree upon and gradually establish over time. To date, there has not yet been evaluation of a fully implemented SWAP. Experience in Ghana, however, shows increased government health spending in line with agreements negotiated with external partners, which might likely have a positive impact on health outcomes.

SWAPs provide a framework as to how to work towards a broad-based consensus. Budgeting via a SWAP helps to make conflicting interests transparent and encourages a dialogue between donors and government. However, SWAPs only provide a framework; their success depends on the genuine commitment of

governments towards pro-poor policy (Peters 1998). If the parties cannot establish such a commitment, any externally proposed pro-poor initiative has a high likelihood of failure.

### Marginal Budgeting for Bottleneck (MBB)

Despite extensive Sector Reforms, the health systems in many SSA countries still fail to reach large numbers of women and children—especially the poorest and most vulnerable—with these interventions. It is increasingly clear that the strategies adopted previously in the health sector have to be different.

This situation triggers a growing demand for tools that help answer three questions:

- *What are the major health systems bottlenecks hampering the delivery of health services, and what is the potential for their improvement?*
- *How much money is needed for the expected results?*
- *How much can be achieved in health outcomes by removing the bottlenecks?*

The MBB tool recently developed by UNICEF, the World Bank and WHO, and tested in several countries is a response to this demand.

The mainstay of MBB is to identify country/province specific “implementation constraints” of health system and estimate the “marginal costs” to overcome them. MBB uses existing information available for selected tracer interventions to identify the “bottlenecks,” — the weakest links in the chain of conditions and debate various options to address them. The tool also allows to assess the likely impact of alternate options on health outcomes based on available evidence. The MBB approach thus helps in improving allocative efficiency of government health budgets. This makes MBB dif-

ferent from traditional approaches of programming and budgeting of health interventions.

However, the tool is not meant to be used as a quick fix solution for improving health outcomes. Adequate local participation and consultation are important pre-requisites to identify the bottlenecks for implementing evidence based interventions and discuss alternate strategies for overcoming the bottlenecks based on local experiences. The indicators and unit costs need to be adapted to local needs. The tool can help to generate alternate scenarios using different strategies to enable policy makers to choose the best option. The results are country specific and temptation to generalize the scenarios to other countries should be restricted.

#### **What to expect from MBB?**

##### **This Tool Helps Analyze: Coverage Frontiers, Costs and Impact of Policy Options**

- What New Interventions? (Home Based Neonatal Care/Essential Obstetric Care)
- By whom? (Public/Private sector)
- How? (Supply or Demand Focus)
- To Whom? (Geographic/Social Targeting)
- With What? (Input Mix)
- At what Cost? (for Drugs, Salaries, Construction)
- Who Pays? (Public/OOPs)

*Source: R. Knippenberg, A. Soucat, W. Vanlerberghe et al.*

## Who is Covered?

Overall, many African countries have undertaken important efforts to improve health access for poor people. The outcome differs from country to country but benefit–incidence analysis suggests that there is significant potential for improvements. This section will review empirical evidence illustrating how new financing and RAP arrangements can be applied to improve health access for poor people.

### Addressing inequities

A study carried out a benefit–incidence analysis to assess whether existing resource allocation arrangements in seven African countries reach the poor (Castro-Real et al., 2000). The results indicate considerable inequity with the richest income quintile receiving twice as many benefits as the lowest quintile from government health spending. For example, in Guinea, 48 percent of public health expenditure went to the highest income quintile and only 4 percent to the lowest one. Out of the seven countries, only South Africa managed to give the lowest and the highest incomes a similar share, one of the reasons being that wealthy South

Africans rely on private care (Castro-Real et al., 2000).

This inequity is especially striking for hospital care and much less important for primary care. The poor–rich benefit ratio (using unweighted averages) for hospital care is 11 to 34 while it is only 15 to 23 for primary care (Castro Real et al., 2000). This confirms that targeting health spending to the poor in Africa would require spending less on hospitals and more on primary care facilities. However, one of the reasons for which governments subsidize tertiary health services is that no insurance

**Table 8: Benefit incidence of public spending on health in selected countries, by population quintiles**

Country	Quintile shares of all health going to	
	The Poorest	The Richest
Guinea (1994)	4	48
Ghana (1992)	12	33
Cote d'Ivoire (1995)	11	32
Madagascar (1993)	12	30
Tanzania (92–93)	17	29
Kenya (1992)	14	24
South Africa (1994)	16	17
Unweighted average	15	23

Source: Castro-Real et al., 2000

market exists. Households cannot insure themselves against the risk of serious illness or injury and the consequent need for very expensive treatment (Castro Real et al., 2000).

On the other hand, some countries have made significant headway in tackling this equity problem. Ghana, for example, where benefit incidence has increased slightly for the poorest one-fifth of the population, from 12 to 13 percent, and decreased for the richest two quintiles of the population, from 54 to 50 percent, between 1992 and 1998. The middle income group also seems to benefit more from public health services than before. Similarly, the rural population benefits significantly more in '98, getting 61 percent of resources compared to 51 percent in 1992 (World Bank, Ghana PAD, 2002).

