CURRENT CONCERNS
ARA Paper number 12

HEALTH SECTOR REFORM IN SUB-SAHARAN AFRICA -
A REVIEW OF EXPERIENCES, INFORMATION
GAPS AND RESEARCH NEEDS

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Evidence-Based Health Sector Reforms in Sub-Saharan Africa,
Arusha, Tanzania, 20-23 November 1995
SYNOPSIS AND ACKNOWLEDGEMENTS

Countries across Africa are engaged in redefining their health policies and restructuring institutions in response to the challenges posed by an economic decline, dramatic increase in poverty, and serious erosion of the human development achievements over the past two decades. While Health For All (HFA) through Primary Health Care (PHC) remains the main goal of health development in Africa, health sector reform is urgently needed in order to re-shape the future of health systems in the African region. African health systems need to be reformed in order to strengthen their capacity to provide an adequate access to quality care for all populations, especially vulnerable groups, and thus to reduce on a sustainable basis the most common causes of morbidity and mortality.

African countries are in no way homogeneous, and present many different stages of health system development as well as different nature and direction of health sector reform. In spite of this divergence, there are many commonalities, and the aimed objectives, the issues addressed and the tools mobilized are often similar or comparable across the borders. While every reform experience is country specific, there are always important lessons to learn from comparing options and evaluating effects of various reform initiatives.

Various reform initiatives should not be viewed as isolated measures but need to be addressed as a complex systemic effort aimed at improving equity, efficiency, quality and sustainability through a well-informed action involving all three key aspects of health systems, e.g. organization, financing and service delivery. Health sector reforms require specific data and objective evidence for rational decision-making and implementation which underscore the critical value of sound health policy and systems research (HSR).

The Intercountry Meeting on Achieving Evidence-Based Health Sector Reforms In Sub-Saharan Africa held in Arusha, Tanzania, from 20-23 November, 1995 provided a forum for the countries of the region to share experiences on the implementation of health sector reforms in their respective health systems as well as identifying relevant research issues.

Apart from the extensive review of literature on the subject of health sector reforms, this document draws from the experiences of the various countries represented at the meeting. It assesses their achievements and failures, explores the need for specific data to monitor the impact of reforms and identifies the areas of future concerns in the region. It also reviews the capacity for health systems research in SSA and its potential to contribute to evidence-based health sector reforms reconciled with principles of HFA.

Important contributions provided by all participants of the Intercountry Meeting in Arusha through submitting country reports and actively participating in discussions are gratefully acknowledged (list of participants is attached as Annex 1). Special thanks go to those who contributed to and commented on background documents prepared for the Meeting and its final report, particularly Mr Andrew Creese, Division of Analysis, Research and Assessment, WHO Geneva; Ms Tania Draebel, Division of Analysis, Research and Assessment (currently with WHO Mauritius); Dr Dave Haran, Health Systems Development, Liverpool School of Tropical Medicine, UK; Dr Roland Msiska, Health Reform Implementation Team, Ministry of Health, Zambia (currently with UNAIDS Geneva); Professor Gabriel Mwaluko, Health Systems Research, WHO/AFRO Zimbabwe; Dr Ebrahim M. Samba, Regional Director, WHO/AFRO; Dr Luis G. Sambo, Director Health Systems Development, WHO/AFRO; Dr Eleuther Tarimo, Director Division of Analysis, Research and Assessment, WHO Geneva.
BACKGROUND TO HEALTH SECTOR REFORMS

What are Health Sector Reforms? Governments everywhere including Sub-Saharan Africa (SSA) are redefining health policies, restructuring institutions, and looking for new ways of organizing and financing health systems and delivering health care services through health sector reforms.

Although there is no universally accepted definition of what constitutes health sector reform, it is widely agreed that health sector reforms are concerned with changing both health policies and the institutions that facilitate implementation of those policies, and the changes they bring about are both purposeful and directed by government policy.

The working definition used by participating countries at the Intercountry Meeting in Arusha, Tanzania was:

*Health sector reform is a sustained process of fundamental change in policy and institutional arrangements, guided by government, designed to improve the functioning and performance of the health sector and ultimately the health status of the population.*

This definition has the advantage of focusing on a long term process, in which government has a key role, and whose ultimate purpose is health improvement. It also has the advantage of not being tied to specific components or policy instruments as defining the reform process, and thus allowing for a wide range of different country contexts.

The main expected outcome of health sector reforms is health improvement or health gain. More specifically, health sector reforms are concerned with achieving the following objectives: *improved equity in health and health care; increase and better management of health resources; improved performance of health system and quality of care; and greater satisfaction of consumers and providers of health care.*

Through institutional changes, governments aim to change the organizations and management systems that have largely constrained the implementation of health policies. The assumption is that without fundamental institutional changes existing organizational structures and management systems will fail to deal adequately with the issues of efficiency, quality, cost containment, equity, access and responsiveness to popular demand.

The Components of Health Sector Reforms. *Organizational change, financing change and service delivery change* were identified at the Arusha Meeting as main areas of health reforms. The issues to be addressed and the options selected depend on the circumstances in each country, the problems faced and the feasibility of specific changes.

Defining the actual components of reform is highly complex and the selection should respond to specific needs and be based on a thorough analysis of existing constraints and the effects of implementing each option. For reforms to be effective they must be able to address deficiencies in the allocation, management and mobilisation of resources that already exist within the health sector in most countries.
Table 1.
Components of Health Sector Reform Programmes

<table>
<thead>
<tr>
<th>Improving the Performance of the Civil Service:</th>
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<tbody>
<tr>
<td>Reducing staff numbers, new pay and grading schemes (e.g. performance related incentives);</td>
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<tr>
<td>Better job descriptions and appraisal systems;</td>
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<tr>
<td>Improved financial accounting, disbursement systems;</td>
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<tr>
<td>Establishing executive agencies.</td>
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<thead>
<tr>
<th>Decentralization:</th>
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<tbody>
<tr>
<td>Delegating responsibility for management and/or provision of health care to local government or to agencies;</td>
</tr>
<tr>
<td>Establishing self-governing hospitals and autonomous district boards.</td>
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</table>

<table>
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<tr>
<th>Improving the Functioning of Health Ministries:</th>
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</thead>
<tbody>
<tr>
<td>Organizational restructuring;</td>
</tr>
<tr>
<td>Improving human and financial resource management;</td>
</tr>
<tr>
<td>Strengthening policy and planning functions;</td>
</tr>
<tr>
<td>Developing standards for health care provision and for monitoring performance;</td>
</tr>
<tr>
<td>Defining national disease priorities and cost effective clinical and public health interventions.</td>
</tr>
</tbody>
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<tr>
<th>Broadening Health Financing Options:</th>
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<tbody>
<tr>
<td>Introducing user fees, community financing, voucher systems, social insurance schemes and private insurance.</td>
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<tr>
<th>Introducing Managed Competitions:</th>
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<tbody>
<tr>
<td>Promoting competition between providers of clinical care and/or support services through single or multiple purchasers.</td>
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<tr>
<th>Working with the Private Sector:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing systems for regulating, contracting with or franchising private sector providers, including NGOs and commercial organizations.</td>
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</table>

Implementation of reforms. The major purpose of reforms is to create conditions within the health sector for the provision of efficient, cost-effective, accessible, equitable and good quality essential health care.

Policy reform may be difficult to achieve in an environment going through rapid political and economic change. Other factors that influence the success of health sector reform in Africa have been: drought, overall decline in the macro-economic situation and opposition of political groups to user fees and privatisation reforms. However, it is important to note that some policy reforms may come about more quickly in times of crisis whereas institutional reforms may be difficult to achieve under circumstances of political upheaval and change.

Health sector reforms require specific information and objective evidence for rational decision-making. The monitoring of the impact of reforms implemented is currently insufficient and efforts to document and disseminate experiences and thus build on previous mistakes and achievements have so far been limited.

SSA countries are burdened by factors that have generated critical shortages of resource inputs to the health sector, changing political commitments and new patterns of demand that are important triggers for reform. Some are countries in transition from centralised, one-party
systems to liberal democracies. As a consequence of democratic changes, conflicts of a social, cultural, and ethnic nature previously subdued are resurfacing. Others are recovering from war, drought and other emergencies.

Gradual and cautious implementation avails itself of continuous monitoring of the process and allows for the introduction of the necessary modifications as was the case with Botswana. Where reform constitutes part of a larger political agenda, this has to be implemented over a short period of time before the initiative is lost. Zambia stands out as the most radical and comprehensive reformer (Kalumba 1994).

Table 2.
Developmental Stages of Health Sector Reforms

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td><strong>NO REFORMS.</strong> Currently there are no plans for reforms stated either in formal or informal government documents, and no groups within the health sector undertaking a major sectoral review with the intention of proposing an agenda for action.</td>
</tr>
<tr>
<td>Stage 1</td>
<td><strong>HEALTH SECTOR APPRAISAL.</strong> A group of persons, either from the Government or from an external international agency have undertaken or are undertaking a major study of the health sector. The sector diagnosis will be used or is being used to design a health sector reform agenda. The results of the study may be available but they have not yet been formally or officially endorsed. The study is often funded from outside sources.</td>
</tr>
<tr>
<td>Stage 2</td>
<td><strong>HEALTH REFORMS PLAN.</strong> A clear, articulate plan for health sector reform exists on paper. It defines key sectoral issues and points to major areas of intervention. The document is official, but does not yet show a government approved implementation agenda. Some form of funding to implement the plan is contemplated, but has not yet materialised, although technical assistance might have been provided in order to prepare the plan and fund preliminary studies.</td>
</tr>
<tr>
<td>Stage 3</td>
<td><strong>ACHIEVING CONSENSUS.</strong> The official document for reforms has received official backing and has achieved a degree of political and social consensus within the country which, to some extent, guarantees its future viability. The process will often result in modifications to the original plan that will require a degree of flexibility from all parties involved. There is strong evidence that the plan will have financial support towards its implementation, normally from external sources.</td>
</tr>
<tr>
<td>Stage 4</td>
<td><strong>FUNDING.</strong> Resources for funding key components of an agreed agenda for reforms are in place. They normally originate in external sources. The implementation of the plan has not yet begun for various reasons, e.g. problems of administration, approval by parliament or meeting the conditions established by the lending or donor agency.</td>
</tr>
<tr>
<td>Stage 5</td>
<td><strong>IMPLEMENTATION OF AGENDA.</strong> An agenda for implementation has been agreed. The agenda provides clear indications of interventions that will be attempted against a tentative calendar by individuals, groups, departments having been nominated for implementation. Specific activities, such as pilot interventions or preparation of new legislation, may already be underway.</td>
</tr>
<tr>
<td>Stage 6</td>
<td><strong>ACTUAL IMPLEMENTATION.</strong> The programme for reforms is being implemented. Specific activities are taking place as part of the programme. A steering committee is in place and co-ordinated by a senior government official.</td>
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**Financing the Reform Process.** Developing countries cannot afford to immediately implement reforms as a whole because of limited resources, manpower and market infrastructure.

The UN System-wide Special Initiative for Africa is an effort that recognises the need for a region-wide plan of action that will take into account all relevant factors to ensure that all countries in the African region are directly involved in the Initiative from the beginning.
The principal goal of the Initiative is to enable African countries to reform their health systems to ensure adequate access to primary care for all populations, including especially women, children and other vulnerable groups. The second goal of the Initiative is to reduce the heavy and increasing burden of communicable diseases and ill-health (especially malaria, AIDS, tuberculosis and malnutrition) borne by these countries.

It is important to note that the Initiative which is a collaborative effort by all UN agencies is led at the national level by the countries themselves. The Initiative derives from existing strengths and supports the conduct of systems research aimed at ensuring a consistently high standard of performance in the health sector. Rather than confining this Special Initiative to a few selected countries that meet the World Bank criteria it is envisaged that all countries embark on reforms simultaneously, but at different stages of development.

The scarcity of real resources coupled with limited financial resources are liable to constrain the performance of the system due to restricted supplies. Only 2-3 per cent of the Gross Domestic Product (GDP) is currently spent on health care in these countries, hence, the question is not only equity, but efficiency and efficacy in the use of the limited medical resources available. The management skills and relevant institutions are relatively scarce and a good market infrastructure to support decentralised private medical practice is just emerging.

Assessing the Evidence. Evidence is required to lead and support the process of health reform as well as providing valid and current knowledge concerning priority issues. Policy studies can play a crucial role in the identification and assessment of policy options, and in the development of consensus and ownership of a decision on which option to implement.

To the extent that the Ministry of Health is accountable for the impact of any reform implemented, the conduct of studies during the design and implementation helps facilitate understanding of the consequences. Whilst policy objectives may be clear, there is less clarity about specific strategies or mechanisms through which to attain these objectives. There is inadequate and sometimes contradictory evidence about the likely outcome from the various approaches and options. Several research questions therefore, need to be addressed by the respective countries before decisions on health sector reform policies are undertaken and depending on the circumstances of each country.

HSR which concerns itself with applied research can bridge the gap between research and policy making as it focuses on current problems and is action-oriented. Because it is cost effective, timely and employs a participatory, multi-sectoral and multi-disciplinary approach, it lends itself to be used as a tool for generating inputs into the information needs for health sector reform. The current HSR network in Eastern and Southern African countries affords a unique opportunity through the Joint HSR Project for information exchange among the participating countries and beyond.

CONTEXT OF REFORMS IN SUB-SAHARAN AFRICA

Most health care delivery systems in SSA share several common characteristics. Firstly, they were inherited from the colonial era when they were designed and developed to provide free medical services to the army and colonial administrators at strategic locations. Secondly,
missionaries and other private organizations established hospitals and dispensaries that catered mostly for the under-privileged at modest fees for services rendered. Upon independence health care systems in these countries characterised by gross inequities with the more privileged urbanites having greater access to health care.

It was only after independence that many governments were able to expand their health care services through the development of a relevant infrastructure. This was facilitated by the favourable economic environment which existed at the time, and services were provided free of charge. Progress towards access to personal care defined as the patient being no more than an hour away from a health care facility by local means of transport has varied from country to country. Only 11 per cent of the rural population in Cote d'Ivoire, 15 per cent in Somalia and 30 per cent in Liberia, Niger and Nigeria have such access. However, there are countries that have recorded some improvements in such access through implementation of PHC, for instance 99 per cent access is reported in Mauritius and 85 per cent in Botswana.

**Objectives of Health Care Policy in SSA.** The health policies of SSA have been heavily influenced by the historical poor distribution of health care services as well as by the recommendations of the International Conference on PHC in Alma-Ata in 1978. This Conference provided the impetus for a radical re-think about health care policies of developing countries and influenced the planning, organization and management of the health sector in these and other countries of the world.

Health policy objectives are concerned with improving social justice and recognition of the special needs of those least able to take the initiative in seeking health care and those who are most vulnerable or at general risk.

For this reason, governments provided free access to the majority of the disadvantaged rural population at all public health facilities which were centrally financed from tax-based revenues. Whilst this was not explicitly stated, consumer choice was limited and there was no autonomy for private providers of health care to operate.

**Performance and Problems of Health Systems in SSA.** The problems confronting the health sector in Africa are complex, and countries have considerable difficulty in meeting the challenges and ensuring availability and quality of PHC. Health sector reform is urgently needed to re-shape the future of health care systems in the region. Its aim is to reform African health care systems by strengthening the capacity of institutions and communities to ensure access for all to quality care. Whilst all developing countries have adopted strategies towards HFA through PHC, several factors have militated achievement of this ideal and constituted obstacles to proper performance of health care systems.

There is discordance between the population health care needs of different social groups and the allocation of resources to each of these groups. In other words, a problem of inequity. South Africa, for example, spends in the order of US$1,200 per capita per annum on health care. This average disguises enormous disparities and inequities within the country. An equivalent of 13 per cent of GDP spent on health care through medical aid schemes covers less than 20 per cent of the population while expenditure in the public sector covering 80 per
cent of the population is equivalent to 3.5 per cent of GDP¹.

The application of structural adjustment policies have led in many countries to a reduction in resources for the health and other social sectors. Between 1991 and 1995 government expenditure on health care declined in real terms by 33 per cent in Zimbabwe. Tanzania had similar experiences between 1973-1974 when per capita expenditure was reduced by 50 per cent. Thus, there is a lack of available resources to solve priority problems. Some current liberalisation measures in these countries are in potential conflict with the equitable foundations of national HFA strategies. This has led to scarce resources being used inefficiently. Available resources are allocated to non-priority health problems and to technologies with high cost and low effectiveness, thus wasting resources and generating unnecessary costs. Many countries have been looking for alternatives to central financing of health services from Treasury since the 1980s. Too much is spent on salaries compared to operating costs and on tertiary rather than primary levels of care. As a result very little is left for other inputs like pharmaceuticals and maintenance, and rural areas are deprived of essential inputs.

In spite of rapid deterioration in economic and political circumstances in SSA, much has been achieved through the PHC strategy in these countries. There has been greater emphasis on prevention and advances in appropriate technology. There was improved immunisation coverage which contributed to an overall decline in infant mortality.

However, economic recession and subsequent implementation of structural adjustment programmes have had a profound effect on PHC implementation. Whilst health care has generally been regarded as a public commitment to be provided by governments free of charge, in the face of economic depression and adjustment, the public sector is increasingly under pressure and is faced with health care delivery systems that are underfunded and characterised by crumbling infrastructure for health care and social services.

Whereas, in 1978 the assumption was that the public health sector, through the Ministries of Health, would be responsible for implementing PHC policies, it is now clear that there is a rethink on the role of the state in the provision of health services.

The majority of the SSA countries have suffered serious reversals of their economic fortunes leading to a decline in government revenues. Most of these governments reacted by extensive borrowing, resulting in huge external debts. The resultant chronic shortage of funds has made it impossible to maintain the growing network of facilities that had been developed soon after independence. The almost complete erosion of operating and maintenance costs have resulted in a demoralised and under-paid workforce operating in dilapidated and unsanitary facilities with virtually no medical supplies, materials and functioning equipment.

There is continued rapid population growth and the emergent impact of HIV/AIDS, malaria, tuberculosis, cholera and yellow fever spanning the sub-continent. Massive imbalances exist

¹From country presentation on Health Sector Reform and Development of a District Health System in South Africa at the Interregional Meeting in Earache.
between curative and preventive activities in a context of weak management at all levels that impedes implementation of policy. It is not unusual for major urban hospitals to receive more than half of the public funds spent on health care and to account for 50 to 80 per cent of recurrent health care expenditure by government. For example, in the early 1980s this proportion was 74 per cent in Lesotho, 54 per cent in Zimbabwe, 49 per cent in Botswana (Barnum and Kutzin 1993).

In response to some of these factors, some common ground in health care policy has been identified. Widespread initiatives are in place in health care financing with different types of community involvement. There is a shift by many of the governments from the previous position of providing free services, and user fees are now the rule rather than the exception in SSA. Policies toward the private sector are now more accommodating.

