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Strategies for Achieving Health Financing Reform in Africa

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Summary. — African ministries of health have been discussing and adopting far-reaching health sector policy reforms since the 1980s. Experience has shown that a broad array of institutional reforms and management processes — such as civil service reform, decentralization, strengthened management capacity, building political consensus on priorities, overcoming bureaucratic constraints — is needed to complement and support the more technical, economic and financing policy solutions to adopting and implementing these reforms. This article identifies some of the main obstacles that African countries face in designing, adopting, and implementing health financing reform and the strategies they have used to overcome these obstacles. It also draws lessons learned about resolving specific design and implementation issues to avoid common pitfalls and to create conditions for success. Copyright © 1996 Elsevier Science Ltd

1. INTRODUCTION

In sub-Saharan African countries discussions about health financing reform have centered on ways to improve the sustainability, equity, and access of health services. These discussions also include debate on the impact of health financing reforms and resource allocation on effectiveness, efficiency, and quality of health care, as well as on the respective roles of the public and private sectors.

Many ministries of health, service providers, and researchers have identified characteristics that lead to poor performance in African health systems. These characteristics include: insufficient funding, inefficient use of available resources, inadequate allocation of health resources to cost-effective health services (especially insufficient funding for primary health care in favor of support for hospitals), lack of incentives for health workers to provide quality care, inadequate regulation or inappropriate barriers to the private sector provision of health care, inequitable distribution of resources between urban and rural areas and between poor and better-off populations, and high household health expenditures even in the midst of "free care" systems.

To address these problems in the past decade, most African governments have instituted cost recovery through user fees for health services or medicines as one of the primary methods of health financing reform. The initial impetus for these reforms is usually recognition that government budgets have not been able, and will probably not be able in the short term, to support an adequate, or even a minimum, level of health services for the population. In addition to raising revenues to promote financial sustainability, ministries of health have also sought to use fees as a means to improve the availability and quality of care, and ultimately health status.

In addition to user fees, other methods, such as private insurance or community-based social financing, also exist to mobilize and organize financial resources for health service delivery. Alternative ways to allocate and organize health resources are also available to help solve the performance problems that African health sectors face and to reach goals for improving the quality and access of health care.

Many studies have been conducted on the technical policy issues related to these health financing reform efforts. These studies identify, for example,

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the advantages and disadvantages of various financing alternatives and the effects that these reforms have had on typical health sector goals, such as improved access, quality, and efficiency of care (Shaw and Griffin, 1995; Kutzin, 1993; World Bank, 1987, 1993, 1994a; Griffin, 1988; Gilson, Russell and Buse, 1995; Russell and Gilson, 1995; McPake, 1993). Other crosscutting documents have synthesized health financing policy issues, experience, and research findings from Africa (Bitran, 1995; Setzer and Lindner, 1995; Leighton, 1995a and 1995b; Makinen and Leighton, 1993; McLees, 1994). This article complements the economic and financing policy analyses by focusing on strategic and implementation issues related to health financing reform and on strategies that African ministries of health have used to overcome the principal obstacles to achieving reform.

2. OVERVIEW OF HEALTH FINANCING REFORM IN AFRICA

(a) *Reform strategies and goals*

Health financing reform policies, broadly defined, involve alternative arrangements for paying for, allocating, organizing, and managing health resources. In sub-Saharan Africa, health financing reforms are often grouped into three broad strategies, as shown in Table 1. As the exhibit shows, these strategies have both primary and secondary goals or effects. For example, raising revenues through user fees may be undertaken primarily with the goal of promoting financial sustainability. User fees also affect — and can be designed deliberately to affect — Ministry of Health (MOH) goals for equity, access, efficiency, and quality of health care (Shaw and Griffin, 1995; Leighton, 1995a; World Bank, 1994).

Of the 31 African countries now implementing cost recovery, about one-fourth (Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Zambia) have made revenue raising the primary goal. The others emphasize raising revenue to make quality improvements in primary health care, such as assuring a steady supply of drugs or improving health workers' motivation through personnel incentives (Nolan and Turbat, 1995; Shaw and Griffin, 1995).

(b) *Common strategic and implementation issues*

Considering the substantial shift in policy that this array of financing reform strategies involves for the public health systems of many African countries, ministries of health have typically faced several issues concerning how to proceed. In addition to technical questions regarding financing policy reforms (such as what fee structures exist, how the poor can be protected, whether insurance mechanisms are appropriate in rural Africa, and how hospitals can be financed), ministries face a variety of strategic, institutional, management, and procedural issues that this article addresses. These include:

— What are the general strategies that ministries of health need to employ to address obstacles to health financing reform?

— What strategies have been used effectively to facilitate and inform decisions about the design of policy reforms?

— What phasing strategies have been tried and been successful for implementing reforms?