In conclusion, targeting the poor via: 1) a better supply and provision of services through outreach to reach them where they live; or via 2) demand mechanisms through subsidies; or 3) some kind of risk pooling mechanisms, is one of the most urgent challenges governments are facing in efforts to improve health indicators.

### **Where else can the poor go for services?**

Although the public sector plays an important role in health service delivery in Africa, public providers still fail in general to concentrate on the poor, and seem to rather support the better-off population. There is thus a need for governments to specifically target the poor.

There is evidence that the poor buy services from the private sector, but to a different extent in each country in Africa. On one end, in 1997 in Eritrea, the private sector was used as a source of care by fewer than 20 percent of medical care seekers (World Bank, 2001). The same happened in Ethiopia where a study showed that between 1997 and 2000, nearly 80 percent of the population obtained their care for malaria from the public sector

(Ethiopia Survey, 2002). On the other end, more than 60 percent of the children belonging to the poorest 20 percent of the population were treated outside the public sector for their most recent ARI or diarrhoea bout in 16 out of 19 SSA countries (Bustreo et al., 2003). In the same way, in Uganda, of the sick children who were seeking treatment for diarrhoea, cough or fever, only 17 percent went to a public institution, 41 percent were brought to a private clinic. This latter percentage was lower among the caretakers who were less educated (33 percent) and higher among the more educated (47 percent) (Ministry Of Health Uganda, 2001). Data for 1997 in Ghana suggests that in general the patients prefer to use private for profit services for minor ailments because of slowness, unavailability of drugs and poor staff attitude in the public facilities. But for more serious cases, government or mission facilities are perceived to be better (Ghana Policy Analysis and Development Group, 1999 referred to in World Bank Ghana PAD, 2002). In South Africa public sector primary care is free, yet around 30 percent of people without medical insurance still choose to pay out of their own pocket to attend facilities in the private sector. Even in the lowest income quintile this proportion is estimated to be 20 percent (Palmer et al., 2001).

Who comprises the private sector? Most for-profit providers work in urban areas, other private providers cater to rural as well as to poor urban populations. For example in Benin, 60 percent of service providers are concentrated in the capital city, while only 15 percent of the population lives there (Decaillet and May, 2000), but mission and church hospitals supply crucial health services to disadvantaged and poor areas. In Zimbabwe, about 35 percent of all hospital beds are privately owned, and about 96 percent are located in poor and disadvantaged areas (Gilson et al., 2000).

Although for-profit providers are less common in Africa than in other non-industrialized countries, they play an important role, and it is

a very rapidly expanding sector: it was estimated that in the 1980's and early 1990's the number of for-profit physicians in eight African countries ranged from 2 (Burundi) to 86 (Zimbabwe), significantly below the average of 213 for all developing countries. About 46 percent of all physicians were private in Africa (Hanson and Berman, 1998). In Cotonou, the capital of Benin, alone there are 328 private providers. One-half of the managers of those private structures admit having a second job, and half of those said it was a job in the public sector. It is interesting to note that more than 75 percent of those private providers are open or available 24 hours a day. It was also found that the majority of those providers accepted to treat a poor person freely or through credit with less than 10 percent said they would refuse to treat a person who could not pay (Decaillet and May, 2000). Tanzania began to encourage private provision of health care in 1991, and it is estimated that between that date and 1996 there was a 36-fold increase in the number of private for-profit dispensaries and that the number of for-profit hospitals increased five-fold (McLaughlin 2004). Development of this sector is also seen as a way to reverse the brain-drain, as is the case in Ghana. For-profit hospitals have a strong foothold mainly in Kenya and South Africa (Shaw and Griffin, 1995). In Ethiopia, the private sector and NGOs owned 9 percent of hospitals and 28 percent of clinics in 1995, the numbers increased respectively to 24 and 41 percent in 2000 (Abay Asfaw, 2003).

Since urbanization is rapidly increasing in SSA from 34% in 2000 to 51% in 2030 (L'Intelligent, 2002), private health providers will likely grow quickly to serve those 621 million inhabitants in 2030.

In rural areas, private providers are also quite present, but more as NGOs and traditional healers. In Kenya, in 1998, among the rural people who sought care for young children with diarrhea or cough, 52% went to a private provider, this figure was 55% for the

urban population (Marek et al., 2004). In Guinea's rural areas, independent practitioners who do home visits absorb 91 percent of the out-of-pocket expenditures (44 percent in urban areas), and private clinics absorb another 44 percent of urban out-of-pocket expenditures (4 percent in rural areas) (Schwabe et al., 2003). Those rural independent practitioners are likely to be mainly traditional healers and midwives.