Donors are important financiers of health care in SSA, where donor aid accounts for up to 20 per cent of total health care expenditure in some countries. Between 1981 and 1986 external assistance for health from official and private voluntary sources averaged more than US$1.50 per capita in SSA. By 1990 this had risen to almost US$ 2.50 per capita. While beneficial in promoting health care initiatives, this assistance has had some negative effects in some instances. This has arisen from donors insisting on certain policy orientation and reform, preferred priorities and selection of health strategies. As a result, in extreme cases health authorities have abdicated responsibilities for health care policy formulation. The vertical nature and inappropriate capital expenditure bias of external financing has often worked against sustainability. In Rwanda, for instance, more than 20 per cent of donor financing was earmarked for AIDS alone.

SSA countries have some major differences that have the potential to influence the nature and direction of health care reforms. Armed struggle and democratisation of governments have given birth to new countries with new governments e.g. Eritrea, Namibia and South Africa. These countries are preoccupied with the need to develop national health care policies for the first time within a wider context of economic and social restructuring process.

Some countries have experienced democratisation with changes in government and this may have important consequences for health care policy. Several others are emerging from essentially civil conflict and face special needs for reconstruction and reconciliation of all sectors. The majority of countries are implementing Structural Adjustment Programmes (SAP) yet others can be classified as in "no change" situations. Thus, there is a diversity in the political and economic complexion of SSA countries. Even when countries appear to fall into a similar category, there are often radically different approaches to the reform process in health care.

It should be apparent that no single formula will be appropriate to cover the implementation of health care reforms across the board. Economic and political circumstances and leadership are most influential in determining the course, pace and extent of reforms.

Key Issues for Health Sector Reforms in SSA. Most countries of SSA have embarked on health sector reforms for a variety of reasons and are at different stages of the reform process. Whilst commitment to HA and PHC remains the major goal for health care development in Africa, several factors operate against access to essential health care and as such these
inequities are unnecessary, avoidable and unjust. To surmount some of these problems, these countries have explored health care policies that explore several options in the organization, management and financing of the health sector. The framework of health sector reforms in these countries evolves around the following key issues: financing of health services, institutional and organizational arrangements, service delivery changes.

The underlying values on which health policy is based, such as equity, quality, sustainability, cost-effectiveness, partnership, participation often come into conflict in the design and implementation of actual reform policies. New financing mechanisms, for example, may bring additional resources and contribute to sustainability, but may worsen inequities in access to care if a policy choice is not the right one, or it is not designed and introduced properly to protect those most in need.

Health sector reforms require specific data and objective evidence for rational decision-making. While many decisions are clearly influenced by other factors, scientifically proven and reliable evidence can obviously guide the leadership towards a better course of action. HSR, by providing such evidence, can clarify the likely trade-offs between health reform objectives, both before policy change is implemented through option appraisals and assessments of people's preferences, and after implementation, through prompt and reliable monitoring.

However, the impact of HSR on policy development and implementation is still week in the SSA. The link between policy-making and research is not in place, and relevant processes and mechanisms are not properly installed. Research in many cases is commissioned by donor agencies rather than by Ministries of Health or other domestic stakeholders, and much of the expertise on health reforms-related research appears to come from outside the continent, even where the local capacity is available.

There is an urgent need to raise awareness on the role and value of health systems research, and, in addition to continuing capacity building efforts, to orient existing capacities towards policy-focused research as well as to foster the use of its results in decision-making. Policymakers need to be involved from the outset in planning policy-related research, where they participate in defining research agenda, they are more likely to accept and use research results.

Donors role in the reform process in Sub-Saharan Africa is quite important, and better donor co-ordination is a cause of concern in many African countries. Recently, dialogue among donors appears to address a more holistic form of sectoral support to the reform process, replacing to some degree the previous tendency of donors to support certain programmes or activities. The UN Special Initiative for Africa offers a potential mechanism for enhancing and harmonizing donor support in this area.

INSTITUTIONAL AND ORGANIZATIONAL CHANGES

Organizational/institutional change in the health sector was identified as central to the whole reform process. Its common guiding principles include improving management and accountability; setting priorities, monitoring performance and tracking the use of resources; and defining clear institutional relationships.
Civil Service Reform and Changing Roles of Government

Health sector reform is often occurring against the wider background of civil service reform, and many countries in SSA are currently in the process of reorganizing and reorienting their Ministries of Health within this context. The reduction of personnel establishments has been seen as the key to improving terms and conditions within a constrained budget, and thereby increasing efficiency. Success in SSA has been limited partly because of the political difficulties of retrenchment and partly because a reduction in the size of the workforce alone does not free up sufficient resources to make salary levels attractive to those who remain.

The view that the role of central Ministries of Health should shift from management and delivery of services towards policy formulation, monitoring, co-ordination and regulation was expressed by participating countries at the Intercountry Meeting in Harare.

The slow pace in civil service reforms has prompted initiatives to de-link the health sector from the civil service. Ghana is an example of a country that is attempting to establish a National Health Service with separate conditions of service for health workers from those applying to the rest of the civil service. In Zambia, the establishment of autonomous Health Boards will probably achieve some degree of independence from general public service regulations. In other countries where the health sector is in some respects a lead sector in overall reform, civil service reform measures have been seen as a constraining rather than an enabling factor in meeting overall objectives of the reform process.

Decentralization

In SSA decentralization is viewed favourably as a tool to implement PHC since communities and districts are involved in priority setting and decision making. The functions which are being decentralised and the actors involved differ from country to country. Decentralization is often equated with the devolution of responsibility to local government agencies or taken as a dynamic process of changing relationships between the centre and the periphery. The local level takes on more and more authority and responsibility. One of the objectives of this process is to reduce the involvement of the national Ministries of Health in the management and delivery of services, restricting their activities to policy formulation, monitoring, co-ordination and regulation.

The proponents of decentralization argue that a centralised bureaucracy suffers from undue rigidity, administrative over-extension and inability to tailor services to the needs of a heterogeneous clientele. Many countries have pursued decentralization as a solution to delays which are caused by congestion in channels of administration and communication. Government responsiveness to local public problems has improved, and this in turn makes it possible for the quality and quantity of services provided to the local communities to be upgraded. Ideally the local communities play an active role in development, taking part in project identification, placing and implementation.

Decentralization has a spectrum from deconcentration through devolution to delegation and privatization. Deconcentration is the handing over of some administrative authority to local offices of central ministries in an attempt to improve effectiveness and efficiency of delivery systems. There is very little or no delegation of decision making or discretionary powers. It
is a mere shifting of workload from centrally located officials to staff or offices outside the national capital. Devolution involves the creation or strengthening of local government whose activities are outside direct control of central government. Local governments are empowered to reuse revenue and some expenditures on local programmes and projects. Delegation entails transfer of managerial responsibility for defined functions to organizations outside central government. Central government transfers specified duties and functions to subordinate administrative units in the form of public corporations, regional development agencies and various parastatal organizations. Privatization comes about when a central government divests itself of responsibilities for certain functions, and private institutions then perform functions previously undertaken or regulated by central government.

When these definitions are applied to health care systems, a mixture of different forms within the same system is commonly found with some functions deconcentrated while others are devolved or delegated.

Zambia represents the most radical intention in the planning for election of autonomous District Health Boards expected to receive extensive powers from central government in areas of resource allocation, manpower recruitment and management. In Nigeria, many difficulties have arisen in the process of handing over a greater degree of responsibility to local government. In many countries local government authorities have very limited managerial capacity and are dependent on the centre for most, if not all, their resources. In Mozambique, decentralization has so far largely taken place within the health sector itself. Semi-autonomy is developing as a result of isolation during the war rather than by deliberate reform.

In Benin, devolved decision making has contributed to an increase in equity in health care delivery and reinforced partnership with local communities. In Botswana, decentralization has led the government to define its priorities to avoid exclusion of under-privileged population groups. Together with Tanzania, this process has taken the form of transfer of sectoral responsibilities to elected local governments. In Botswana there is discernible conflict over priorities when it comes to health care. Centrally designed programmes and projects come with money which determines action, without much local discussion or relevance or alternative priorities (Magedal et al 1995).

Effective implementation often proves difficult for various reasons, some of which are: reluctance by central level to transfer the power that matters - resources to local level, lack of the right management skills at local level, and sometimes because the accompanying changes/supporting roles that are needed at central level, e.g. monitoring, are not in place. Powerful interest groups, such as civil servants, may not be willing to be employed by local government and may undermine any attempts to decentralize decision making to the districts.

Decentralization engenders the proliferation of administrative arrangements at the local level and therefore, a deterioration in the quality of administration in that larger numbers of officials with narrow outlooks and hardly any relevant working experience are employed.

In Botswana the District Officer has remained a central government post. What is unclear is how the District Medical Officer's technical responsibility relates to the administrative responsibility carried by the District Administration and the District Council. There is
typical confusion about lines of authority and lines of accountability. Is it the council that is managing the health care services or the paymaster in the Ministry of Health? The centre still plays a role in establishing equitable means of allocating resources between districts and to ensure the existence of effective mechanisms for managing the health labour market.

**Influence of Decentralization on Equity, Efficiency and Sustainability.** Decentralization has the potential to increase inter- and intra-regional inequities as well as serving as an excuse by central government to abrogate its responsibility to the poor and vulnerable. With the local retention of revenue and autonomous recruiting of health care staff the less well off districts tend to suffer compared to the resource endowed districts.

If the decentralized administrative structure is not consistent with the organization of the referral system, the efficiency of patient management will be compromised. Some countries are faced with the dilemma of trying to harmonize political districts with administrative/health care districts. While national policy calls for an integrated referral system, the organization of the health sector inhibits this.

The success of decentralization hinges upon the adequacy of administrative and managerial capacity of the unit to which responsibility is devolved. A review of the Barnako Initiative schemes in five African countries concluded that strengthening the capacity of lower levels of the health care system is a prerequisite for successful decentralization (McPake, Henson and Mills 1992).

Certain policy concerns related to decentralization have been expressed from experiences in countries in SSA:

- Lack of harmonization of political parties with administrative districts.
- Shortage of a critical mass of trained and capable personnel at different levels.
- Absence of appropriate criteria/guidelines for allocation of resources between districts in a decentralized health system.
- Tensions between the levels of health care delivery systems following decentralization.
- Devolution of responsibilities without authority and resources.

More firm evidence is needed in order to decide what functions and responsibilities should be shifted peripherally and to which individuals within those institutions. More information needs to be generated on the effects of decentralization on health care services and on the health status of the population. There is also a need to develop rational resource allocation formulae and financial management skills at both the central and local level that can be linked to support, supervision and relevant continuing education.

Experience has shown that handing over responsibilities to local authorities does not come without difficulties. What is the best composition of District Boards? What is the appropriate skills mix and leadership of the health care management team from the
professional and technical point of view?

Within the context of a decentralized system, who are the main players articulating the common interest in health care, and who formulate health care priorities and influence them as they are formed? What is the role and nature of spokespersons for the community as patients, tax payers and citizens? What are the best procedures for public debate and consensus?

What are the best ways in which the structure of health expenditure must be changed to suit the interest of a decentralized health delivery system? How can creative funding structures/insurance schemes (local funds, regional budgets, etc.) be modified to be able to collect money, distribute it according to local needs, assure quality, satisfy the expectation of the major players or must state agencies make up for the flaws in present structures? In case there are financial deficits how do the local institutions deal with them?

It is important to develop an appropriate legislative framework, policies, strategies for personnel development and deployment as well as capital investment, new facilities and the closure of redundant facilities and material resources. These need to be articulated in very clear terms and the role and responsibilities of the central offices in case a local authority is not able to provide the services as envisaged.

Processes and responsibilities of supervision and management of the decentralization and decentralized systems, especially the assessment from the point of view of the population and community health care needs, have to be developed.

Countries participating in the Intercountry Meeting in Earache expressed concern about the need to develop regional and district capacity to integrate drug management and national use of drugs into health care activities so that districts and sub-districts are able to respond to local drug needs.

Furthermore, a decentralized District Health Delivery Unit should have the authority, capacity and capability to detect and respond to disease and other outbreaks outside central control. For example, a district with a complete epidemic preparedness plan should have an independent epidemic control team, storage facilities and logistics, laboratory facilities and supplies to be mobilized, independent of central control.

Additional questions that lend themselves to further scientific scrutiny include further inquiry into which forms of decentralization are most effective in achieving these outcomes and output objectives. Are decentralized systems responsive to consumer/community defined needs and do they improve democratic decision making in other areas? What types of human resources and what skills are necessary for effective decentralization?

Role of the Private and NGO Sectors

There is a notable trend by many countries in recent years of promoting private providers to help compensate for shortfalls in government provision of health care services. Many Ministries of Health are now reviewing their subsidy and regulatory roles with respect to private providers, in an attempt to harmonize private financing with, where possible, the
provision of public health care objectives. The complex mix of public and private interests in the human resources field, where the same people may work in both sectors, i.e. private practice and public health care facilities, is being examined in several countries. Public financing of private providers, e.g. missions in Africa, is substantial and there is a need to specify more clearly what governments expect in return for this funding and to monitor the performance of NGOs and other private providers.

Very little HSR has concentrated on this area in these countries. For the purposes of this discussion, the private sector includes all organizations and individuals working outside the direct control of the state, including traditional practitioners. These include both for-profit private companies and individuals and not-for-profit private organizations.

It has been stated that private sectors flourish mainly during resource-rich times or at least among the resource-rich sections of communities. The promotion of the private sector during periods of structural adjustment programmes may thus be ill-conceived and impracticable (Sarah Bennett, 1991).

*Private For-Profit Providers.* Private for-profit providers of health care are an important part of the supply of health services in many African countries. A for-profit market, whilst believed to be an efficient means of organising production and consumption, given certain conditions, can be shown to achieve what is called Pareto-efficiency, i.e. a point where no one can be made better off without making someone else worse off.

In some countries such as Zimbabwe, Namibia and South Africa there are substantial private sectors supported by employer based insurance schemes. In Zimbabwe, 74 per cent of the payouts by Medical Aid Schemes go to care given by private practitioners while about 40 per cent of doctors work full-time in the private for-profit sector. In other countries, the private sector remains rather limited, as in Tanzania, Malawi and Mozambique. In Cameroon, more than 35 per cent of the available health care facilities belong to the private sector.

Almost inevitably the expansion of the private sector increases the demand for doctors and contributes to internal brain drain. Several measures have been tested in order to try and retain doctors. Measures such as, bonding (Zimbabwe and Lesotho), raising public sector salaries (Nigeria, Zimbabwe) and allowing public sector doctors to engage in private practice after hours (Zimbabwe). Most of these policies, however, appear to be ineffective and in some cases have been abandoned.

The current shortage of government resources makes expansion of the private for-profit providers an appealing option for many African governments. However, when people have the option of obtaining free health care at public health care facilities this tends to increase barriers to private sector development. While, on the other hand, when user fees become common place in public facilities, households are likely to be interested in alternative ways of paying for their health care. Benin, Guinea and Mali have established regulations to include traditional healers in the pool of health providers and this has expanded geographical and social coverage.

*Regulations and Incentives for Private For-Profit Providers.* Previously, relationships with the private sector have been very much in the control and command mode with regulations
stipulating exactly what the private sector could and could not do. In 1967, for example, the government in Tanzania passed a law to stop private practice by individuals. This is because governments are often concerned about issues of solidarity and equity and that private providers do not give consumers a fair deal. Furthermore, market failures in the provision of health care require governments to intervene in relation to provision of public goods such as immunizations and care for communicable diseases.

In most countries in the region the initial stage of regulation is the licensing and registration of the practitioner and the facility from which the services will be offered. For a facility to be registered it may have to meet certain structural requirements as well as qualifications and characteristics of the practitioner. This serves both to control the quantity and quality of care as well as that of the providers of care. While regulatory mechanisms vary across countries, such regulations are weak. In Kenya and Zimbabwe, doctors must have at least three years experience before they can operate privately. In Zimbabwe, a doctor, indeed any health care professional, has to have an "open practising" certificate from the Health Professions Council which allows him/her to practice medicine independently and privately. The Ministry of Health and the Health Professions Council are currently reviewing the eligibility criteria for a doctor to be able to practice privately. They are considering the introduction of a qualification in Family Practice which all doctors intending to go into general practice will need to sit and pass before they can be issued with a licence to undertake private practice.

In some countries, there is provision for and authority to inspect such facilities, e.g. Nigeria, Mozambique, Tanzania and Zimbabwe. Quality is monitored by professional bodies in Nigeria and Zimbabwe. In these two countries complaints about treatment are widely publicized and legal facilities for prosecution over malpractice exist.

In most countries private providers are paid on a fee-for-service basis which tends to lead to over-servicing. It is uncommon for private practitioners' fees for uninsured patients to be regulated. It would be extremely difficult to regulate such provider fees anywhere. Medical insurance schemes discuss and agree with the private practitioners on the level of fees to be charged to insured patients, for example, the Relative Value Schedule in Zimbabwe is updated on a regular basis.

In Ghana, a private practice may offer medical, laboratory and pharmaceutical operations all on the same site. In Zimbabwe, on the other hand, there are regulations against the integration of services by single general practitioners to discourage them from excessive prescriptions and investigations. However, group practices can integrate such services in Zimbabwe. In Rwanda and Zimbabwe, private physicians are authorised to keep and supply pharmaceuticals only if there is no pharmacy open to the public within a certain radius.

The picture of the regulation of pharmaceutical outlets is mixed. In some Southern African Countries pharmacies are tightly regulated whereas, elsewhere in SSA there is a proliferation of unlicensed drug sellers, in some cases within the informal sector. In Zimbabwe, the Drugs Control Council registers and controls the prescription, sale, dispensing and storage of drugs by both private and public sectors. The Zimbabwe Regional Drugs Control Laboratory conducts quality control on all such products for use in the country. The situation in West Africa is generally less well regulated. The Federal Ministry of Health in Nigeria passed the Essential Drugs Law which prohibits any drugs, other than those on the essential drugs list, being brought into Nigeria. In one area of Senegal it was estimated that illegal drug sales accounted for 43 per cent of the value of drugs sold.
The enforcement of the existing regulations governing the private health sector is often lax or at best weak. Much of the regulation is through self regulation by professional bodies who often may not protect the interests of the consumers. In Zimbabwe, the Ministry of Health has expressed the opinion that regulations are not effectively policed and as a result complaints against registered practitioners are common. The government has now legislated and provided for a statutory inspectorate body.

Severe restrictions on private practice are counter-productive and a collaborative approach should be advocated. Private for-profit providers can be encouraged to collaborate with the public sector through non-monetary incentives such as organization of continuing education, the provision of locums and membership in planning and policy committees.

To enhance collaboration, Zimbabwe has established a committee of representatives from both public and private for-profit and private not-for-profit sector and the Advisory Board on Public Health. This Board advises the Minister of Health on public health issues. In Malawi, the council includes only public and private not-for-profit providers but is due for expansion.

In Ethiopia, the private sector is allowed to purchase drugs and other medical supplies from government sources. In Zimbabwe, some private institutions can source drugs from the government medical stores at prices up to five times cheaper than in the private drug market. In other countries the public sector provides vaccines, condoms and/or contraceptives to private practitioners in order to encourage them to offer preventive services. In Nigeria and Zimbabwe vaccines are provided free to general practitioners willing to offer such services. In some countries private providers are encouraged, through tax incentives in which medical supplies are exempt from customs duties or by offering tax relief to private providers to locate to under-served areas. At the same time, governments should be cautioned against over-subsidizing the private sector which services mainly the wealthy at the expense of the poor.