— How have ministries resolved specific design

Table 1. *Health sector financing reform: purpose, goals, strategies*

Overall purpose of health financing reform: Improve Health Status		
Strategy (Technique)	Primary goal	Secondary goal or impact
Raise revenue (e.g., user fees; insurance plans and prepayment schemes to pool risk and make it easier to mobilize resources for health)	Financial sustainability	Equity Access Efficiency Quality
Reallocate resources (e.g., increase MOH budget share for PHC and cost-effective service packages; reduce government subsidies for hospitals; shift HIV/AIDS treatment out of hospitals)	Efficiency and cost-effectiveness	Equity Quality Financial sustainability
Develop alternative organization of service delivery resources (e.g., increase role of private providers; establish HMOs; involve employer-based health providers; decentralize MOH responsibilities for health services to regional or district level)	Efficiency and cost-effectiveness	Access Financial sustainability

and implementation issues? What are the common problems and conditions for success?

— What information is needed to make decisions concerning financing reform?

Experience has shown that a broad array of institutional reforms and management processes —such as civil service reform, decentralization, strengthening management capacity, building political consensus on priorities, and overcoming bureaucratic constraints — are needed to complement and support the more technical solutions to implementing health financing reforms (Walt, 1994; Leighton, 1995a). To address the multiple technical and institutional issues confronting African health systems, a combination of strategies is usually necessary to achieve a consensus on health financing reform policies and to implement the policies.

3. COMMON OBSTACLES TO ACHIEVING HEALTH FINANCING POLICY REFORM

Any country attempting major changes in the financing and organization of their health sector faces a number of formidable obstacles. While the specific set of obstacles differ by country, most sub-Saharan countries are confronted with major political and institutional obstacles, such as policy conflicts, political instability, and weak institutional capacity. There are also several economic, health sector and financing specific constraints, such as economic decline and slowed development, incomplete health sector development, and limited data on which to base informed decisions on likely outcomes of alternatives that might be adopted. Often, erratic donor funding and conflicting donor policy pressures compound these problems.

Many of the obstacles to health financing policy reform and the strategies to overcome them are similar to those for any type of major policy reform, whether in financing or in program policy, in the health sector or in another sector. While lessons learned about these obstacles are not original to health financing reform, it is worthwhile to review them briefly to illustrate the combination of approaches needed and to emphasize that noneconomic factors are as important as economic and financial ones to achieving health financing reform.

The following discusses six of the most prominent obstacles.

(a) *Conflicting policy goals*

Policy conflicts in health financing debates are among the principal reasons that building consensus on reform objectives and strategies has been difficult in many countries and that, consequently, discussing, adopting, and starting national implementation of health financing reform has been an extended process lasting at least five, and frequently up to 10 years. These conflicts have emerged on two levels.

One set of conflicts has existed between African governments and international donors. For example, some international donors, including the World Bank and several bilateral donors, have argued for overall financing reforms across the health sector, emphasizing the economic rationale for user fees, instituting or expanding health insurance, expanding the role of private sector providers, and improving the allocation of resources (World Bank, 1987 and 1994a; USAID, 1980, 1982, and 1988). Until recently, however, most African governments have generally affirmed policies in place since independence that health care should be "free of charge" and provided by the government. Another common conflict stems from the fact that donors tend to emphasize and fund primary health care and environmental health services and programs, while governments must respond to the strong demand of their populations for hospital-based services.

A second set of policy conflicts exists among the various health financing goals, which can conflict with each other or cause disruptive adjustments in parts of the health system. These conflicts often make it difficult to reach consensus on trade offs. For example, attempts to raise revenues from user fees may improve financial sustainability, but can hurt equity or create disincentives to use needed services, if countermeasures are not taken. Goals to provide health services for widely dispersed populations can improve the access of health services for underserved groups, but conflict with goals to improve efficiency in terms of cost-per-person served.

Alternative financing methods also involve significant political considerations and tradeoffs. For instance, attempts to reallocate government funding toward more cost-effective primary and preventive health services can conflict with the population's demand for curative care and health worker training. Ministries of finance are traditionally against local health facilities retaining revenues from user fees, which others argue is needed to provide incentives to collect the fees and make cost recovery effective in improving health services. Health personnel who are benefiting from the informal fee collection procedures tend to resist efforts to standardize and monitor these procedures under official cost recovery policies.

Equity goals can also conflict with each other. One of the overarching policy tradeoffs confronting ministry officials involves balancing the need for additional revenue to improve quality and access of care, on the one hand, with the government's longstanding commitment to the "entitlement" of the whole population to health services provided free-of-charge. Another common conflict involves using public funds to subsidize health services for important employment

or other interest groups (such as civil servants, the military, students), which drains resources that could be directed toward subsidies for the poor.

(b) *Political instability*

Political instability makes it difficult to achieve the consensus needed to mobilize political and public opinion, and to bring together the various interest groups (such as doctors and nurses, pharmacists, key ministries, central and local authorities, and NGOs) that need to be accommodated. In Niger, for example, health workers were on strike for 95 days in 1994. In the Central African Republic, civil servants did not receive their salaries for nearly a year in 1994. Ministers of health are often at their posts for less than two years, resulting in corresponding changes in their top staff. Parliaments or national assemblies can be disbanded, holding any needed legislative reform hostage. These and other events, such as military coups and civil wars, interrupt the dynamics of the reform process and people's confidence that government can introduce change effectively and without hidden agendas.