Recent research also suggests that private providers, in particular NGOs, often provide health services more efficiently than do governments. A study on the performance of church and mission hospitals in Ghana, Tanzania and Zimbabwe showed that they were on average more efficient than their government counterparts: In Tanzania, private hospitals treated twice as many outpatients and inpatients as the government hospitals. In Ghana, private and government hospitals had similar costs but drug availability was about 15 percent higher in private facilities. In Zimbabwe, the average doctor to bed ratio was significantly higher for private providers (Gilson et al., 1997). Another case study from Zimbabwe suggests that subsidies to non-profit providers leads to better improvements in equity than those to for-profit providers (Mudyarabikwa, 2000). In Ethiopia (Ethiopia Survey, 2002), recurrent costs per patients treated in 2 public and 3 NGO health stations and clinics in 1999 showed that the cost was 12.6 and 9.8 Birrs respectively; however, at the health center level the NGO spends 42 Birrs while the public sector spends 38 Birrs; finally at the hospital level the recurrent cost per patient is lowest in the public sector at 21 Birrs, followed by a sugar factory hospital at 41 Birrs while a private hospital spent the most, at 114 Birrs. So evidence is not quite conclusive on how cost efficient the private sector is compared to the public. For the moment, one should, therefore, look to the private sector to improve quality and coverage more than to decrease costs.

What can be done? Already in 1993, the World Development Report called for an increased use of the private sector to improve equity and efficiency (World Bank, 1993).

Africa is very rich in local traditional organizations, such as age groups, women groups, youth groups, sports groups, which can be mobilized to work with communities, as the case of Senegal illustrates (see Box 8 below). Such local organizations are considered part of the private sector too. Thus, partnerships with the private sector have the potential to improve equity in African health systems. To date, most countries are starting to implement formal agreements between private providers and the government. Generally, there seems to be an increased appreciation of the importance of private providers as an untapped resource to effectively deliver health services. The private for-profit sector could continue to serve the rich urban population making this segment of the population pay for it, while the public sector and not-for-profit private sector could concentrate on the poor.

Increased partnership with the private sector, however, will require that governments shift their effort to functions such as regulation and leave more service delivery to the private sector. Current regulations of the private sector are inadequate. In Tanzania and Zimbabwe current regulations: (i) focus on individual inputs rather than health system organizations; (ii) aim to control entry and quality rather than explicitly quantity, price or distribution; and

(iii) fail to address the market-level problems of anti-competitive practices and lack of patient rights (Lilani et al., 2000).

In Ethiopia, the private sector is constrained in a variety of ways. One constraint is licensure. Providers obtain their licenses only from regional health bureaus, and this is perceived to be overly centralized and could be delegated to the zonal level. License renewal is also time consuming and bureaucratic (Ethiopia Survey, 2002).

Some might argue that many governments have a limited capacity to regulate, and this is, indeed, why the unregulated private market flourishes. So, in countries with very limited capacity, it is more helpful to think in terms of what can be achieved in the short- and long-term. In the short-term, efforts can be made to: (i) increase health related knowledge and information to users, (ii) work with commercial and informal providers (traditional healers, street drug vendors, etc.) to improve dispensing and treatment practices; (iii) expand good practices where they exist; and (iv) encourage local organizations to manage or monitor health provisions. In the long-term, policy needs to concentrate on building capacity to (i) develop regulatory frameworks and formal accountability mechanisms to improve health sector performance, (ii) contract with providers against specific outputs, and (iii) establish information systems to monitor performance (Bloom and Standing, 2001).

**Box 8: The government as an active purchaser through strategic contracting in Senegal**

An example of successful contracting by the public sector for preventive services can be found in community nutrition projects in Senegal. (Marek et al., 1999) This project avoided most of the challenges mentioned by Anne Mills (1997). In Senegal, contract management was delegated to a third party, an NGO called Agetip which became the project management unit. This project management entity manages and monitors contracts for the government and is responsible for project implementation and results. Transaction costs of introducing and maintaining the contracts amount to 17 percent of total project costs. As the project is focused on improving the nutritional status of malnourished children, it is a clear example of using strategic purchasing to benefit the poor. This was further verified by results of a study in Senegal that demonstrated that 79 percent of project expenditures were spent in the poor peri-urban target neighborhoods.

High-risk children receive the following services: monthly growth monitoring; weekly nutrition and health education services to mothers; referral to health centers and home visits when necessary; food supplementation for the malnourished; improved access to water. Service delivery is contracted out as well as training, supervision and operations research. Services are delivered by a group of previously unemployed young people who create a legal entity, and who come from and live in the target neighborhoods. The youth groups who are the service providers, are supervised by a supervisor (often a pair of unemployed medical doctors) who is, in turn, supervised by Agetip.

The project did not use competition to award contracts for overall project management but open tendering was used to choose the supervising NGOs. The youth entities are chosen by their communities and they sign a formal contract with Agetip. Contractual agreements specify the services that are to be provided, the number of beneficiaries served, and the amount of attendance to weekly health and nutrition education sessions required. Performance is assessed by evaluating results as reported in the management information system that is built and maintained by each service delivery unit. Supervisors and community nutrition workers can be fired if their performance is below expectations. The same four indicators are monitored monthly by the targeted community, the supervisors and Agetip. Local community committees monitored in part the service delivery, which increased accountability.