Legislation for compulsory health insurance while difficult for most in SSA is likely to encourage use of private providers. However, tax rebates for those opting for private health insurance will benefit the better off and undermine the funding base for government.

**Contracting and Competition within the Public Sector.** Contracting entails shifting partial or incomplete responsibility for the provision of clinical or non-clinical services to the private sector, while the responsibility for financing remains with the public sector.

In many instances private sector expansion has appeared to be directly related to the deterioration of standards within the public sector. While many public health institutions in SSA are plagued by poor efficiency and a lack of provider responsiveness to the needs of providers, it is important to note that for internal markets to work well, a substantial amount of information and managerial skills are required. This is to facilitate the purchasers, the Ministries of Health, to identify the best providers and to negotiate contracts with them.

Because of the above limitation it is unlikely that the internal market model is replaceable in most of SSA. However, several countries have some experience of contracting out services with the private for-profit sector. The experience of Lesotho in contracting out non-clinical services, such as catering, is relevant to many other developing countries. However, due to the small size of the local private sector and limited access to capital, only two companies
could bid for the contract. The supplier, being in a powerful position, was able to charge more than competitive rates.

In Uganda, non-governmental organizations and private health care providers are developing new contractual relationships with the state sector. The Ministry of Health encourages hospitals to contract out support services like management and supervision, e.g. meals for staff and laundries are already run by private contractors in some bigger hospitals (Angelo Stefanini 1995).

Information requirements for contracting out are very high. In Lesotho, the contract with catering firms did not specify who was responsible for meeting overhead costs such as power and maintenance, and this led to confusion.

In Zimbabwe, the contracting out of support services is currently on the drawing board, and a unit has been created to be responsible for market testing, drawing up contracts and monitoring implementation of the contracts to be drawn up for hospital security, catering, cleaning and laundry. For practical reasons, this exercise will be limited to large central hospitals which are located in urban areas where there is a private sector presence.

Some examples of contracting out of clinical services are available in a variety of forms. In Namibia, surgical care in rural areas is often carried out by teams of general practitioners in private practice under contract with the Ministry of Health. The general practitioners are remunerated on the basis of workload (sessions) and number of procedures undertaken.

The cost of this scheme to the Ministry of Health is low. Some private specialists are paid on a sessional basis. Contracts have also been developed with specific institutions. Zimbabwe and Zambia have experience in developing contracts with many hospitals to provide services to eligible populations. In Zimbabwe, the hospital charges the Ministry of Health directly on a fee-for-services basis. In South Africa, there is considerable contracting and some hospitals are known as contract hospitals established specifically to provide care to government patients and payment is usually on the basis of a fixed fee per patient day.

Many countries have established private beds within government facilities, i.e. Zimbabwe, Tanzania, Kenya, Zambia, Mozambique and Malawi. Such arrangements have the advantage that doctors do not disappear to a private clinic, but are allowed to charge the private patients a fee. There is, however, a clear cut conflict of interest in that physicians divide their time between public and private practices. Some physicians meet most patients in the public sector and then persuade them to seek further care in the private sector.

The shortage of information and the great uncertainties, both theoretically and empirically, about how private providers and financiers in the developing world behave suggest an incremental approach to privatization of services, combined with serious attempts to provide the evidence and to monitor such efforts.

*Private Not-For-Profit Providers.* In SSA, private not-for-profit providers constitutes an extremely important part of the health sector. It includes missions or church facilities, international organizations and local non-governmental organizations.

The missions or church facilities provide a substantial proportion of health care service particularly in SSA, with estimates in the region of 30 per cent of total services in Zambia.
and Ghana, 60 per cent in Zimbabwe, and 50 per cent in Uganda. Many of these institutions are in remote areas and thus usually have a responsibility in caring for the health of some of the poorest members of society. Non-governmental organizations, as a whole, provide 41 per cent of general referrals and general hospitals at district level and 39 per cent of the hospital beds in Uganda.

Because of the long history in the SSA, the private not-for-profit providers have a well defined relationship with the public sector.

Previously, there has often been friction between government and church facilities and this has led on occasion, to the duplication of facilities and poor coordination with the public health sector.

Table 3
Policies to Change the Public/Private Mix

<table>
<thead>
<tr>
<th>FINANCE</th>
<th>PROVISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Legislation for compulsory health insurance: A statute ruling that all firms with a minimum number of employees should provide them with health insurance. This is likely to encourage use of private providers.</td>
<td>h. Contracting out: Government retains responsibility for the service and continues to finance it, but provision is undertaken privately. Clinical, non-clinical and management services could be contracted out.</td>
</tr>
<tr>
<td>b. Supplementary user charges: Increasing the level of non-tax financing of public health services through user fees.</td>
<td>i. Termination of certain services: Certain services such as provision of drugs could be terminated or reduced in the hope that the private sector would take over this activity.</td>
</tr>
<tr>
<td>c. Financial arrangements to reduce risk of private insurance companies: Small insurance companies face a high risk of losses. By offering reinsurance or stop loss provisions, government can reduce this risk and encourage the establishment of private insurance firms.</td>
<td>j. Health care vouchers: Services continue to be publicly financed, but instead of using this revenue to provide services directly, the government issues citizens with health care vouchers which would then be used to pay for services at public or private facilities.</td>
</tr>
<tr>
<td>d. Tax relief: Provision of tax relief to all those who opt for private health insurance.</td>
<td>k. Raise fees in government sector: More expensive government services may encourage individuals to transfer their demand to the private sector.</td>
</tr>
<tr>
<td>e. Opting-out: Permitting firms to opt out of compulsory social insurance if they provide a satisfactory alternative insurance scheme.</td>
<td>l. Support to traditional practitioners: Encourage practice of traditional practitioners through training courses, supply of essential drugs etc.</td>
</tr>
<tr>
<td>f. Dekker Plan (Netherlands): Establishment of consumer choice between competing private insurers combined with central fund paying risk-related contributions to insurers. (Also pro-competition reforms in provision of services).</td>
<td>m. Public choice model: Patient choice amongst public health care facilities at primary and hospital level. Provider budgets to follow patients.</td>
</tr>
<tr>
<td>g. Training, consultancy and demonstration projects: Variety of interventions to develop skills and institutional capacity within the private sector and demonstrate potential for success.</td>
<td>n. Internal markets (UK): Extension of notion of contracting to clinical services. District Health Authority to purchase services from both public and private provider facilities.</td>
</tr>
</tbody>
</table>

Source: Sara Bennett "The Mystique of Markets: Public and Private Health Care in Developing Countries".
In most countries co-ordinating bodies have been formed to provide a forum to collaborate with the Ministry of Health. In Malawi and Ghana there is the Christian Health Association of Malawi (CHAM) and of Ghana (CHAG) and in Tanzania, the Christian Medical Board of Tanzania (CMBT).

Table 4
Degree of Not-For-Profit (NFP) Involvement in Health in Selected SSA Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Per cent of hospitals owned by NFP sector</th>
<th>Per cent of beds owned by NFP sector</th>
<th>Name of umbrella organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>6</td>
<td>5</td>
<td>Christian Relief and Development Agency (CRDA)</td>
</tr>
<tr>
<td>Ghana</td>
<td>50 (Ashanti region)</td>
<td>25</td>
<td>Christian Health Association of Ghana (CHAG)</td>
</tr>
<tr>
<td>Kenya</td>
<td>20</td>
<td>22</td>
<td>Christian Hospital Association of Kenya (CHAK) and Catholic Secretariat (CS)</td>
</tr>
<tr>
<td>Lesotho</td>
<td>50</td>
<td></td>
<td>Private Health Association of Lesotho (PHAL)</td>
</tr>
<tr>
<td>Malawi</td>
<td>30</td>
<td>38</td>
<td>Christian Health Association of Malawi (CHAM)</td>
</tr>
<tr>
<td>Uganda</td>
<td>40</td>
<td>39</td>
<td>Uganda Protestant Medical Bureau (UPMB) and Uganda Catholic Medical Bureau (UCMB)</td>
</tr>
<tr>
<td>Zambia</td>
<td>40</td>
<td></td>
<td>Churches Medical Association of Zambia (CMAZ)</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td></td>
<td>35</td>
<td>Zimbabwe Association of Church Related Hospitals (ZACH)</td>
</tr>
</tbody>
</table>

Source: Background papers for WHO Intercountry Meeting on Public/Private Mix, Namibia (1993) and Dejong (1991)

More recently, mission facilities have won a reputation for providing quality care efficiently. Limited data exists to support this observation, although a number of reasons have been advanced such as emphasis on training and supervision of staff and greater flexibility to adapt to local conditions without being bound by bureaucracy, willingness to experiment with new management techniques and the religious motivation of many staff members.

However, the not-for-profit sector still has problems. Many church facilities are facing declining external support and are desperately short of operating funds. The principal reason for this shortage of funds appears to be a drying up of resources from overseas in the midst of rising costs, a decline in real value of government subsidies and fee differentials between public and private sectors.

In Zambia in 1990, the Ministry of Health allocated 6 per cent of its total budget to mission facilities although they provided about 30 per cent of all care. In Lesotho overseas support
has been withdrawn and costs have also risen. As demand at church hospitals has fallen, revenue has dropped further and thus quality of care has declined. Little is known about the financial status of church facilities, worldwide.

*Regulations and Incentives for Private Not-For-Profit Providers.* In SSA, all the not-for-profit providers have to register with government before they may establish any health care facility or health care programme. Quality regulation tends to be weak. Professional supervision by the District or Provincial Health Authority is essential in Zimbabwe, more so for those church hospitals that provide nurses training. In Uganda, in order to qualify for free supply of essential drugs, health units must pass inspection.

In several countries, e.g. Ethiopia, Ghana and Malawi, a standard reporting system for not-for-profit providers is operational. In Ghana, some non-governmental organizations report and others do not. While in most countries missions tend to report directly to the centre, in Zimbabwe, mission hospitals report to the local health managers as far as professional matters and health information is concerned. In Ethiopia, like in most SSA countries, it is extremely difficult for governments to judge the appropriate level of support to give to private not-for-profit providers, if the level of external contributions is unknown.

Some governments in the region regulate the fees by private not-for-profit providers. In Zambia, mission facilities used to be prohibited from charging for their services in line with government policy of free health care for all. There are similar conditions in Zimbabwe for mission hospitals not to charge patients below a certain threshold of income in line with the government fee structures. In Tanzania, the government fixes prices for certain services offered by not-for-profit providers under the 1977 Private Hospitals Act (Gilson et al 1994). While there are concerns of overcharging by certain providers and non-governmental organizations in Ethiopia, no steps to control the situation are in place.

Because of the significant contribution of not-for-profit providers to health of the majority of the poor in the region, governments have conceded to providing certain subsidies and special incentives to this sector. The majority of countries have conditions attached to the granting of these incentives. For instance, in Tanzania, non-governmental organizations must provide audited accounts in order to receive any financial assistance, while in Malawi, the payment of salaries is limited to local staff. In Zimbabwe, the Ministry of Health and Child Welfare pays for the salaries of all mission health staff at the same level as those of other health workers in the public sector, including expatriate professionals. The level of trust and openness between the Ministries of Health and not-for-profit sector vary from country to country.

The majority of the agreements between missions and governments are at best informal contracts with few attempts at formalising the relationship. Some limited contracting arrangements are available in Uganda and Zambia. In Zambia contracting is done for some specialised services such as AIDS prevention and home based care. In Tanzania arrangements for missions to act as district designated hospitals are formalised through a contractual agreement with government. In Zimbabwe, such similar designation is informal.

*Conclusions on the Role of the Private Sector.* Unlike the private sector, government has a special responsibility to ensure equitable access to care for those unable to purchase it and powers of compulsion enabling it to fulfil functions the private sector cannot. Ministries of Health have to provide leadership and develop national health policies, strategies and long term plans to enhance the partnership between government and the private sector. Clear
regulatory laws and effective regulatory mechanisms to ensure that the boundaries of acceptable behaviour for all providers are understood by all health care providers are essential. Ministries of Health have to clearly specify their government expectations from private providers in return for subsidies.

*Equity.* Developing contracts with the private for-profit providers has the potential to increase access to health care for the disadvantaged groups, to the extent that contracts encourage an increase in the availability of services. Not-for-profit providers usually establish facilities in areas where government facilities do not exist, thus providing access to health care services for populations with otherwise limited alternatives for care. Tax relief policies, on the other hand, contribute as direct subsidies to the beneficiaries who are usually those most able to pay.

**Table 5**
**Incentives to Not-For-Profit Providers in Selected SSA Countries**

<table>
<thead>
<tr>
<th>INCENTIVES</th>
<th>COUNTRIES WHICH OPERATE THEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lump sum annual subsidies</td>
<td>Ethiopia, Namibia, Tanzania, Uganda, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Secondment of health personnel</td>
<td>Ethiopia, Ghana, Tanzania, Swaziland, Uganda, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Payment of staff salaries</td>
<td>Ethiopia, Ghana, Malawi, Namibia, Nigeria, Tanzania, Zimbabwe</td>
</tr>
<tr>
<td>Tax free imports of equipment and drugs</td>
<td>Ethiopia, Ghana, Nigeria, Tanzania, Uganda, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Purchase of drugs from government drugs stores</td>
<td>Ethiopia, Ghana, Malawi, Tanzania, Uganda, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Payment of retirement benefits</td>
<td>Namibia, Nigeria</td>
</tr>
</tbody>
</table>

Source: Background papers for WHO Intercountry Meeting on Public/Private Mix, Namibia (1993).

*Efficiency.* Capacity building for effective management of contracts may require the investment of yet more public funds in order to take advantage of efficiency gains that are perceived to exist in the private sector. Better policy co-ordination between the public sector and not-for-profit providers on issues of location, size and staffing patterns of health facilities should lead to improvements in the overall efficiency of the health sector. On the other hand, inappropriate incentives may encourage private providers to over-service patients.

*Quality.* It has been suggested that contracting may lead to quality improvements. This can only take place in an environment of competition for contracts. Countries with poorly developed private provider workers are unlikely to realise the full potential of service contracting. Services provided by not-for-profit providers are often perceived to be of higher quality than those available in public sector facilities. The rapid increase in private providers requires monitoring to ensure that the standards of care remain acceptable.

*Information Gaps.* Before any meaningful policies can be formulated on the private sector, better information has to be assured in the areas of financing, provision and utilisation. The
biggest gap in this information is on provision of health care by the private sector.

Experiences with the private sector in SSA are limited and so is the knowledge about how they operate, who exactly they serve and how much money they make. The matter of whether the private sector is efficient may not be debatable, but the desirability of particular privatisation policies should be evaluated on a case by case basis. What is needed are data which will elucidate and inform governments about the operations of the private sector so that they are in a better position to fulfil some of the functions. Efforts to test the significance and usefulness of the private sector are hindered by lack of experience in this area in developing countries, particularly in SSA.

Evidence is such that the effectiveness of the market style is increasing in efficiency and cost containment when used as allocative mechanisms on the production side of the system. On the financial side, there are no successes reported where there is commitment to universal access to equal services.

A greater understanding is needed of many issues of privatisation as market oriented regions have taken health care systems into uncharted waters. Among many other areas governments need to understand the factors affecting the quality of care given by private providers so that new arrangements for monitoring, evaluating and setting of standards will accompany the various reform policies, especially decentralization. Effective and equitable cost containment and quality assurance systems require systems to monitor and control fraud and abuse and an appeals process for both provider and beneficiaries.

There are conflicts between different policy objectives, i.e. efficiency versus equity or effectiveness, and between different reform instruments, i.e. negotiated contracts versus patient choice, which have confused providers and slowed implementation. Within this context it is essential to collect additional and more regular information on the cost and quality of government health care, the costs and feasibility of different forms of regulatory mechanisms and private sector characteristics in terms of care offered and consumers of these services.

One of the underlying reasons for the limited research on the private sector may be the problem of getting collaboration from private providers or at least access to their records. To facilitate this process a greater sense of partnership and further legislation or the enforcement of existing laws requiring the private sector to provide regular reports would probably assist future research and understanding of this area.

The impact of a basic health care package seems, in itself, a routinized form of health care rationing, which confronts assumptions inherent within equity based principles of medically necessary service provision. If services excluded from publicly insured packages are desired by citizens, then private providers and potential private insurers will make these available. Less financially well off citizens will have difficulty in obtaining them. This calls for a careful review of the content of the basic health care package by the various governments to meet the respective population needs.

In both developing and developed countries, there is a reassessment of the roles of government. There is the need to promote efficiency in the health sector and greater sensitivity to the needs of their people. Privatisation is certainly not the panacea for the
problems health sectors face in developing countries. In developed countries the emerging consensus seems to be in favour of the middle path of combining public financing with greater competition amongst providers. In SSA, the governments may share neither the objectives nor the institutional capacity but probably need to move from the current simplistic view of the role of public and private sectors to a more sophisticated and appropriate framework.

Governments have to research and develop functioning financial markets, viable tax management and expenditure accounts systems and legal regulatory structures to provide a basic framework for the organization and operation of public and private insurers, providers and suppliers.

**Human Resources Development and Capacity Building**

It is the responsibility of national governments to provide basic health care services and to regulate the private sector. To be effective in carrying out these responsibilities, policies have to be developed, priorities established, and a plan of action developed implemented and monitored. This can only take place in an environment abundant with know-how, human, financial and other resources, training and research capabilities.

Africa still has an inappropriate skills mix of health teams and an inequitable distribution of human resources to be able to perform the functions of a decentralised health care delivery system. For decentralization to succeed governments must have technically competent multi-disciplinary and/or polyvalent staff, especially in the rural areas, both as a remedy for lack of manpower and to improve the mix of skills. The SSA countries have attempted to assure appropriate types and distribution of health manpower through medical education and regulatory policies affecting geographic locations of practices. The overall objective is to improve sector performances in terms of dimensions such as efficiency, equity, public satisfaction and health care outcome.

Capacity building involves more than knowledge transfer, but has to be considered in terms of knowledge, processes and practices. Capabilities need to be strengthened and sustained only when practice is built into the process itself.

Whilst there is no accepted definition of capacity building, two categories can, however, be distinguished. *Strategic capacity*, which refers to institutional ability to carry out all those responsibilities in the health sector which are accorded to governments. These are responsibilities other than the actual delivery of health care service. These include all the activities that must take place before service intervention can be implemented effectively, i.e. systematic policy development, planning, resource generation, monitoring and other similar matters. *Operational capacity* refers to those institutional abilities which make it possible to carry out those activities that result in the delivery of services in any system. They include clinics, hospitals, private practices, programmes and other preventive care services like water supply, sanitation, health education, in-service training etc.