(c) *Weak institutional capacity*

Weak institutional capacity restricts a country's ability to assess current performance, identify options, project the likely impact of reforms, formulate and implement plans, and administer complex insurance reimbursement mechanisms or reliable means testing procedures to protect the poor. It also restricts the ability of ministries of health to collect and analyze needed information. Financial, management and health information systems that collect health status and utilization data are often not in place or do not produce reliable data. Frequent turnover of top ministry officials and of mid-level staff with much needed skills eliminates institutional memory and the capacity to carry out the job. In addition, the common lack of rural banking facilities makes it difficult for local health facilities and community health committees to manage revenues from user fees. Independent auditing capabilities and firms are also weak to nonexistent in many sub-Saharan African countries.

(d) *Poor economic conditions*

For most African countries, poor and declining economic conditions have been perhaps the major factor forcing them to consider making significant changes in the financing and organization of government health services. These conditions have eroded the resources needed for governments to live up to their commitment to provide health care for all. Economic decline has not only limited governments' taxing capacity, it also restricts the population's ability to pay for health services under cost recovery schemes. The concern of ministries of health that people will not be able to pay for health care and that imposing fees will inhibit the population's use of needed services has been one of the major obstacles to adopting official charges in government health facilities. In addition, the slow development of financial institutions and formal wage sector employment has limited the potential for health insurance to grow or for credit to become available for the start-up of private health providers. In some countries, foreign exchange constraints and balance-of-payment deficits have put pressure on drug importation, while, in others, trade agreements have limited purchasing options.

(e) *Incomplete health sector development*

The capacity and development of the health sector differs considerably among African countries, as well as among geographic regions in any single country. But, in general, incomplete health sector development means, to varying degrees, that primary, secondary and tertiary care services are not well differentiated or linked by referral networks. The geographic distribution of health services is highly uneven, and reliable quality assurance mechanisms for health services, products, and medicines are virtually nonexistent. The private sector delivery of health services is often rudimentary, because of either economic or legal constraints. Pharmacies are usually not widely available or well regulated, and informal, unregulated sellers of medicines and injections abound. Furthermore, communication channels do not exist for coordination, record keeping, and dialogue between the public sector and those private sector providers and suppliers that do exist.

Private health insurance is rare or unable to operate on an actuarially sound basis. Social insurance and health insurance plans for civil servants may exist, but frequently do not reimburse providers for health services delivered to covered populations. In addition, financial management skills and systems are often not in place in health facilities or at the central Ministry level to implement either fee-for-service or insurance reimbursement reforms. In addition, the infrastructure for drug inventory and distribution is often weak or nonexistent.

(f) *Information constraints*

Data on several aspects of the health care system that are essential for informed decision making for health financing reform are often quite limited.

Information on the costs of current health care services at hospitals, health centers, and health posts are not reliable or are unavailable. Little is known about what people are currently spending on health services and medicines or how that spending would change if prices were increased and quality and access improved. Little information exists to help evaluate the utilization of health services by different socioeconomic and demographic groups. In addition, much of the available data on the success of small-scale experiments with cost recovery and revolving drug funds are out-of-date, scattered, and not comparable.

In spite of the recognition of the potential advantages of user fees and related reforms, many ministries of health and health providers have been concerned that people will not be willing or able to pay for health services, that changing from systems where services have been officially free of charge will create barriers for the poor, or that private or public sector fees will discourage the utilization of high-priority preventive and primary care services. Typically, little information exists in the country considering health sector reforms to help answer these questions. Ministries of health have also been concerned that fees will not raise adequate revenue to justify the implementation costs or the costs of improving quality. Too little information has also been available on the effectiveness of various methods to protect the poor or on the efficiency and quality of private sector providers.

Because of a lack of data on these issues, policy makers often delay making socially and politically difficult decisions and many "myths" concerning health financing reform have arisen. For example, in the absence of information to the contrary, people tend to believe that the poor are unwilling to pay for health services, that there is no role for the private sector in achieving the public health agenda, or that insurance or prepayment mechanisms will not work in the poorest rural areas. Ministry officials and others may believe that providing services "free of charge" promotes equity, makes health care affordable, and encourages the appropriate utilization of needed health care. Data collected in many African countries, however, frequently dispel these beliefs and encourage officials to adopt reforms that may achieve these goals more effectively.

4. STRATEGIES FOR OVERCOMING THE MAIN OBSTACLES TO HEALTH POLICY REFORM

(a) *General strategies*

Ministries of health that have designed, adopted, and are implementing national health financing reforms have at least partially overcome many of these obstacles. To do this requires using several general strategies, as applicable to health financing reform as to reform in any other sector. Some of the most important of these strategies include:

— Building consensus domestically and among donors
— Exercising and maintaining ministry of health leadership in the effort
— Strengthening institutional capacity and the skills of personnel
— Adapting and updating reforms to economic conditions
— Developing health organizational and financial infrastructure
— Collecting, analyzing, and disseminating relevant data and information

Table 2 provides examples of strategies that African ministries of health have used to address the major obstacles to health financing reform.

Although the specific obstacles and approaches will be different in each country, the strategies and mechanisms for resolving policy conflicts and addressing political, institutional, economic, health infrastructure, and information constraints need to be in place throughout the reform process — from the early stages of considering reforms, while debates are proceeding, and throughout implementation.

