PUBLIC AND PRIVATE ROLES IN HEALTH

A review and analysis of experience in sub-Saharan Africa

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World Health Organization
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SYNOPSIS

This paper considers the changing roles of government in sub-Saharan Africa in both the financing of health care and the provision of health care. Four themes are selected for in-depth review and analysis of experience. These themes are user fees for public health care services, insurance, government's relationship with private for-profit providers and government's relationship with the not-for-profit sector.

The macro-economic crisis across the continent has created a financing gap in the health sectors of most countries. In response to this problem, and in keeping with broader ideological trends, many African countries have adopted policies changing the relative roles of public and private sectors in health care. All but five countries in sub-Saharan Africa have now implemented some form of user fees for public health care services. Health insurance coverage remains limited but many countries are actively pursuing policies to promote it. Attitudes towards the private for-profit sector have changed remarkably during the past decade; previously viewed in many African countries as a pariah, it is increasingly seen as a partner. Some not-for-profit providers have also benefitted from the policy shift. In countries such as Uganda and Ethiopia there have been marked increases in the level of development aid channelled to not-for-profit organizations.

What can be learnt from experiences in Africa so far? In areas such as user fees a considerable body of evidence has now accumulated. For the other selected themes the conclusions are rather less firmly based, but nonetheless may be useful in shaping future policy developments. There are also some over-arching conclusions to the paper. Firstly reforms in any of the areas discussed should not be seen as isolated policies. All four areas are closely interconnected and should also be coordinated with other aspects of health sector reform such as decentralization, reform of the civil service etc. Secondly the article underlines the continuing primacy of government in the health sector. The role of government is certainly changing. Less and less is it seen as the principal provider of services, but its role in financing health care is of continuing importance, and increasingly the significance of policy making and coordination tasks are being recognized.
1. INTRODUCTION

Recent political, social and economic changes in countries at all levels of development have generated a growing awareness of the pluralistic nature of both health care financing and provision. The issues of the role of government and of public sector capacity to regulate and coordinate diverse health agencies have become major concerns. The question of how to engender closer public/private collaboration for health has received heightened attention. Global trends towards democracy, pluralism and greater private sector involvement have all taken root in sub-Saharan Africa. Many African countries are now considering the changing role of government in the health sector.

The global economic crisis and the subsequent restructuring measures adopted by most countries have affected the health sector. This is particularly the case in sub-Saharan Africa. With a few exceptions levels of GNP on the continent are low and have declined during the past decade (see Appendix 1). A few countries such as Burkina Faso, Burundi and Chad have managed to buck the trend, but it is rare that economic growth has kept pace with the growth of the population. Despite low levels of income, health expenditure as a percentage of GDP in Africa appears relatively high. Since Independence many African governments have channelled a substantial proportion of public funds to the health sector, but faced with recent fiscal pressures the health sector share of the government budget has often contracted. Even in those countries which have managed to protect the health sector share, the real resources for health have commonly declined.

The scale of health problems in African countries continues to be large. Appendix 1 highlights the shortage of doctors in most African countries, the high child mortality rates and generally low immunization coverage. The 1993 World Development Report estimated that the burden of disease per person in Africa was far greater than that anywhere else in the world (World Bank, 1993). A clear funding gap has thus emerged between the health care needs of the population and the resources available. In many African countries donor contributions have become essential in plugging this gap; in Mozambique over 50% of health sector expenditure comes from donors, in Benin, Burundi, Chad, Tanzania and Uganda over 40% of total funding comes from donors. Donor funding, though currently essential, is far from being a perfect solution; it is often short term, tied to a particular project, may have complex accounting procedures and is generally difficult to coordinate and plan. Donors are often aware of these problems and new more flexible forms of donor funding are emerging in the health sector, but there is a clear need to generate more resources locally.
Many countries in Africa have explored different ways of mobilizing resources, both public and private. As appendix 1 shows the level of private expenditure in the health care sector of African countries is already fairly high with on average 44% of local health care expenditure coming from the private sector, but many recent developments place even greater emphasis on both the private provision and the private financing of health care. Often these policies have followed a long period of mistrust and lack of confidence in relations between the public and the private sectors.

This document reviews and analyses recent African experience with changing the public/private mix for health. It draws on the proceedings of an Intercountry Meeting on Public/Private Collaboration for "Health for All" which was organized by WHO and DANIDA, and hosted by the Government of Namibia in October 1993\(^1\) (WHO, 1994), but also incorporates up-to-date material from a variety of other sources.

The format of the document is as follows. Section 2 introduces the underlying principles behind a discussion of the public/private mix and identifies four main policy themes:

1. User fees for public health services;
2. Health insurance;
3. The role of private for-profit providers;
4. The role of the not-for-profit sector.

Sections (3-6) discuss these four major themes with emphasis on the issues of overall policy objectives, regulatory and incentive structures, and impact on standards and quality of care. Each section of the document provides a brief introduction to the principles and an analysis of comparative experiences. The final section (7) draws together the evidence emerging in each of the four theme areas and attempts to link it to the broader health sector reform debate.

Those who are pressed for time could simply read the conclusions of each separate section and the overall conclusions at the end of the document. Alternatively readers may be interested in only one theme; each section is self-contained and could be read on its own. An annotated bibliography is provided for readers who wish to pursue further some of the issues discussed here. The annotations are grouped by theme and cover recent key documents in the field. There is also advice on where to get the documents.

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\(^1\) Countries participating at the meeting were Cameroon, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Namibia, Tanzania, Uganda, Zambia and Zimbabwe.
2. PRINCIPLES

2.1 Definitions

The term private sector is used here to signify all those organizations and individuals working outside the direct control of the state, that is both for-profit private companies and individuals, and not-for-profit (NFP) private organizations. The private sector therefore includes a very diverse set of individuals and organizations. In particular there are likely to be considerable differences between the for-profit and the NFP segments of the private sector. Economic arguments concerning the role of the private sector and the market are generally concerned with the for-profit motivation and the way in which this encourages agents to behave. The motivations of NFP providers are diverse but are often characterized as being closer to those of the public sector. Not-for-profit providers include international non-governmental organizations (NGOs), national voluntary associations, religious missions and community self-help groups.

In discussing the public/private mix it is useful to distinguish between the financing and provision of services (see Table 1). Services may be publicly financed and publicly provided (for example, the national health services in many countries), or privately financed and provided (for example, private health care funded by private insurance). Increasingly governments are experimenting with health care systems mixing public and private elements. For example, private finance may coexist with public provision (e.g. where there are user fees for government services) or public finance may be used to purchase private services (e.g. by contracting of laundry services or contracting for specific clinical services).

<table>
<thead>
<tr>
<th></th>
<th>PROVISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>FINANCING</td>
<td></td>
</tr>
<tr>
<td>PUBLIC</td>
<td>Government funding and provision, free at point of use: NHS services.</td>
</tr>
<tr>
<td>PRIVATE</td>
<td>Supplementary direct user charges. Private beds in public hospitals.</td>
</tr>
</tbody>
</table>

Table 1
The Public/Private Mix in Financing and Provision
This document focuses on two policy approaches to promote the private sector in the **financing**
of services (user charges and insurance) and two policy areas relating to the private
**provision** of services; issues concerning the **relationship between the government and the**
private NFP sector, and government and the private for-profit sector.

User charges are considered here in the context of the public provision of care. Insurance on
the other hand is often used to purchase private health care as well as public health care. In
looking at private provision we consider not only privately financed services but also the
potential role of government as a purchaser of private care.

### 2.2 The role of government

Governments have been active players in the health sectors not only of sub-Saharan Africa but
throughout the world, there are good reasons for this; economic, political and pragmatic
reasons. Economists normally have faith in the ability of the market place to provide and
allocate services efficiently. However the characteristics of health care are such that a market
solution is unlikely to be a good one. The reasons why this is so have been well rehearsed
elsewhere (e.g. Stiglitz, 1989) and are only briefly considered here.

Problems of externalities and public goods have commonly been cited as a reason for
government involvement in health care, particularly in developing countries. Some health care
services such as immunization have benefits which accrue not only to the recipient of the
service but to others who are not directly involved in the transaction. This is known as an
externality. A more extreme case is that of public goods, such vector control, where the
benefits accrue to the community as a whole and it is neither feasible nor rational to prevent
any one individual from benefitting. If government leaves the provision of these services to
the market, then they are most likely to be under-provided.

For personal clinical care the most important question is that of imperfect information; the
efficiency of a market depends on the existence of informed consumers who are able to select
a service which offers value for money. In the health sector consumers often lack information
about which is the most appropriate treatment and what would be a good price for it, instead
they rely on health workers to make decisions on their behalf. This is potentially problematic
as health workers may act to increase their own incomes rather than the well being of the
patient. Problems of imperfect information also arise in the insurance market; in particular
insured people may be encouraged to consume services which they don't really need but which
are free.
Furthermore monopoly may be a problem in the health care sector leading to high prices. In sub-Saharan Africa there are often a limited number of health care providers, limited competition between them and consequently little incentive to keep prices down.

An equally important but more political reason for government intervention in health care is equity. Different governments have different conceptions of what equity means, but most would agree that government has a responsibility to ensure that the poor and the vulnerable have some access to health care.

Unfortunately governments are not always able to operate in an efficient and just manner. Public sector services are often over-burdened, and under-funded, resources may be skewed to expensive tertiary facilities rather than cost-effective primary care. It is possible that such governments do more harm than good in the market place. In considering an appropriate role for government pragmatic considerations must be taken into account. Is government capable of fulfilling the role identified for it?

Until recently debates about the appropriate role of government were polarized around two undesirable extremes of total government provision and financing, and total private provision and financing. However it has become increasingly clear that there are many alternative roles for government: government may be a regulator, a coordinator, an incentive setter, a provider of privately funded services or a purchaser of privately financed services. Government may enter into joint ventures with the private sector or it may subsidize private sector activities. Which of these roles suit government will depend to a considerable degree on local political, economic and social conditions. Whilst maintaining a focus on the four issues identified above, this paper documents and analyses the changing roles of government in the health sector of sub-Saharan Africa.
3. USER FEES FOR PUBLIC HEALTH SERVICES

3.1 Introduction

Since independence many African countries have delivered health care services free of charge. This was partly an attempt to redress previous inequalities in access to health care, and partly because health care was seen as a right. During the past decade many African countries have introduced charges, or substantially raised what were previously nominal fees.

A recent review found that all Francophone sub-Saharan countries and virtually all Anglophone and Lusophone countries had some user fee system (table 2) (Nolan and Turbat, 1993). Of those which have not implemented user fees, four countries are planning to do so. Malawi and Tanzania are both engaged in detailed planning for the phased introduction of a charging policy. In several countries the fee system is an ad hoc (and often outdated) set of charges for selected services or certain types of patient, more or less evenly applied. In at least one case (Nigeria), user fees co-exist with a public commitment to providing free services to public employees.

<table>
<thead>
<tr>
<th>National user fee system</th>
<th>Anglo/Lusophone countries</th>
<th>Francophone countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>None but intention to implement</td>
<td>Angola, Malawi, Sao Tome, Tanzania</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>Botswana</td>
<td></td>
</tr>
</tbody>
</table>

Table 2
Status of User Fee Implementation

SOURCE: Nolan and Turbat (1993)

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2 The whole of this section on user fees for public health services draws heavily on the recent review carried out by Nolan and Turbat.
Three main objectives in charging patients have been identified: raising additional money, improving efficiency, and increasing the quality of care. Efficiency may be enhanced by user fees if the fee schedule is structured in such a way as to encourage patients to use health care in an efficient manner (for example, to seek primary care first rather than go directly to the hospital) and providers to give an efficient service (for example, not to over-provide drugs). In terms of quality of care, a beneficial impact may result from two different factors (i) increased revenue may be used to enhance quality and (ii) providers may become more responsive to their patients' needs because of the fee payment.

The impact of user fees on equity has been a subject of major debate; one would expect utilization to drop following a fee increase and that the drop in attendances be particularly marked amongst low income groups. However a counter-argument suggests that standards of government care in sub-Saharan Africa are often so low that even the poor may resort to the private sector, thus a price increase combined with quality improvement may make government care relatively more affordable to the majority (McPake, 1993). The question remains of how to protect the poor minority.

3.2 Success in achieving objectives

Raising additional money

For Africa as a whole, income from fees averages less than 5% of government expenditures for health. The modest overall role of fees in national health care financing is illustrated in Mozambique, where total fee income (1992) was estimated at less than 1% of total government recurrent health spending. Malawi, which currently only charges private patients in government hospitals, estimates that its existing schedule yields 2 - 5% of recurrent costs. The Nigerian Ministry of Health states:

User fees in government institutions . . . cannot, by any stretch of the imagination, be relied on to make a significant contribution to the growth of health services in the country (MOH Nigeria, 1993).