In the health sector, it is essential that staff be familiar with the nature of the sector reforms. Their professional backgrounds do not always equip them to initiate policy reform or undertake policy analysis. Deliberate efforts to encourage potential users to draw upon these new capabilities will be made. In other words, capacity building should not be a purely supply-oriented exercise. It should pay special attention to the task of creating or stimulating
the demand to use the capabilities being created. This task may well call for a participative approach on the donor side so that most governments and agencies may internalise the new needs and ideas. Health sector experience is pertinent in this context. Given the importance people attach to curative care or as a result of their improved awareness, the training given to doctors tends to be well utilised in many places. The same cannot be said for policy analysts or managers. The mind-set of Health Ministry policy makers may need to be influenced and changed as part of the strategy for capacity building.

Barriers to capacity building for health care policy reform and utilization of capacity are discussed below. An invisible barrier to the creation and utilization of capacity is the lack of information and awareness of important users who should be demanding such capacity. When potential users, e.g. policy makers, are indifferent or even hostile to policy reform due to ignorance, support of capacity building is likely to remain weak and existing capacity may seldom be used. If, for example, doctors and other professionals are unaware of the need for policy analysis and reform and uncertain as to what it means, they will obviously not support capacity building to facilitate it.

A second barrier is the perverse incentives of users that may militate against capacity building. In this case, potential users may be well informed about what policy reform could do, but tend to resist reform because it might cause them to lose their power and patronage. When policy makers stand to gain from the status quo, they will have no incentive to support reform or capacity building to achieve it. In general, it takes a major crisis to break the stranglehold of vested interests. This is why reforms such as privatization occur only in countries facing a severe financial crisis. Sometimes, exceptional leaders or a new regime uncommitted to the status quo may initiate reforms. They could then be allies in the capacity building exercise.

Finally, lack of financial resources tends to weaken capacity building efforts. Immediate and pressing problems always tend to win in the battle for scarce resources. When adequate resources are not allocated, the newly created capacities tend to be poorly maintained, a familiar phenomenon in the wake of project completion. Skilled professionals leave the new institutions or remain unmotivated to perform as their compensation is not competitive. Human and institutional capabilities thus remain underutilised. Donor support can play a strategic role in dealing with this barrier.

Developing country governments and donors need to consider and adopt certain strategic ideas on capacity building for health care policy reform. There is a need to take a long term view of capacity building, to plan ahead for the proper utilization of the human and institutional capabilities being created, to explore the role that twinning arrangements with foreign institutions can play in the capacity building process, and to look into regional collaboration for capacity building.

Many governments will need to create new institutions and review the operations of old ones in order to build the capacities required for policy analysis and implementation. Several analytical and technical capacities are required in the following areas:

- Demographic analysis - these capabilities provide the basic requirements for a population based health care system and a basis for assessing the impact of the
disease burden on the population.

- **Epidemiological surveillance** - these capacities need to be greatly enhanced as health intervention strategies move towards interventions involving regulation, taxation, subsidies and information programmes in order to reduce communicable and environmental conditions.

- **Economic and financial analysis** - this is needed to measure the cost-effectiveness of alternative intervention strategies as well as to assess the overall claim of the health care sector on scarce development resources.

- **Environmental monitoring** - to take place beyond the traditional water and sanitation activities to monitor and control a much broader range of environmental risks including air pollution, toxic waste, traffic hazards and other risks of injury.

These capacities ultimately have to be developed at the regional and local levels as well as the national level.

The creation and efficient use of human and institutional capabilities in a wide variety of fields, including policy analysis, is a basic challenge for all developing countries. In their preoccupation with numerous projects, mobilization of funds and operational problems that require immediate attention, governments may sometimes get distracted from this fundamental function. In the final analysis, the pace of development and the ability to successfully respond to new problems in a society will depend on its indigenous human and institutional capabilities. A priority concern of governments should be, therefore, to see how the capabilities of its civil servants can be retained, strengthened and sustained over time. Politicization of the civil service that leads to the mass exodus of skilled civil servants with change of government, as was the case in Latin American countries, can result in the inefficient use of the capacity that already exists within the country. Broader civil service reforms need to seriously address this issue in countries where this problem persists.

Policy reform capacity is a field in which governments stand to gain by encouraging capacity building outside of governments. Multiple centres of health policy reform capacity, for example, would be an asset when a Ministry is in need of independent assessments and options. To be able to draw upon such independent centres of advice, Ministries need to have in-house units with skills in the formulation of issues, identification of suitable experts/institutions, and interpretation and use of their findings and advice.

There is considerable scope for the use of twinning arrangements for the development of capacity. A certain degree of dependence of one institution on another is implied in the concept of twinning. The process should be so planned, however, that dependence declines over time and more equal relationships between institutions becomes possible through the capacity building process. Twinning is possible not only between foreign and developing country institutions but also between institutions in the same country. Thus the better developed institutions of training, research or consultancy in a country can play a useful role in the development and upgrading of other local institutions through long term collaborative arrangements. Governments should facilitate this process and arrange for the financing of such collaboration, if necessary. A major problem here is the lack of information about the
kinds of capabilities, both human and institutional that exist in developing countries. External donors often find it difficult to identify suitable consultants, and centres of expertise in different fields simply because information is not readily available. Here again, governments as well as professional associations, can play an active role in assembling, updating and disseminating the relevant information.

There is clearly a trade-off between the attention that government needs to give to specific policy reforms today and its willingness to invest in long term capacity building for policy reform. When capacity building is neglected, the chances are that its dependence on external advice to undertake policy reform will continue into the future. This is because policy reform is not a one time task that becomes redundant once the problems of structural adjustment that many countries face today are satisfactorily resolved. The need for further reforms will emerge over time as new problems arise and as major changes occur in the national and global environments. A country needs to develop and sustain human and institutional capabilities in policy analysis, reform and implementation in order that it may effectively anticipate and respond to the new problems without having to seek external advice and support every time. Capacity building may not yield answers to the policy dilemmas and choices being faced by a government today because the process takes time to generate the needed skills and institutional strengths. It must be seen as an investment that society must make today to be more self-reliant in policy analysis and reform in the future.

During the Intercountry Meeting in Arusha countries shared experiences with regard to human resources development and management. Ghana is facing the difficulty of attracting and retaining staff in peripheral areas. As a result, staff distribution is heavily skewed in favour of urban areas. There is a general absence of planning capabilities and systems. The limited planning that has taken place has virtually ignored the private sector, particularly the private for-profit sub-sector. Planned reforms include a review of the bureaucratic system governing staff deployment and the incentive system used to attract staff to under-developed areas. Personnel processes will be decentralized as far down as practicable. Performance and productivity will be the basis for promotion rather than mere length of service. Districts, regions and institutions will control their personnel budget and advertise for the staff they need. These reforms are aimed at rewarding performance and providing incentives for staff posted or transferred to "difficult" areas. However, until now, the focus of attention in Ghana has been primarily on training and the development of a staff data base.

Experience from Zambia indicates that devolution of resources, when combined with increased staff autonomy, leads to improved morale of health workers, and availability of essential supplies at health care facilities is insured. To achieve the health reform goals in Zambia capacity building has been given high priority, aimed at overcoming the constraints of human resources (technical and managerial support) available to implement health care reforms.

Benin initiated the project of "co-operative health clinics" in 1991, aimed at reducing the high unemployment rate of health personnel and to improve qualitative and quantitative health care delivery. The project is co-financed by WHO and UNDP. The problem of unemployment started in 1987 when the Ministry of Health began freezing recruitment in the public sector, resulting in under-staffing of health care facilities, whilst unemployment among graduating health care personnel continued to rise. A similar situation prevailed in
Zimbabwe after the implementation of the first phase of the Structural Adjustment Program. The Ministry of Health and Child Welfare could not employ all the nurses it produced from the nurses training institutions, while at the same time, the institutions were severely understaffed. As a result, a lot of nurses left to go to neighbouring countries.

In Botswana, capacity building is considered a priority which must be carried out at all levels simultaneously and continuously. It is a complex endeavour that goes far beyond the training and retraining of professional personnel and community health workers, and involves the delicate task of re-educating political leaders and high level management as part of an awareness raising process of fundamental importance. The process includes the provision of information to the public as a prerequisite for their participation. This calls for the involvement of mass media and mobilization of all agencies directly or indirectly active in the field of health care. It also entails the development of new methodologies on a continuous basis, as well as conducting action-oriented research as and when needed.

In Ethiopia, human resource development for health policy reform focuses on developing a team approach to health care; training of community based task-oriented frontline and middle level health workers of appropriate, professional standards; recruitment and training of these categories at regional and local level; development of appropriate continuing education for all categories of health workers and developing an attractive career structure, remuneration and incentives for all categories of health workers within their respective systems of employment.

In Malawi, the inadequate and inequitable distribution of staff is a result of the inadequate training capacity of the training institutions; absence of a training policy and a health sector human resource development plan; shortage of housing, especially in rural areas; and lack of incentives for staff posted to rural and remote areas.

As part of the development of its Health Recovery Programme, the government of Mozambique in 1992, approved the Ministry of Health Manpower Development Plan (1992-2002). The plan aims to increase the productivity of health personnel and to improve the quality of care they provide. Attention is paid to encourage health care personnel to work in rural areas. Efforts will be made to recruit more trainees from under-privileged areas, and personnel who have worked in priority areas will receive preference for post-basic training. Housing will be provided and allowances given for hardship postings and lost opportunities for earning additional income. Regulations regarding obligations to serve in rural and other priority areas will be developed.

Several factors that adversely influence the recruitment, appropriate deployment and retention of health personnel in SSA have been identified.

♦ Unfulfilled job satisfaction as evidenced by unsatisfactory working conditions, poor infrastructure, inadequate amenities such as schooling for children and lack of accommodation.

♦ Social problems within marriages related to transfers and posting.

♦ Underdeveloped human resources planning and management capacity.
Lack of comprehensive and clear career structures.

Lack of adequate training capacity to produce enough health care personnel.

Lack of attractive incentives to reward those willing to serve in rural or disadvantaged areas.

Strategies that have been put in place or are being contemplated to rectify the above situation, have included the following:

- improving the physical working environment through the provision of accommodation, refurbishing and appropriately equipping health care facilities;

- introducing attractive remuneration and incentive packages for all categories of health workers, e.g. subsidized housing, special allowances and opportunities for continuing education for those deployed to rural areas;

- decentralization and simplification of personnel management processes and procedures, allowing districts/regions/institutions to control their own personnel budget and to advertise for staff that they need;

- training of an appropriate range and category of health personnel, e.g. polyvalent, community-based, task-oriented health care workers and developing attractive career structures;

- recruitment of trainees from underprivileged provinces and regions;

- development of comprehensive human resources planning, development and management capacity.

CHANGES IN HEALTH FINANCING

During the past decade external and internal economic factors have severely restricted public expenditure in most of the SSA countries. Consequently a number of countries in the Region have found it increasingly difficult to allocate sufficient funds for the public health sector.

Many of the SSA countries are now shifting away from central control and financing systems and adopting alternative options for financing health care. Non-governmental sources for both finance and provision of services through the private sector are being actively encouraged. Alternative sources of finance have included special health taxes or "sin-taxes" generated from tax revenues on health damaging goods or activities, donor assistance, charitable donations to voluntary health providers, user fees and health insurance.

This trend means greater responsibility for individuals, families and communities. The role of government in the production, distribution and allocation of health care funds is being redefined. All these changes have far-reaching consequences on equity, access, quality, effectiveness, efficiency and sustainability of health care services.
There is, however, no doubt that government have the main responsibility for the overall health and health care development. The aim is to make better use of existing resources as well as increasing the involvement of other sectors, thus improving efficiency and equity. Certain activities of a public goods nature are not appealing to the private sector to supply, for example, safe water and sanitation, vector control and health education. There may also be equity concerns that will motivate governments to intervene as the poor may not be able to access the needed essential health care.

Public (Government) Financing

The extent to which government in SSA has contributed to health financing is varied. Payment for health care comes from general government revenue which is dependent on direct or indirect taxes, export earnings and deficit financing. Most of the countries in the region rely heavily on donor funding for up to 20 per cent of their health expenditure.

Currently government spending is still concentrated on hospitals, especially tertiary hospital and special health institutions. There is disproportionately high expenditure on staff and facilities as compared to other recurrent inputs such as, pharmaceuticals and maintenance, resulting in low productivity (Barnum and Kutzin 1993, Mills 1990).

The prospects for continued government expenditure on health care have been thwarted by a decline in economic performance and slowdown in economic growth resulting in declining levels of expenditure and share of public health in GNP.

Between 1981-1986, the average annual growth rates of GNP per capita for Kenya, Zimbabwe and Liberia were: 1.03 per cent, 0.64 per cent and 3.48 per cent respectively (IMF 1989). In Zimbabwe, between 1980-1988 health expenditure as a percentage of GDP averaged 2.6 per cent. Between 1990-1995, the per capita expenditure on health declined from US$22 to US$13 - a reduction of 40 per cent.

Whilst the cost of achieving PHC is estimated to be US$10 per person per year (World Bank 1987), the public health sectors in SSA countries does not seem capable of financing PHC.

Efficiency, Equity and Allocative Efficiency. Faced with limited health care budgets, governments have opted to mobilise new resources to finance health care. One area which the reforms attempt to target is the improvement of the functioning of the health sector through principles of operational efficiency. Efforts are underway to reallocate resources from costly providers, especially tertiary institutions, to basic health care services like immunization, family planning, vector control and health education.

SSA countries have health care systems where the major part of their health care budget has traditionally catered for urban populations. The majority of the population lives in rural areas where they do not receive an appropriate share of public money. In Lesotho, for instance, in 1983-84, urban hospitals and health care centres servicing the high income population received 84 per cent of the Ministry of Health budget (World Bank 1987).

Therefore, government resources for health often benefit the better off rather than the poorest, because of inefficient patterns of resource allocation. As a result, the health gain achieved
through public expenditure is often small. It has been suggested that recent pressure to look for alternative sources of finance has diverted governments' attention to resource mobilization, instead of better resource allocation. Only few countries are addressing the question of equity and efficiency in the allocation of public financial resources for health. Although the inequity is widely recognized to be a problem, there are very few assessments of the scale and recent trends in equity in public financing and use of government health services in Africa. This is an area with a critical need and important opportunities for health systems research, which has been somewhat eclipsed in the recent enthusiasm for alternative financing approaches.

User Charges/Fees

User charges/fees may be made for a wide range of health care delivered by different types of health care providers such as private practitioners, traditional healers or public health care facilities. This discussion will mainly deal with user charges at public health care facilities.

Relatively, more experience is now available concerning various government policies and activities for systems for user charges or user fees for publicly-provided health care in SSA countries. The shift towards private sources of finance, notably user fees, took place during the 1980s, when the countries of the Region either increased or introduced fees for government-provided health care services.

User fees were introduced in Kenya on 1 December 1989 first at the Kenyata National Hospital and Provincial General Hospitals followed by District and Sub-District Hospitals and lastly in Health Care Centres. Through user fees, popularly referred to as the Facility Improvement Fund, it has been possible to generate additional revenue to supplement what is allocated to public health from the Treasury. Since government allocation to the public sector both for development and recurrent expenditure has been falling over the past decade due to economic constraints affecting the country, cost sharing has proved to be a viable alternative to rescue the public health sector from the financial crisis in which it finds itself.

Health sector reforms in Ghana heralded the introduction of user charges at government health care facilities and the strengthening of the collection of user charges through legislation in 1985. The aim of this policy was to collect token fees at the facilities to recover 100 per cent of drug costs from the patients. By 1994 income from drug charges and other fees amounted to approximately 8 per cent, on average, while drug costs constituted 15 per cent of total recurrent costs.

As a source of finance, private out-of-pocket expenditures for health care account for more than 40 per cent of total health care expenditure in Africa, while the government contributes about 37 per cent (Paul Shaw et al 1995). This is evidenced from studies that have shown that despite a policy of free health care, private out-of-pocket expenditure for drugs, traditional medicines and user-fees paid to practitioners, and/or travel and other opportunity costs are higher than government spending. This can help free up government resources to be used for providing goods of a public nature to foster equity.

There is considerable experience with user fees in SSA more so from missions and non-governmental organizations that have long operated health care facilities on a cost recovery basis to supplement charitable donations from overseas.
The objectives advanced for the collection of fees have included: *increase of revenue for the health sector*, *improving efficiency through the rationalisation of utilisation of services*, *fostering community participation and attaining financial sustainability of the health sector*. The impact and experiences with user fees in the region have been a subject of debate.

The setting of fee levels has not always been based on the economic costs of health care as very limited health service costing studies had been undertaken prior to the introduction of the fee structures. There are possibilities and evidence that the extension of a user fee system has the potential to adversely affect household utilization of health care. Thus, workable methods of exemption from payment may be required to sustain health care utilization among those who need health care, but have difficulties in paying for the services.

Administrative costs associated with the majority of cost recovery schemes have been observed to be too much for government budgets to sustain. These are associated, at the local level, with costs of collection of fees, accounting, safeguarding and storing of revenue and supervision. Poor communication manifesting in lack of good roads and telephones increases administrative hurdles towards efficient implementation of a cost recovery scheme.

Empirical evidence has shown that for an effective user charges system, a policy has to be adopted to have retention by health care facilities of some or all revenues collected and to grant facilities the right to spend these supplemental revenues effectively and efficiently.

*Raising Additional Resources.* There are several countries in the region whose main objective of user fees is revenue as a source of additional fees. This includes Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia and Zambia. Others emphasize improvements in PHC service, especially those participating in the Bamako Initiative.

At a national level the capacity of user charges to increase overall health sector revenue significantly has been found to be limited. With a range of 2-12 per cent it is unlikely that this will rise above 25 per cent in the foreseeable future. However, it has been observed that where the threshold of deterrent amongst the poor has not yet been reached, the share of recurrent government expenditures seem to improve over time as has occurred in Cote d'Ivoire, Ethiopia, Lesotho and Zimbabwe. It is important to note that people's ability to pay in SSA is extremely limited and dependent on seasonal factors in agricultural production.

At the lower levels of the health delivery system, fee income has proved to be a substantial percentage of recurrent expenditures. Recurrent costs have usually consisted of pharmaceuticals, stationery, water and electricity and the maintenance of buildings, vehicles and other materials.

Some community financing schemes have included salaries at the health care facility level. At the health care facility level experience also indicates the effectiveness of user charges to provide a significant amount of revenue to recover non-salary operating costs. In many Francophone countries there are community financing schemes/projects which have high cost recovery rates compared to national cost recovery schemes. Because the costs per unit of service are much lower at the health care centres than at larger hospitals, these health care facilities yield a relatively higher proportion of their operating costs than hospitals. There is apparently greater willingness to pay for tangible products, such as drugs, at the community level.
In Benin, user fees consistently contributed between 42-46 per cent of the overall operating costs at 44 health care centres participating in the Bamako Initiative. In Lesotho, this proportion for both district hospitals and health care centres was between 13-22 per cent. While in the Democratic Republic of Congo (former Zaire), the cost recovery at health care centres contributed between 109-111 per cent between 1986 and 1988, Bwamanda Hospital recovered 24-30 per cent (World Bank data, Paul Shaw).