Malnutrition rates decreased rapidly and coverage steadily increased. A community based study confirmed that malnutrition rates decreased steadily and that after 17 months of project implementation severe malnutrition disappeared among children of 6-11 months and moderate malnutrition fell from 28 to 24 percent among the 6 to 35-month age group. Project managers believe that the decrease in malnutrition is caused more by better care through regular growth monitoring and nutritional education for mothers than by the food supplement.

## Current Trends and Practices in Purchasing Health Services

**N**ational Health Accounts revealed that in ESA, 53 percent of health expenditures go through private purchasers: 33 percent through households, 11 percent through NGOs, 9 percent through private insurance and employers (ESA NHA, 2000).

In spite of those figures, governments in Africa are still in the early stage of the financing-providers split, and only recently did timid efforts start to purchase services in a strategic way.

### **Public–public arrangements: Local level purchasing within a decentralized public model**

As mentioned previously, in recent years, some countries in SSA have decentralized their publicly funded health systems. This move toward decentralization has been partly driven by the belief that local control over resources will result in better performing health systems because local authorities are more accountable to their populations. Design and implementation of “decentralization” in the continent has included a variety of models ranging from the establishment of regional bodies that have no

influence over critical management decisions such as hiring and firing or how resources will be allocated to models with a higher degree of local control. There are some attempts at autonomization of hospitals, but no data is yet available to assess their impact. Few systems have effectively evaluated the impact of these reforms. One exception is Burkina Faso where the health system has been decentralized (see Box 9). It must be noted that this successful experience has since ceased in Burkina itself, as mentioned previously.

### **Public–private arrangements**

International advisors have been actively promoting contracting out health services rather than direct government provision as a way to improve efficiency and quality of care and to improve access by providing services in regions where public providers are scarce. While governments in Africa have contracted the private sector to provide non-health services such as laundry, food service, and cleaning there are few examples of governments contracting private sector providers to deliver health services and fewer cases that have been evaluated. The Government of Malawi plans to contract out clean-

### Box 9: Innovation in RAP arrangements within a hierarchical public structure: Burkina Faso Case study

Presented here is the bottom-up planning, oversight, and resource control approach implemented by Burkina Faso (Eichler, 2001). One of the primary strategies to improve performance of primary health care in Burkina Faso is to engage each community to assume leadership for their own community's health. Community committees have been established to: formulate priorities for health; identify strategies to solve identified problems; incorporate strategies into annual action plans; oversee operations of community primary health care facilities; establish local user fee schedules for cost recovery; manage drug depots as revolving drug funds; and to manage funding from the government, donors and user fees. What is unique is that action plans are developed at the community level and funds flow from the central level to districts and then to communities and are managed at the community level. Communities effectively become purchasers for some inputs important for primary health care service delivery (e.g., motorbikes for health education outreach and essential drugs), control user fees, manage funds for drugs and consultations, and oversee the performance of the primary health care workers whose salaries are covered through the central ministry.

Central to this model of decentralization is the bottom-up approach to developing action plans. Each year action plans are developed at the regional, district, and community level (defined as the group of villages served by a primary health care center) according to a clear process established by the central ministry. Action plans define specific activities that will be carried out by each level in the system to address priority problems, the funding required, indicators of performance, and procedures for appropriate management of funds. Manuals document the process to be followed and provide formats for preparing budgets and performance indicators. Staff in regions and districts facilitate the planning process with community health committees to develop community level action plans. Each year a conference is organized with the regions, the central government and donors to discuss and approve plans and to obtain commitments to contribute resources. After this consultative process, plans are revised and funding commitments are made.

While defining performance targets that communities perceive to be important is an approach to focus efforts on results, communities are not fully held accountable for achieving the goals established in their action plans. Current management agreements do not contain either rewards for attaining targets or penalties for failing to reach them. Burkina Faso is considering introducing explicit performance based funding to provide more powerful incentives to each level in the public system to attain performance goals. The current information system is adequate for monitoring key primary health care indicators and the management system could be revised to accommodate a performance based payment scheme.