Table 3 illustrating the current range of cost recovery in sub-Saharan Africa confirms that early estimates of potential revenue (World Bank, 1987) were over-optimistic.

But at lower levels of the system and at the individual health facilities, fee income may be a more substantial percentage of expenditures. One district in Cameroon recovered 31% of its non-salary running costs through fees. A hospital in Addis Ababa, Ethiopia recovered over 40% of its recurrent costs. Zambia estimates potential fee income by facilities at between 6%
(rural) and 15% (urban areas) of expenditure. In many of the Francophone countries in particular there are locally run projects which have high cost recovery rates.

In addition, the usefulness of additional income at the level of the health facility may be much greater than the monetary figure suggests. Very small expenditures for maintenance, emergency purchases of drugs or spare parts, may make a major difference to the quality of service. Though small in aggregate, such money can be vital when retained locally and spent on urgent priorities.

For fee income to improve services, it must be retained by the Ministry of Health, preferably at the point of collection. Unless the health workers and communities who are involved in the payment and delivery of services have control over the funds, they will have no incentive to be diligent in collecting revenue, and careful in spending it. At the same time, the Ministry of Finance must recognize efficiency improvements in health, and maintain levels of funding from general tax revenue.
### Table 3
Achievement of National Systems of User Fees with respect to Three National Goals

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>INCREASE REVENUE</th>
<th>ENHANCE EFFICIENCY</th>
<th>IMPROVE QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAMBIA</td>
<td>38% drug costs (90/91)</td>
<td>same fee across levels</td>
<td>drug availability improved, but still interruptions in supply</td>
</tr>
<tr>
<td>GHANA</td>
<td>5-6% recurrent costs (90/91)</td>
<td>fee varies with level</td>
<td>drug shortages continue following fee increase</td>
</tr>
<tr>
<td>KENYA</td>
<td>45% non-staff, non-drug operating budget at provincial general hospitals.</td>
<td>fee varies with level</td>
<td>User interviews suggest quality improvement</td>
</tr>
<tr>
<td>LESOTHO</td>
<td>9% recurrent costs (91/92)</td>
<td>fee varies with level and reduced for referrals</td>
<td>No clear pattern</td>
</tr>
<tr>
<td>MOZAMBIQUE</td>
<td>&lt;1.5% target</td>
<td>same fee across levels, waiver for referrals</td>
<td>No evidence</td>
</tr>
<tr>
<td>ZIMBABWE</td>
<td>3.5% recurrent costs</td>
<td>fee varies with level, no waiver</td>
<td>No evidence</td>
</tr>
<tr>
<td>BENIN</td>
<td>43% recurrent costs in BI districts</td>
<td>now waivers</td>
<td>drug availability improved at HCs</td>
</tr>
<tr>
<td>BURUNDI</td>
<td>?</td>
<td>Prepayment or fees</td>
<td>drug availability improved at HCs</td>
</tr>
<tr>
<td>CAMEROON</td>
<td>?</td>
<td>Prepayment or fees</td>
<td>drug availability improved at HCs</td>
</tr>
<tr>
<td>COTE D'IVOIRE</td>
<td>7% MOH recurrent budget</td>
<td>fee varies across levels</td>
<td>drug availability improved at HCs</td>
</tr>
<tr>
<td>GUINEA</td>
<td>varies by region; up to 100% non-salary recurrent costs in some areas.</td>
<td>fees set locally</td>
<td>surveys and focus groups suggest quality improvement at HCs</td>
</tr>
<tr>
<td>MALI</td>
<td>1-2% MOH recurrent budget</td>
<td>fee varies across levels</td>
<td>?</td>
</tr>
<tr>
<td>SENEGAL</td>
<td>4% MOH recurrent budget</td>
<td>?</td>
<td>No evidence</td>
</tr>
</tbody>
</table>

SOURCE: Nolan and Turbat (1993) and background papers for WHO Namibia meeting
Improving efficiency
Several countries aim to improve efficiency through their user fee system. Most commonly this means reducing crowding at secondary and tertiary level health facilities, by a "cascading" system of charges; no charges or low charges at the lowest level, and higher charges at each level of the health care system. Table 3 illustrates which countries have adopted a cascading system. In addition to those listed, Zambia and Namibia also have cascading fee schedules. A cascading system should enhance allocational efficiency by encouraging patients to use more cost-effective services, but the incentives offered may not always be appropriate. In Lesotho for example, a patient being referred from the health centre to the hospital level and paying fees at both levels will actually pay more than someone going directly to the hospital. This problem may be removed if there are substantial waivers or reductions for referrals. Several countries have built this into their fee schedules.

Most of the fee systems in Anglophone Africa are centrally organized, whereas Francophone Africa gives greater autonomy to local areas. The local flexibility has some advantages but makes it rather harder to establish appropriate incentives for use of the health care system as a whole.

Quality improvement
Improving quality must be a primary objective of fee policy. Countries' experience shows that people expect better health care if it is costing them more. Existing evidence on quality improvement is fragmentary. In Cameroon a pilot study was implemented where a comparison was made between three health centres which increased fees and used the extra revenue to purchase drugs thus improving the quality of care, and another two control health centres where no change was made. Utilization rates increased amongst the group of health centres with fees (Litvack and Bodart, 1993).

In Ghana focus group discussions carried out in two regions of the country shortly after the major increase in user fees in 1985 found that people particularly resented paying for health care when drugs were unavailable (Waddington and Enyimayew, 1990). As a result of this observation a 'cash and carry' system for drugs has been implemented whereby health staff can use fee revenue to purchase more drugs so as to improve quality of care.

In Kenya, over half of the expenditures made from fee income in a two and a half year period were for two items: maintenance, and the purchase of emergency drugs. Service quality would probably have been lower had these expenditures not been possible. In Zambia it is felt that quality improves as health workers feel more accountable to patients when the latter pay them.
Zambian health workers are allowed to use 10% of income from fees as personnel bonuses. Observations in Zambia also indicate that as quality improves, utilization increases.

In Francophone Africa there is rather more evidence to suggest that quality has improved with fees. Most of this evidence however is in terms of improved drug availability. Only in Guinea is there evidence to suggest that other aspects of quality of care have improved.

3.3 Process questions

Fee setting
There is a wide range of approaches to setting fees. Actual costs are the basis for setting fees for private patients in public facilities in Namibia. Fees can be charged for registration, per consultation, or per episode of illness. In addition, charges for drugs and dressings can be set in many different ways. Cameroon uses a system of cross subsidies in setting drugs prices, for example, essential drugs such as chloroquine are subsidized by the prices paid for less essential items, and the transport costs to more remote areas are subsidized by districts closer to the central medical stores. Some methods of raising fees may be more acceptable than others. For example, most people recognize that drugs are valuable, and are prepared to pay for them. In Kenya, registration fees for outpatients proved unpopular particularly when drugs and other medical supplies were out-of-stock, so the revised fee system charges people according to the number of items prescribed.

Regular small increases in user fees in line with inflation are likely to be more acceptable to the population than large increases in fees every few years. In Zaire the fee level is linked to the price of the local staple so that it keeps up with the cost of living. Such a mechanism also ensures that fees are not eroded by inflation to the extent where the administrative costs outweigh the revenue collected.

Economic conditions may vary greatly within a country, particularly one so large as Nigeria, and under such circumstances some degree of flexibility in fees, according to local circumstances, may be desirable. At the same time, centrally promoted guidelines are necessary to prevent wild fluctuations from one health facility to another. Cameroon's drug prices are set locally, whilst the consultation fee is a standard charge.

Whilst cash is likely to be the preferred mode of payment some people who are unable to pay cash may be able to pay in kind. A mission hospital in Namibia asks indigent patients or patients' relatives to pay by spending some time doing suitable hospital work. The timing of
the payment is also important. In several of the Francophone countries prepayment schemes exist allowing potential patients to time their payments so that they coincide with when cash is available.

**Exemptions**

In order to ensure that user fees are reasonably equitable a system of exemptions is likely to be required to protect the poor who cannot afford to pay the regular fee. Exemptions may also be used for diseases of public health importance such as tuberculosis, and for high priority services such as MCH and FP. However planning and implementing exemptions is a complex process. In many countries identifying who is poor is not a straightforward task. Poorly defined exemption mechanisms may protect those who are not poor (lowering revenues unnecessarily) or not protect those who are poor (adversely affecting equity). The more sensitive exemption mechanisms (for example those based on household income) often carry a heavy administrative burden if they are properly implemented.

In Francophone Africa five countries have defined exemption schemes (Mali, Mauritania, Niger, Rwanda, Senegal). Normally a local health committee or the commune or a local administrator decides who should be exempted, but few countries have clear cut guidelines as to who should be counted as indigent. There is little information on the frequency of exemptions, but in Mali up to 30 or 50% of the patients at some hospitals are exempted.

Anglophone countries appear to have more defined exemption schemes (including Ethiopia, The Gambia, Ghana, Kenya, Lesotho, Mozambique, Namibia, Swaziland and Zimbabwe). In these countries it is more likely to be the facility staff who choose whom to exempt, but village health committees, chiefs and administrators also play a role. Again the definition of who is indigent is left quite unclear, only Zimbabwe specifies an income level below which a person may be exempted. In practice it would appear that although these schemes are defined centrally they also leave a considerable degree of freedom to the local level in implementation.

Who is exempted from fees is likely to be a fairly political question. Often groups are exempted who are not poor. This was the case in Ghana and several other countries where government employees were exempted. The experience in Ghana shows that exempting people by their employment category rapidly depletes the pool of potential income for health. In Kenya on the other hand, during the 1989 attempt to increase user fees, virtually no one was exempted. This was partly due to the fact that the exemption system was poorly defined. A recent paper on Kenya used household income levels to establish appropriate exemption criteria and estimated that 12-34% of the population may need to be exempted (Huber, 1993).
Fee levels and exemption practices need to be determined according to individual countries' circumstances, with consideration of the effect on likely revenues. High fees and high levels of exemptions may mean that only a small minority contribute towards the service. Low fees and low exemptions may ultimately raise more revenue by covering many more people. Many policy makers feel that the matter of exemptions should be handled at the local level and in consultation with the community.

Retention and re-cycling of fee income
Major differences exist among countries in how revenue is used. In Ethiopia, Namibia and Malawi (at present) all fee income reverts to the central treasury. In other countries, various agreements about fee retention have been established. Revenue in Ghana is split between different levels of the health care system and the treasury. In Kenya, the health facility retains 100% of revenue collected, and is supposed to allocate 75% of this to improvements at the facility and the other 25% to preventive and promotive work. Zambia, Mozambique and Nigeria have also established full fee retention arrangements. Malawi's proposed revenue-sharing system is for a 50/50 split between health facilities and the Ministry of Health.

Given the decentralized nature of schemes in Francophone countries it is understandable that there is a greater chance of all funds being retained at the facility or community level; this is the case in Burundi, CAR, Congo, Guinea, Mali, Niger, Togo and Zaire. In Cameroon and Senegal, only health centres retain all of their fee income; hospitals remit some of their income to the central treasury.

Managing fee income
Receipts, accounting, banking, audit and the overseeing of expenditures from fee revenue all require suitable management systems and skills. During the second attempt to implement fees in Kenya, considerable attention has been paid to management issues. Fee implementation has been phased starting with national and provincial hospitals and before a facility implements user fees, staff undergo a short training course covering all aspects of fund management. A financial information system has been established with hospitals providing performance reports every four months and districts (including health centres) every two months. Embezzlement has been experienced in several countries. In Ghana and Kenya, banking arrangements have been inefficient, leading to a loss of money (Kenya) and purchasing power (Ghana). By involving both communities and health workers in the management of fee revenue the scheme is likely to be more acceptable to the local people, better targeted on local priorities and probably more transparent in management. Spending priorities need to be identified in advance, so that fee income is used promptly whenever possible.
3.4 Equity issues and the impact of fees

Considerable evidence on the impact of fees on utilization patterns has now accumulated. In Kenya a 38% decline in MOH hospital outpatient and health centre attendances followed the December 1989 fee introduction. However it would appear that the more recent, better planned and managed fee increase is not having such a negative effect. In Ghana it is estimated that nationwide, outpatient utilization dropped by more than half after the 1985 fee increase (Dakpallah quoted in Waddington and Enyimayew, 1990). In urban areas, utilization recovered after several months, but it took several years for attendances in rural areas to reach their previous levels. Table 4 crudely summarizes the findings of a recent study on utilization patterns post increase in user fees.

