Health Financing

Bamako boost for primary care
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In Senegal the generation of funds from the users of public health services in accordance with a strategy based on the Bamako Initiative is proving to be an extremely effective means of cost recovery and, in conjunction with management changes, is helping to improve the standard and scope of primary care.

Senegal adopted the principles of primary care in 1978 and subsequently achieved considerable improvements in major health indicators. Nevertheless, at the beginning of the 1990s much remained to be done to improve the primary health care services, and far-reaching reforms of the health sector were therefore undertaken, including the decentralization of planning, the introduction of an essential drugs policy, and the adoption of a strategy based on the Bamako Initiative. Also of significance was the passing of a law on the organization and operation of health committees. The strategy was carefully tested in three of the country’s 45 health districts and by 1994 it was being applied in all of them.

Consultation fees

Patients are required to pay fees for preventive or curative consultations in district health facilities. At health posts the charges are approximately US$ 0.10 and $0.20 for child and adult consultations respectively. At health centres the charge for an outpatient visit is usually $0.40, while for inpatient care the prices are in the range $6-10, irrespective of the duration of hospitalization. Most health committees apply rates that were set by central officials when the payment system was established. The price structure has remained largely unchanged since the beginning of the 1980s.

The consultation fees are used to cover recurrent costs that are not met by either the government health budget or receipts from local communities. Initially, payments made by patients were intended to supplement funds allocated by the state rather than to cover current operating costs of health facilities. In the districts, however, state funds allocated for operating purposes are spent almost exclusively at the district hospitals, where the cost of services is much higher than at health posts. The user fees allow the districts to supplement state support for hospitalization and certain expensive procedures such as X-ray and laboratory investigations.

The health posts operate almost exclusively on the strength of fees collected from their clients. This used to be the only form of participation
by patients; 60% of the collected monies were used for the purchase of essential drugs while the remainder were used to cover operating costs. Since the new strategy was introduced, however, all funds derived from consultation fees have been used for current operating costs.

**Paying for essential drugs**

Until 1992, drugs offered in the public sector were free of charge, but this is no longer the case. It was decided that drugs should be sold in all public health facilities and that their prices should be regulated by the government. The recommended prices were 10% above those at the national pharmacy, which was allowed to sell drugs at a 5% profit margin. In fact the district health committees tended to charge more than the recommended prices, and in June 1995 a mark-up of 50% was authorized by the Ministry of Health and Social Action.

The generic drugs sold by health centres and health posts are nearly all on the national list of essential drugs. The manager of the drugs stock in a given facility is allowed to serve only persons in possession of prescriptions that have been written there. Rationalization has helped to keep the cost of treatment very low, although prices vary from district to district, depending on the progress made in applying different stages of the strategy.

The first stage includes the estimation of each health unit’s drug requirements, which vary with the number of patients and consultations in the previous year, the most frequent infections by age and sex, the sources of funding, the procurement system, and the methods of managing essential drugs. In the second stage, focusing on the management of primary care activities, special attention is given to the development of management tools, the rationalization and standardization of diagnosis and treatment protocols for most common diseases, and the development of monitoring methods.

**Progress**

Analyses were made of cost recovery and cost per case. Information was collected every six months at each health post by a team of three or more, including the nurse in charge and a health committee representative. During 1995 a survey of user contributions to the financing of primary care was conducted in all 45 health districts. Several small-scale evaluations, including a consideration of financial matters, were conducted at the operational level by district staff who wanted to make adjustments in strategy implementation. The level of achievement under the strategy was monitored on the basis of Tanahashi’s methodology for health coverage assessment, which considered availability, accessibility, utilization, adequacy and effectiveness (1).

In 1994, approximately $3 500 000 were collected as fees from users of public health services, equivalent to 60% of the total budget of the 45 health districts. Of this amount, 61% came from users’ purchases of essential drugs and the remainder from consultation fees. Operating costs amounted to 84% of the revenue collected; they included the costs of essential drugs (57% of the total), community health workers’ salaries (20%), maintenance of the cold chain (4%), and other maintenance (12%). Vaccines, contraceptives and the treatment of leprosy and tuberculosis were provided free of charge to the districts.