Countries such as Cameroon, the Central African Republic, and Niger have followed these principal strategies over an extended period and are both now introducing cost recovery reforms nationwide. Other countries, such as Kenya, have followed some of these strategies and omitted others, such as adequate consensus-building and public information, and, as a result, have suffered setbacks and had to adjust course. The following sections identify several patterns in the experience of African countries with these strategies during the design and implementation of health financing reform.

(b) *Strategies to inform design decisions*

Three obstacles tend to dominate during the design phase: policy conflicts, information constraints, and institutional weakness. During this phase MOH officials want to know whether various reform options are likely to be effective in their country. They need to identify what the specific problems are and to quantify their magnitude and potential impact. They also have to resolve the concerns of all those who must approve the decision at the national level. In addition, they usually want to minimize the uncertainty and risk they face in deciding to adopt major policy change.

Ministries that have successfully adopted national reform programs have chosen a variety of approaches to addressing these constraints. Table 3 illustrates three of the main strategies that some African coun-

Table 2. *Strategies to overcome obstacles to health financing reform*

Obstacles	Strategies
Political & institutional factors:	
Policy conflicts	Build consensus and negotiate with relevant ministries and international donors, public and private sector health providers, and interest groups so that all "buy into" the process and negotiated goals.
	Set clear goals and establish balance among competing objectives.
	Evaluate periodically and make adjustments needed to achieve intended goals.
Political instability	Exercise consistent MOH leadership, commitment, perseverance below the political appointee level.
	Inform and brief new political appointees.
Weak institutional capacity	Strengthen institutional capacity through training and identifying organizational focal points and responsible individuals.
	Conduct implementation in phases.
	Avoid overly complex approaches and attempting multiple reforms simultaneously.
	Expect reform process and results to take time.
Health sector & financing-specific factors:	
Poor economic conditions	Take advantage of recent openness to macroeconomic policy change.
	Adapt financing strategies and techniques to current income distribution, tax capacity, economic cycles, and employment structure with built-in flexibility to change as economic conditions change.
Incomplete health sector development	Develop infrastructure for medicine purchase and supply, financial management, quality assurance, private sector provision of health care, and information/monitoring systems.
	Adapt financing mechanisms to organizational capacity and infrastructure, urban-rural differences, population preferences, and public-private mix.
	Implement reform in phases; monitor, evaluate, and disseminate results to policy-makers, program & facility managers, and other stakeholders frequently.
Information constraints	Collect and analyze locally relevant data and experience.
	Assess experience of other countries.
	Disseminate information to relevant central and local MOH and other government officials and interest groups.
	Conduct public information campaigns.

tries have followed for informing and facilitating decision making during the design phase. Given the emphasis ministries of health have placed on cost recovery as the focus of reform, these examples refer primarily to decisions to adopt some form of user fee for government-provided health services. However, these strategies are applicable to broader reform packages as well.

One of the three main strategies leading up to decisions to adopt national cost recovery reforms involves analyzing multiple, "natural" experiments in the country. This entails assessing lessons learned and identifying options that are evident in the cost recovery experience of church missions, other NGOs, small donor projects, and the private sector. A second strategy involves conducting official pilot test(s) in one or more regions or districts of the country to demonstrate the feasibility of the main option(s) under consideration, with the explicit purpose of using the information to develop a prototype for national reform. A third strategy centers around a national planning effort by experts which involves an assessment of international

Table 3. *Strategies to inform decisions for the design of health financing reform: illustrative African countries*

Multiple Experiments	Official Pilot Tests	National Planning
Central African Republic	Niger	Kenya
Cameroon	Senegal	Ghana
	Zambia	Zimbabwe

experience and the in-country collection of baseline data to develop a well-designed national plan for reform (Cassels and Janovsky, 1992; Republic of Ghana, 1995; Asenso-Okyere, 1995; Baer and Hung, 1994; Litvak and Bodart, 1993; Owona-Essomba, Bryant and Bodart, 1993; Diop, Yazbeck and Bitran, 1995; Knowles, Yazbeck and Brewster, 1994; Bitran, Brewster and Ba, 1994; Bennett and Musambo, 1990; Lagerstedt, 1993; Berman, Nwuke and Rannan-Eliya, 1995; Hecht, Overholt and Holmberg, 1993; Leighton *et al.*, 1994; Leighton, 1994; McInnes, 1993; Setzer, Leighton and Emrey, 1992; Overholt *et al.*, 1989; Makinen *et al.*, 1989).

(c) *Strategies for implementing cost recovery reforms*

Several obstacles tend to dominate considerations on how exactly to introduce and implement health financing reforms such as cost recovery. These include institutional weakness, incomplete health sector development, and remaining policy conflicts on specific design details. With respect to cost recovery, some countries that have designed and adopted a national program have used strategies to phase in reforms in order to overcome these obstacles.

Phasing in the implementation of reforms is particularly important where institutional capacity and key aspects of the health infrastructure (such as systems for drug distribution, financial management, monitoring, supervision, and quality assurance) need to be strengthened. Weak infrastructure and institutional capacity make it impossible to implement cost recovery simultaneously at all levels of the health system throughout the country. Phasing, on the other hand, allows time for the necessary preparation and allows lessons and skills learned during each stage to be applied to the next.