**Table 4**

<table>
<thead>
<tr>
<th>Francophone</th>
<th>Increase in Utilization</th>
<th>Decrease in Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin, Burundi, Cameroon, Guinea, Mauritania, Senegal, Togo</td>
<td>Burkina Faso</td>
<td></td>
</tr>
</tbody>
</table>

| Anglophone | Sierra Leone | Gambia, Ghana, Kenya, Lesotho, Mozambique, Swaziland, Zambia, Zimbabwe |

SOURCE: Nolan and Turbat (1993)

Quite different patterns emerge between the Anglophone and the Francophone countries. For example in Cameroon locally organized user fee systems appear to have had a largely positive effect on both quality and levels of utilization, whereas in Kenya the highly centralized system first implemented in 1989 had a very negative effect upon utilization. Many of the Francophone countries had been successful in raising the key indicator of drug availability. Drugs seem to be very critical in people’s perception of quality of care and this probably explains much of the observed utilization increases.

It is difficult to avoid the conclusion that the model of decentralized, community based projects appears to be more successful in terms of meeting both revenue raising and quality improvement objectives than the more bureaucratic, centralized approaches adopted in much of Anglophone Africa. However there are some caveats to this conclusion. Firstly data from Francophone countries often comes from small scale projects, which are not strictly comparable with the national schemes adopted in Anglophone countries. It is unclear whether
the same conclusions would hold if the schemes were implemented nationally. Secondly many of the Francophone schemes have been supported by substantial external technical assistance. This support is not generally included in the cost recovery calculations. Thirdly the 'pre-fee' situation in Anglophone and Francophone Africa was not strictly comparable. Francophone countries often had extremely poor quality health care and limited government funding resulting in low utilization rates. This is not the case in many Anglophone countries.

Despite the increase in utilization in Francophone countries there is little evidence indicating who uses the facilities after fee increases. Only in Cameroon is there data to indicate that the poor may benefit relatively more than other groups from the quality improvement (Litvack and Bodart, 1993). More studies examining the socio-economic profile of users are required. To complement specific research studies, general monitoring of the impact of fee changes on utilization is important, so that not only total attendances, but the age, sex and disease pattern of people who stay away can be assessed.
3.5 Conclusions on User fees

Nearly all sub-Saharan African countries have now implemented user fees for public health care services. Although income from fees is likely to be small in relation to total health expenditure, it can provide important supplementary finance, particularly for running costs at lower level health facilities. However, people react to fee increases in the manner which economic theory would suggest; they consume less health care services if the service remains unchanged. Fee increases must not be seen as an isolated revenue-raising device, but as a way of contributing to better incentives and performance in the health system as a whole. **Introducing fees, or making big increases where fee schedules have become out of date, should be one part of a "package" of reforms aimed at improving the efficiency, accountability and quality of public health services.**

This review seems to suggest that decentralized community based schemes in Africa often meet objectives better than more centralized bureaucratic ones. There are clearly some lessons here for how fee systems should be designed, but the models pursued by many Francophone countries are in many respects unproven; they have limited coverage, their degree of replicability is unclear and relations with higher levels of the system often not resolved.

A number of **specific conclusions** can be drawn about the design of fee systems:

- **Local retention**, wholly or partly, at the health facility collecting fees, is an essential part of the package. Without local control over revenue, incentives to staff to produce visible improvement in service quality will be lacking. The Ministry of Finance should understand that the health budget should not be reduced when fees are retained, as fees are part of a process of improving performance.

- **Public information and education** about the reform package is necessary, as introducing fees often means reversing policies established at Independence.

- **Careful preparatory work** for cost-sharing is required, and should include training in basic financial management and banking arrangements, development of audit procedures, and the establishment of local committees to oversee the use of fee income. Mechanisms should be developed or strengthened at local and national level for monitoring the impact of fee changes on utilization, revenue and service quality.
• **Fee systems should encourage people to use primary services** and consequently should be carefully structured. Local decisions on actual fee levels are desirable, within centrally-defined guidelines. Innovative arrangements to accept payment in kind (e.g. in maize, animals or donated time) should be encouraged wherever people cannot pay in cash, and where such payments can be easily used by the health facility.

• **Countries should formulate exemption mechanisms** for the poor, for certain public health problems and for high priority services. Central guidelines on exemptions with local discretion in the application of these guidelines appears appropriate. Further research may be needed to help provide guidelines on whom should be exempted.

• **Provision should be made for the periodic increase of fees** in line with inflation.

• **Technical assistance requirements** relate principally to the need to build national capacity to manage fee systems, they include:

  - Strengthening of monitoring capacity to assess impact of fees on utilization.
  - Development of management systems and capacity.
  - Assessment of alternative fee setting and exemption systems, and exploration of payment in kind mechanisms.
  - Exchange of experience among countries reforming fee systems and cost-recovery.
4. HEALTH INSURANCE

4.1 Introduction

The fundamental rationale for insurance is that of risk sharing: by its very nature health care expenditure is often unexpected and potentially large. However what cannot be predicted for the individual is statistically predictable for an adequately large group (Mills, 1985). Under an insurance scheme a premium is paid for each individual, in return the costs of care for that individual are covered should they fall ill.

However the main reason why sub-Saharan African countries have, during the past decade, considered developing health insurance is to generate a reliable source of extra revenue. As already seen user fees are unlikely to raise substantial revenue as consumers find themselves unable to pay the full cost of services when they are needed. Insurance schemes by sharing the cost of care between the healthy and the sick may substantially raise cost recovery ratios. In much of Africa however the coverage of formal insurance schemes is limited by the small number of people in formal employment. This fact also jeopardizes the potential equity advantages of health insurance over user fees. Insurance has a social solidarity function; it is possible for the wealthy to subsidize the poor and the healthy to subsidize the sick, but if schemes only cover a relatively affluent minority of the population then such benefits are not fully reaped.

Few African countries appear to have explicitly aimed at increasing efficiency through the development of health insurance, however this is also a potential benefit. Many middle income countries have developed health insurance schemes partly as a way of setting appropriate incentives for public and private providers.

There are many different types of health insurance schemes and some quite complex classification systems have been developed. For the purposes of this document we consider four main types:

- **social health insurance**: generally compulsory and organized by government, premiums paid by both employer and employee and often applying principally to those in formal employment. Two types of scheme can be distinguished; the primary benefit model where health care benefits are financed by a specific health insurance contribution and the secondary benefit model where health care

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3 Sometimes referred to as national health insurance.
benefits are financed from general social security contributions which also cover other types of benefits.

- **employer based schemes**: group insurance established around employers. Sometimes the insurance agency is a non-profit employee cooperative.

- **community based health insurance**: organized locally by the community, with premiums paid by households, covering both those in formal and non-formal employment.

- **private health insurance**: voluntary, generally covering the wealthiest part of the population; individuals may choose to take out private insurance or it may be a perquisite associated with employment.

It should be noted that in sub-Saharan Africa all such schemes only partially cover the population and run side by side with a tax funded public system.

Table 5 summarizes the type of schemes operating in sub-Saharan African countries. In addition to the schemes represented a very small private for-profit health insurance sector is operating in most countries. Little information is available about the coverage and nature of private for-profit health insurance schemes.

**Table 5**

**Summary of Health Insurance Schemes in sub-Saharan Africa**

<table>
<thead>
<tr>
<th>TYPE OF SCHEME</th>
<th>COUNTRIES CURRENTLY OPERATING SCHEME</th>
<th>COUNTRIES CONSIDERING SCHEME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary benefit SS</td>
<td>Cape Verde, Gabon, Kenya</td>
<td>Ethiopia, Ghana, Mozambique, Mali, Nigeria, Zambia.</td>
</tr>
<tr>
<td>Secondary benefit SS</td>
<td>Congo, Cameroon, Mali, Senegal, Togo, Gabon.</td>
<td></td>
</tr>
<tr>
<td>Employer based schemes</td>
<td>Burundi, Madagascar, Mali, Nigeria, Togo, Swaziland, Zimbabwe, Zambia, South Africa, Namibia.</td>
<td></td>
</tr>
<tr>
<td>Community based schemes</td>
<td>Guinea Bissau, Burundi and local schemes in Ghana and Zaire.</td>
<td>Zambia for rural areas</td>
</tr>
</tbody>
</table>

SOURCE: ILO (1993) and background papers for WHO Namibia workshop
4.2 Social health insurance schemes

In terms of social health insurance Francophone and Anglophone Africa have quite distinct experiences tracing back to different colonial approaches. In French speaking countries health policy traditionally focused on the labour force whereas in Anglophone Africa the first formal health care delivery systems were targeted at the bureaucracy. Many French speaking countries have 'Action sanitaire et sociale' schemes, established during 1950s and 60s, covering most of the formal labour force, to which health care benefits have been added. In Anglophone Africa it was not possible to simply add benefits to existing schemes as the population coverage was so limited, instead new funds and operating modes needed to be established. This was a considerable challenge and it is not surprising that many Anglophone countries developed smaller scale employer based schemes instead. Kenya is the exception where a compulsory social health insurance scheme, the National Health Insurance Fund (NHIF) was established.

The secondary benefit type schemes in Francophone Africa are often inadequate as they provide limited health benefits (often only outpatient care and maternal and child health care) through their own clinics, which are difficult for many insured persons to access. In Anglophone Africa insurance coverage is often very limited. Thus the current policies of many sub-Saharan African countries are concerned with the development of primary benefit social health insurance. However of the recent initiatives few countries have reached implementation stage. Indeed in some countries progress in implementation has been very slow despite the fact that agreement on the goal of social health insurance was reached many years ago.

Characteristics of schemes
Table 6 presents the available information on the design of social health insurance schemes in selected countries and by six different characteristics:

- Who is covered by the scheme?
- What benefits are provided by the scheme?
- Who administers the scheme?
- Who delivers health services under the scheme?
- How is the health care provider paid?
- How is the scheme financed?

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4 This section on social health insurance schemes draws considerably on ILO (1993).
Coverage is generally limited to those in the formal sector and is often compulsory so as to avoid the problem of only the less healthy people joining (known as adverse selection). In Nigeria however a voluntary scheme has been chosen as a compulsory scheme was seen as politically unacceptable. Of the countries considered in the table four have quite a comprehensive benefit package whereas Kenya and Mozambique focus on inpatient care alone. All of the schemes are (to be) operated by an independent organization, but only the Cameroonian scheme (based on the French secondary benefit model) has its own facilities through which health care is provided. Most schemes in sub-Saharan Africa work on a fee-for-service basis, but two of the proposed schemes (in Mozambique and Nigeria) plan to use a capitation payment. There is considerable diversity in contributions, in particular in the division of contributions between employer and employee. In Kenya the entire premium is currently paid by the employee him or herself. Contrast this with the proposed scheme in Nigeria where the employee pays only 20% of the premium. It is possible however that in this circumstance employers will pass some of the cost on to their employees through wage levels, other parts of the cost may be passed on to the consumer through higher prices.
Table 6
Characteristics of Countries' Social Health Insurance Schemes

<table>
<thead>
<tr>
<th>CAMEROON (since 1956)</th>
<th>GHANA (proposed)</th>
<th>KENYA (since 1966)</th>
<th>MOZAMBIQUE (proposed)</th>
<th>NIGERIA (proposed)</th>
<th>ZAMBIA (proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td>380,000 (60% formal workforce) insured + dependants</td>
<td>Up to 2.5m formal sector employees, civil servants and cocoa farmers + dependants.</td>
<td>Compulsory for all public sector employees. Voluntary for others.</td>
<td>Firms with 10 or more employees</td>
<td>Voluntary Formal sector employees (3.9% pop)</td>
</tr>
<tr>
<td>Benefit package</td>
<td>Comprehensive</td>
<td>All excluding TB, AIDS and Public health measures</td>
<td>Hospitalizations.</td>
<td>IP stays of more than 3 days</td>
<td>Comprehensive Comprehensive</td>
</tr>
<tr>
<td>Administration</td>
<td>SS Fund</td>
<td>Independent body</td>
<td>Parastatal</td>
<td>Existing Social Security Institute</td>
<td>Proposed National Health Board. Problem of limited technical capacity</td>
</tr>
<tr>
<td>Provider Payment</td>
<td>Salaries &amp; budgets</td>
<td>Retrospective fee-for-service for outpatients, itemized billing for inpatients, based on agreed fee levels.</td>
<td>Fee-for-service with partial reimbursement for private providers. Direct full payment for public providers.</td>
<td>? Capitation</td>
<td>Capitation. NHI Board covers costs of inpatient care after first 10 days.</td>
</tr>
<tr>
<td>Finance</td>
<td>12.45-19% of salaries for all SS benefits. Split between employer and employee.</td>
<td>Paid entirely by employer or cocoa marketing board for cocoa farmers.</td>
<td>Employee contribution only, approx. 3% on a graduated scale. Plans for employers to contribute 0.2% of salary.</td>
<td>Employer 4% salary. Employee 3% salary.</td>
<td>10-15% of salary, of which employer pays 80%, employee 20%. Formal - as a % salary. Informal - flat rate.</td>
</tr>
</tbody>
</table>

SOURCE: WHO Namibia country background papers and ILO (1993)
Issues relating to social health insurance

There are a number of fundamental issues relating to the potential success of implementation of social health insurance schemes:

- **Equity**: the size of the formal employment sector in many sub-Saharan African countries is less than 10% of the population (e.g. 6% in Cameroon, 4% in Zambia). Often government employees make up a large proportion of those in formal sector employment. There is a danger that social health insurance skews resources towards this already relatively wealthy section of the population. The degree to which the scheme is inequitable depends considerably upon the design of the scheme and the overall policy package of government. Schemes are likely to be particularly inequitable in financing if government contributes to the premiums. Where services are delivered by the direct mode, it is common in Africa for the local uninsured population to also benefit from the service outlets, but such models of direct provision have other problems such as inefficiency due to the duplication of facilities. In the model of indirect provision there is a danger that government hospitals will focus attention on the insured worker to the detriment of care provided to uninsured patients. Critical to this whole question is the degree to which the Ministry of Health shifts its own funding to focus more resources on uninsured workers.