The average cost of a case for both consultation and drugs rarely exceeded $1.20, whether involving preventive or curative care. The low costs were attributable to:

- the essential drugs policy;
- the rationalization and standardization of
protocols for the diagnosis and treatment of most common conditions;
- the provision of subsidies by donor agencies and financing by government for primary care services.

The second, third and fourth half-yearly monitorings conducted at the health posts in the districts of Matam, Podor and Bignona each revealed a reduction in the average cost per case. The figure had fallen to approximately $0.60 when the second stage of the strategy was reached, representing a substantial saving for patients.

The prices of drugs in the public sector are significantly lower than those in the private sector. Private pharmacies still sell drugs under their brand names in small packages and have no financial support whereby prices might be subsidized; all costs have to be met with monies derived from drug sales. Given a GNP per capita of $419 it appears that essential drugs are well within the means of the rural population. About 90% of the prescriptions written are submitted to pharmacies.

Despite the small amount of money collected per case, expenditure was covered in all 494 health posts monitored in December 1994. The revenue from drug sales and consultation fees has made it possible to achieve complete recovery of operating expenditure in the health posts. The salaries of all government employees are paid by the Ministry of Health and Social Action.

Senegal’s primary health care strategy includes a community assistance programme intended to provide the poorest people with drugs free of charge. It was assumed that the decentralization of the collection and management of users’ fees to local health committees would mean that better care would be taken of the poor. Unfortunately, there are no clear criteria for identifying the poorest people. To date the assistance programme has been badly run and problems of inequity remain.

Geographical accessibility to primary care facilities is satisfactory. Over 70% of the population lives within 5 km of a health post. The utilization of services is increasing at a majority of health posts, having reached at least 80% for immunization, prenatal care and primary curative care. The figures for adequate coverage and effective coverage have risen to over 60% in many districts.

The increased participation of patients in the financing of primary care permits the public health posts to be financially self-sufficient. They rely exclusively on user fees to cover the recurrent costs of primary care. The charging of a consultation fee for each visit brings about an improvement in the allocation of resources for health facilities. The health sector is now jointly financed by government, local communities and patients.

All services in the districts are in fact subsidized, whether by government through the payment of certain capital and recurrent costs or by the local communities. The revenue collected locally is substantially larger than the amount provided by the state.

It is easier to obtain money from users by selling drugs than by providing services. Even so, a substantial proportion of revenue was collected for curative care services, and this can be linked to their being offered at the health post level, where both private benefit and registered demand are highest. The different proportions of revenue deriving from various services result from the absolute numbers of people using them and the greater willingness of users to pay for curative than for preventive services.
The costs per case and per contact are very low. Apart from government personnel, the only expenses in the operation of health posts are for electricity, where available, and water, if the national water company supplies it. In most health posts, kerosene lamps are used for lighting, and water comes from wells on site. The cost of running health posts is kept down because of state subsidies and the efforts of the local communities, who collaborate with government officials.

The model of patient-financed health care in Senegal appears to be the best one possible given present conditions. However, the members of the local health committees that manage the monies collected often lack adequate preparation for this responsibility. Their training is entrusted to district staff and the nurses in charge of the health posts, who, unfortunately, are overburdened with other tasks. For this reason a microplanning process, including the production of a detailed budget, is undertaken after monitoring has been done, in order to improve the allocation of resources to priority areas.

This model links the government, which is responsible for the salaries of health personnel and investment in materials, with the users of the health care services, who pay the operating costs of primary care facilities. The population is able to address its health care needs in collaboration with local health committees. The state thus obtains financial support while the possibility is created for co-management of the health system by its personnel and members of the local communities.

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In this model it is assumed that mechanisms and guidelines are in place for the efficient and wise use of receipts. In Senegal, clearly defined procedures are followed between the collection and utilization of money, and approaches to improving the performance of health posts have been established. It is hard to ascertain how well and how often managers at district level follow the guidelines. This presents a major challenge wherever attempts are made to adopt a user fee system. Patients demand services of high quality, and if health systems are to succeed in the long run they must be able to provide them.

Reference