In addition, although legislatures may have passed laws authorizing fee collection in public sector health facilities, policy conflicts may still emerge during the drafting of regulations that can block key decisions, such as the type of fee to charge for outpatient care, the amount of the mark-up on the price of drugs, or whether health care workers should continue to receive percentages of fee revenues. Alternatively, a country may have reached a consensus on adopting certain types of financing policy change (e.g., cost recovery for hospital services, and cost recovery for drugs at the primary care level), but not others (e.g., private sector development, or insurance). Phasing in reforms allows time to resolve these additional policy issues.

Countries have used four broad phasing strategies to implement national cost recovery programs over periods ranging from one to two years to three to five years. Table 4 shows these strategies and illustrative countries that have used them (Knippenberg *et al.*, 1990; UNICEF, 1992 and 1995; Collins and Hussein, 1993; Leighton, 1992; McInnes, 1991; Mbiti, Mworia and Hussein, 1993; McPake, 1993; see also references for Table 3). As the exhibit shows, these strategies involve either selecting a type of health facility or service with which to begin, or focusing on all health services within a "manageable" geographic area, such as a district.

Not all countries have adopted strategies to phase in reforms. Some have proceeded with simultaneous implementation throughout the country by decree and the issuing of circulars. This approach is particularly common when countries make revisions to already-established cost recovery programs. Ghana and Zimbabwe, for example, followed this strategy in making revisions in the 1980s announcing new fees that all public health facilities should adopt.

In spite of certain broadly distinguishable phasing strategies that some countries have adopted, in practice, the design and implementation of reforms do not always constitute clearly distinct phases. The implementation of national policies does not always immediately follow the official adoption of cost recovery, the demonstration of successful pilots, or lessons learned about weaknesses that need to be corrected. The opposite pattern is also common: health personnel often begin charging fees informally before laws or regulations are officially changed. Household surveys in Niger in 1992, for example, showed that 34% of the people who sought care at government health facilities paid for those services in one district and 39% in another, even though services were officially free of charge (Willis and Leighton, 1995).

One of the main tasks that ministries of health have had is to coordinate all the disparate cost recovery efforts that have existed in the public, private nonprofit (e.g., church missions), and community sectors or, alternatively, to decide officially to have a highly decentralized system. Similarly, the degree to which

Table 4. *Strategies for phasing in national cost recovery reforms: illustrative African countries*

Hospitals first	Primary health care first	Hospitals & PHC on separate tracks	Phase in by district (all health facilities)
Kenya	Senegal Many Bamako initiative countries	Central African Republic Niger	Cameroon Zambia

cost recovery is implemented in public health facilities in Africa ranges from implementation in scattered facilities and communities, to a minimal national system not enforced systematically, to a national system of officially sanctioned user charges at all health facility levels. Two recent World Bank studies identify 17 African countries in this latter category (Shaw and Griffin, 1995; Nolan and Turbat, 1995). Even among these cases, countries differ in the extent to which the official national cost recovery system is uniformly practiced, how long it has existed and the scope and type of reforms it has enacted.

(d) *Implementing a broad package of reforms*

Table 1 identified three broad health sector reform strategies: raising revenues, reallocating resources, and changing the organization of health service delivery resources. In principle, these strategies represent phases of increasingly complex reforms — from introducing user fees in the public sector, to supporting the expansion of third-party reimbursement in the public sector as well as private insurance, to instituting broad organizational changes affecting overall resource allocation in the health sector between public and private providers as well as between central and local MOH authorities. In theory, one would expect that countries with greater institutional capacity and higher income would be more likely to undertake the more complex reforms than those with less-developed health infrastructures. Phasing in the more complex reforms would take place as economies prosper and health systems become more developed.

The process of implementing these broader reform packages has not, however, followed these patterns as closely as one might expect. Countries considering, or in early stages of designing and implementing, broad reform strategies have adopted various combinations of initiatives. For example, most of the lowest income countries have attempted only to implement cost recovery in public facilities and have not yet embarked on major efforts to encourage expansion of private sector health providers, development of health insurance, or reallocation of government health care resources. But some of the lowest income countries, such as Tanzania, have adopted vigorous private sector expansion policies along with cost recovery, and are taking steps to reallocate public resources to the most cost-effective health services and to improve the Ministry of Health's role in regulating quality of care.

In some higher income African countries, such as Cameroon, mandated employer insurance coverage exists, but the ministry of health has concentrated health financing reform efforts on cost recovery and user fees in the public sector, without yet making linkages between public and private financing. Other higher income African countries (e.g., Senegal) have had health benefit coverage under social security programs and some private insurance for some time, but are just now beginning to move beyond focusing on user fees in government health facilities to consider insurance-based reimbursement initiatives with the aim of strengthening health financing in the public and private sectors. By the same token, while some higher income countries, such as Zimbabwe, have maintained central control over fee revenues (requiring most or all to be returned to the treasury), some middle-income countries, such as Zambia, have fully decentralized financial responsibilities to districts and health facilities, as part of a program of ambitious, broad-scale financing reforms.