- **Administrative Capacity**: administration of social insurance schemes is a complicated task and there are signs that schemes in sub-Saharan Africa have inadequate management capacity. For example, most schemes, even years after their inception, have not been able to cover the complete population sub-group which has a legal right to care. The administrative load is particularly heavy where the income tax system does not cover the majority of the population, or it is easy to evade taxes. Under such circumstances it may be necessary to set up special mechanisms to collect premiums. Insurance fund administrators must also ensure access to a defined package of benefits. This involves enabling insured persons to identify themselves as such, and making sure that both providers and insured persons are aware of their entitlements.

Administrators must also ensure that payments do not outstrip revenues. Many of the existing schemes in Africa have cost-containment problems, this is particularly so in the secondary benefit schemes where an imbalance between contributions and payouts takes longer to come to light. Capitation based payment mechanisms, such as those planned to be adopted in Nigeria and Mozambique may help resolve this problem; the level of expenditure under such schemes is easier to predict and there are incentives to the provider to keep costs low. However failure to contain costs in existing social health insurance schemes indicates a fundamental lack of financial skills and underlying weak information systems. If adequate data systems existed then it would be easier to correct imbalances at a much earlier point.
Despite the fact that administrative systems are often weak, administrative costs may be high. 14% of income of the Kenyan NHIF goes on administration, this is probably just acceptable, but elsewhere in Africa the administrative costs are higher. The social security scheme in Mali which has only 60,000 beneficiaries is estimated to spend about half of the contribution income on administrative costs (Abel-Smith and Creese, 1989). The smaller the scale of the scheme the higher the proportion of administrative costs is likely to be.

- **Revenue raising capacity**: if the prime motive for adopting health insurance is to increase cost recovery rates then what is the evidence on social insurance schemes' revenue raising ability? This is particularly a concern in cases where there is low insurance coverage and thus low revenue. Estimates really need to be made on a country by country basis but as general guidance ILO suggests that 'social security coverage for 20% of the population will increase overall health funding by 12-15%’ (ILO, 1993). In Ghana where it is planned that employers pay the full insurance premium it has been estimated that the scheme will require government to pay an additional 2.6 billion Cedis, whereas the scheme will generate a total revenue of 6 billion Cedis. For comparison the total (public and private) health spending in Ghana is currently approximately 21.5 billion Cedis.

In addition to the fundamental issues identified above there are also questions relating to the process of implementation.

People are often reluctant to support the establishment of social health insurance schemes because (i) they currently pay low fees in the government sector (ii) the quality of care provided may not be adequately high for people to think it worth paying for and (iii) people are sceptical that the resources collected will actually be used to improve quality. User fees appear to be a logically prior step to expanding health insurance coverage. In Zambia it is reported that people are requesting that insurance schemes be established to help them pay user fees.

Currently the demand for health insurance in sub-Saharan African countries is limited. Health insurance schemes are instead promoted by health care providers; governments are keen to raise extra revenue, and private providers wish to gain income security. In Nigeria the enthusiasm of private providers was such that the general public became sceptical about the benefits of the scheme to insured persons. In Ghana the Medical Association (GMA) has pushed hard for the adoption of an insurance scheme but has been frustrated by government’s lack of progress. The Society of Private Medical and Dental Practitioners, a group under the umbrella of the GMA, has developed its own voluntary insurance scheme which was launched in October 1993.
Strong interest groups may form around the proposal for a social health insurance scheme, as has occurred in Nigeria. Civil servants who currently receive good health care benefits are unwilling to join a scheme which has less desirable conditions. Interest groups may also try to influence specific aspects of scheme design. In Nigeria, pharmacists are unhappy with a capitation based payment mechanism as it means that their payment will come via the physician. In addition the very nature of social health insurance schemes means that they must be developed over a period of some years. Macroeconomic and political instability therefore threaten the progress of implementation.

Finally, Ministries of Health may find that they have limited control over the operations of social health insurance schemes. For example, the National Health Insurance Fund in Kenya is an independent parastatal body. Population coverage of the scheme is limited but more problematic is the fact that only a small proportion of medical bills are reimbursed. Statistics are not available, but as an illustration, a reimbursement of KSh 1,800 was given on a total bill of KSh 13,000, where the annual premium was approximately KSh 30,000. Because of low reimbursement rates the Fund has a large surplus, however the MOH has limited ability to influence the operations of the Fund.

Conclusions on social health insurance
African countries face a difficult decision in weighing up the potential revenue gains from health insurance vis-à-vis a possible degradation of equity and high administrative costs. It is likely that the countries most in need of extra revenue will have the most difficulty in establishing social health insurance schemes. Like the other policy reforms discussed in this document it is clear that social health insurance should be part of a broader strategic plan. Many of the difficulties which have occurred with existing schemes are due to the ad hoc nature of their introduction. To reap the full benefit of social health insurance there must be corresponding shifts in MOH policy.

Finally, although social health insurance may relieve government of some of its financial responsibility it will increase government’s responsibilities in terms of regulation, coordination, etc. Social health insurance schemes must be properly monitored to ensure that appropriate services are being delivered, that adverse equity effects are not occurring, to prevent cost inflation and to promote efficiency. Often new bodies are established outside of the MOH to administer social health insurance schemes. Under such circumstances the MOH must ensure that clear guidelines giving them some responsibility for policy on the health insurance element of the scheme are in place.
4.3 Employer based insurance

Not-for-profit health insurance schemes based upon trade union or employee groups are relatively common in the Southern African region. In Zimbabwe an estimated 5.6% of the population is covered by such schemes, 20% in South Africa and approximately 4% in Namibia. In Zimbabwe there has been a steady growth since Independence in the number of people covered by these schemes. A Namibian private insurance scheme is now developing a new 'low income' fund for those earning less than N$2,000 (approximately US$600) per month in order to expand coverage further.

Medical Aid schemes reimburse both inpatient and outpatient care, but may exclude certain services. For example in Namibia extra insurance must be purchased to cover hip replacements or high technology heart bypass surgery. Contributions to the scheme are generally set as a percentage of salary, and both employer and employee contribute; in Zimbabwe the premium is split 50:50. As contributions to the schemes are tax exempt there is (i) a considerable incentive for employers and employees to join the schemes and (ii) a substantial government subsidy. Although insured persons are able to use both public and private sector providers the majority of care takes place in the private sector. It is estimated that in Zimbabwe 74% of payouts are for consultations with private practitioners and pharmaceutical boards, 23% for admissions to private hospitals and just 3% are to the public sector. Providers under the scheme are paid on a fee-for-service basis. In South Africa an annual amount of Rand 5.3 billion (approximately US$1.6 billion) flows from such insurance schemes to private providers or approximately 68% of the estimated total expenditure in the private sector (Booysen, 1992).

Cost containment is also a problem in these schemes. In both Zimbabwe and Namibia there are serious concerns about over-servicing by providers under the scheme. In South Africa the ratio of medical scheme expenditure to public expenditure increased from 0.39 in 1981 to 0.59 in 1989. This was due partly to an increase in the number of people covered by medical aid schemes but also to a large increase in private per capita expenditure under the schemes (Booysen, 1992). The politically powerful position of private providers has made it difficult for the Medical Aid Schemes to introduce cost containment mechanisms. The Namibian Medical Aid scheme is considering setting up its own primary care clinic to act as a gatekeeper for private sector services.

In Zambia some of the government hospitals which have been given board status have agreed contracts with employers whereby the companies pay a lump sum deposit plus a non-refundable capitation fee and the hospital then provides comprehensive services for the insured
group. By integrating insurance and provider functions, it is possible that such Health Maintenance Organization (HMO)-style arrangements will be able to contain costs.

4.4 Community based health insurance

The limited coverage of formal social health insurance schemes has induced many countries to consider alternative community based insurance schemes. In three countries, Guinea Bissau, Burundi and Zaire such schemes are relatively well established. More recently pilot community insurance schemes have started in some Anglophone countries such as Kenya and Ghana. Zambia plans to develop such a scheme throughout the rural areas.

Table 7 summarizes the nature of the schemes. It is apparent that unlike the social insurance schemes, community based schemes tend to be voluntary as it is difficult to enforce membership amongst the rural population. However both the Bwamanda scheme in Zaire and the Abota scheme in Guinea Bissau, have measures to guard against adverse selection (Shepard et al., 1990; Chabot et al., 1989). In Guinea Bissau it was agreed that at least 75% of the households in a village should join if the village were to join. In Zaire if one member of the household joined then all must. In Burundi no such mechanism exists and a recent study concluded that there was a limited degree of adverse selection (Arhin, 1994). The schemes are generally not designed to cover all health care costs. The Bwamanda scheme managed to cover 79% of the hospital's recurrent costs in 1988, but the other schemes only aim at cost recovery on drugs and do not always achieve this. In one area of Burundi just 34% of drug costs were being recovered, and although some parts of the population said they were willing to pay more in order to secure a more reliable drug supply the most common reason given for not joining the scheme was affordability (Arhin, 1994).
Table 7
Characteristics of Community Based Insurance Schemes

<table>
<thead>
<tr>
<th></th>
<th>GUINEA BISSAU</th>
<th>BWAMANDA, ZAIRE</th>
<th>BURUNDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td>Voluntary 200,000 (20% pop) covered by 1988.</td>
<td>Voluntary Approx 65,000 covered (1990). Scheme operative in one health zone only.</td>
<td>Voluntary Unknown. In one area 23% of the population currently covered.</td>
</tr>
<tr>
<td>Benefit Package</td>
<td>Comprehensive</td>
<td>Hospital care only</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Administration</td>
<td>Village health committee</td>
<td>Government health provider</td>
<td>Commune (local administrative body)</td>
</tr>
<tr>
<td>Health Service</td>
<td>CHWs and referral to other government facilities</td>
<td>Direct by public providers</td>
<td>Indirect by public providers.</td>
</tr>
<tr>
<td>Delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Payment</td>
<td>Revenue used only to purchase drugs</td>
<td>Revenue supplements zone’s health budget.</td>
<td>Revenue used to purchase drugs.</td>
</tr>
<tr>
<td>Finance</td>
<td>Initially voluntary contribution by adults. Over time this converged to fairly standard rate in each village.</td>
<td>Individual flat rate, plus employer contribution for formal sector workers.</td>
<td>Flat rate per household.</td>
</tr>
</tbody>
</table>

SOURCE: Arhin (1994); Chabot et al. (1989); Shepard et al. (1990)

All of the schemes described here appear to be reasonably well integrated into the health care system as a whole. This is an important issue with respect to community based schemes: if insured persons are required to pay fees at a higher level of the health care system the scheme is likely to be unattractive and offer inappropriate incentives. The schemes appeared to be appreciated by the local population. In particular in Guinea Bissau cash liquidity is low at certain times of the year and the ability to time payments was important (Chabot, 1989). In Burundi women particularly appreciated the scheme; they have low cash incomes but are expected to provide for the family’s health needs. With an insurance scheme they did not need to ask the male head of household for money each time they went to the clinic (Arhin, 1994).

In the proposed Zambian scheme rural households would, on a voluntary basis, make an annual contribution, in cash or in kind, which entitles them to a family health card. This card would then be used to access care throughout the county. Both curative and preventive care are included. The scheme would be administered locally with community co-management of funds. All funds would be retained locally although some would be passed from the health centre to the district hospital to pay for referral services. Guidelines would be provided by the
central MOH, but much flexibility would be given to districts in establishing precise operating arrangements.