In Senegal, under the Bamako Initiative a Survey showed that contributions of user fees to public health care facilities ranged from 5-11 per cent of hospital funding, 8-23 per cent at health care centres, 14-35 per cent of health post funding and 87 per cent, on average, of health hut funding (Bitran et al, 1993).

Coupled with decision-making powers in drug procurement at local level, health care facilities tend to rationalise the use of drugs and also avoid the numerous waste evidenced at other facilities that provide free services.

The limiting factors to full potential recovery are poor capacity to administer cost recovery schemes; poor quality of services; sub-economic fee levels; no fee for service incentives to local staff; and abuse of exemption policies.

More recently, mission facilities have won a reputation for providing quality care efficiently. Limited data exists to support this observation, although a number of reasons have been advanced such as emphasis on training and supervision of staff and greater flexibility to adapt to local conditions without being bound by bureaucracy, willingness to experiment with new management techniques and the religious motivation of many staff members.

*Improving Efficiency.* The contribution of direct payments to technical and allocative efficiency have been linked to conforming with the referral system, promoting rational use of drugs and discouraging frivolous use of health care services.

The introduction of cascading levels of fees, e.g. having low prices at first contact facilities, higher prices at the district hospitals and highest at the tertiary hospitals, has been an attempt to strengthen the referral system in Zimbabwe where 80 per cent of outpatients at one central hospital were found to be non-referrals. This gives individuals incentives to enter the health care system at the lowest level of health care delivery. Malawi plans to implement a phased cost sharing strategy aimed at discouraging the population from using hospitals as their entry point into the health care system.

In Kasongo District in the Democratic Republic of Congo (former Zaire), user fees have simultaneously reduced the use of the district hospital as the first point of service while increasing attendance at Health Centres in the district (Criel and Van Balen 1993).

Certain behavioural responses may be triggered by user charges whereby health care workers tend to prescribe more extensive treatments. Where providers' income depend on collected fees, practitioners may tend to over-prescribe in order to increase their revenues.

The concept of administrative efficiency is an issue when unreasonable restrictions are imposed on the allocation of revenues towards various expenditure categories at the lower level and when the imposition of excessive reporting requirements may increase administrative costs unnecessarily.
Table 6
User Fee Revenue as a Per Cent of Recurrent Government and Hospital Expenditures

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>REVENUE AS PERCENT OF RECURRENT HOSPITAL EXPENDITURE</th>
<th>YEAR</th>
<th>REVENUE AS PERCENT OF GOVERNMENT EXPENDITURE ON HEALTH</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>1.3&lt;br&gt;2.8</td>
<td>1979&lt;br&gt;1983</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Urban&lt;br&gt;32.0&lt;br&gt;Rural&lt;br&gt;23.0</td>
<td>1984/1985</td>
<td>15 to 20&lt;br&gt;Mid 1980s</td>
<td></td>
</tr>
<tr>
<td>Ghana</td>
<td>Central&lt;br&gt;15.0</td>
<td>1991</td>
<td>5.2&lt;br&gt;12.1</td>
<td>1984&lt;br&gt;1987</td>
</tr>
<tr>
<td>Lesotho</td>
<td>5.0</td>
<td>1994/95</td>
<td>5.7&lt;br&gt;9.0</td>
<td>1984&lt;br&gt;1991/92</td>
</tr>
<tr>
<td>Malawi</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>3.3</td>
<td>1983</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>8.5</td>
<td>1985</td>
</tr>
<tr>
<td>Niger</td>
<td>Private Facilities&lt;br&gt;58.0</td>
<td>1986/87</td>
<td>Not Applicable&lt;br&gt;Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>7.0</td>
<td>1984</td>
</tr>
<tr>
<td>Senegal</td>
<td>Public Facilities&lt;br&gt;8.0</td>
<td>1993</td>
<td>Not Applicable&lt;br&gt;Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>Missions&lt;br&gt;72.0</td>
<td>1992</td>
<td>Not Applicable&lt;br&gt;Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>Public Facilities&lt;br&gt;3.0</td>
<td>1989</td>
<td>Not Applicable&lt;br&gt;Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>2.2&lt;br&gt;3.5&lt;br&gt;1.5</td>
<td>1986&lt;br&gt;1991/92&lt;br&gt;1994</td>
</tr>
</tbody>
</table>

Adapted from: Paul Shaw et al (1996)

Confronted with, in addition to other factors, inefficiencies in the collection and administration of exemption policies, the Zimbabwe Government abolished user fees at rural health centres in 1995. From the Zimbabwe experience certain well co-ordinated steps have been found to be worthwhile pursuing for successful reforms of a cost recovery programme (Hecht 1993):

♦ setting overall cost recovery objectives and targets;
♦ periodic reviews of fee schedules;

♦ preparing and distributing simplified manuals of rules for charges at health facilities;

♦ designing and carrying out a communications campaign to inform health workers and the general public about fee policies;

♦ developing strategies to assess patients ability to pay so as to facilitate exemption policies;

♦ developing appropriate, relevant, timely and accurate billings and collections;

♦ setting cost recovery targets for each facility and establishing incentives for facilities to increase revenue collection;

♦ conducting management training programmes for health care workers.

**Ensuring Equity.** The issue of equity deals with accessibility of health care and the affordability by consumers of appropriate health care. This is particularly relevant in this region which has a very high and increasing proportion of populations in abject poverty. People must be willing and able to pay for services, in the first instance, as well as it being clear what people are willing to pay for.

Sophisticated demand analyses which take into account both the monetary and opportunity costs indicate that, although higher income levels of health care users are not very sensitive to price changes, the demand for health care from poorer people drops as fees increase.

Several studies in SSA have demonstrated that substantial fee increases trigger an almost immediate drop in demand. Evidence from Zimbabwe demonstrated in 1991 that increasing user charges had negative effects on health service utilisation and status. The use of MCH services decreased by 30 per cent compared to the previous year and the number of babies born before their mothers reached hospital increased by 4 per cent (Hongoro 1993). In Kenya, there was a 38 per cent decline in Ministry of Health hospital outpatient and health care centre attendances following the introduction of user charges in 1989. Whilst utilization rebounds after some time in urban areas in higher income groups, for poorer members of society the demand does not increase and utilization rates remained low (Yoder 1989, Bennett 1989).

In Ghana, outpatient utilization dropped by more than 50 per cent after the 1985 fee increase. In urban areas, utilization recovered after several months only to take several years for a similar experience to be recorded in the rural populations (Waddington 1989). There is no evidence that those deterred from using the services did not actually need them (Creese 1991). Without an analysis of changing utilization patterns, the tendency has been to overstate drop offs. Studies from outpatient utilisation statistics apparently cannot fulfil the criteria needed to examine the impact of fee increases on individual and family welfare. The limitation being that the service point is not able to collect information on persons who were sick but did not seek health care. It is important to know what happens to those who stop
using health care after an increase in fees. This issue can only be resolved through the study of data from a more detailed household or community based study (Madibata, Matji et al 1996).

In the Central African Republic, a survey showed that 64-81 per cent of those interviewed were willing to pay the cost that had been estimated to improve certain aspects of public health services (Weaver et al 1993). Similar opinion polls on willingness to pay in Tanzania indicated that 87 per cent of respondents agreed with the view that people will pay if assured of a good service (Mujinja and Mabala 1992). In Zambia, only 4 per cent of families cited inability to pay as a reason for not seeking care.

The fact of the matter is that households already pay significant out of pocket amounts for health care. Chances are that people are willing to pay if they perceive the services to be of acceptable quality, taking into account the need for exemptions or subsidies for the poor.

A study in Tanzania in 1993 indicated that whilst the rich make the greatest use of health services at fee charging hospitals and health care centres as would be expected, they featured and accounted for 37 per cent of the utilization of services in government hospitals.

Experience in community based schemes appears to indicate a largely positive effect on both quality and levels of utilization. Community financing schemes have generally had a positive effect on drug availability. Research in Cameroon found that access to health care for the population, especially the poor, improved as a result of a policy which introduced fees and quality improvements in Adamaua province. Population access is enhanced and not impeded, when substantial quality improvements accompany fee increases (Litvack and Bordart 1993).

When a portion of revenue from the user fees is retained at the point of collection, especially at lower levels, equity can be fostered. Generally it is at the health care centre that budgetary shortfalls tend to be felt hardest. Experience shows that facilities which retained revenues performed better than facilities which remitted revenues to the Treasury. If revenue from charging people who are willing and able to pay for expensive services can be used to help subsidise those least able to pay, equity can be approximated.

Exemptions. Most user fee policies in SSA have involved greater equity at the expense of some efficiency through granting the disadvantage and vulnerable groups exemptions from payment or charging them lower prices. This has entailed additional administrative costs to enforce a means of regular monitoring of patients and the implementation of differential fees.

Special concerns have been expressed by governments of SSA concerning individual reform policies that appear to have damaging effects on overall health objectives whether expressed in terms of equity, efficiency or acceptability to communities.

A survey on official cost recovery policies in SSA suggests that exemptions are not universal as only one country out of 21 has an official income ceiling below which people are exempted. The rest had exemptions with no clear criteria to determine entitlement.
Whilst the majority of exemptions covered the poor and vulnerable, a few extended to cover certain communicable diseases in order to increase the probability that persons with such diseases will seek treatment. Such benefits not only assists those affected, but also protects other members of the community who would otherwise be exposed to the disease were the affected not successfully treated. Ghana, Mali and Zimbabwe have exemption policies in which tuberculosis is treated, free of charge, at all government health care facilities.

In most of these countries, identifying who is poor is a very complex and demanding task. In Lesotho, criteria are applied to distinguish between the poor and the non-poor, with exemptions awarded to those with no income and no land, livestock or other belongings. In such schemes local health committees, local administrators or chiefs decide on who should be exempted.

Sometimes groups who are not poor are also exempt. This was the case in Ghana in 1986, where employees of the Ministry of Health and their dependents were exempt from payment of user fees. The revenue that was potentially collectable without exemptions represented about 21 per cent of total collections for the year (Waddington and Enyimayew 1990). Currently in Zimbabwe the full cost of health care for the poor, due to city health care facilities and one teaching hospital, are to be fully reimbursed from the Social Dimensions Fund (SDF). However, this Fund has not had sufficient means to pay for these services.

At the local level some patients may try to pay less or avoid paying, usually with the help of health care personnel who expect favours in return. This limitation in the capacity of the administration of exemptions, in most countries, is probably the most important explanation for their infrequency and ineffectiveness in SSA. Fee levels and exemption policies need to be country-specific and should be handled at the local level in consultation with the community.

Prospects for User Fee Schemes. Cost recovery schemes have generally not yielded their potential for additional revenue because charges are not administered and collected efficiently. Research concerning regional constraints remains highly underdeveloped.

Supplying patients with the necessary information about the benefits of cost sharing makes them more receptive to user fees, especially when they know what charges to expect when they seek care. One way of dealing with this is to launch an information campaign prior to introducing or raising fees. In Zimbabwe, for example, the pricing structure for services is posted in visible places at clinics and hospitals.

When revenues from user fees are retained at the point of collection, they can be used to improve quality of care, especially the supply and availability of drugs. This also motivates staff who also want to be associated with the provision of higher quality services to their clients.

Efficient collection and administration of fees at hospitals is of critical importance taking into consideration the expensive care provided at such facilities. Failure to collect fees when patients are discharged from hospitals can result in huge amounts being owed to Ministries of Health. The areas contributing to poor fee recovery include low fees, poor billing and lax collection procedures.
From experiences in West Africa, based on a survey of hospital fee collection systems Vogel (1988) recommends:

- well defined entrance points for the hospital;
- the issuance of receipts, with duplicate copies, to serve as evidence for payment;
- a rigorously enforced system for determining those eligible for exemption;
- training for all staff to confirm the importance of enforcing collection;
- periodic spot checks to establish that the above recommendations are being carried out by all staff; and
- periodic audits of the financial transactions and flow of funds.

Periodic adjustment of fee levels must be an integral part of the fee system to keep pace with inflation. In countries where an act of government was necessary to change fee levels, prices remained unchanged for many years, as in Botswana, Lesotho and Zimbabwe. The first increase in levels of user fees in Zimbabwe took place in 1993 after the user fees had been introduced in the early 1980s. From 1 May 1996 the inpatient hospital and outpatient fees in Zimbabwe have been reviewed upwards by more than 50 per cent to match those of the private health sector. The treasury has also agreed that revenue collected at the hospitals will be retained for local use at the point of collection. In Ghana, while fees have not been officially revised since 1987, many health care facilities begun collecting higher fees and increased mark-ups on drug sales.

In Guinea-Bissau, the failure to adjust fees to inflation reduced revenues to an almost insignificant share of total recurrent expenditures (Eklund and Staven 1990). Similar experiences of erosion of revenues have been observed in Ghana, Zambia and the Democratic Republic of Congo (former Zaire).

Most countries in SSA recognise that strengthening the district health care systems as the operational unit for organising and managing PHC cannot be pursued without changes in health care financing strategies. With the introduction of Management Boards, it is essential that this and other representative groups be involved in establishing some of the rules of the scheme. The granting of exemptions or general administration of the fee structure calls for additional monitoring, accounting and/or actual knowledge if the schemes are to remain financially sound. Sound financial management systems must be put in place and staff should undergo appropriate training covering all aspects of fund management.

The accommodation of in-kind payments is generally more awkward and time consuming than cash transactions. This, however, permits some form of alternate payment for low income households and affords them options for access to health services (McPake et al 1993).

User fee policies still have a long way to go to realise their potential contribution to cost sharing in SSA. If user fees are to be effective, acceptable ways to tap and administer these
resources for the benefit of both the health delivery system and the community need to be explored.

Governments must be clear about the contribution of user fees in the total financial needs including the necessary steps the governments themselves will take to ensure subsidies to cover budgetary shortfalls in service provision.

Appropriate exemption policies must be put in place especially for health services of a public health goods nature, such as immunisation and specified infectious diseases as well as focusing on vulnerable groups who would otherwise have been excluded from benefiting from the health care delivery system. Exemption policies need to be explicitly articulated to both staff and clients.

Managers, staff of health care centres and hospitals, including Management Boards, should be made more autonomous in planning and control over budgets, as well as retaining all, or a portion of the fees collected. Procedures should be put in place to effectively manage these and other health related resources.

The effects of cost recovery on resource mobilisation, utilisation rates, efficiency, equity and sustainability of national health care systems requires effective monitoring and evaluation strategies. An information base for policy analysis in this area is mandatory.

**Health Insurance**

The main objectives in implementing health insurance is *to increase revenue, reduce financial barriers to care and improve efficiency of resource allocation and use*. Health insurance is a system in which prospective consumers of health care make payments to a third party in the form of an insurance scheme which, in the event of future illness, will pay the provider of care for some or all of the expenses incurred.

This involves a highly complex combination of incentives to providers, consumers and third party fund holders. Health insurance is thus a risk-pooling or risk-sharing system, a means of financial protection against the risk of unexpected and expensive illness. Without access to such insurance, many people are unable to obtain treatment or must incur debts to pay hospital bills, more so now that many African governments are rethinking their roles in the provision of curative health care services.

Employer-provided health care, for example, is not considered health insurance according to Vogel's conservative definition of formal health insurance. Prevailing government health insurance arrangements in SSA, under this classification (Vogel, World Bank Data), are as follows:

- those that provide universal free health care financed by national tax revenues, as in Tanzania;
- compulsory social security schemes for the entire formal labour force, as in Senegal;
special health insurance funds for government employees, as in Sudan;

those that provide a discount at health care facilities for government employees, as in Ethiopia;

other public schemes, such as a fringe benefit, as in Kenya;

mandated employer coverage of health care for employees, as in the Democratic Republic of Congo (former Zaire).

Markets for health insurance are considered generally absent or inadequate in sub-Saharan Africa.

Insurance firms find transaction costs prohibitive whenever they lack information about the risk of illnesses as such information is necessary to calculate the insurance premiums. With such a lack of information there is a tendency for the insured's behaviour to be characterized by moral hazard. This occurs whenever the probability of illness and/or the demand for health care is not independent of the insured's attitude towards prevention of illness.

For instance, an insured individual who is not confronted directly with the full cost of health care services may be rather careless about his own health and express excessive demand for health care. In the event of inadequate prediction of such behaviour the premiums may not be sufficient to cover the insurance payments.

It is also difficult, more so in rural areas of SSA, to collect premiums on a regular basis because of poor communications and fluctuating incomes. In the case of Zimbabwe for example, the administrative costs of member Medical Aid Societies are probably less than 10 per cent of revenues (Vogel 1993). An alternative would be to offer insurance premiums above the fair premium level or only to groups who lend themselves to regular payment schedules like people in formal sector jobs.

It is important to consider health policy objectives and whether the proposed health insurance scheme is appropriate to meet these policy objectives. All the potential stakeholders need to be identified, their views solicited and taken into consideration from the early planning stages of a health insurance scheme. Once a determination has been made on the type of health insurance scheme, its advantages over alternatives need to be determined.

Several practical considerations need to be made in the development of a health insurance scheme which includes the issue of coverage, universal versus selective and access to services by the uninsured. The environment in which the health insurance scheme will operate, for example a labour market, largely determines the viability of Social Health Insurance (SHI). SHI works best with few, large employers and stable employment and worst where a large population is self-employed or where there is large-scale unemployment.

Efficient risk-pooling for a viable scheme requires large numbers together with varied and different risk groups. Opportunities for opting out increase overall risks and threaten the potential for viability. Furthermore, most insurance schemes use earnings as the contribution base and as such it is important to determine if this base is already overtaxed or not and what effects the contributions will have on work incentives as well as competitiveness. As a complementary incentive, does income tax need to be lowered or not? What other base(s) are available and feasible?
### Table 7
Profile of Health Insurance Coverage in SSA

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PROVIDED BY</th>
<th>GROUPS COVERED</th>
<th>PER CENT OF POPULATION COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>♦ Social Insurance Scheme</td>
<td>Formal sector employees</td>
<td>9</td>
</tr>
<tr>
<td>Burundi</td>
<td>♦ &quot;Mutuelle&quot; for Public Servants</td>
<td>Civil Servants Parastatal Employees</td>
<td>10-15</td>
</tr>
<tr>
<td>Cameroon</td>
<td>♦ National Social Insurance Fund</td>
<td>Employees</td>
<td>No account</td>
</tr>
<tr>
<td>Congo, Democratic</td>
<td>♦ Employers Buy Health Insurance or Provide Care</td>
<td>Employees</td>
<td>No account</td>
</tr>
<tr>
<td>Republic of Cote d'Ivoire</td>
<td>♦ Social Insurance Scheme &quot;Mutuelle&quot;; ♦ Private Insurers</td>
<td>Employees</td>
<td>No account</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>♦ Private Insurer</td>
<td>No account</td>
<td>0.01</td>
</tr>
<tr>
<td>Kenya</td>
<td>♦ National Health Insurance Fund</td>
<td>Employees and Families</td>
<td>Up to 25</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Unknown</td>
<td>Employees</td>
<td>No account</td>
</tr>
<tr>
<td>Mali</td>
<td>♦ Social Insurance Scheme ♦ Company Schemes</td>
<td>Employees</td>
<td>About 3</td>
</tr>
<tr>
<td>Namibia</td>
<td>♦ Public Schemes ♦ Private Schemes</td>
<td>Employees and Families</td>
<td>20 per cent of formal labour force</td>
</tr>
<tr>
<td>Nigeria</td>
<td>♦ Private Insurers</td>
<td>No information</td>
<td>4</td>
</tr>
<tr>
<td>Senegal</td>
<td>♦ Civil Service Employers ♦ Private Insurers</td>
<td>Employees</td>
<td>13</td>
</tr>
<tr>
<td>Tanzania</td>
<td>♦ Private Insurers</td>
<td>No account</td>
<td>1</td>
</tr>
<tr>
<td>Zambia</td>
<td>♦ State Mining Company Provides Care</td>
<td>Employees and Families</td>
<td>6</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Private Insurers</td>
<td>No account</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: Nolan and Turbat (1993) and World Bank Reports.