Since reform initiatives in the areas of insurance, the private sector, resource reallocation and financial decentralization are relatively new, or still in the planning and design stage, it is too early to identify phasing patterns or implementation strategies that have clearly been successful. For example, a few countries have plans for comprehensive changes that they hope to make within a three to five year period. The MOH in Ghana has plans to improve cost recovery performance at public health facilities, decentralize financial management to the district level, grant autonomy to tertiary hospitals, and develop a national health insurance scheme. Zambia plans to implement insurance prepayment schemes, along with the graduated cost recovery now in place at all public health facilities. These efforts are all part of policies to reallocate government resources toward cost-effective health services and a comprehensive decentralization plan under which districts have full responsibility for planning, budgeting, and setting user fees for government health services.

Several countries have implemented initiatives to reallocate resources to cost-effective health services. But each of these countries have adopted quite different approaches. Kenya, for example, explicitly requires a portion of the revenues from hospital fees to be applied to primary health care services. Zambia has recently implemented a global budgeting system for districts based on estimates of the cost of a cost-effective package of health care. Ghana and Tanzania are developing health service packages and considering options for using them to reallocate government health resources.

5. LESSONS LEARNED ABOUT DESIGN AND IMPLEMENTATION STRATEGIES

(a) *Policy development and implementation*

Several general lessons emerge from the experience of sub-Saharan Africa in developing and implementing health financing reform. These lessons include the following:

Table 5. *Lessons learned about design and implementation of health financing reform in African countries*

Action Areas	Actions/Decisions Needed	Information Needed	Conditions for Success	Common Problems
Design:				
Goals and objectives	Establish consensus among relevant ministries, health personnel, interest groups, & the public.	Main actors, actions needed for decision; financial, utilization, quality etc. data showing need for reform and likely impact of reform options.	Clear goals, objectives adapted to country circumstances & developed with full participation of relevant decision makers & implementers.	Lack of consensus; no forum for deciding goals; unclear or contradictory goals; medical personnel resistance; conflicting donor pressures; unrealistic time frames.
Laws and regulations	Revise all relevant laws and regulations.	Existing laws, regulations; current practice *vis-à-vis* changes; "political mapping" of stakeholders' positions.	Inter-ministerial consensus; parliamentary cooperation; political stability	Long delays; Details in law instead of laws with basic framework and details delegated to line ministries.
Price structure and fee levels	Decide or update: how much to charge for which services using what method (fee for service, episode, visit, etc).	Consumer demand data (willingness, ability to pay; use of services, etc, for various income, demographic, geographic groups); cost data.	Administratively simple fee structure; price signals for efficient/effective use of services & resources; fee levels affordable for majority (not 100 percent) of population; fees cover significant share of non-salary recurrent costs; willingness to try policy, monitor, evaluate, and revise.	No hierarchy in fee structure for lower/higher levels of care or different patient income levels; hospital fee systems too complex; drug fees too low; tendency to over-study before acting.
Fee exemption rules	Decide/update fee exemption categories for target groups (e.g., civil servants, students, military, the poor, children); and services (e.g. preventive, chronic).	Effectiveness and impact on costs and service use of current or planned exemption categories & practices; demographic, income, health status information about groups who would benefit from the exemptions.	Clear, easily administered eligibility criteria; simple means testing methods; special emphasis on improving operation of exemptions for the poorest; periodic evaluation of effectiveness.	Too many groups exempt; unclear exemption rules; difficulties identifying income levels accurately; high share of exemptions given to non-poor.
Fee retention	Decide distribution of fee revenue (e.g., health facility keeps all; share goes to district; all goes to Treasury; all goes for medicines, share goes to personnel).	Current law re distribution of fees collected in public sector, extent of need for redistribution to facilities not in financially viable catchment areas; resource gap that fee revenue should fill; cost for service package to be provided.	Significant portion of fees retained at facility level as incentive for collection; MOH subsidy raised or portion of fee revenues redistributed for equity across catchment areas; MOH funding maintained so that fee revenues are a net addition to resources.	Lack of incentives for health personnel to collect fees; unclear or unenforced rules; lack of banking facilities in rural areas; low revenue potential for facilities in poorest or underpopulated areas; poor financial management supervision, safeguarding of funds