Although community based health insurance has many potential advantages, experience with it is limited. Careful planning, management, and monitoring is required in the implementation of such schemes. In particular for the scheme to be really a community initiative, measures must be taken to include the community at each step of development. A delicate balance must be sought between allowing local flexibility and yet giving adequately clear central guidelines with respect to the operation of the scheme and especially the use of funds.
4.5 Conclusions on health insurance

Current health insurance arrangements in sub-Saharan Africa cover only the minority. Social health insurance schemes have natural limits placed upon them by the degree of organized labour. In order for health insurance to reach out to the rural areas and informal sector workers, innovative approaches are required. Such schemes need to be decentralized and flexible to meet local requirements.

Regardless of the type of scheme adopted health insurance brings a considerable administrative burden in terms of design details, implementation of schemes and regular monitoring to ensure appropriate operation of schemes. Many African countries are short of the skilled staff who can perform such functions. A phased approach to implementation of health insurance schemes may thus be desirable. Technical assistance may also be required. The technical assistance requirements expressed by African health policy makers include help in assessing options for health insurance, researching the relationship between appropriate tax policies and premium payment and exploring the demand for health insurance. In addition financial assistance in developing administrative facilities and in establishing the initial working capital of a fund may be useful.

Given the current apparent lack of demand for health insurance in many African countries it would seem particularly important to coordinate closely user fee and health insurance policy. If user fees are significant then people are more likely to want health insurance to ensure that they can pay for health care. However the demand for health insurance in Africa is still likely to be limited by some parts of the population simply being unable to afford health insurance premiums.

It is also important to consider the quality of care provided. People will not wish to pay insurance premiums to gain access to poor quality care; adequate quality assurance mechanisms need to be in place before insurance is introduced. Proper monitoring mechanisms should also be established before implementation. The monitoring mechanisms should address issues such as affordability, utilization, finance and consumer perceptions of quality of care.
Many African policy makers feel that the state should not have a monopoly on health insurance. Give the severe shortage of health care funding in Africa at the moment it seems that a multiplicity of health insurance schemes may be acceptable in the short run as a way to maximize available resources. In the longer run such schemes would need to be coordinated to prevent both inefficiencies and inequities from occurring. Although government has an important role in encouraging private health insurance through creating an appropriate regulating and enabling environment, governments need to be cautious about financial incentives to this sector. Unintended government subsidy to private insurance (though tax relief on premiums) is likely to be inequitable.
5. REGULATION AND INCENTIVE SETTING FOR PRIVATE FOR-PROFIT PROVIDERS

5.1 Introduction

Although the private for-profit sector is of significance throughout Africa its size and nature varies considerably. In some countries such as Zimbabwe, Namibia and South Africa there are substantial private sectors which are supported principally by formal sector workers with insurance. In Zimbabwe 74% of the payouts by Medical Aid Schemes go to care given by private practitioners. An estimated 40% of doctors in Zimbabwe work full time in the private for-profit sector. In many other African countries insurance coverage remains limited but a liberal regulatory environment means that the private sector is still fairly substantial, this is true for example of Ghana and Nigeria. Finally some countries have in the past severely circumscribed or completely banned the private sector. The private sector in these countries remains limited; this is true of Tanzania, Malawi and Mozambique.

Private providers tend to establish themselves first in curative activities requiring little capital, such as small clinics. As insurance becomes more extensive it is possible for more capital intensive activities to be undertaken. For example of the estimated 35 private doctors in Malawi in 1988 all were in private clinics, whereas of the eleven and a half thousand private doctors in South Africa over 30% were working at the hospital level.

Unlike some parts of the world, sub-Saharan Africa continues to suffer from a shortage of trained health personnel, particularly doctors. Almost inevitably the expansion of the private sector increases demand for doctors and other health personnel. Salaries in the private sector are normally higher than in the public thus causing braindrain from the public sector. African countries have experimented with various measures to attempt to retain staff, such as bonding (e.g. Zimbabwe, Lesotho) and raising public sector salaries to make them more competitive (e.g. Nigeria, Zimbabwe), but none of these policies appear to be particularly effective.
After Independence several countries (such as Tanzania and Mozambique) completely banned private for-profit activities and others severely limited it (such as Malawi). These measures were often drive by ideological reasons. However in the long run the policies have proved unsustainable as many doctors have left to go abroad. It is estimated that more than 170 doctors left Tanzania after the legislation was passed (WHO, 1991). Rather more liberal attitudes towards private practice now prevail across the continent, but there are still difficult questions concerning, for example, the right of public sector doctors to carry out private practice.

The size and scope of the private sector in Africa leads to different priority policy concerns in different countries, however it is possible to identify a common core of problems:

- Governments are often concerned that private for-profit providers do not give consumers a fair deal; they may provide low quality care, supply unnecessary services or over-charge.

- Government may be concerned about the equity implications of substantial private sectors; in Zimbabwe the private sector accounts for 37% of health sector expenditure but benefits no more than 10% of the total population. The private sector is often concentrated in urban areas. Again in Zimbabwe 75% of private practitioners are located in Harare or Bulawayo.

Set against such problems are the potential benefits which the private sector may bring:

- Private providers stimulated by profit may be more efficient than the public sector. It is even possible that competition between the two sectors encourages public providers to improve service delivery.

- The private sector may bring additional, badly needed resources into the health sector.

For many African governments the current shortage of government resources is such that expansion of the private for-profit sector is an appealing policy option. The success with which this policy is pursued will depend partly upon factors outside the control of the Ministry of Health such as the populations’ ability and willingness to pay for health care, and partly upon factors which the Ministry has direct control over, such as the regulatory environment and the incentives facing private providers. This section addresses principally those areas of policy which the MOH has direct control over.
5.2 Regulation

Regulation is necessary to ensure that private for-profit providers offer an acceptable service. Government regulation may cover:

- **the quality of care** e.g. by specifying certain minimum structural standards
- **the quantity of care** e.g. by controlling the number of for-profit providers which can register
- **the price of care** e.g. by agreeing with representatives of the private sector a fixed fee schedule.

Regulation is sometimes seen as an obstruction to the effective functioning of the market, and indeed cumbersome regulatory procedures carry a cost both to government and to the private sector. However in order to protect both the consumer and bona fide private providers some regulation is essential. Regulatory structures should be designed to match the specific conditions within a country, and to avoid unnecessary cost, regulatory mechanisms should be as simple to operate as possible (Bennett et al., 1994).

The first stage of regulation is the licensing and registration of the facility. This serves both to control the quantity and quality of care and provides the baseline data required for further regulation. Often medical personnel are licensed by the medical (or other professional) council, whereas medical facilities must be registered with the MOH. Regulatory laws may specify (i) the physical characteristics required by a facility in order to be allowed to operate and (ii) the qualifications and characteristics of the practitioner. For example, in Kenya a private clinic must:

- be kept in good order and state of repair
- not be a residential building
- keep essential drugs and an accurate record of all drugs.

In addition a doctor must have at least three years experience before s/he can operate privately, must observe ethical standards and a private practitioner is only allowed to operate more than one clinic when the Medical Practitioners' and Dentists' Board gives its permission. Such permission would only be granted when both clinics were in rural, and thus under-served, areas (Mutungi, 1992).
Doctors in Kenya are allowed to perform all sorts of medical procedures whereas clinical officers operating privately are only allowed to perform a limited list of procedures. However it is much harder to enforce such regulation which is concerned with process aspects of quality of care, than it is to regulate structural aspects of quality of care which are relatively easy to observe. The study by Mutungi concluded that privately practising clinical officers required closer supervision to ensure that they gave an adequate standard of care.

No examples of government regulation of private practitioner fees in African countries were found, although medical insurance schemes do agree fees for insured patients with private practitioners. It is extremely difficult to regulate provider fees partly due to the diversity of services offered, and also due to the fact that not all private providers operate under an umbrella organization, thus negotiation with many different providers may be required.

In Zimbabwe private practitioners are not allowed to dispense drugs or do laboratory tests. Regulation prohibiting the integration of services is designed to prevent practitioners from over-prescribing in order to increase their incomes. In Ghana however private practitioners may offer medical, laboratory and pharmaceutical operations on the same site.

The number of private health care providers may be relatively few but there are often very many private pharmaceutical outlets. The sheer numbers of private drug sellers makes them very difficult to regulate. Some Southern African countries have been able to regulate pharmacies quite tightly but elsewhere there is a proliferation of unlicensed drug sellers. In Zimbabwe the Drugs Control Council which is an arm of government registers and controls the prescription, sale, dispensing and storage of drugs by both the private and public sectors. The situation in West Africa is generally less well regulated. In one suburb of Senegal it was estimated that illicit sellers accounted for 43% by value of the drugs sold (Farsin, 1988). There is also a large unlicensed pharmaceutical sector in Nigeria. As street vendors are unqualified a big problem with fake drugs emerged (Bartholet, 1990). Nigeria has now taken steps to make the drugs market safer by drafting a list of just 410 essential drugs that can be legally administered. The law also states that advertisements for proprietary products must give equal prominence to their generic identity. It is unclear how well these new laws are being enforced. In 1990 the federal task force on drugs in Lagos had no vehicles of its own and offices were without telephones (Bartholet, 1990).

Despite the fact that regulations governing the private sector exist in most countries, the enforcement of regulatory controls is often lacking or at best weak. Much regulatory authority rests with medical or other professional councils. In Ghana such councils were established
during the 1950s, but it is only quite recently that they have started to receive funding from government. Without such funding the Councils barely operated. Even if medical councils or their equivalent are well funded they may not protect the interests of the consumer. For example in Zimbabwe the Medical Council has failed to publicize cases of malpractice for fear that they may discredit the profession. In Zimbabwe the MOH feels that regulations are not effectively policed, complaints against registered practitioners are common and the government is now considering subsidiary legislation to provide for the establishment of a statutory inspectorate body which will regularly inspect private hospitals, clinics, nursing homes and GP practices.

5.3 Incentives and coordination

Private for-profit providers can be encouraged to collaborate with the public sector through non-monetary incentives (such as continuing education, the provision of locums, etc.) or through monetary incentives such as the subsidized purchase of drugs and other supplies or government payments for certain services provided. An alternative way in which government may provide certain incentives to the private sector is through the use of the payment mechanism. Different forms of payment have different incentives inherent in them. If there are large social health insurance schemes then adjusting the form of payment may be a relatively easy and very effective way of influencing private provider behaviour. However as discussed in section 4, health insurance coverage is limited in sub-Saharan Africa and thus such mechanisms are of less importance.

Several countries have experimented with the free provision of supplies such as vaccines, condoms and other contraceptives to private practitioners in order to encourage them to offer preventive services. In Nigeria vaccines and condoms were provided free. In the early nineteen-eighties Zimbabwe supplied free vaccines to private practitioners, however this was stopped when it was found that private practitioners were charging for these services. Despite the fact that the vaccines were free the private practitioners still incurred other costs and it was probably unrealistic to expect them to stop charging altogether; a lower fee should have been agreed to reflect the subsidy.

Economic theory would suggest that services with externalities (such as immunization) should be subsidized in order to encourage people to use the service. However if government is already providing the service at a subsidized price then the argument for subsidizing private practitioners is less clear. There is substantial evidence suggesting that some consumers are willing to purchase preventive services such as family planning, even if they must pay for it
(e.g. Lewis and Kenney, 1988). Governments should be careful that they do not subsidize preventive care given to the wealthy who would have used the service in any case. Improving the quality of public sector delivery may be a better use of scarce resources.

Other incentives offered to private providers are directed more generally at supporting the development of the private sector. In Ethiopia private providers may purchase drugs, dressings and medical equipment from government sources, so there is an implicit subsidy as government warehouse prices are often lower than those of private suppliers. Private provision may also be encouraged through tax incentives, for example by exempting certain medical supplies from customs duties or by offering tax relief to private providers who locate in underserved areas. Opportunities for training both overseas and locally are also important incentives to raise the quality of private providers’ work.

Most contacts with private providers in Africa are by uninsured patients and are paid for directly by the patient. Under these circumstances the most common payment mechanism is that of fee-for-service; the inherent incentive in this mechanism is for the provider to over-provide services, although this is likely to be limited by patients’ ability and willingness to pay. In Southern Africa there is more substantial insurance coverage but the payment mechanism varies between each scheme. Most of the services provided under insurance in Namibia, South Africa and Zimbabwe are paid for on a fee-for-service basis, however in Zimbabwe the payment is made direct to the provider without any co-payment by the patient, in South Africa the payment is made directly by the insurance agency but there is usually some co-payment by the patient, in Namibia the patient must first pay out-of-pocket and is then reimbursed by the insurance agency. The co-payment in South Africa is designed to prevent the patient from demanding excessive amounts of health care services which may occur if the price at point of use is zero. The Namibian model may also deter excess consumption as the patient must pay the full cost of care in advance.