How are service entitlements to be determined? It is important that these guide the level of contributions to the insurance fund. What strategies are to be put in place to constrain over-utilization of health care services by the insured? The existing infrastructure should have the potential to be upgraded to provide good quality, efficient and appropriate
entitlements. Relationships between the scheme and the providers of health care have to be considered in the context of a conducive legal framework and watertight contractual agreements. A lot of training and institutional development and the availability of skilled personnel to support the scheme will need to be in place.

Health care institutions operating within the context of health insurance schemes should have the managerial flexibility and the freedom to innovate. Should hospitals continue to generate funds through payments, but require central approval for spending or, should they generate funds and require no such approval? What options do they have to respond to patient demand for access to and provision of higher quality services? What happens if these hospitals cut services?

Community Based Health Insurance (Community Financing). Experience with prepayment community services has been successful in some countries. Contributions are collected when cash incomes are highest and these help to guarantee that rural dwellers have on-going access to health care, even during seasons when there is little cash available. Such schemes have been evaluated in Burundi, Democratic Republic of Congo (former Zaire) and Guinea Bissau (Eklund and Stavern forthcoming). Community insurance schemes are generally voluntary and do not cover the full cost of health care. In the Bwamanda Insurance Plan in the Democratic Republic of Congo (former Zaire), for example, beneficiaries are entitled to hospital benefits only if they have a referral slip from a health care centre (Shepherd, Vian and Kleiman 1990). The Plan covers 80 per cent of hospital costs while the other schemes aim at cost recovery on drugs. This Insurance Plan was developed in 1975 and is organised around one district reference hospital and its satellite health care centres. Whilst enrolment is voluntary, to eliminate adverse selection, all members of the family are required to join if one joins. The principal draw back of the voluntary insurance approach is differential access to care between the insured and the uninsured, with greater use by the insured.

The success of this Plan in organising and sustaining the services provided in the health zone demonstrates that insurance can be a viable option for financing health services in a rural area with a population primarily composed of self-employed farmers.

Ghana, Kenya and Zambia have proposed similar schemes for rural households. In 1993 Zambia launched an experiment based on prepayment in kind, a bag of grain, in return for a health card entitling participating families to treatment for a year (Cassels and Janovsky 1995).

Careful planning, management and monitoring is required in implementing such schemes and measures have to be taken to safeguard the operation of the scheme and especially the use of funds.

Ideally, it should be possible to locate a group that will lend itself to group insurance coverage even among those with little money. Lack of supply of health care facilities in some areas makes insurance meaningless and in some cases health insurance may not be needed because health care is still supplied free of charge by governments or other agencies. One of the major problems in such collective insurance schemes is the potential danger that if these schemes deviate too much from population demand, various forms of non-compliance will arise. These contributions may be delayed or refused. Careful study of a community's attitude, preferences and economy is therefore needed before such schemes are implemented.
Formal Health Insurance. The scope for compulsory health insurance schemes in much of SSA was generally thought to be severely restricted due to a limited number of people in formal employment as well as the deteriorating economic conditions.

Recent surveys indicate that this view is changing and that 15 countries in the region have formal insurance systems in place (Nolan, Brian and Turbat 1993, World Bank Data). 18 countries had no formal system, 4 had a form of employer-provided programme and one, whose status could not be determined, thus indicating a promising future for health insurance in Africa.

Employer Based Insurance. Many countries in the Region rely on not-for-profit health insurance schemes that are based on employee groups. In Zimbabwe only 5.6 per cent of the population is covered by such schemes, 20 per cent in South Africa and 4 per cent in Namibia. The benefits vary from private employers reimbursing all medical costs incurred by their workers to provision of medical allowances and the operation of hospitals and clinics that cater for employees and their dependents. In some cases private employers have contracted private and mission hospitals and clinics to provide services to their employees.

Several such schemes are known to operate in the various countries. In Tanzania, the National Insurance Corporation manages policies for 43 employers with a total workforce of 2,000 employees. There is also the Tanzania Occupational Health Service covering about 250,000 employees on the basis of a prepaid plan. A proportion of employees are on some form of self-insurance (Paul Shaw and Griffin).

Contributions may be on the basis of a percentage of salary and both the employer and employee contribute. In Zimbabwe the ratio is 50:50. The contributions in Zimbabwe are tax exempt, thus providing an incentive to the employer through a form of government subsidy. Though the insured persons have the option of using both public and private providers of care, the majority of the care is obtained from the private health sector. The providers are paid on a fee-for-service basis.

In Zambia, some of the public health care facilities have contracts with employers whereby the companies pay a lump some deposit plus a non-refundable capitation fee and the hospital provides comprehensive services for the insured group.

Social Health Insurance. In this type of insurance the payment of health care is made through a health fund. Contributions come from both the employers and employees. A typical feature of this type of insurance is that the payment is independent of actuarial risk. The scheme may either be universal and compulsory or, to a lesser extent, based on voluntary coverage. Coverage is generally limited to those individuals in the formal sector and is often compulsory to overcome the phenomenon of adverse selection.

In some countries the benefits are comprehensive covering both ambulatory and inpatient services whereas in others the benefits are limited to inpatient services. While the majority of schemes operate on a fee-for-service basis, those proposed for Mozambique and Nigeria plan to use a capitation payment.
Some governments both provide and request mandatory contributions for health insurance coverage for civil servants. As governments are usually the single largest employers, this in effect increases health expenditure for a group that is relatively economically advantaged compared to the rural population.

Consumption by the insured of services from government health care facilities already heavily subsidized implies a double subsidy for this group. In 1991, public expenditure on services consumed by government employees (6 per cent of the population) in Burundi came to approximately 30 per cent of total government health expenditure (World Bank 1993).

Zimbabwe is currently undertaking feasibility studies for a National Health Insurance based on capitation grants to primary level providers. In addition, it would be mandatory, and primary benefits would be based on the District Core Health Services already in place. It is proposed that additional services, beyond the core services, would be paid by the individual through private health insurance.

The preliminary findings of one such study by the K. Peat Marwick Management Group on the proposed SHI in Zimbabwe was presented to the Ministry of Health and Child Welfare in March 1996. On attitudes towards insurance the rural and poor people were found to be less inclined to put money aside for future health-related needs. Their major concerns were based on the potential for abuse of such funds both at the official level and by other members. There was a strong desire and preference for local decision-making and local fund management. There was scepticism about the potential for quality improvements in health care which would warrant investment. Pre-payment was favoured by those who wanted flexibility and who also wanted to be able to use the money the following year in the event that they did not get sick. The same applied to those who could not afford insurance. Those with small and irregular incomes and those who preferred banking their money to earn interest favoured payment on presentation. As the study preliminary concluded that those attitudes indicate a potential for SHI, especially at hospital level provided certain conditions prevail such as:

♦ user fee and the price of the SHI package provide the right incentives;
♦ absolute transparency (marketing, communications and administration);
♦ local ownership/control;
♦ improvement in the quality of services.

_Raising Additional Resources._ Contrary to tax-financed systems, health insurance contributions are earmarked as health resources and are least likely to be diverted for other use. Organizational problems characteristic of the varied bureaucratic echelons in these countries have to be overcome to guarantee the functioning of low cost and efficient administration of such schemes.

With increasing unemployment and decreases in real wages, the levels of resources with the health insurance schemes also decrease since contributions are related to wages. Furthermore, with the effects of Structural Adjustment Programmes in some of these
economies, the proportion of people who are self-employed is increasing. Universally, countries have failed to collect proper contributions from self-employed people.

In some countries, it is necessary to put in place a fee structure at government facilities in order to tap resources from an insurance system. If facilities do not charge fees or have any capacity to process bills for insured patients, they cannot benefit from an insurance system.

In the Kasongo Health District of the Democratic Republic of Congo (former Zaire), approximately 60 per cent of District Hospital revenue is derived from insurance.

**Improving Efficiency.** Concern has focused on the potential of health insurance plans to encourage those insured to use services more than they would, had they not been members i.e. the moral hazard. However, while it is not inevitable, the impact of insurance depends on the form of contract between the provider and the insurance institute. Forcing clients to pay for part of the costs may reduce this hazard.

Reimbursement of fee-for-services for curative services has the potential to escalate costs for curative care, thus increasing the imbalance between expenditure on preventive versus curative care. In the same manner physicians may tend to be more elaborate when treating patients covered by insurance than to those paying for themselves.

Administration costs are one of the main factors to be considered in developing new modalities for social health insurance. Experiences in this area are varied, for example, in Mali such costs were estimated to be about 50 per cent (Nkamang 1985). In Zimbabwe, the administrative costs of member Medical Aid Societies are probably less than 10 per cent of revenue (Vogel 1993) and 14 per cent for the Kenya National Insurance Fund. This variation may be due to poor administrative capacity and insufficient financial control in some countries. Costs for administering private insurance may thus be lower than those of other systems, especially government programmes which tend to be inherently inefficient. Failure to contain costs in existing social insurance schemes indicates a fundamental lack of financial skills and weak information systems.

**Ensuring Equity.** Ideally, insurance schemes should transfer resources not only from the healthy to the sick, but also from the rich to the poor, especially when contributions are compulsory. In order for this to be possible, contributions should be income-related but benefits provided on a needs basis.

Because governments are major employers in countries of the SSA, there is the potential for Social Health Insurance to skew resources towards this relatively well-off segment of the population, especially when government contributes to the premiums. In Zimbabwe, where contributions were tax-exempt, this translates to a subsidy to those members contributing to insurance at the expense of the public health expenditure for the poor.

In Burundi, in 1980, it was found that total expenditure on 45,000 insured persons was more than the regular Ministry of Health budget (Nkamang 1985).

A way in which health insurance can promote equity is the extent to which it frees government resources to be used for the uninsured part of the population. Whilst private
insurers covered less than 5 per cent of the population in 1987, they were responsible for an equivalent of 30 per cent of total health expenditures. This allowed extra funds for use in public health services.

Experience from elsewhere indicates that even if there is a large formal sector, universal health insurance coverage cannot be achieved through market mechanisms and private health insurance coverage. Imposing regulations on private insurers to eliminate exclusion for pre-existing conditions, and other forms of risk avoidance, can contribute to a more balanced coverage.

The Potential for Health Insurance in SSA. South Africa and Zimbabwe probably have the best developed private market and thus, with increased investment or donor funds, the potential is great (Shaw and Griffin 1995). The majority of other countries have an employer mandate to provide a system of risk-sharing, creating a strong base that can be increased to provide extended coverage.

The lack of a formal medical infrastructure, poorly defined cost recovery strategies and less urbanization tend to mandate against the development of health insurance in some of these countries in the region.

The recent trend in the Region towards charging fees for medical services creates an enabling environment for the development of more organised private health care. At the same time reliance on competitive forces in the provision of care is still fairly unrealistic and may be undesirable for many countries in the sub-region. Firstly, resources, mainly manpower, are not available for genuine competition. Secondly, the epidemiological profile and the need to eliminate communicable diseases cannot be left to competitive forces.

Community financing schemes through organizations like village development associations, co-operatives and parents associations, especially in the rural areas, have been put in place in some countries. Such schemes have been based on some form of pre-payment and may involve payments in kind for simple health activities. The potential for such schemes is probably limited and nationwide financing schemes may well be advisable.

External Financing

This type of financing forms a significant proportion of expenditure on health in SSA countries. Such funding can be substantial, up to 90 per cent of the total public health funding in some countries. Most of this aid has been used to develop infrastructure and the training and continuing education for health care personnel.

Several problems arise in the event of relying excessively on external donors, especially when there is an economic downturn in donor countries. The negative spillover on external assistance usually has an adverse effect on the continuity of projects in recipient countries. With limited availability of funds donors may shift away from the poorer countries to those more politically or commercially important.

As indicated earlier, projects that have developed infrastructure have often planned for recurrent costs to be financed by national resources, once the capital has been installed or the
personnel trained. Most often than not, governments in recipient countries are often unprepared and have not designed the appropriate inclusions for such recurrent costs. This problem is acute in many SSA countries where a major share of capital expenditure for health is reported to be financed by external aid (WHO 1988).

The current trend is for donors to give priority to financing recurrent costs of existing projects in order to make more adequate use of existing resources. Foreign aid will thus be viewed as a complementary mechanism to domestic financing efforts rather than a substitute for such efforts.

Changing Roles of Key Actors in Health Financing

The changes taking place in the financing arrangements for health care are accompanied and often supported by changing roles of key actors in the health care delivery system: consumers who benefit from health care, providers who sell their services, purchasers who pay on behalf of consumers and governments who play an intermediate role for all of the above.

Consumers. The openness of the health care market has conferred an opportunity for increased choices on health care providers to consumers and this has reinforced competition in the for-profit market. The consumer has the choice to enter into third party purchaser plans and to be involved in the management of health care through representation in health boards within a decentralised health system. Regulatory controls protect the consumer who also has access to consumer information.

Providers. Privatization, either active or passive, has helped compensate for shortfalls of government for provision and financing of health care. A number of countries have attempted to provide and give consumers greater choice by providing private services in public facilities, so that those who can pay for better quality care can obtain it. Malawi, Zambia, Kenya, Mozambique, Zimbabwe and Tanzania all have private beds in government hospitals. In Zimbabwe, government specialists and private practitioners have access to practising privately in government facilities out of hours and as sessional consultants respectively. In such arrangements the physician providing care generally retains a proportion of the fee paid as an incentive, usually through third party payments. Such arrangements have resulted in governments subsidizing these elite services rather than the other way around.

From experiences in other countries, one has to keep in mind unforeseen and negative consequences for the health care system resulting from the promotion of the private-for-profit sector. The private sector is more active in personal curative care and providers tend to exploit the market by providing high priced commodities irrespective of whether these may be actually needed or not. Providers often group themselves into professional bodies which protect and seek support for the interests of their members, particularly advocating fee increases and adoption of alternative financing mechanisms.

Purchasers. With the emergence of privatization and social insurance, the role of purchasers (government, insurance agencies etc.) has been strengthened. Contracting out of services is being adopted on a limited scale in developing countries for non-clinical services like laundry, catering, security and equipment maintenance to the private sector. Lesotho has
contracted out catering and security services, and Nigeria has contracted out laboratory services. Contracting out in Zimbabwe is being undertaken within the context of the Public Service Reform programme. The services to be contracted out include laundry, cleaning, security and catering at the Central Hospitals which are located in urban areas where market testing has been undertaken.

The experience with contracting out of clinical services is limited but fairly successful, and examples are available from Namibia, South Africa and Zimbabwe. In South Africa there are hospitals known as contractor hospitals established specifically to provide care to government patients. Payment is usually on the basis of a fixed-fee per patient per day.

In Zimbabwe, the Ministry of Health and Child Welfare contracts with some hospitals to provide services to the local population which is not covered by government health facilities. Government patients eligible for free health services may attend on referral and the hospital charges the Ministry of Health directly on a fee-for-services basis. This arrangement has recently come under scrutiny as there are concerns about the costing of these services as well as allocative efficiency. Experience usually indicates an increase in the cost of a service when it is contracted out, but this is usually offset by increased efficiency in the delivery of such contracted services.

Government. Regardless of changes in health care financing, the government remains responsible for setting national health priorities and determining the means by which national health objectives can be achieved. A diminished role for government financing in SSA is generally from economic and political necessity rather than from a change in political orientation.

The major responsibility of government, in the provision of health care, is to protect the most vulnerable and to fund public services. The state must assume a central role in terms of regulation, policy-making and provision of information.

Some Conclusions on Health Financing

Experience with user fees is fast gaining ground in the Region, but it may be a long time before its full potential to contribute to overall government expenditure on health care is realized. There is a need for countries in the region to review and share experiences on cost recovery and to develop strategies to monitor and evaluate the performance of the various financing options.

Studies on user fees suggest that they may have an adverse effect on utilization of health services, especially among the poor, unless the following conditions prevail:

♦ increased availability of essential supplies at facility level;

♦ higher perceived quality;

♦ greater accountability of providers to the population;

♦ retention and local management of revenues;
a phased rather than sudden increase in prices.

There are still considerable gaps in information on the impact and interaction between cost recovery and the health delivery systems in the region. Several areas need to be explored:

- the likely revenue potential of user fees;
- determining the appropriate levels of fees;
- information on people's ability and willingness to pay;
- determination of the consequences to those not able to pay;
- linkages between user-fees and perceptions of quality of use;
- practical exemption policies for the vulnerable groups;
- information on how to deal with revenue collection, costs and utilization.

Indications are that there is a promising future for health insurance in the region, but careful planning will be required to guarantee sustainability. This potential can be enhanced if:

- there is adequate actuarial data/information on health conditions and expenditures, earnings, taxation and the contribution base;
- cost recovery strategies are fully established and operational;
- an adequate health infrastructure is created to provide for entitlements and a potential for private sector development and consumer choice;
- the potential for adequate coverage with particular attention being paid to the needs and difficulties of penetrating and providing for rural populations, the self-employed, and the unemployed;
- conducive administrative capacities to satisfy administrative needs of a health insurance scheme are in place;
- there is development of the much needed skills in financial management.

Countries in the region should recognise that a variety of strategies are available to improve the financing of health systems, each of which is likely to have some good and some bad consequences. Thus innovative strategies should be implemented to suit the unique conditions in each of the respective countries. It is important not to lose sight of the essential role of government in policy-making, regulation, information gathering and dissemination.
SERVICE DELIVERY CHANGE

The Intercountry Meeting in Arusha reiterated the importance and rationale for changing service delivery in order to strengthen health services by defining a set of cost effective interventions, including the main components of PHC. As the majority of participating countries are in the process of introducing essential packages and integrated service delivery strategies, it is important that the rationale for change is clearly articulated and understood. Does the perceived need for change come from: the desire to provide better or more services, the need to improve the provision of health care and the provision of increased choice or the need to match expenditure to resources? To what extent are public health services, i.e. immunisation, maternal and child health, family planning, health promotion, environmental health, etc., to be added or excluded from the area of responsibility of the state organised health system? Understanding the organization of the delivery system in terms of number and types of manpower, facilities and their geographic location, their interaction across different levels of care with financing and reimbursement policies in affecting access, quality and cost, is essential.