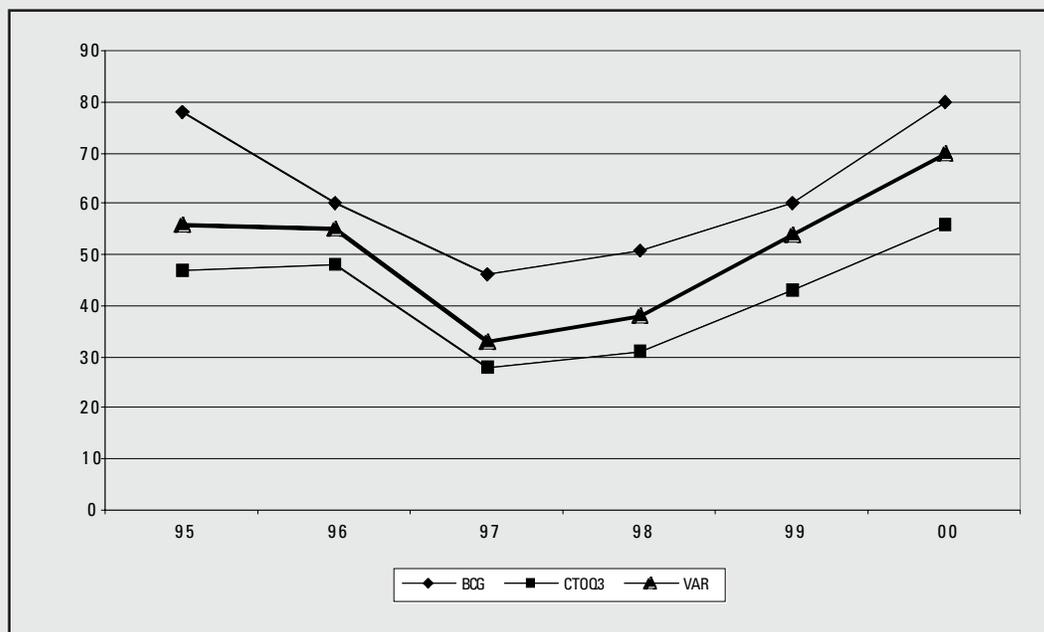
*(continued on next page)*

ing, maintenance and other ancillary services affecting 5,237 civil servants who will then be retrenched from the civil service, retrained or be absorbed by the private sector (Picazo, 2002).

Anne Mills (1997) describes examples of contracting with the private for-profit hospital sector in South Africa and Zimbabwe with mixed results. She cautions that key issues that must be

**Box 9** (continued)

Results so far are promising but more experience is needed before conclusions can be drawn about whether this is a model to propose for the rest of SSA. By 2001, all communities in Burkina Faso had developed action plans indicating a high degree of inclusion of the poor and rural population. There is wide agreement that one of the contributors to success is the availability of adequate financial resources that are managed at the local level. Data indicate that since implementation of this decentralized model availability of essential drugs has increased slightly; immunization coverage has increased markedly (see Chart below); the percentage of women receiving at least 2 prenatal visits has increased from 41 to 52 percent; assisted deliveries have increased from 30 to 33 percent, and use of modern family planning methods remains low with the family planning prevalence rate showing a slight increase from 3.7 to 4.9. The transaction costs of implementing this approach are estimated to range between US\$ 0.03 per capita under the lowest cost scenario and US\$ 0.12 per beneficiary under the highest cost scenario. If performance across key primary health indicators continues to improve it is easy to argue that this investment is justified.

**Immunization coverage in Burkina Faso (1995–2000)**

Sources: 1995-1999 Ministry of Health and Eichler 2001.

considered include: the capacity of the contracting agency; the details of the design of contracts; the capacity to implement contracts; and the characteristics of the supply and labor markets.

Although Governments have historically been providing subsidies to not-for-profit

providers, no formal contracts were drawn as such. Contracting is a new trend.

Good and bad reasons to work with the private sector: Whether the private sector has some comparative advantages depends on specific situational circumstances and how the

partnership was established. There is, however, evidence to show that using the private sector can increase equity, especially if NGOs or Community-based organizations are used to work in areas not covered by the public sector. Another advantage of using the private sector is the possibility of improving quality of services, mainly through better accountability to the client. Finally, the private sector can in many instances increase coverage very fast when mobilized. There already exist good examples of different types of instruments upon which to build, such as contracting, leasing and concessions (Marek and Yamamoto, 2003).

Private not-for-profit providers have been proven effective in reaching the poor in areas which have been typically under-served by using explicit contractual agreements. For example, in a community nutrition project in Senegal, service delivery was contracted out to local youth groups, to cover poor peri-urban areas (see Box 8).

### **Private–private arrangements**

Another approach to increasing the availability of adequate quality health services and essential medicines is to stimulate the development of private providers. One way to do this is through franchises. Franchisors develop a business model that franchisees can buy into. Each franchise is a private business. Franchisees must comply with standards and procedures developed by the franchisor, sell products purchased through the franchisor, and charge prices determined by the franchisor. Moreover, the franchisees must comply with the franchisor's management and reporting systems. This degree of standardization offers assurances to consumers of quality and consistency.

One level of strategic purchasing happens when the franchisor purchases products to supply the franchisees. In a social franchise

that is motivated to achieve social goals, this approach to purchasing enables the franchisor to take advantage of market power to negotiate low prices and assure quality with suppliers. After products are distributed to franchisees, final purchases are made either with out-of-pocket payments by consumers or by consumers who have some form of third party payment. Governments can stimulate the creation of franchises by making capital available and by establishing social priorities. If franchises are viable private enterprises, they are sustainable.

There are a few franchises in Africa, some are for reproductive health services, such as Mary Stopes in East Africa, others produce and distribute condoms or impregnated mosquito nets. Many seem to face the problem of sustainability as they cannot recover all their costs they need to have subsidies in order to continue reaching the poor. A promising franchise is that of Cry for the World, in Kenya, which sells drugs (see Box 10).