Alternative payment mechanisms, such as capitation based payment whereby the provider is paid an annual fee for each patient registered, may help to contain costs by offering the provider an incentive to reduce services delivered. No African country has yet adopted such a mechanism in its insurance scheme.
To enhance collaboration some countries have established committees including both the public and private sector. In Zimbabwe for example, the Advisory Board on Public Health is made up of public, private for-profit and private not-for-profit representatives and advises the Ministry of Health on public health issues. In Malawi the council includes only public and private not-for-profit providers, but expansion to cover the for-profit sector through a Health Coordinating Committee is being considered.

5.4 Towards internal markets

Many industrialized countries are currently undertaking far-reaching health sector reform, and there are clearly strong parallels between some aspects of industrialized country reforms and those in developing countries. This is particularly true of attempts to incorporate market mechanisms into the public health care sector. The UK reforms separate the purchasers of health care (known as District Health Authorities) from the providers (the hospitals) in an effort to stimulate competition between providers and thus improve efficiency. Instead of paying providers through a global budget, health authorities now contract with providers for various specific services. In the US the Clinton plan aims to control health care costs whilst ensuring universal health care coverage. To do this, regional health care purchasing agencies will be established. Like the health authorities in the UK these purchasing agencies should encourage competition among physicians and hospitals so as to improve efficiency.

These reforms are often referred to as internal markets or managed competition. In order for them to work well a substantial amount of information and managerial skills are required to help the purchasers identify the best providers and to negotiate contracts with them. Because of these informational and managerial requirements it is unlikely that the internal market model is replicable in sub-Saharan Africa, but aspects of the idea may be relevant (Mcpake and Ngalande-Banda, 1994). In particular several African governments have some experience of contracting for services with the private for-profit sector.

Contracting Example 1 - Namibia

In Namibia private general practitioners are routinely contracted to provide surgery in remote rural areas. The GPs are remunerated on the basis of (i) workload in terms of the number of sessions carried out (this accounts for one third of payment) and (ii) the number of procedures carried out and extent of work out of normal hours (which accounts for the remaining two thirds of payment). The contract is normally with an individual but specifies 60-80 hours per week and therefore is carried out by a team of doctors.
A cost-effectiveness analysis of the scheme found that it cost approximately 75% of a full time government appointment including benefits, recurrent costs and perquisites. The Namibian Ministry of Health perceives the principle benefits of the scheme to be the continuity of care offered (as there is low turnover in private practice) and the extensive experience of the consulting GPs. Administration of the scheme is relatively simple for the Ministry and cost is low. On the other hand GPs tend to give priority to their private clinics over contracted work and the scheme places considerable administrative burdens upon the GPs themselves. Finally because the GPs are contracted rather than full time employees the MOH feels that they are not entirely under its control.

**Contracting Example 2 - Zimbabwe**

In Zimbabwe the MOH contracts with mine hospitals to provide services to the local population. A recent study examined the long standing contract between the Ministry of Health and Wankie Colliery hospital (McPake and Hongoro, 1992). Government patients may attend the hospital, and the hospital charges the MOH directly on a fee-for-service basis. The study compared the price paid by government for care at the mine hospital to the cost of care in the nearest government hospital. It was found that the recurrent costs at the government hospital were consistently higher than the prices charged by Wankie Colliery Hospital despite the fact that quality, both in terms of facilities available and patients perceptions of care were better at the mine hospital. The mine hospital claimed that it was cross-subsidizing government patients but the study was unable to verify this. Economies of scale may also affect the difference between the costs in the government hospital and prices charged to government by the mine hospital. Although it seemed technically efficient to contract out services to the colliery the researchers were concerned about allocative efficiency. The mine hospital is very popular, and although it served only a small population it accounted for 70% of provincial non-salary costs. The contract has very recently been terminated because of the high total cost to government.

Other examples of contracting with the private for-profit sector have been identified, but limited information about them is available. In South Africa there is considerable contracting; some hospitals known as contractor hospitals were established specifically to provide care to government patients. Often these hospitals provide specialist care such as for TB patients and psychiatric patients but there are also a few general hospitals (Booysen, 1992). Payment is usually on the basis of a fixed fee per patient day and often payment is guaranteed for 75% occupancy rates meaning that government bears the risk of occupancy rates dropping lower than this (and thus pushing up unit costs). In 1989 twenty-three contractor hospitals provided 14,500 beds. An evaluation of the contracting of general health care services to such hospitals is underway (Broomberg, personal communication).
Many countries have experience with the contracting of non-clinical services. Nigeria has contracted out laboratory services, Zimbabwe laboratory and equipment maintenance services, Lesotho catering and security services. No proper evaluation of these activities has yet been completed. The Zimbabwe MOH felt that on the whole, effectiveness of service delivery had increased, but so had costs. The contracting out of equipment maintenance services had been least satisfactory as it was now difficult for the ministry to set priorities. In Lesotho some teething problems were experienced with the contracting out of catering, as the contractor company expected to be able to use the government power supply and the contract had not specified adequately clearly who was responsible for fuel. The contracting of security services was seen to be successful as previously it had been difficult to dismiss government employed security guards if they were found to be dishonest. A private firm could be far more ruthless in its employment policy.

Several countries have established private pay beds within government facilities (including Zimbabwe, Tanzania, Kenya, Zambia, Mozambique and Malawi). The prime purpose of these beds is often to increase hospitals’ revenue but if doctors are allowed to retain some of the fees charged to private patients then it may also satisfy their wish to carry out private practice. Such an arrangement has the advantage that doctors do not disappear to a private clinic, but the private paying patients may still consume a large amount of their time, and there is a danger that the private patients consume more than their fair share of other hospital resources. In Mozambique, when the scheme was first introduced, scarce drug supplies were concentrated on the paying patients.

Finally governments have endeavoured to use the skills of private doctors within the public sector. Since 1987, when it has become easier for doctors in Malawi to enter private practice, a number of more experienced doctors, particularly those who used to be overseas have taken up private practice. Government allows such doctors to use the facilities of public hospitals for their private patients if, in return they agree to see certain government cases requiring specialist treatment free of charge. Zimbabwe has a similar scheme.
5.5 Conclusions on private for-profit providers

Complete or almost total banning of the private for-profit sector appears unfeasible and not to be recommended as a policy. Yet it is clear that market failures in the health sector necessitate a strong government able to influence private sector behaviour. Although most sub-Saharan African countries have a legal framework for regulation few countries have been able to enforce regulations effectively. Medical councils and other professional bodies are often entrusted with many regulatory powers, and just as has occurred in the developed world they may be 'captured' by the very agents whom they are supposed to be regulating. It may be necessary to back-up the regulatory authority of medical and other professional councils with a government regulatory body as is being suggested in Zimbabwe. The larger the number of regulatory organizations the less the risk of regulatory capture is likely to be.

Many African policy makers are questioning the 'conflictual' model of public/private relationships which a regulatory approach implies. Incentives may be used as an alternative to regulation. Perhaps the most effective incentives are structured by the payment mechanism, but in most of sub-Saharan Africa insurance schemes are so limited that this is not a viable approach. Government may structure other incentives such as tax breaks, subsidized supplies, accreditation schemes etc. Although some of these incentives are in place in sub-Saharan African countries, it is rare that they have been structured with specific objectives in mind. Frequently incentives are indiscriminately applied to all private for-profit providers regardless of where they locate or what services they offer.

Several African countries have tried to encourage private for-profit providers to offer preventive services by giving them free supplies. These experiences have not been evaluated and it is unclear whether they are necessary. Despite the popular wisdom that private providers do not offer preventive services, emerging evidence suggests that many private doctors are active in this area. A clear profile of what services private doctors offer and who consumes them, is necessary in order to help develop appropriate government policy on incentive setting for private providers.

Sub-Saharan Africa has had considerable experience with various forms of contracting. Evaluations of such contracting experiences are now beginning to emerge. On an a priori basis many would argue that contracting is unlikely to work in many African countries because of the limited number of competing suppliers. However the evaluations so far suggest that government administrative capacity may be a greater constraint.
The private for-profit sector in sub-Saharan Africa is an extremely diverse sector and its interface with government is becoming increasingly complex. This section has tried to reflect some of the innovative arrangements for harnessing and enhancing the operations of the private for-profit sector which have taken place in Africa. It is noticeable however that government relationships with the private for-profit sector have been little researched or evaluated.
6. REGULATION AND INCENTIVE SETTING FOR PRIVATE NOT-FOR-PROFIT HEALTH CARE PROVIDERS

6.1 Introduction

In much of sub-Saharan Africa private not-for-profit (NFP) health care providers constitute an extremely important part of the health care sector. Like the private for-profit sector, the NFP sector groups a variety of providers with differing motivations and with varying degrees of access to resources. In particular it is useful to distinguish between religious missions and other non-governmental organizations (NGOs) such as the Red Cross, Save the Children Fund, World Vision etc. In terms of ownership of facilities and number of beds the religious missions are by far the most important group of providers (Table 8).

<table>
<thead>
<tr>
<th>Country</th>
<th>% hospitals owned by NFP sector</th>
<th>% 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>&gt;50*</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 (ZACRH)</td>
</tr>
</tbody>
</table>

Note: *Figure is for the Ashanti region.
SOURCE: Background papers for WHO Namibia meeting and DeJong (1991)
Most religious missions in sub-Saharan Africa have been established for many years and have
developed a relatively well defined relationship with government. Christian missions have
often established umbrella organizations which advise and coordinate the activities of their
members as well as providing a contact point for government. Table 8 lists the umbrella
organizations active in selected countries.

In recent years several sub-Saharan African countries have experienced a proliferation of
NGOs. This is particularly true in countries such as Uganda, Mozambique and Ethiopia where
governments are undergoing difficult post conflict, reconstruction phases. NGOs have taken
over from government in those areas and activities where government capacity is lacking.
Growth of the NGO sector has been encouraged by a shift in donor policies towards aid
provision through NGOs rather than government. For example it is estimated that 55% of the
development assistance provided by the World Bank to Africa in 1991 was in partnership with
NGOs (Landell-Mills, 1992). This trend is particularly marked in countries where government
is viewed to be weak or lacking credibility.

Both national and international NGOs are active in health care in Africa. Some international
NGOs such as Christian Aid do not operate any of their own projects but rather channel
funding through local NGOs. Others such as Save the Children Fund, Action Aid, etc. carry
out their own projects in countries. In addition to the broad development NGOs which may
incorporate a health care element into their projects, there are some NGOs which specialize
in a particular area of health care. For example the International Union Against Tuberculosis
and Lung Disease works exclusively on these diseases, Médecins Sans Frontières focuses its
efforts in unstable areas. In Uganda there are organizations known as 'briefcase' NGOs,
which are generally owned by businessmen and developed in response to donors' enthusiasm
to channel funding through NGOs.

For Ministries of Health, a growing NFP sector whilst relieving the Ministry of some tasks
may also bring new burdens, particularly in terms of the need for greater regulation and
coordination.

6.2 Regulation

There are many parallels between the regulation of private for-profit and private not-for-profit
providers. Like the for-profit sector, NFP providers in sub-Saharan Africa must usually
register with government before they can establish any health care facility or health care
programme. Professionals working in NFP facilities are, like their colleagues in government
and the for-profit sector, regulated by their respective professional councils. As for the for-profit sector quality regulation tends to be quite weak. In Uganda the following processes were described: firstly self-assessment through annual reports etc., secondly inspection by both the local district team and central level teams and thirdly a form of accreditation is in place. In order to qualify for the free supply of essential drugs, health units must pass inspection. In general however there is surprisingly little quality regulation given the level of government support to NFP providers (see section 6.3). NFP providers have often been viewed as offering a higher quality service than public providers but the evidence to support this is mixed (Gilson et al., 1994).

One area where NFP providers are sometimes more tightly regulated than for-profit providers is with respect to the information they provide to government. In several countries such as Ethiopia, Ghana and Malawi, a standard reporting system for NFP providers is operational. However in reality it would appear that little or no action is taken if the requisite forms are not completed. In Ghana some NGOs report and others do not (DeJong, 1991). In some countries, such as Uganda, the reports to government should include financial reports. In particular returns for publicly supported activities (such as childhood immunizations) are mandatory. However these reports tend to go directly to the central level by-passing the district health teams and local authorities. It is true in many African countries that missions report directly to the centre thus by-passing their local managers. In Ethiopia NFP providers' lack of financial transparency has been a cause for concern. It is extremely difficult for government to judge the appropriate level of support to give to private NFP providers if the level of external contributions is unknown.

A few governments have attempted to regulate the fees charged by private NFP providers. For example under the Kaunda regime in Zambia, mission facilities were officially prohibited from charging for their services as the government had a policy of free health care for all. However as government subsidy to the missions and overseas financial support dried up, the missions were forced to start charging fees. In Tanzania the government is able to fix the price for certain services offered by NFP providers under the 1977 Private Hospital Act (Gilson et al., 1994). On the other hand in Ethiopia there is a concern in the Ministry of Health that some NGOs are charging excessively high prices for services, but no steps to regulate prices have yet been taken.