Priority Setting

Despite epidemiological diversity amongst developing countries, infectious and parasitic diseases remain a priority in SSA. It is unrealistic to come up with global priorities for developing countries. The approach should consider the continuing evolution of disease control priorities based on social and economic transformations which these countries are undergoing. Despite the generality in programmatic shifts from primary prevention to post transition needs, it is imperative to note that SSA has suffered from epidemiological polarisation and epidemiological stagnation. The polarisation is evident both across classes as well as geographic regions.

Decisions about the type of services to be provided have been the subject of close scrutiny as well as the necessity for a consensus towards financing and providing cost-effective interventions. Scarcity of resources has given new impetus for attention to priority setting.

Priority setting is a process of ranking options so as to make the best use of limited resources, and involves organization and management interventions as well as health care interventions. The latter covers both clinical and public health interventions as their separation is unhelpful and artificial. Effective priority setting requires a clear vision of the type of health system a country wants to develop and is helped by setting the priorities within the framework of PHC.

Many existing priority setting methodologies are based mainly on the extent to which various interventions can reduce morbidity and mortality. Such selective approaches to the provision of health care obviously have shortcomings of creating vertical programmes and neglecting other equally important health care objectives that have to be considered by decision-makers in priority setting, particularly in poor countries. These include establishing a sound infrastructure, improving its organization and management, reducing inequities in health and health care, addressing the health transition, and ensuring decentralized decision-making.

Similar concerns are being expressed with regard to such complex priority setting tools as the disability-adjusted-life-years (DALYs): they are limited to only one set of problems, which is
morbidity and mortality, have the drawbacks of selective PHC approaches and vertical programmes, and thus might lead to inappropriate priorities.

Although there is a universal agreement that health care should be provided in a decentralized way with participation of many decision-makers, priority setting is frequently still top-down with priorities being set at the national level for the whole health system. However, there are also many examples of increasing the scope of priority setting at district level with involvement of community, within the framework of national policy objectives. For example, in Zambia districts are now being given their own budgets and can deploy them according to locally defined priorities but within firm central guidelines. Bottom-up planning and priority setting with community participation has been reported by Tanzania. In Tanzania, PHC committees exist, but not all of them meet regularly, and their legal status is unclear limiting their potential influence. In Kenya, district development committees provide a clear forum for public participation, but in practice they often have little influence.

The possibilities for priority setting in districts remain beset by a number of obstacles including lack of information, tensions between central control and local autonomy, limited technical and managerial capacity, conflict between local priorities and centrally managed vertical programmes, problems of donor influence, and budgetary problems.

Transparent and accountable methods for setting priorities are clearly needed when resources are scarce. With a growing tendency to decentralize service provision decisions to more peripheral providers, central Ministries might expect to promote broad priority principles, allowing local providers, communities and purchasers to make decisions about local priorities.

This is an area where considerable rethinking and operational research is needed. Researchers need to move from their preoccupation with assessing the health impacts of individual health interventions to assessing the impacts of mixes or groupings of health care interventions such as, for example, integrated MCH programme, taking into consideration the existing forms of organization of services. To be of a maximum practical use, evaluations and experiments with alternative systems of priority setting should aim at achieving several health objectives concurrently. For priority setting is about choosing appropriate mixes within a specific context and situation.

**Essential Packages**

The terms priorities and packages are frequently used interchangeably, but a distinction can be usefully drawn between them. Priorities are interventions that are considered to be important, be they in health care, organization, or management, and they can be ranked from higher to lower. Packages are defined groups of priorities that can be standardized to ensure that equivalent interventions are delivered wherever the package is made operational. Within the package all interventions have equal status, and the package as a whole has been costed.

The possible contents of a package are conceived differently by different agencies. Some see a package as containing only clinical and public health interventions, while others see it as including also organizational and management interventions. WHO defines a package comprehensively as including a mix of health care, management and organizational interventions, as packages of health care interventions alone run the risk of being developed into vertical programmes with the adverse consequences already experienced with that pattern of health care delivery.
Most SSA countries have adopted the principle of defining a package of essential health services and started its implementation, and many activities have been taken place throughout the region within this context. These include conducting surveys, costing services, developing profiles of provinces and districts, strengthening information systems, sensitizing health workers and community, and conducting assessments of initial implementation.

Through an intensive analytical process the Ministry of Health in Zambia has defined a package of cost effective care to which the government will ensure all Zambians have access. The definition of packages of care, how they will be delivered and how much they cost continues to be defined. A similar process of defining core services to be delivered at the rural health centre and the district hospital and the resources needed were defined and costed in Zimbabwe in 1995 and will be linked to the development of the proposed social health insurance scheme.

While the reasons for developing a package are common, and its components do not differ dramatically from country to country, there are differences between countries in the mechanisms by which such packages are derived, the approaches to operationalizing them, and the implications for the delivery and financing of care. A number of countries have adopted a district health systems package defined by WHO/AFRO, in some cases with local modifications. Others have assessed their priority areas independently, in few cases through analytical assessments of the burden of disease and cost-effectiveness analysis of interventions. The definition of a package in some countries has implied that resources for the delivery of the package will be reallocated from central programmes and the higher levels of care which fall outside of the package. In others its implementation has been financed by donors or has simply been a way to reorganize financing for PHC.

There is a common belief that essential health services packages should be defined for various levels of health care delivery system. For example, Zambia has developed a strategy in which packages are based on competencies of care from the household through to the tertiary hospital level. Packages that are level-specific should be defined in a way that ensures that there are clear links between levels, and that all packages have a common objective. A district hospital package, for example, must be designed to support the activities of the health centres. Adequate provision of manpower with appropriate skills mix should be ensured and appropriate facilities and technologies made available in order to deliver the packages at each level. This particular concept emphasizes the organizational and management priorities and reflects health services performance issues, that differs quite substantially from the World Bank approach, in which a standard package of clinical and public health interventions is suggested without specifying organizational and management concerns.

While a package of care is principally used to define what the government decides to provide, it is possible that the private sector might provide a package of services in areas not served by the government sector. Some countries as, for example, Uganda encourages this practice and the government provides support to NGOs in delivery of essential package of services. Packages may be a way for better coordination of priorities in sectors with different goals and sources of funding.
District level capacity to identify priorities as well as implement and manage a package is considered essential and needs to be strengthened in many countries.

Based on national conceptualization of the package, strategic plans must be developed in order to ensure the formulation of essential health, organizational and management interventions based on priority needs and optimize the use of resources in a cost-effective, sustainable and equitable manner.

There is a general concern that traditions in vertical approaches are often an obstacle to implement integrated packages, and there is a need to clearly define the roles of the government, donor agencies and the community in implementing packages.

This is an area which requires further intensive research and sharing of experiences. Countries should perform cost-effectiveness analysis of interventions included in the packages, and continuously monitor and re-assess their implementation within the changing social and economic environment.

**Integrated Service Provision**

There is a common move in all countries towards integrated service delivery as an approach which is sustainable, efficient and convenient for both providers and users. However, integration of health services versus vertical programmes is a major challenge in the Region, and service fragmentation is still a serious problem in many countries. Vertical programmes producing tangible results in a short time, which though are normally not maintained in the long term, are still being advocated by some internal and external agencies.

In many countries, within fragmented services, individual programmes have their own, often different, rules and procedures for reporting, accounting, obtaining supplies, and supervision. This multiplies the managerial load of clinics and health centres. Many vertical programmes are often implemented by a limited number of health workers like, for instance, in Tanzania where more than twenty different vertical programmes with different managerial procedures are being dealt with by two or three health workers. Under such circumstances, it is difficult to plan service delivery on a population-defined problem basis and to use scarce resources efficiently.

A comprehensive understanding of integration of health services means a process of bringing together common functions within and between organizations to solve common problems, developing a commitment to shared vision and goals and using common technologies and resources to achieve these goals. The aim is to promote primary health care services which are fully integrated under the management of a district health team. Special programmes can, of course, be required in certain circumstances, but an integrated health service must be available to sustain the activities and the achievements of the vertical programmes in the long run. The two approaches are not mutually exclusive, but need to be viewed as complementary.

Integration of health services can have several elements which together build up a picture of the overall extent of integration. Integration of service tasks within a given setting involves multipurpose clinics, multipurpose staff, integration of certain services functions. Integration
of management and support functions relates to comprehensive and intersectoral planning, emphasis on multipurpose PHC programmes in budgeting and financial processes, integrated information systems, integrated rather than specialized training, multipurpose supervisory visits, comprehensive research planning and implementation. Integration of organizational components requires the efforts of different resource providers at various levels to be integrated through various coordinating mechanisms, the district hospital to become not only a referral centre but also a resource for support services, health and other development efforts to be integrated across several sectors, and health care to be integrated into community and family activities.

Integration of health services leads to more efficient use of resources, enhanced overall effectiveness of the health system and improved consumer satisfaction. Addressing health problems in a holistic manner increases the overall impact on health status of the population. Furthermore, integration normally reduces differences in access and utilization of services between geographical and socioeconomic groups, thus leading to greater equity in health and health care.

Countries have various approaches to integration. Zambia promotes integration based on decentralization. In Ghana, vertical programmes are being integrated into functional groupings linked in a single entity. Integration of vertical programmes is also being pursued in Guinea. In Cameroon, integrated health centres ensure the integration of promotional, preventive and curative services. NGOs services are being integrated with the government ones in Tanzania. Integrated planning of comprehensive health services is the emphasis in Botswana. Several East African countries have integrated service functions based on the "supermarket" approach initiated in Tanzania for integration of all essential health care requirements for mothers and children.

The integrated delivery of care is closely linked with and influenced by the way in which priorities are set. Disease-based priority setting is likely to lead to vertical programmes thus maintaining and even worsening the fragmentation of services.

Quality Improvement

Monitoring and assuring quality of care is another important feature of health care delivery systems, all the more important in an era of increasingly tight budget constraints. The success or failure of many reform measures depend on the way they affect peoples' perception of service quality. Access to essential drugs, functioning equipment, proper location of clinics and other facilities, outreach programmes, properly trained health workers, clean drinking water and proper nutrition are essential first steps of reform. Widely implemented substantial policy and organizational changes have the potential to improve service quality if the right incentive and management structures are designed.

The problem of some technical facets of quality which seriously contribute to the underutilization of government health facilities has become more pronounced in much of Africa in recent years. The way patients are received has an important effect on their judgment of service quality. Absence, rudeness and indifference of health workers as well as dirty and uncared health facilities are widely reported. Inadequate knowledge, procedures, records, information are also common. Non-functioning equipment and unavailability of
drugs and basic supplies is a widespread reality. While some of these problems are pure results of under-resourcing or local mismanagement, some others, particularly those of drug supply management and management of physical assets, i.e. hospital and medical equipment and buildings, have broader policy and management roots.

Drug and physical assets management are key issues for ensuring effective health service delivery, and efforts towards their improvement should be an essential part of reform programmes. Failure to do so has the potential to hamper and distort all other efforts undertaken to enhance health systems performance.

Drug costs are second to staff costs in many African public health systems. Reductions in social sector budgets, due to response to adjustment programmes, and the recent devaluation of the CFA has left a number of countries in a precarious drug supply situation.

A number of measures to remedy the situation based on the essential drugs concept and the rational use of drugs have been reported by countries as part of their health sector reform initiatives. Clearer roles and functions for various levels of the health system are being defined in order to strengthen the mechanisms for purchase, storage and distribution of drugs. This include reinforcing of Ministry of Health supply organizations' capacity for inspection of supply structures and facilities. District and local capacities to effectively integrate drug management into health care activities are being strengthened. Drug allocation is being decentralized to the district level and capacity of hospitals and health centres to better respond to local drug needs is being developed. Cost recovery mechanisms, revolving funds and autonomous medical stores are being established. Strengthening of drug regulatory agencies in order to ensure the quality of supplies is being considered as priority by all countries.

However, in most countries, a number of constraints such as management inefficiency in supply agencies due to lack of qualified manpower and appropriate information and tools as well as lack of technical capacity at district and lower levels, seriously affects the implementation of strategies for application of the essential drugs concept. Bilateral donor assistance has mitigated the situation in some countries, but the problem of long term sustainability is formidable. A concerted international action is needed to support countries in development and implementation of effective national drug policies, as part of national health policies. Even if this is ensured, there will still be emergency needs for drugs at country level that cannot be foreseen. The creation of a solidarity fund to assist such countries, subject to strict criteria for access, would serve a valuable purpose.

Most countries experience serious wastage of resources and decreased quality of care due to poor planning and management of acquisition and utilization of health services physical infrastructure and equipment. The most pressing problem is not the lack of medical equipment but equipment, usually around half of it, in some cases even more, that is not usable or not used at any given time. Although some of this equipment is inappropriate to country's health priorities and conditions, the bulk of it is appropriate and could contribute to country's health goals but lies idle due to inappropriate management of its introduction to the country. Absence of suitable policies, and lack of managerial and technical expertise are underlying reasons preventing African countries to fully utilize the potential of physical infrastructure and equipment.
Strengthening of country capacities for proper introduction and management of physical facilities and equipment is one of the reform measures critically needed in order to improve the performance of health systems in their countries. In some SSA countries concrete steps are being taken in this direction. These include development of specific policies on infrastructure and equipment as part of overall health policies and development plans. Strategies to strengthen health care technical services at district, provincial and central levels are being taken and required human resource being trained in order to ensure proper selection, procurement, maintenance and use of technologies. Efforts are being made to define essential equipment for various categories of health institutions and to establish norms for health facilities at different levels.

More research on these issues is required, and it should consider country experiences with setting and monitoring national policies and standards, and review options for making good infrastructure management, and especially informed technology choice and preventive maintenance, a more widespread reality in African health care systems.

Establishing structure, process and outcome standards is essential for monitoring health sector performance as well as the impact of specific reform policies. As an example, the Strategic Plan will define new standards for the reformed Zambian health care system. National standards are intended to provide guidance to districts in setting local standards and to provide national estimates on the resources needed to transform the existing system into a more cost effective one.

Quality assurance measures such as conditions of participation for hospitals, licensing policies and manpower training standards have been said to be the appropriate choices most relevant to SSA countries given their current infrastructures, as they attempt to upgrade and monitor the quality of care rendered in their health care systems.

Studies in several countries have shown that people are willing to pay for better quality care. Ministries of Health need to know how to support districts and health care facilities in bringing this about. Improving equity by making services more accessible to people cannot be attempted until existing peripheral services are better used. A critical look at the performance of hospitals and health care centres appears essential. In Zimbabwe, for example, competition amongst district or central hospitals for Best District/Central Hospital Awards are conducted on an annual basis.

There is uncertainty in implementing innovative ideas whose effects are difficult to predict. Studies of the outcome in settings where these ideas are implemented experimentally or nationwide, will help to reduce this uncertainty and may encourage policy makers to be more bold with such potentially important measures. One of the difficulties for Ministries of Health which intend to decentralise health services or purchase them directly from the private sector, lies with ensuring that they are obtaining value for tax-payers money in terms of the quality and quantity of outputs and outcomes. Research is needed to test alternative means in order to discover whether they can be relied upon for resource distribution, quality assurance and decision-making with regard to performance incentives.
Whilst there is general talk of the need for management training to yield efficiency gains once a system has been decentralised, there is generally little information to help them select the most promising candidates and to apply methods which maximise learning and skills acquisition. There is therefore a need to evaluate experiences in this field.

THE ROLE OF DONORS IN HEALTH SECTOR REFORM

There can be little doubt that donors have played an influential role in the reform process in many African countries. Bilateral donors have given vital direct budgetary support which has supported the operations of health care systems. The proportional impact of donor support in influencing health care policies and programme strategies is relatively large. This is particularly true when the assistance promotes policies which lead to a reallocation of national resources. The impact of the donor-driven child survival initiative in promoting immunizations and oral rehydration therapy worldwide is an excellent example.

Recent problems in developed countries, such as increased unemployment and high costs of unemployment support, increasing concern about international debt problems and changes in donor policy, mean that donors are unlikely to significantly increase their levels of external assistance.

Countries in the region have expressed concern about the lack of donor co-ordination where they have concentrated on particular instruments of reform policies, such as user charges and community financing, using this as a lead instrument in the wider reform process. Other donors focus on recurrent budget support in a number of African countries.

It has been observed that reform processes are currently characterised by particular pre-occupation of the specific donor, rather than country priorities. When looking at the way in which health care systems have evolved and are currently configured in many developing countries, a share of the blame for failures undoubtedly falls on donor agencies. Donors need to be invited to develop a voluntary code of conduct in relation to support for the health sector reform in the SSA region. There is a need for donors to support national plans and priorities, emphasis on partnership co-operation in which partner countries have the main responsibility for setting policies, directing and implementing programmes.

More recently, dialogue among donors appears to address a more holistic form of sectoral support to the reform process replacing, to some degree, the previous tendency of donors to support certain programmes or activities.

Three categories of external assistance were discussed at the Intercountry Meeting in Harare:

- allocation to specific projects (project aid);
- broad budget support; and
- broad sectoral development support.

At the Arusha meeting donor representatives discussed and clarified respective funding policies and the importance attached to certain reform policies. While there were areas of a common approach, it was clear that various donor agencies had specific areas they felt deserved particular attention. DANIDA and NORAD emphasized the need for flexibility, country driven and country based donor co-ordination with institutional capacity.
strengthening. DANIDA is moving from the strict project and narrow programme support towards a broad sectoral approach, i.e. in Zambia and proposals for Zimbabwe. In a move towards more integrated approaches in Zambia, DANIDA supported development of the District Health Administrator's capacity in the areas of budgeting and financial management.

NORAD is currently collaborating with the government of Botswana on the decentralization process. Three options are available for Norwegian development co-operation: bilateral, multilateral and NGO channels. The multilateral channel is particularly relevant in the context of broad health care reform programmes and to have an important role in the context of donor co-ordination. The bilateral channel has a high degree of flexibility and is a useful tool for supporting specific reform issues and activities which otherwise would be underfinanced. Aid support through NGOs has the potential to strengthen links between the public and private sector.

The ODA view is to address the more fundamental institutional issues involved in improving the function of the sector, emphasizing on evidence driven reforms and the importance of sharing experiences, and providing technical and financial assistance in this area.

A strong case should be made for the role of multilateral organizations in the question of supporting governments in a health sector reform process. WHO, UNDP, UNESCO, UNFPA, UNICEF and the World Bank are the key actors in this arena. The UN System-Wide Special Initiative on Africa's first goal is to reform basic health care systems and to ensure adequate access to PHC for all populations. The aim of this collaborative effort is to strengthen the institutional capacity of African health care systems led at national level by the countries themselves. It is envisaged that the agencies will come together to co-ordinate funding and to harmonize technical inputs.

It is important for donors to appreciate that there is not one single right way of reforming health care systems and that attempts to reconcile varying positions between or among donors, whenever they arise, should have a high priority rather than having conflicts place the reform process in jeopardy. The importance of working together at the international level to share experiences, establish key principles and explore systems for monitoring and evaluation cannot be over-emphasized.