In addition to franchises, there are several large companies which act as purchasers as well as financiers for the health of their workers. Mining and large agricultural estates have been known to invest heavily to reach the communities from where their workers come, especially in regards to AIDS.

### **Demand-side strategies to enable purchasing among target groups**

A potentially powerful strategy to enable priority population groups to purchase health services is to subsidize their demand. One such mechanism is to provide consumers with vouchers that enables their access to either discounted or completely free services. A project in Tanzania provided pregnant women with vouchers to purchase insecticide-treated nets (ITNs) (see Box 11). The mixed results provide good lessons for the design and implementation of similar schemes in SSA (Marchant et

**Box 10: Expanding access to essential medicines through franchised drug shops in Kenya**

Cry for the World Foundation (CFW) started a network of franchised drug retail outlets in the districts of Kirinyaga and Mbere in Kenya in early 2000. By 2002, 26 retail shops had been opened. Initially, the shops were operated by community health workers who received training by the franchisor. In order to open an outlet, an outlet manager must provide 20 percent of the financing and take a loan for the additional 80 percent for an interest rate of 18 percent per year. Only drugs on Kenya's essential drug list are sold. Outlet managers are required to distribute only those products that are supplied through CFW and to keep financial and stock management records and records of patient interactions according to the rules of the franchise. Prices are determined by CFW and are considered to be among the lowest in Kenya (Marsden, 2002).

At the central level in Nairobi, CFW is responsible for helping to establish new shops, supervising and developing training materials, purchasing drugs and supervising drug distribution, assuring drug quality control, and managing relationships with the MOH. Supervisors located at the district level train franchise outlet owners and assure that franchise procedures are being followed. Because franchisees own their shops and earn a return on sales, they have financial incentives to be responsive to population preferences by adapting location, hours of operation, styles of interaction, and physical appearance of their shops.

By 2002, a population of roughly 100,000 people were being served by CFW outlets. A study of sales and patient interaction records examined the impact of the franchise on prevention and treatment for malaria. Of the 60,000 patient records that were examined, over 20,000 were found to be for malaria. Record reviews found that outlets are strictly adhering to national treatment guidelines which indicates that quality services are being provided. In addition, impregnated bed-nets were sold by outlets. CFW does claim to be reaching the poor, but not the very poor who cannot pay (CFW, 2002).

al., 2002), and to help answer the question of whether vouchers can be used to target population groups to increase utilization of a product or service.

Conclusions about the effectiveness of vouchers to stimulate demand cannot fully be made based on this experience in Tanzania. What is clear is that in order to be effective, a social marketing strategy must target purchasers in households and that incentives to use the system in ways other than is intended must be considered as part of the design and implementation process. This example is included as a strategy that has potential to stimulate service utilization among target pop-

ulation groups in SSA but more evidence is needed.

Overall there are some very good purchasing experiences to build upon to reach the poor in SSA, especially in terms of public–public and public–private arrangements. It would be relatively easy to build on the positive experiences in order to go to scale. More attention needs to be given to evaluating the schemes and to training of both government and private actors in contracting. There's also a need to provide the nurturing policy and administrative environment for those schemes to be implemented with the least hurdles possible.

**Box 11: Vouchers to improve access to ITNs among pregnant women in Tanzania: a strategy to stimulate demand side purchasing**

Vouchers intended to enable pregnant women and children under five to purchase ITNs at a discounted price were tested in the Kilombero Valley region of southern Tanzania in 1999 (Marchant et al., 2002). Sleeping under ITNs has been linked to reduced incidences of anemia and malaria in pregnant women and the young children who tend to sleep with their mothers. As designed, public maternal and child health (MCH) clinics in the region were supposed to give pregnant women and mothers with young children vouchers that provided a 17 percent discount in price of ITNs available at local retail outlets. In effect, this discount reduced the price of a net from US\$ 3.8 to US\$ 3.1. MCH workers were given training in how to communicate the importance of ITNs to pregnant clients and in how to explain the way vouchers worked. Outlet retailers submitted the vouchers for reimbursement for the discounted amount plus an additional handling fee.

To assess impact, a sample of 505 pregnant women in their third trimester were interviewed at their homes. Among this group, 97 percent attended MCH clinics. In spite of this high attendance only 28 percent had heard about the vouchers and only 2 percent reported having been given a voucher. Of the 10 women who reported receiving a voucher, 80 percent had used it to purchase an ITN. Of the remaining 131 women who knew about the vouchers but had not received one, 83 said that they did not want one because the discounted price was still too high for them to afford. Another 29 said that they already had an ITN at home and therefore did not need the voucher. Only a small percentage of women (5 percent) said they did not understand how to use vouchers.