Part of the difficulty with regulating the NFP sector is (like the for-profit sector) its diversity. The differing motivations, scale and areas of operation mean that it is quite difficult to arrive at standard guidelines for NFP providers.
6.3 Incentives and coordination

Through the umbrella organizations, mission providers have been able to secure many subsidies and special incentives from government. A summary of these incentives in selected countries is presented in Table 9.

<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</td>
<td>Ethiopia, Ghana, Nigeria, Tanzania, Uganda, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>and drugs</td>
<td></td>
</tr>
<tr>
<td>Purchase of drugs from</td>
<td>Ethiopia, Ghana, Malawi, Tanzania, Uganda, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>government drugs stores</td>
<td></td>
</tr>
<tr>
<td>Payment of retirement benefits</td>
<td>Namibia, Nigeria</td>
</tr>
</tbody>
</table>

SOURCE: Background papers for the WHO Namibia meeting

In the case of Tanzania, there is also financial support to the annual conferences of the Tanzanian Christian Medical Association, while in Ghana, all expenses of NFP training institutions are borne by the government. Other incentives include the donation of structures such as buildings (Ghana).

A number of countries have conditions attached to the granting of incentives. For example in Tanzania, NGOs must provide audited accounts in order to receive any financial assistance, while in Malawi the payment of salaries is limited to local staff. Such conditions may make the relationship between the MOH and the umbrella organizations a delicate one. Christian Missions would like to be regulated and guided on a collaborative basis rather than being controlled by government as may seem to be implied by some of the conditions. On the other hand, government feels it has a right to be informed about what is going on in the private NFP sector. The level of trust and openness between the MOH and the NFP sector varies between countries. In Zimbabwe the relationship is a very good one, other countries are not so fortunate.
Through these various subsidies government has provided quite a high level of support to mission providers (see table 10). However current constraints upon government finance may severely affect this key source of funding for missions. For example, in Zambia the proportion of the MOH budget going as a subvention to the missions fell from 11% in 1978 to 6.4% in 1989 (CMAZ, 1989). Moreover in real terms the MOH budget had declined significantly during this period. These trends have placed a number of mission hospitals on the continent in an extremely vulnerable financial position. From the Ministry of Health perspective there is concern that as government support to the missions dries up, government leverage over the missions will also evaporate.

<table>
<thead>
<tr>
<th></th>
<th>Source of Funding</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government</td>
<td>Other</td>
<td>Fees</td>
</tr>
<tr>
<td>Ghana</td>
<td>45%</td>
<td>5%</td>
<td>50%</td>
</tr>
<tr>
<td>Malawi</td>
<td>40%</td>
<td>20-30%</td>
<td>30-40%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>33%</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Uganda</td>
<td>10%</td>
<td>10-20%</td>
<td>70-80%</td>
</tr>
</tbody>
</table>

SOURCE: Gilson et al. (1994)

Many mission facilities have increased their fees in response to declining levels of funding from other sources. This has sometimes led to large discrepancies between mission and government facilities in fees charged. Such discrepancies are likely to upset referral systems between public and NFP providers and may cause a drop in attendances at NFP facilities exacerbating existing imbalances further. In Lesotho one of the specific objectives of raising fees in 1988 was to attract patients away from over-crowded MOH facilities to under-utilized mission facilities. However there appear to be few other examples of successful collaboration in the coordination of fees and definition of referral mechanisms.

NGOs tend to be less cohesive than the mission sector and thus more difficult to coordinate with. Sometimes government has taken the initiative and organized a coordinating forum such as the Rehabilitation and Relief Commission of Ethiopia and the Primary Health Care Forum in Zimbabwe. Elsewhere the NGOs themselves have taken greater initiative such as in the Council for NGOs (CONGOMA) in Malawi and the Coordinating Assembly of NGOs in

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5 Principally local and external donations.
Swaziland. Some of the reasons for the lack of success in establishing such umbrella organizations may be attributed to the operational time scale of the NGOs which is often shorter than that of the religious missions and the frequently weak resource base which encourages a dependence on foreign funding (DeJong, 1991) and hence a lack of sustainability. Simukonda (1992) further attributes the lack of success in coordination to the heterogeneity of NGOs and the 'heroic' approach of some which makes them reluctant to concede any degree of autonomy.

In some countries NFP organizations feel unjustly excluded from the policy making process. Where NFPs are important health care providers this may have a serious negative effect, with the NFP sector's response to policy change being slower than it would otherwise have been. In some cases, policies such as the AIDS control programmes in Malawi have had to be modified on account of delayed input from the NFP providers.

Elsewhere however there is concern that NFPs, and NGOs in particular, have de facto achieved considerable power in policy making which may be inappropriate given their weak accountability. This has often been achieved in areas where government is weak and NGOs are a significant provider. Some NGOs such as Save the Children Fund now explicitly try to work, and integrate their efforts, at different levels of the health care system, including policy making. Whilst concern about excessive influence of NGOs is undoubtedly a valid one, it should be placed in the context of previous criticism of NGOs suggesting that they focus too much on discrete projects without taking into account the broader government policy perspective.

At the core there is a difficult question here, concerning the degree to which NGOs do integrate and become part of the government system and the degree to which they hold power within that system. Undoubtedly the question cannot be answered without reference to the strength of government itself and the type and character of the NGOs involved.

6.4 MOH contracting with the not-for-profit sector

The long standing informal agreements between missions and governments could be described as an informal contract, but few countries have attempted to formalize this relationship. A legally binding contract between the MOH and individual missions may potentially offer advantages to both parties by clearly specifying the level of subsidy to be given and the level of services to be provided in return. In Namibia one mission institution, wishing to gain greater financial security, approached the MOH to propose a 3-year contract for its services.
In Tanzania arrangements for missions to act as district designated hospitals are formalized through a contractual agreement with government.

Some experiences with 'limited' contracting arrangements are available in Uganda and Zambia. In both, 'contracting-in' is done in the areas of technical medical skills and management skills available in the NFP sector. In Uganda, this is most common between the MOH and international NGOs and may be undertaken as part of donor funded project. For example, using USAID funds the Ugandan MOH has contracted out some AIDS counselling services to a local NGO. In Zambia, contracting-in from the NFP sector is done for some specialized services such as AIDS prevention and home based care for AIDS patients.
6.5 *Conclusions on the private NFP sector*

The private NFP sector is an extremely important partner in health care in the majority of sub-Saharan countries. However, for its contribution to be fully harnessed there are some steps that should be taken to ensure that the activities of the NFP sector are in harmony with those of the MOH.

A clear legal framework for national policy is necessary, covering requirements for registration of professionals and NFP facilities. Under this legal framework the MOH should set guidelines for its own staff in terms of monitoring and supervising NFP facilities, and should establish appropriate procedures for NFP providers to report on activities undertaken and resources used.

In order for the MOH to supervise NFP providers and ensure a good quality of care, MOH supervisory capacity needs to be strengthened. One possible approach is the establishment of a coordination unit within the MOH. Alternatively greater responsibilities could be given to the district level which interfaces more directly with NFP providers.

Government incentives are important to the viability of the NFP sector and they should be tailored to match the needs and stated policies of the country. Such incentives should be provided so as to direct NFP providers into areas where government is unable to provide services, such as in remote rural areas or in the care of special types of patients, or in the provision of certain services. Further important incentives for NFP providers are the availability of further training, research and consultancy opportunities.

NFP providers need to be consulted during the process of policy development. Failure to do so may ultimately result in problems in policy implementation. Given the importance of NFP providers in sub-Saharan Africa their support and understanding is crucial for a range of policies including for example decentralization, implementation of fees and insurance.

A number of specific areas where coordination could be improved were identified. On training, collaboration should extend beyond basic training to the provision of continuing education to health personnel already serving in the NFP sector. This would strengthen human resources development at the same time as building stronger links between the sectors. Secondly improved coordination on price setting would benefit both the NFP sector and the MOH as existing price differentials often generate irrational utilization patterns.
It is worth exploring further the potential of contracting arrangements to increase transparency in dealings between public and NFP sectors. Such contracting arrangements could be used for direct service provision by NFP providers, thus formalizing the existing relationship and offering greater security to mission providers. Government could also contract in scarce skills from the NFP sector.

Patterns of financial support to NFP providers has undergone profound change recently, yet it is difficult to draw any simple conclusions. The two main trends are a decrease in government funding, and in some situations an increase in international donor funding. Declining levels of government funding is likely to mean a decline in the levels of government influence over NFPs. Where NFPs are now receiving substantial funds from international donors this is likely to strengthen their role in the policy making process. Elsewhere some NFP providers are in dire financial straits. As their input is often critical to the health care system government may consider ways in which it can channel more donor support to them. This issue needs to be considered particularly carefully in countries such as Zambia and Ghana where donors are now providing considerable recurrent budget support to the MOH.

In sub-Saharan Africa NFP providers have been one of the main groups of ‘winners’ as international and bilateral organizations have reoriented their aid programmes in order to support plurality and democracy. However, whereas some NFPs in Africa have long proven track records in support of public health objectives, others have a far less substantial record. Both government and donors need to distinguish carefully between the various types of NFP providers they are working with and the roles which these providers play. Above all governments need considerable capacity of their own to plan with and coordinate such a diverse set of actors, and to ensure that NFP providers are accountable.
7. CONCLUSIONS

The increased complexity in the public/private mix means that government roles are changing, not diminishing.

In the finance of health care most sub-Saharan African governments accept and positively encourage a multiplicity of funding sources, but at the same time government continues to bear the principal responsibility for the financing of care, and this is likely to last into the mid/long term. User fees in public health care facilities, though significant in the qualitative nature of their contribution, actually cover a small percentage of recurrent costs. The conditions for the development of insurance schemes in Africa are not perfect, such schemes will take a considerable time to develop. **The primary role of the Ministry of Health in financing health care services in Africa must be clearly understood by all government ministries.**

Concerning the **provision of health care**, in most African countries government has always been one among many providers, although this has not always been fully acknowledged in Ministry of Health policies. Focus on the public/private mix has raised awareness of the role of other providers. Governments are now considering how they can ensure that all providers work together in a coordinated manner.

**Promoting partnership** is the theme which most Ministries of Health are now pursuing. Partnership can be enhanced through development of appropriate coordinating mechanisms at the various levels of the health system. There are several examples of national coordinating health committees/councils which bring together leaders of the public and private sectors. Such mechanisms should help the MOH in developing national health policies, strategies and long term plans. The lack of clear policies and plans, stating the roles and responsibilities of different sectors jeopardizes any public/private partnership.

To support this collaborative approach **government requires clear regulatory laws and effective regulatory mechanisms** to ensure that the boundaries of acceptable behaviour for all providers (both public and private) are understood by all and that action is taken when unacceptable behaviour occurs. Prohibiting private practice and other restrictive measures have been shown to be counter-productive, nonetheless some regulations are required including the licensing of practitioners, measures to ensure minimum standards of quality, and to prevent the over-supply of services. Government experience with health care regulation in sub-Saharan Africa (as in many places) has not been very successful. More critical analysis of why
regulatory failures occur, and in particular how the role of Medical Councils as agents of quality assurance can be strengthened, is required.

**Public finance of private providers** is quite substantial; there are subsidies to missions, less overt subsidies to private for-profit agencies and contracting out of several government services to the private sector. The key question here is: how can government ensure that it gets good value for money from these arrangements?

Firstly it appears that there is a need to **specify more clearly what government expects of private providers in return for subsidies**. In particular there are often ill-defined informal contracts between missions and government, which may benefit from being more clearly articulated. There are also signs that the private sector itself may welcome greater clarity and frankness in its relationship with government.

Secondly, there is a need to **develop stronger mechanisms to monitor whether or not private providers meet government expectations**. Both for-profit and not-for-profit providers should give the public health sector **appropriate health care information**, which government should use as a basis for monitoring and should also disseminate. A unit or section within the MOH should be identified as having responsibility for coordinating with private providers.

There are extremely close connections between the four main themes discussed in this paper. **Changes in any of the four main areas identified** must take place as part of an integrated strategy for health sector reform. For example it seems that user fees are a logical precursor to health insurance. In turn health insurance will probably promote the sustainability and scope of activity of the private for-profit sector. NGOs and missions have played a particularly important role in exploring innovative and decentralized methods of raising finance for health care.

In deciding policies on the four themes discussed here **Ministries of Health should not ignore the potential for efficiency gains to be made within their current activities**. Strengthened management systems, decentralization, shifting of budgetary allocations to priority services may be better or perhaps complementary policy choices.