There is a feeling amongst donors that reform processes are often initiated with very vague objectives and a feeling that something has to be done. The successful implementation of health sector reform is dependent on the scope and quality of partnership created before and during the process among the shareholders in the health system. Countries at the Earache Meeting emphasized the need for ensuring national ownership through joint strategic planning. A process which requires that donors shift from playing the leading role to a more supportive or collaborative role. This involves convincing donors to give up some control of the process and to work as a team with the recipient at all stages of the process. A strategy that appears particularly promising is the provision of funds to countries to allow them to commission studies by national institutions on issues they consider important.

Technical assistance remains a major vehicle for exchange of expertise related to health sector reform design and implementation. Agencies like the GTZ view themselves as having, as primary role, assisting countries in policy formulation and evidence based
decision-making. Donor financed technical assistance did not always guarantee that the best expertise was made available to a particular country since the number of consultants was influenced by donors. Analysis of the contents of reform packages always shows considerable repetition, and few country-specific agendas can be found, particularly in the areas of health financing, decentralization, management and systems development. Some recommendations are based on little evidence with regard to effectiveness in the region.

An area of contention in the role of donor support for health sector reform has been financial accountability. Generally, accounting requirements should ideally follow from the donor's policy goals and not constrain them. If aid is provided to promote institutional reform, then in theory it should be accounted for in terms of whether these reforms have actually been implemented. However, the difficulty has been that most donors are required by their constituencies to account for how the money was actually spent. The state of national accounts systems favours the provision of tightly controlled project aid which can easily distort government spending priorities or the establishment of a myriad of parallel accounts and management systems which undermines the institutions which the aid programme aims to support.

One of the major objectives is to improve collaboration amongst member states by organising seminars on health sector reform. According to country representatives from the SSA region, donors should provide support to countries for this network as well as resources to facilitate the reform process. Donors stressed the shift from discrete project support to consolidated sector support and the need for shifting ownership of reforms to countries and an increased use of local experts in the problem solving process.

Donor co-ordination was advocated so as to reduce contradictory and overlap activities and technical advice was to be rooted in evidence rather than donor interests. Donor lending agencies ought to consider that whilst country involvement, of the type that is generally argued for, can certainly lead to more lengthy and complex design of aid packages, it could also result in less ambivalence and greater commitment on the part of the country governments.

In a much broader sense, in the context of the UN Special Initiative for Africa, WHO proposes to intensify its technical support to Africa through:

♦ assistance to countries in the formulation and implementation of policies and planning for health sector reform;

♦ assistance to countries in the preparation and marketing of proposals for health sector reform as well as facilitating the mobilization of resource support;

♦ sharing of country experiences on specific aspects of the reform process and its effects, through documentation, intercountry meeting and tailored study tours;

♦ the expansion of policy oriented research capacity in countries and the creation of a regional data bank on reform processes and experiences.

The World Bank is expected to play the lead role in fund mobilization.
ROLE OF HEALTH SYSTEMS AND POLICY RESEARCH

A number of important questions as to how the perceived need for change has come about remain unanswered. Whether it was from the desire to provide better or more services, the need to improve provision of health care, the provision of increased choice, the need to match expenditure to resources or to implement a new concept of social justice are amongst them.

The experience of countries in SSA has not been well documented and thus priorities of common interest amongst SSA countries on health sector reforms have only recently begun to be addressed. Such experiences and lessons drawn from their comparison are crucially important so that countries which are about to embark on a reform process or are already implementing reform have access to scientific information based on the success or otherwise of a particular reform initiative. No single reform can be recommended for all countries, and what is needed is more analytical information on the different strategies and methods that have proved effective.

Evidence is required to lead and support the process of reforms. To this effect, HSR is of critical value as a unique tool to provide guidance on right policy choices, and objective evidence for rational decision-making, which would not otherwise be obtainable. It helps policy-makers to define which policies are to be the most effective, efficient and relevant as well as to ensure that proposed measures and set objectives respond adequately to the identified needs and comply with main sectoral goals. It also provides managers with the technical knowledge to translate these policies into action, monitor implementation, and evaluate outcomes.

How and to what extent HSR influences policy is, of course, important questions. NOT undertaking policy-related research, however, clearly means that policy CANNOT be influenced or informed by research process. When policy development and implementation proceeds without adequate research information, reforms may have unexpected adverse consequences. In a number of actual instances this has happened in African countries.

For example, there have been reliably documented accounts in several countries such as Ghana, Kenya, Lesotho, Swaziland, Zimbabwe, of the large scale deterrence that introduction or increase of user fees has had on outpatient attendance. Where studies have been done on who was mainly affected by these changes, the elderly, the young and people with sexually transmitted diseases have appeared on the list, as well as rural dwellers generally. So some, possibly many, patients have suffered because the policy was not designed to exempt those most in need. No-one gains from underinformed policy- and decision-making, and those who loose are, in the first place, the most vulnerable population groups.

Policy-makers have not emerged unscathed. Sudden reversals of policy and popular protest have made them to ask searching questions about whether the policy is the right one or being introduced in the right way. And the only tool to provide answers is HSR, which can clarify the likely trade-offs between various health reform objectives, both before policy is implemented through option appraisals and assessment of people's preferences, and in the course or after implementation through prompt and reliable monitoring and evaluation. It can thus help decision-makers by giving them a quantitative and qualitative forecast of what is likely under different policy scenarios. It can also help providers and users of health care by anticipating their reactions to different policy options, and ensuring that their needs are recognized in policy design and implementation. Information on options, their implications,
consequences, and on experience from elsewhere helps to broaden the constituency of debate and participation in health policy.

It has become increasingly obvious that testing and monitoring the effects of health sector reform interventions cannot be achieved through conventional research methodologies alone. The *sine qua non* for policy design, implementation and evaluation is appropriate epidemiological, socioeconomic, medical and financial information. Data that can contribute to national health accounts which provide information on all health care expenditures, by type of service and source of payment, are of critical importance for rational decision-making. Such accounts must include public subsidies and private expenditures as well as black market activities and side payments to medical care providers.

Conceptual research provides new insights into complex issues and serves to generate a common understanding of terms used and questions to be addressed. Retrospective case studies have dealt traditionally with the evaluation related to experiential evidence. On the other hand, prospective evaluations and experiments have been advocated in the form of piloting certain reforms rather than wholesale national implementation of them (Janovsky and Cassels 1995).

*Research and policy makers.* Policy is affected by research. The process of influence must be seen not as being always direct but as a process of enlightenment - many research ideas filtering through to policy makers. Utilisation of research results is also affected by the nature and intimacy of the links between policy makers and researchers. If HSR is to provide the basis for adopting and guiding policy and institutional reform, it is useful to examine what factors are most likely to influence the use made of research findings in decision-making.

Where policy makers take the lead in defining information needs and research priorities, participate in designing research agenda, commission studies on specific questions of direct concern to them, and get themselves involved in the research process, it is highly likely that research results will be accepted, and policy development and implementation will be influenced and guided by research evidence. The reasons why decision makers disregard results of research they have initiated may be due to the fact that decision-making is a complex process in which reliable information is only one interfering factor. Constraints of an ideological, political or financial nature might weigh heavier in the process and incite decision makers to follow trends more than facts. However, while many different political and economic factors and forces have clearly their influence on a decision-making process, scientifically proven evidence and reliable research information can guide the leadership towards better course of action and more rational decisions. Research can also have an impact on policy-making less directly through influencing public or political opinion.

At the same time, more sensitization work amongst policy-makers is needed, and researchers have to take more proactive and aggressive position in clarifying the role of research information in decision-making, promoting HSR within the entire health community and thus strengthening the research culture. HSR should not be an isolated academic exercise. Research information and findings presented to policy-makers should be user friendly and well packaged for adoption. It should be timely, avoid being contradictory, and recommendations should be feasible. Often, a simple alert about the possible problem and its
causes may be the most useful information for policy-makers who can then modify the course of action accordingly or request a further study.

Regional HSR Capacity. Africa has many human resources capable of contributing information relevant to the health sector reform process. There exists a substantial pool of economists, social scientists, and public health specialists at African universities, institutes of public health and public administration. Capacity-building for HSR has been addressed as a priority issue by WHO, and a substantial number of health and health-related workers have been trained in research methodologies, and HSR has been institutionalized in many African countries. In addition, several other organizations have been active in providing support in this area.

Most countries in the region report considerable progress achieved in recent years in developing their HSR capacity. So countries of Eastern and Southern Africa participating in the Joint Health Systems Research Programme were particularly successful in creating a favourable policy environment for HSR, institutionalizing it by establishing multidisciplinary research units at Ministries of Health, and developing a critical mass of researchers by training over 1000 health and health-related workers in HSR concepts and methods, with over 200 trained as research trainers. Although this training was particularly focused on district health workers in tackling operational problems, in the last few years more policy-oriented work has been supported by the Programme in a number of countries. WHO in collaboration with the Council on Health Research for Development (COHRED) is currently promoting the development of a similar initiative in West Africa based on the expansion of experiences of the Joint HSR Programme. The WHO also supports capacity building in health economics at the Centre Regional Pour le Developpement Sanitaire, Benin, jointly with the German Technical Cooperation Agency (GTZ) and IDRC, and at the University of Cape Town, South Africa.

In addition, a substantial number of researchers, mainly at university or national Ministry of Health level, have been trained through programmes such as the International Health Policy Programme (IHPP) and the Social and Economic Research Programme of the WHO/World Bank/UNDP Special Programme for Research and Training in Tropical Diseases (TDR). Policy-related research work is also being supported, inter alia, within such initiatives as the Essential National Health Research (ENHR) promoted through COHRED, and activities of such NGOs as INCLEN or SOMA-NET, which also maintains an African network of health policy-oriented researchers, as well as the GTZ Project on Reproductive Health and Health Care Reform in the Southern African Region.

However, despite its acclaimed usefulness in addressing priority problems and existing considerable HSR potential in SSA, it has not yet become an essential part of the managerial process and has not been properly institutionalized in many African countries. HSR capacity is often concentrated in institutions of higher learning with a very weak link, if any, between policy-making and research. This capacity at district and community level remain very limited. There is a lack of coordination of available human and institutional resources. Even where the local capacity is available or in countries with a large potential capacity for HSR, research in many cases is commissioned by donor agencies rather than by Ministries of Health or other domestic stakeholders, and much of the expertise on health reforms-related research appears to come from outside the continent.
Therefore, there is a urgent need for further intensifying efforts for HSR capacity building and promotion. A regional HSR data bank should be developed. Regional collaboration and technical assistance from international organizations should be enhanced and better coordinated.

*Health Sector Reform Research Agenda.* To receive priority, a research initiative must have the potential to tell us something new, and add to the state-of-the-art in relation to the topic concerned. It may be politically important to support research that documents the benefits and/or problems associated with introducing specific reform measures in the context of a specific country.

Priority research issues and research agenda for reform components discussed above can be summarized as follows.

**Organizational change.**

♦ Impact of decentralization on efficiency, equity, quality and health outcomes.

♦ Various types of decentralization and their cost-effectiveness.

♦ Conditions for effective decentralization.

♦ Mechanisms of resource allocation at different levels.

♦ Tasks and functions of various levels and various sectors.

♦ Government roles in ensuring quality and equity in private provision.

♦ Approaches to collaboration with private sector to maximize its impact on health outcomes.

♦ Community participation.

♦ Effects and consequences of the reorganization process.

♦ Human resources development issues in the context of decentralization, growing role of private sector, and changing functions and structures of Ministries of Health.

*Financing change.*

♦ Ability and willingness to pay for services, and utilization response from user charges.

♦ Exemption mechanisms and equity issues.

♦ Quality effects from user fees.

♦ Product costing, payer/payee mechanisms, criteria for grants and subsidies.
Management and administrative costs of cost recovery schemes.

Comparative analysis of insurance schemes including problems of coverage and equity, efficiency, effectiveness and quality assurance, cost control, managerial and administrative arrangements.

Sustainability of community insurance schemes including design and operation of successful schemes, and their linkages with government financing and provision.

Service delivery change.

Typology of health care providers at all levels.

System analysis of functions at different levels.

Monitoring of referral systems.

Alternative systems for priority setting.

Implementation of health care packages, their cost-effectiveness and effect on utilization.

Integration of services and the process of organizational change for greater integration.

Access to and quality of care, consumer satisfaction with services.

Drug supply management and rational use of drugs, management of physical assets including selection, acquisition, maintenance and use of equipment, and health facilities planning.

The above list is not, of course, exhaustive. Each of the issues mentioned has many more areas for a detailed investigation. If to take a public/private mix as an example, pertinent areas of inquiry include how this sector can best be taken advantage of to improve coverage of public health care activities, especially related to missions, traditional and informal medical sectors; who uses the private sector in terms of gender, socioeconomic status, types of illness, etc.; which policy or programme tools can be used to take advantage of their existing patient contacts. The question of incipient subsidies by the public sector to the private sector needs to be explored with a view to determining the magnitude and reducing it. Identification of those services which can best be provided by the private sector and how private providers can be encouraged to supply them. What the political constraints are and how these can be accommodated. Furthermore, a greater understanding is needed of characteristics of the private sector in terms of care offered and the users; factors affecting the quality of care given by private providers; the costs and feasibility of different forms of regulation; what should be the government role in financing versus provision; how can the government optimise managed competition in health provision.

Conclusion of the Role of HSR. A central characteristic of HSR is the continuity it provides from problem identification through research formulation and implementation, to the incorporation of results in decision making. What is needed is more information on the different strategies and methods that have proved effective. Policy makers in SSA and
elsewhere are demanding information about what is being done elsewhere; what works, what does not work and why; whether it can be imported, adapted, adopted and how. Countries need to know how to evaluate the relevance of one country's reforms to another and how to consider alternative courses of action as well as having simple methods for assessing the situation prevailing in the country that wishes to adapt and adopt policies and reforms.

In examining the different components of health sector reform programmes, many questions could and should be addressed by countries before decisions on health sector reform policies are undertaken. There is need for review and analysis of policy options and their potential effects on a regular basis. The available critical mass for HSR must be empowered with essential skills to do the work. A telling omission of many health initiatives in Africa is the exclusion of the consumers of health care. Health sector reform documents are often produced centrally and community participation is loudly alluded to but seldom actually given a chance. The essence is based on creating an enabling environment for health systems by giving households and communities more control over their health and health care services.

The issue of monitoring and evaluation in health sector reform is essential in order to assess reasons for the success or failure of decisions made and to allow others to learn from such experiences. The role of networking cannot be over-emphasized in facilitating the dissemination of research results and sharing experiences. A great deal of information is already available on health sector reforms but most of it in unpublished literature which is often difficult to access. To avoid repetition and to learn from the experiences of others, information needs to be made widely available among countries of the SSA Region. The issues to be addressed and research questions to be answered will, however, depend on the circumstances of each country and the feasibility of introducing specific changes.

Therefore, HSR has a key role to play in the reform process: technically, in providing evidence for decision-making and tools for problem-solving; politically, in widening the constituency of interest and understanding of health reforms; and, internationally, as a forum for sharing experiences, mistakes and achievements. Health sector reforms especially demand an explicit link between researchers and decision-makers for ensuring that research addresses priority issues, and its results are optimally used.

GENERAL CONCLUSIONS - LOOKING AHEAD

Health care systems throughout the world find it difficult to reduce costs and safeguard quality. In general, the users of health care services are having to pay more for them, and in some cases this is making the system unsustainable. Even where costs can be met, the payment mechanisms used can make a decisive difference in terms of equity and efficiency (Creese 1994).

In the SSA countries, the role of the state in social policy development in general and in health specifically is one of full responsibility for the provision of health care services and facilities for its citizens. While it is not necessary that all functions be undertaken by the state or its agencies, the state has the obligation to protect the vulnerable through instruments of policy.
The government has to be involved in finance and provision of basic care through choosing to finance packages that are cost-effective. However, the main challenge is the lack of good evidence for assessing some forms of care. Because there may be little justification for public finance outside the basic cost-effective package, health insurance comes into play.

Insurance cover is crucial for more expensive care as people can pay out-of-pocket for less expensive care. The government needs to intervene to ensure that freedom of choice in any insurance scheme does not contradict the cost-effectiveness principles. Experience indicates there is no evidence that charging user fees will rationalise demand. In fact, higher prices could reduce demand but this does not make it more cost-effective.

The people who are covered by health care financing schemes may over-utilise the health care resources because they perceive that it is their right to receive these services. People might also under-utilise the services if they think that they will receive inferior care. If coverage refers to the degree to which effective provisions are given to those who have real needs of service, it is not always true that more services lead to more coverage. Also, services that are over-utilised might lead to inequitable access to services of other low-income under-privileged groups.

In many developing countries there is a need to develop and improve on measurement, monitoring and management of health care services, especially when financial demands of health care have put increasing pressures on national economies. Reliable evidence, when available, should be used for policy-making, education, quality insurance, planning new research, purchase of health care and legal advice.

If health care systems are to be transformed to meet the challenges of the future, a high priority must be given to empowering Health Ministries to carry out the monitoring and regulatory tasks needed to effectively function in new areas and, to be able to effect a total system response.

The Ministry of Health must respond from the primary to the tertiary levels of care. Government policy should therefore address at least four issues:

♦ the target groups;

♦ the regulations and their enforcement;

♦ financing;

♦ the delivery of services.

If equity is desirable, government policy must define disadvantaged groups most in need of cost effective health care, and who do not have the ability nor the incentive to pay for the basic package.

Regulations must be directed to promote the provision of cost-effective care to the most needy groups and promote provider and consumer interaction.
Epidemiology and economic analysis to be afforded the opportunity to guide the generation of adequate financing and direct incentives for high quality, cost-effective care appropriate to target groups.

Health care delivery should not only include service in the professional sector (public and private) but also in the traditional sector.

Equity, efficiency and quality of interventions being central to the goals of reform and, therefore, should guide the organization, financing and performance of health care delivery systems. This implies that the reform process will take time and involve technical expertise, resources, infrastructure, data and information. The feasibility of reform depends on at least three aspects.

Firstly, the issue of technical feasibility. Given the economic tools that are available, questions nevertheless arise as to how applicable they are to the region. Among the many capacities needed are those of: problem identification, cost-effectiveness analysis, priority ranking, technology assessment and financial analysis.

Secondly, the feasibility for organizational changes including the change in the role of Ministries of Health and the roles of the public and private sectors. These changes are obviously country-specific and must be resolved locally.

Thirdly, the question of management feasibility. Is it feasible for the country to manage the system? Are human resources available? Is the management information system functional? The lack of appreciation of the importance of evidence-based decisions both at the macro and micro level is the main threat in SSA efforts to implement health sector reforms. The importance of the goals, reasons, framework, agents and tools and the process itself need to be considered in instituting the reform process.

In the area of capacity building, countries should make a commitment to a comprehensive capacity development strategy and take direct responsibility for its realisation. A significant proportion of the health care development budget should be targeted for capacity building. Serious consideration should be made for the establishment of regional health policy think tanks.

In looking to the future, international aid should be viewed and categorised on the basis of their objectives, and whether to support the provision of services; influence the policy environment; or support research. These three objectives can be condensed into programme implementation and capacity strengthening.
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