In contrast to the low uptake among pregnant women, 86 percent of all vouchers issued in the study area were used. What is not clear is how many of these vouchers were actually used by eligible women. Suggested explanations for the low use among the target population group include: MCH staff trying to sell vouchers, retailers refusing to accept vouchers, and non-eligible people receiving vouchers (Marchant et al., 2002). It is also possible that eligible women gave false statements about having received the vouchers because they were used to purchase nets for non-eligible family members or they hoped they would receive an additional voucher. In addition, women reported that the majority of purchasing decisions were made by their husbands calling into question whether using MCH clinics attended by women is the most effective vehicle to market and distribute vouchers.

## Conclusion: Misconceptions, Constraints, and Future Opportunities

### Misconceptions

This paper highlights a few (7) common misconceptions:

1) The problem is one of money: although funding for health is severely constrained in SSA, there are plenty of resources which are either not used (large amounts of undisbursed donor money, untapped and unregulated private sector providers, low levels of execution of public budget) or used in an inefficient manner;

2) Resources allocated to primary health care are reaching the poor: they usually benefit the wealthy more than the poor, unless proper targeting mechanisms are in place;

3) The public sector is the main provider of health services in Africa. Although donors have up to recently focused mostly on how to improve public sector spending, there is a large share of health spending which is private, which also needs to be utilized more effectively;

4) Public–private partnerships are justified because they draw on the efficiencies of the private sector. Evidence indicates that public private partnerships are more likely to benefit equity, service quality, and community empowerment than cost control;

5) The private sector can do better than the public sector. This is not always the case. Public–private partnerships are usually justified when a government wants to improve equity, quality, empower communities, but does not want to deliver that service or perform that function itself, or when a private entity has a comparative advantage in service delivery. Such partnerships should not be attempted for other reasons;

6) Working with the private sector means neglecting the public sector. On the contrary, for a government to work effectively with the private sector it has to be able to: 1) negotiate contracts; 2) set up the right enabling environment for the private sector to operate; and 3) provide norms and ensure that they are implemented — among other functions. Other functions, particularly those related to service delivery, can be devolved to the private sector;

7) External aid will solve the problem: reliance on external sources of financing is still very high in most countries, but donors seem to provide aid more based on political considerations, and the fragmentation in external sources of financing adds to the countries' problem of managing and coordinating.

## Constraints to Effective RAP

This paper also highlights some (3) of the constraints faced by governments in Africa:

1) Many governments experience a lack of stewardship. There are many reasons for this, some of which are political and some are technical. Inadequate management of human resource represents a major challenge to African health systems that results in the non-disbursement of a considerable amount of available funds. Added to this is the complexity of managing often conflicting donor priorities and the pressure placed by the HIV/AIDS epidemic and the result is health systems that are overwhelmed and, thus, perform poorly. Governments, with donor support, have tried to introduce SWAPs to establish priorities for the sector and to manage competing donor agendas.

2) The allocation of resources based on historical budgeting only perpetuates existing inequities. Decentralization is one strategy used to improve resource allocation, but it has not yet generated the expected results. Reallocation of resources toward primary care and away from secondary and tertiary care has also proven to be difficult to implement. Even in countries where some reallocation has occurred, the poorest populations are not necessarily the beneficiaries. There is, therefore, a need to target public services specifically to the poor and to ensure that those that can pay, do pay.

3) Donors need to ensure that their aid helps reinforce health systems rather than create fragmentation and more strain on already stretched human resources.

## Future Opportunities to improve RAP

This paper shows that some African governments have already looked for ways to improve resource generation, provide risk protection, and carry out strategic purchasing. This also paper mentions a number of successful examples and lessons learnt which can be built upon, and are to be encouraged. There are trends which need to be encouraged to improve RAP, and we classified them into three categories:

### To improve the policy-side of RAP arrangements:

(i) There are several ways to improve equity, which include:

■ **Risk pooling:** A challenge to the increasing utilization of essential services by the poor is providing mechanisms to protect households from the financial burden of high cost health events. Various insurance schemes can provide this needed financial protection and can result in higher utilization of essential services by removing the financial barriers to access that households face. While each risk pooling scheme is different, experiences contain the following common lessons to be considered when designing and introducing schemes:

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- The human resource capacity needed to manage insurance schemes must be considered carefully;
- Systems are needed to control fraud and abuse by both providers (excessive billing) and patients (sharing membership cards with non-members);
- Payers should use their purchasing power more strategically by using payment mechanisms that consider incentives for both provider and patient behavior;
- There appear to be advantages to enrolling groups rather than individuals to avoid adverse selection;
- Attention needs to be paid to ensuring that services are of adequate quality as perceived by patients;
- Schemes should consider expanding coverage to include high cost services such as hospitalization;
- If catastrophic costs are covered, larger risk pools or social re-insurance schemes will be needed to ensure the financial viability of community schemes;
- Choice of provider may make voluntary schemes more attractive to the population; and
- More attention needs to be paid to effective marketing of voluntary schemes.