There is also a need to consider **short term objectives vis-à-vis long term objectives**. Several of the options discussed seem to be imperfect solutions to difficult situations. But when the macro-economic environment improves how will countries' goals change and will the policy...
initiatives being taken at the moment jeopardize those goals? For example, if the private for-profit sector is promoted now without adequate regulation then in the future cost containment problems may occur. If small scale, decentralized insurance projects are promoted now, how might they be transformed in the future into national, potentially more equitable schemes?

All of the policy reforms discussed here require strong management capacity. The lack of this capacity has been an active constraint on many sub-Saharan African countries. For example in Kenya the first attempt at a user fee system failed largely because of poor management. The second attempt with clearer management strategies and greater management support to the local level appears to be a much greater success. Governments and international donors must continue to build up management skills in the MOH, particularly amongst middle level managers who often bear the responsibility of transforming good ideas into practical plans.

This review has highlighted the considerable diversity which exists within Africa. This diversity indicates that reform policies must be tailored to local conditions. External 'blueprints' are unacceptable and can never take the place of good MOH managers and planners.

Some of the questions raised here link to the decentralization debate. Centralized systems seem to suffer from problems which more flexible local systems avoid. This is certainly clear with respect to user fees and to a lesser extent insurance. To what extent is it true of coordination, regulation and incentive setting for the private sector? The strongest incentives to coordinate and regulate lie at the local level. There may be gains to giving the district level or other devolved organizations greater responsibility for regulation and incentive setting, provided that they are also given adequate resources to fulfil this function. For example a district level contract with mission facilities specifying expected outcomes may be easier to agree and monitor than national level contracts.

On the other hand decentralized systems may suffer from lack of central guidelines. For example a decentralized user fee system may provide inappropriate incentives to the user if higher levels of the health care system charge less. A careful balance needs to be achieved between central guidance and local initiative. Having a clear definition of responsibilities is essential to this.
Finally, the meeting of African Ministers and policy makers in Namibia concluded that there is a need for Ministries of Health to provide dynamic leadership and an enabling environment for all actors in the health sector to work in a holistic and complementary manner. The rising cost of care, increasing populations and low levels of resources make it clear that Ministries of Health cannot do everything single-handed and must select appropriate priority areas for increased attention, and correspondingly identify areas of less priority where responsibility might be relinquished.
REFERENCES

References which are starred are particularly useful ones and are annotated later in the document.


Arhin D (forthcoming) The health card insurance scheme in Burundi: a social asset or non-viable venture? Social Science and Medicine


### BASIC DATA ON SUB-SAHARAN AFRICA RELEVANT TO THE HEALTH SECTOR

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**Source:** World Bank (1993)
ANNOTATED BIBLIOGRAPHY

GENERAL


The health sector in developing countries generally faces problems of insufficient spending on health activities, inefficiency, and inequity. In this document an alternative approach to financing health care is proposed. The primary theme is that the majority of curative health services should be paid for by those who receive the care. This approach would increase the resources available for government provision of basic curative and referral services for the poor.

Four policies for health financing are recommended as an agenda for reform: 1) to charge users of government health facilities, 2) to provide insurance or other risk coverage, 3) to use nongovernmental resources more effectively, and 4) to decentralize government health services. The four policies are proposed as a package of reforms, but it is recognized that countries might wish to move more quickly on some parts than on others. The document has been influential both with respect to World Bank policy and that of developing countries. It is relevant to policy-makers and government officials dealing with financial and organizational aspects of the health sector.


The purpose of the interregional meeting was to share country experiences in managing change in the public/private mix, and to review the role of ministries in harmonizing private sector activities with national health system objectives.

The economic principles and political responsibilities for an appropriate public/private mix in national health systems are reviewed, including issues on the efficiency of the private for-profit sector, privatization policies, regulation mechanisms, and the functions of governments.

Country experiences with changes in the public/private mix are reviewed for selected countries. The descriptions and analyses of the country experiences include assessments of the existing public/private mix in the selected countries, policies to change the balance of the public and private sectors, and regulation of the private sector.

The report provides valuable background information for policy-makers and government officials reviewing or actually planning national health policies on the public/private mix.

The article provides an assessment of the introduction of user fees supplemented with quality improvements by testing how user fees and improved quality affect health facility utilization among the overall population, and specifically among the poorest people in the Adamaoua Province of Cameroon.

The research was conducted in five public health facilities. Three health centres which were to introduce a user fee and quality improvement policy were selected as "treatment" centres, and two comparable facilities not yet phased into this policy were selected as "controls". The article describes in depth the selected research method, i.e. design, validity, measurement tools, etc.

Contrary to several other studies, this study finds that access to health care for the population and particularly for the poor was improving as a result of a policy which introduced user fees and quality improvements at the same time. Since the poor are most responsive to price changes, they appear to benefit more than the non-poor from local quality improvements.

The article is particularly useful for people involved in the planning, implementation and monitoring of user fee systems, and it may also be helpful for people conducting research on user fees.


The article provides a theoretical as well as an empirical overview of the efficiency of user fees in developing countries. The theoretical background is described emphasizing two general criteria: efficiency and equity. The empirical review is elucidated in terms of the impact of user charges on health services utilization, and in terms of factors influencing the implementation of a user fee policy.

Theoretical models predict that user fees are unlikely to promote equity. However, empirical evidence suggests that user charges in many countries can provide scope for welfare gains for the majority. It is argued that many developing countries have little choice but to try to exploit the potential of user charges and their related gains for the majority, but that substantial emphasis should be placed on ensuring quality improvements and equity.

The article is especially useful for people requiring a brief and fairly broad introduction to the context of user fees, both theoretically and empirically.

The authors claim that no clear picture has emerged as to what "works" and what does not work regarding cost recovery, e.g. user fees and health insurance. The aim of the paper is to clarify the conceptual issues around cost recovery, and from that perspective to assess what can be learned from recent experiences with cost recovery in sub-Saharan Africa.

Two competing cost recovery models are analysed: 1) a standard model emphasizing both resources and efficiency arguments for user charges, and 2) the Bamako Initiative model emphasizing user-financing of primary health care at the community level. In addition, the experiences of cost recovery in health in sub-Saharan Africa are described and analysed in depth for each country, and separately for Francophone and Anglophone Africa. In the Francophone countries, user fee systems are frequently decentralized community-based schemes in which a portion of the fee revenue is retained at the community or facility level, whereas the Anglophone countries are often characterized by highly centralized systems in which revenue is remitted to the central level.

The intended audience is primarily policy-makers, but the study should also be of interest to people involved in the implementation of user fees in sub-Saharan Africa.

**INSURANCE**


The aim of the paper is to study the prevailing situation in African countries where social security systems already play a significant role in health care systems.

A questionnaire was sent to virtually all African countries inquiring about the role of social security in health care systems. Based on this body of information, eight countries were selected for more detailed profile analyses: Cameroon, Egypt, Gabon, Ghana, Kenya, Madagascar, Morocco and Tunisia.

It is concluded that social security financing for health appears to be a viable option, given the right political and economic environment. Health insurance is regarded as having considerable potential for alleviating the chronic underfunding of health sectors in Africa. However, it is stressed that insurance financing should not be regarded as a panacea to the underfunding problem.

The paper covers the experiences of most African countries and, as such, provides valuable background information for policy-makers and government officials planning and/or implementing health insurance programmes.

The main themes discussed in the chapter are the advantages and disadvantages of insurance mechanisms for financing health care, and the relative merits of the involvement of public and private institutions in health care.

The experiences of Europe, the United States and developing countries are reviewed with respect to coverage, equity and institutional structure issues, and differences are discussed. Mills argues that whether private or public systems of health care are likely to work more efficiently can be considered as much an ideological issue as one susceptible to empirical assessment.

Mills considers health insurance to be a useful way of financing health care services, primarily for the formal sector of the economy, as long as the distributive effects of service provision do not violate notions of equity, and if health services for the insured do not detract from the care available for other sectors of the population.

The chapter is of special interest to policy-makers and administrative decision-makers within national health systems.


The objectives of the paper are: 1) to document different types of health insurance and prepayment systems in Zaire, 2) to conduct in-depth studies of several health insurance schemes, 3) to discuss with officials from Government agencies the nature of the proposed plans for promotion of health insurance schemes, and 4) to propose additional studies of broader programmes of support for promotion of health insurance.

The paper describes and analyses a total of eight insurance programmes, four in depth and four in more general terms. The descriptions and analyses are based on interviews with officials from various government and non-government agencies. A number of general conclusions are outlined regarding types of insurance, organization and management, resource mobilization, and utilization and access. Following the conclusions, the conditions favouring a successful development of health insurance are listed. The paper finally emphasizes pilot testing, training, information systems and operations research as crucial elements in the planning and implementation of health insurance schemes.

The paper should be useful for people involved in the planning and/or implementation of national health insurance schemes.
THE PRIVATE FOR-PROFIT SECTOR


The article is concerned with aspects of the relationship between private for-profit providers and the state in ensuring safe and appropriate health service provision for the population. In doing so, the state must have mechanisms through which to liaise with private health care providers.

The problems associated with the private sector provision of health services are explored. Experiences with regulation are reviewed, using country case studies as examples.

Issues on incentive setting are also examined. Incentives may be used to encourage provision of services in areas of greatest need; to provide immunization and family planning; to ensure appropriate management of communicable diseases; and to provide useful information on the health priorities in populations.

Priorities for action will depend on the sophistication of the national health care system, the size of the private sector, and the level of economic development.

The article would be useful to health professionals involved in planning or conducting research on private provider behaviour. In addition, the article would be of interest to policy-makers and government officials considering national public/private mix issues.


Contracting out of health services is emerging as a common policy issue in a number of developing countries. The principle of contracting is public sector financing coupled with typically, but not necessarily, private provision of the contracted health services.

In the article, the content and the mechanisms of contracting are reviewed, including a brief description of contracting in selected countries. The theoretical case for contracting is described and analyzed, followed by a discussion of the viability of contracting, including consideration of the potential for real competition to take place, and whether competition will help to promote efficiency.

It is argued that contracting has many theoretical advantages, but that it is unlikely that the conditions for extensive contracting of clinical services exist in most developing countries at present. The use of contracting will, therefore, probably be restricted to small-scale non-clinical services in the foreseeable future.

The article is of interest to policy-makers and administrative decision-makers responsible for local or national health systems.
THE PRIVATE NOT-FOR-PROFIT SECTOR


The purpose of the paper is to set out the distinctive characteristics of NGOs as institutions for providing health care in Africa.

The historical role of NGOs in health care in Africa is reviewed. There is a discussion on the economic and political forces that have combined to bring the NGOs into greater prominence and increase the funds channelled through them. The advantages and disadvantages of NGOs operating in the health sector in Africa are examined.

It is cautioned that more rigorous capacity assessment and evaluation of NGOs are of critical importance to ensure that funds channelled through them are used effectively. The paper concludes with case studies of the role of NGOs in Ghana, Malawi and Swaziland.

The issues discussed in the paper are especially relevant to politicians in sub-Saharan Africa and to NGOs operating in that area. In addition, the paper contains more general lessons about the role of NGOs in developing countries, and the paper could provide valuable lessons also to politicians and NGOs in regions outside sub-Saharan Africa.


The article examines current practices and future opportunities of non-governmental organizations in the health sector, and provides information on the process of policy development with respect to the incorporation of NGOs within national health systems.

It is argued that the motivations of NGOs may not solely be humanitarian, but that other types of motivation, e.g. profit, can be present.

Six groups of health sector NGOs are identified and described, followed by a description of the overall NGO functions, which include service provision, social welfare activities, support activities, and research and advocacy. Issues on the efficiency of health sector NGOs, the coordination with government planners and providers, as well as different policy strategies are analyzed.

It is concluded that the current mixed performance of NGOs in relation to health care provision indicates that policy development with respect to the health sector role of NGOs should be cautious, building on the strengths of NGOs whilst at the same time recognizing their weaknesses.
The article is of interest to policy-makers dealing with the provision of health services, but should also be of interest to donor agencies and NGOs.


Malawi's social welfare organizations in 1985 formed the Council for Social Welfare Services in an attempt to strengthen the delivery of social welfare services to the underprivileged. The purpose of this paper is to examine the feasibility of developing such an organization that works.

The paper focuses on problems such as the heterogeneity of social welfare organizations in terms of their origin, objective guidelines, operational cultures, etc. The overall view is that the council has a long way to go before it achieves its objectives, if that is possible at all, because of the idiosyncratic nature of social welfare organizations. Three main prerequisites for a successful level of coordinated functioning are identified: 1) strong will and commitment of the social welfare organizations to the social welfare problems, 2) the council must be given the level of jurisdictional, moral and resource support that it needs, and 3) the council must develop the technical capacity to achieve its stated goals.

The article is relevant to countries actually coordinating or planning to coordinate different welfare organizations with the existing national health system. In addition, the article would be relevant to welfare organizations, including NGOs.