Table 5. Continued overleaf

Table 5. *Continued*

Action Areas	Actions/Decisions Needed	Information Needed	Conditions for Success	Common Problems
Design:				
Use of fee revenues	Develop national guidelines; allow partial or full facility discretion.	Current needs, costs for quality improvements; expected revenue percent of non-salary costs.	Fee revenues used for quality improvements visible to patients and for personnel performance incentives; central guidance, monitoring provided.	Fees not used to improve health services; no staff incentives to offset low salaries or informal charging practices.
Drug policy and procurement practice	Establish generic drug policy; decide whether central or local procurement; public or private distribution.	Pharmaceutical prices,bidding mechanisms; private pharmacy and NGO drug procurement & distribution practices, capacities; consumer awareness & prescription practices.	Adequate stock of essential, affordable medicines routinely available at/near all health facilities.	Non-generic drugs unaffordable for patients; distribution delays, drug stockouts; inadequate safe-guarding of drug supplies; inefficient or nonexistent public distribution systems; inadequate private pharmacy supply in rural areas.
Insurance coverage	Decide whether to extend, encourage private or social insurance coverage.	Current insurance coverage; consumer demand for insurance; financial risk of illness; assessment of management, actuarial, financial sector capacities.	Insurance available once hospital fees reach full cost recovery; infrastructure conditions and demand for insurance exist; consumers have choice of providers.	Weak insurance reimbursement mechanisms, unclear rules; failure to collect existing insurance & civil servants' health benefit coverage.
Private provider role	Develop policy for private sector role; establish public-private collaboration; decide policy for private practice by public sector health personnel.	Size, distribution of private sector providers; effect of current laws, taxes, credit, public sector salaries on private practice; type and quality of private providers' services.	Collaborative public-private relationships; incentives that promote beneficial market competition, quality standards, affordable prices.	Public-private sector mistrust; no collaborative mechanisms exist; public sector perceived to have lower quality than private; private providers unevenly distributed, high priced; inadequate public regulatory & quality assurance capacity; private practice of public health employees not managed effectively, weakens public services.

Implementation: Phasing	Decide phasing by type of facility, service, and/or geographic area; decide how many major reforms to implement at once.	Assessment of administrative feasibility, costs, equity, effectiveness, technical appropriateness of different options.	Phasing sequence adhered to for linked implementation actions; facility or geographic area starting point not as important as having all of the linked components present in the start-up point(s).	Management systems not in place before fees introduced; public not sufficiently informed before fees introduced; drugs made available before fee schedule is official; availability of required inputs (e.g., training, accounting forms) not synchronized with implementation schedule.
Drug procurement, supply and distribution	Establish new or revised drug supply & distribution system for public facilities.	Assess public and private drug supply & distribution capacities; cost-effectiveness of public, private and mixed alternatives.	Adequate stock of essential, affordable medicines routinely available at/near health facilities; rational drug prescription practices; supervision, controls exist to safeguard drug supply.	Frequent drug stockouts at public facilities; high travel costs for patient to obtain drugs; inefficient central drug procurement & distribution systems; ineffective & inefficient patient spending for drugs.
Public information	Conduct information campaign for public, all health personnel & key interest groups and stakeholders.	Variety of informational materials and media to explain purposes and operation of new fee or insurance systems; cost estimates for materials, distribution, related campaign activities.	Public well-informed about fees, exemptions, and other charges affecting their use of services; health workers well-informed about procedures, cost recovery goals, changes affecting job performance.	Public protest, distrust or misunderstanding; lack of information, or misinformation prevents people from seeking care at public facilities, limits opportunity for health status improvement.
Monitoring & evaluation	Establish systems to assess impact of reforms on population, health facilities, health sector and goals for equity, access, quality, sustainability; provide training to evaluate findings.	Health facility and consumer data on impact of reform (e.g., fees, insurance, more private providers) on people's spending, use of health care, public sector health resources; cost estimates for system start-up, maintenance, related training.	Simple monitoring & evaluation system available & used for periodic update and problem-solving; relevant analytic capacity available,	Relevant data not available routinely to assess impact or need for revision; available data not used or not used well; assessments not followed up with action to make improvements; data not formatted and presented to decision makers and opinion leaders.
Financial management	Revise financial management systems for facilities; strengthen insurance billing & reimbursement systems; provide training in financial management, billing; add specialized staff.	Assessment of need for system update, revision; training needs assessment information; cost estimates for system development, operation, and related training.	Easily administered, transparent financial management system functioning to assure that revenues are safeguarded and used for intended purposes.	Resources not used for intended purposes; inadequate & infrequent monitoring, supervision; lack of clear accountability; staff too busy or unable to do financial management.

Table 5. Continued overleaf

Table 5. *Continued*

Action Areas	Actions/Decisions Needed	Information Needed	Conditions for Success	Common Problems
Management oversight at local level	Establish and train community committees and hospital boards with community representation.	Assessment of current committee experience; needs assessment for training; cost estimates for start-up & training.	Organizational focal point & mechanisms in place to assure that reform goals are achieved & sustained at the local & facility level; committees and boards trained in their roles, not overburdened with details.	Training not reinforced; incentives for oversight not present; patients & communities not well-represented; committees and boards dominated by local elites, one (few) interest groups; committees asked to manage, rather than oversee, operations.
Quality improvement	Training to improve health worker skills, practices & drug prescription; assure supply of essential drugs; establish performance incentives for health workers; establish quality assurance mechanisms.	Assessment of drug supply & prescription practices, of health worker diagnostic & treatment skills for prevalent health problems & cost-effective prevention & treatment interventions; evaluate quality assurance mechanisms for public & private providers.	Fees used for quality improvement; patients perceive they are "getting their money's worth" for payments made; routine monitoring followed by corrective action.	Fees not used to improve quality; patients see no benefit from their fees; means to sustain quality improvements not in place; inefficient/inappropriate drug prescription habits persist.

— It takes time. The scope of reform often envisioned entails substantial changes in behavior of health providers and patients; changing attitudes; new management procedures and systems, including making new information systems functional; a shift in priorities, incentives and decision-making criteria from long-established to unfamiliar ground rules; and balancing the demands of competing interest groups.