Poor people are willing to pay premiums in advance to receive coverage for uncertain future events if they can be assured of access to quality services and that the perceived benefits outweigh the costs. Participation in a community based health insurance scheme tends to increase utilization as compared to the uninsured population. Except in Rwanda where household wealth did not seem to be a determinant of enrollment, studies indicate that having to pay premiums continues to pose a barrier to the participation of poor people. Evidence from CBHI schemes indicates that overall enrollment rates are low and drop out rates are high. An improved design that increases responsiveness, controls expenditures, and effectively markets to the population may increase the success of CBHI schemes in SSA though more time, experience, and evidence is needed.

- **Utilization of targeting instruments:** There are a number of tools that can be utilized for pro-poor strategies, such as vouchers and performance-based contracts. Vouchers represent a demand-side strategy that has the potential to increase access among low income people. By providing consumers with vouchers that entitle them to either discounted or free services, consumers are enabled to obtain essential services from a range of outlets. Establishing the rules and system which govern vouchers and reimbursement of providers calls for government leadership and increased capacity along these lines. Performance-based contracts can be used to increase coverage among certain populations.
- **Marginal Budgeting for Bottlenecks:** Despite extensive Sector Reforms, the health systems in many SSA countries still fail to reach large numbers of women and children—especially the poorest and most vulnerable—with these interventions.

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This situation triggers a growing demand for tools that help answer three questions:

- What are the major health systems bottlenecks hampering the delivery of health services, and what is the potential for their improvement?
- How much money is needed for the expected results?
- How much can be achieved in health outcomes by removing the bottlenecks?

The Marginal Budgeting for Bottlenecks (MBB) tool recently developed by UNICEF, the World Bank and WHO, and tested in several countries is a response to this demand and needs to be monitored and evaluated in the countries where it is being implemented.

- (ii) **Decrease dependency on donors for selected activities.** This is especially important for recurrent costs.
- (iii) **Develop policies to work with the private sector in order** a) to alleviate the burden of financing health services by the poor who already purchase services from the private sector; and b) to harness those existing private resources to achieve public health goals.
- (iv) **Implement public health policies that have a large impact.** Some very cost-effective measures could be implemented by simple policy changes (such as smoking), others need to build on existing successes and go to scale (such as for nutrition and immunization) in a sustained way.

*To improve the organizational-side of RAP arrangements*, there are four primary messages:

- (v) **Develop a culture of results rather than process**, by using performance-based contracts with lower level authorities as well as with the private sector. By doing so, Governments might integrate this approach into the governments' overall decentralization process. This is a way to do away with a hierarchical bureaucratic relationship and it might yield more results. The idea is to encourage decentralization of fiscal resources based on performance targets of lower level authorities. Although many governments in Africa have committed to decentralization, the mechanisms to implement this process need to be improved. The flow of funds should be clearer and traceable, so that all levels know precisely the amount of resources to expect when. Performance-based contracting with districts, as was done in Burkina Faso, shows promise for increasing accountability and results.
- (vi) **less fragmentation in the financing and delivery of health services** must be ensured, wherein the Sector Wide Approach Programs (SWAPS) might be a good start;

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- (vii) provide subsidies to the poor so that they are able to pool resources, increased attention to the potential capacity and contribution of health mutuals is one way to achieve this.

*To improve the institutional-side of RAP arrangements*, here are some options for African Ministries of Health:

- (viii) assume a stronger role as stewards, that is provide regulation, supervision, monitoring and competitive arrangements. Develop mechanisms, guidelines, and ensure adequate training to work with the private sector. The issue is not whether services should be provided by the public sector or by the private sector. What is important is that all the people be covered by quality health services. This paper reveals that both the public and private sectors could greatly improve on ensuring that this important objective is achieved. Governments need to focus on the essential functions that only they can undertake, and harness the potential of private providers for services provision. The private sector can function effectively on a large scale only if the public sector is able to fill its role as regulator. The literature shows that ministries of health are still trying to do everything — but that they are not able to do it. There is, therefore, the need to design simple yet precise public–private partnership strategies, a few examples of which are reviewed in this paper. Such strategies must include strengthening the public sector to: 1) set norms, 2) control quality, and to 3) design and implement regulations so as to provide an enabling environment where the private sector can serve social goals.

To effectively contract service providers, governments also need the capacity to design, negotiate, manage, and evaluate the performance of contractors. An example of effective contracting that avoided the contracting capacity constraints that usually present bottlenecks in many MOHs can be seen in a nutrition project in Senegal (Box 8). By contracting a delegated contract management agency, Agetip, it was possible to minimize transaction costs and ensure the work was done without increasing Government personnel.

Franchises are another approach to increasing availability of services and essential medicines. Presented here is the case of Cry for the World, a franchise of drug retail outlet shops in Kenya that provides access to high quality and reasonably priced essential drugs. Because consumers must pay out-of-pocket for drugs, the poorest population does not specifically benefit. This strategy has the potential to improve access to quality products at controlled prices. Third party payment such as subsidized participation in a CBHI scheme could help increase access to franchise services and products by the poorest people.

Community organizations constitute an opportunity to increase coverage in Africa which still remains to be acknowledged, harnessed and contracted as service providers by governments.

- (ix) separate financing from provision of services in order to help with governance problems and to improve accountability.

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