— Broad political, economic, and institutional obstacles are likely to be as important as technical and economic ones, such as "getting the prices right." Therefore, it is just as important for ministries of health to develop political, institutional, and management skills and methods as it is for them to develop the technical capacity for health financing and economic analysis — or to invite international experts to bridge that gap temporarily. Political and bureaucratic strategies are needed to create the environment for the technical strategies and solutions to work.

— Practice often differs widely from official policy. It is therefore critical to develop monitoring, enforcement, regulatory and public information capacities to ensure that reform policies are implemented as planned in order to achieve the goals that ministries seek.

— The design and implementation of national health financing reform is usually not a linear process. Setbacks are to be expected.[1]

(b) *Elements needed for successful design and implementation*

Several key factors have contributed to the successful design and implementation of health financing reforms, regardless of the particular technical approach adopted. These elements include:

— *MOH leadership.* Although ministries of health differ in the extent to which they have involved regional and facility-level managers in decision making, the central MOH necessarily plays the leading role in designing national-level reform. In cases of political change and turnover of top politically appointed decision makers during the design period (e.g., Cameroon, the Central African Republic, Kenya and Niger), several key individuals working at the central technical level of the MOH maintained a commitment to reform and kept the dialogue open.

— *Using information effectively.* Countries that have successfully adopted reform and moved to implementation have all used information from both their country's experience and that of other countries to help solve technical issues and to develop policy options. They have usually done this during a study period of two to five years, during which information on consumer demand, provider behavior, quality, costs, and institutional and systems capabilities is gathered and analyzed.

— *Building consensus.* Most countries that have successfully adopted national reform and moved on to implementation have emphasized consensus-building, especially through workshops, and have involved NGOs, donors, several ministries and local, as well as central, MOH staff at key points in the decision-making process. Countries using the central planning approach may tend to skip this process, or limit it to developing a consensus among the experts. But that approach has risks, especially at the implementation stage.[2]

(c) *Resolving specific design and implementation issues*

Most countries that have designed and implemented health financing reform over the past 10 to 15 years have faced a number of common issues. The accumulated experience of these countries has produced lessons learned about the main actions, decisions, and information that are needed, about conditions for success, and common problems. While much of this experience has been gained in the course of cost recovery reforms, many of these lessons are applicable for implementing a broader package of health sector reforms as well. Table 5 summarizes these lessons.

NOTES

1. For example, Senegal was in the forefront in Africa with cost recovery pilot projects in urban (Pikine) and rural (Sine-Saloum) areas, as well as decentralization reforms, in the late 1970s and early 1980s. Nevertheless, policy change stagnated for most of the 1980s such that only in 1989 did Senegal adopt a National Policy that called for Bamako-type initiatives throughout the country. Senegal has also been one of the few African countries with mandated employer insurance, but various obstacles have prevented the MOH from using insurance effectively to promote hospital autonomy or a strengthened financing system more generally (Knowles, Yazbeck and Brewster, 1994; Bitran, Brewster and Ba, 1994; World Bank, 1992a).

Central African Republic began exploring options for health financing reform using health cards in 1974, quickly dropped the scheme due to misappropriation of funds, did not take up consideration of reforms again until 1986, passed national legislation authorizing cost recovery in 1989, revised regulations for hospitals in 1990, implemented revised regulations in central hospitals in 1991, had drafted

final regulations for outpatient and primary health care by early 1995, but the third change in Ministers in three years delayed signing of those final regulations, preventing cost recovery from proceeding officially (Leighton, 1994; Leighton *et al.*, 1994; McInnes, 1993).

Zimbabwe considered for several years a proposed update and revision for an already existing cost recovery program, then implemented a new policy in 1994, and annulled part of that reform within one year due to perceived lack of success (Hecht, Overholt and Holmberg, 1993; World Bank, 1992b; Loewenson, Sanders and Davies, 1991).

Zambia's ambitious reforms have only just begun with one aspect (decentralized budget planning) in place in 61 districts, a second aspect (a prepayment plan) tried then suspended until it can be revised, while several other proposed insurance and community financing changes are still on the books (Lagerstedt, 1993; World Bank, 1994b).

2. In Kenya, for example, political consensus was not as strongly established as technical consensus and the first attempt to implement planned reforms was soon stopped by public protest, lack of understanding by health workers in the field, and Presidential intervention. Only after more than an additional year of laying the political groundwork and working out implementation details was reform again initiated, this time successfully (Collins and Hussein, 1993).

In Ghana, the sudden fee increases that central policy makers and experts agreed to without sufficient consultation with the public or health facility workers resulted in sharp declines in utilization. (Waddington and Enyimayew, 1989 and 1990; Shaw and Griffin, 1995).

In Zimbabwe, health workers were not well informed about procedures for implementing the 1994 fee schedule revision and cost recovery revenues were minimal. Patients were not well informed about the revised fee schedule that established incentives for appropriate referral patterns and disincentives for bypassing appropriate lower levels of care. As a result hospital congestion declined only marginally (ARA-TECHTOP, 1995).

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