

**FACILITATOR'S NOTES ON:  
"Mobilising resources in a rural, low-income country context"**

**1. Objectives of case study:**

- To develop skills in critically examining resource mobilisation alternatives for the health sector, on the basis of theory and country experience;
- To gain a detailed understanding of the advantages and disadvantages of alternative resource mobilisation strategies (tax-financing, user fees, community financing, health insurance and promotion and regulation of the private sector).

**2. Key issues to cover before using case study:**

Before using this case study, facilitators must select articles that provide an overview of the alternative resource mobilisation strategies suggested by the Ministry of Health (especially user fees, community financing, social health insurance, and expanding the role of the private sector). These then comprise the resource pack distributed to participants. Possible readings include:

User fees and community financing

- Gilson L (1998). The lessons of user fee experience in Africa. *In: Beattie A, Doherty J, Gilson L, Lambo E, Shaw P (eds). Sustainable Health Care financing in Southern Africa.* Washington DC: World Bank.
- Creese A (1991). User charges for health care: A review of recent experience. *Health Policy and Planning*. 6: 309-319.
- McPake B, Hanson K, Mills A (1993). Community financing of health care in Africa: An evaluation of the Bamako Initiative. *Social Science and Medicine*; 36(11): 1383-1395.
- Lambo E (1998). Aims and performance of prepayment schemes. *In: Beattie A, Doherty J, Gilson L, Lambo E, Shaw P (eds). Sustainable Health Care financing in Southern Africa.* Washington DC: World Bank.

Social Health Insurance

- Kutzin J (1998). Health Insurance for the formal sector in Africa: Yes, but ... *In: Beattie A, Doherty J, Gilson L, Lambo E, Shaw P (eds). Sustainable Health Care financing in Southern Africa.* Washington DC: World Bank.
- Abel-Smith B (1992). Health insurance in developing countries: Lessons from experience. *Health Policy and Planning* 7(3): 215-226.

Taxation and general financing

- Korte R, Richter H, Merkle F, Gorgen H (1992). Financing health services in Sub-Saharan Africa: Options for decision makers during adjustment. *Social Science and Medicine* 34 (1): 1-9.

Expanding the role of the private sector

- Bennett S (1992). Promoting the private sector: A review of developing country trends. *Health Policy and Planning* 7(2): 97-110.
- Bennett S *et al* (1994). Carrot and stick: state mechanisms to influence private provider behaviour. *Health Policy and Planning* 9(1):1-13.

It is not necessary to make a formal presentation on alternative resource mobilisation mechanisms, as participants will obtain this information from the readings provided. However, it is useful to present a framework for evaluating alternative resource mobilisation mechanisms. Participants can then use this framework to critically analyse alternative financing mechanisms, based on the information contained in the readings. An example of one such framework is provided in Appendix A. While it may be helpful for facilitators to distribute a copy of this

framework to participants, the table included in this Appendix should **not be distributed** to participants – it is merely included to assist facilitators in preparing for this role play.

### 3. Overview of case study:

This case study takes about 5 hours to complete, if participants are able to do the necessary reading outside of 'classroom' hours. An additional 1-1.5 hours is required if the articles are read during 'classroom' hours.

#### Introduction (30 minutes)

- The facilitator provides a brief overview of the framework for evaluating alternative resource mobilisation mechanisms.
- The facilitator then sets the context of the role play (briefly explains what participants need to do).
- Five groups (of 4-5 people in each group) should be established. Each group will represent a different stakeholder (Combined committee of doctors and nurses professional associations; Representative organisation of rural villagers; Civil servants union; A non-governmental health care provider; Private practitioners). If there are well over 20 participants, a sixth group could be formed to take on the role of the "Government Commission".
- Each group should then be given a resource pack of articles to review. Groups should decide who will read which paper(s).

#### Individual work (1 - 1.5 hours)

- Individuals read assigned papers. This could occur outside of 'classroom' hours; e.g. if the introduction to the role play occurs at the end of a previous session / the day before, participants can read the paper(s) overnight. Alternatively, participants could be given 1 – 1.5 hours during 'classroom' hours to do this reading.
- Participants should be encouraged to use the framework provided to critically analyse the resource mobilisation strategy they are reviewing.

#### Group work (2.5 – 3 hours)

- The groups should first discuss the country context, based on the information provided in the case study. The facilitator(s) should visit each group to ensure that participants are able to interpret the data presented. In particular, one may need to highlight the fact that this country has low economic growth, a government budget deficit (i.e. that government expenditure exceeds government revenue), a small formal tax base (low income tax) and high levels of unemployment.
- Each group member provides a brief overview of the resource mobilisation mechanism they have reviewed, and a critical evaluation of the pros and cons of this mechanism (drawing on the evaluation framework).
- Groups then discuss the resource mobilisation options, within the context of the stakeholders they are representing. The facilitator should emphasise the 'role-playing' aspect to this case study, i.e. that groups should consider the options from the perspective of the stakeholder group assigned to them (e.g. rural villagers or private practitioners). If a group of participants has been assigned the role of the "Government Commission", they should be encouraged to evaluate the options in terms of what may be 'best for the country overall'. They should anticipate what the different stakeholder groups are likely to recommend and how to respond to recommendations that are 'self-serving' and not in the country's interests. The facilitator is likely to have to provide particularly intensive support to the "Government Commission" group.

- Groups then select their preferred option(s) and prepare a presentation. It may be necessary for the facilitator to stress that the presentation should not only describe the preferred option(s), but also justify this preference. In addition, the presentation should consider complementary actions and implementation strategies.

Presentations (1.5 - 2 hours)

- Either a group of participants or the facilitator(s) can serve as the “Government Commission”. The Commission should call on each group in turn to present their recommendations and to justify their preferences (10 minutes maximum). Other groups may be given an opportunity to clarify key issues after each presentation (2-3 minutes).
- The Commission is then given an opportunity to present its judgement (it may be helpful to allow the commission an opportunity to decide how to respond to specific recommendations made by stakeholder groups, e.g. during a tea break).

Conclusions (30 minutes)

- It is helpful to conclude the role-play with a discussion between participants and facilitator(s) of key issues arising from the case study.

**4. Key issues:**

While there is no ‘correct’ answer to this case study, Appendix B provides an overview of the key issues that usually arise in the presentations, particularly from the Commission’s perspective.

**APPENDIX A: FRAMEWORK FOR EVALUATING ALTERNATIVE RESOURCE MOBILISATION MECHANISMS** (Excerpt from: McIntyre D (1997). *Health care financing and expenditure in South Africa: Towards equity and efficiency in policy making*. PhD Dissertation, University of Cape Town.)

## **Introduction**

When evaluating alternative health care financing mechanisms, a number of factors should be taken into consideration. These include: efficiency and equity criteria, displacement effects, the impact on utilisation of health services, and the impact on service provision.

## **Efficiency**

A key consideration when evaluating alternative sources of health care finance is the level of funding that can be generated, and the potential for this revenue to increase in support of expanding health service provision (i.e. its sustainability). It is important to distinguish between gross and net revenue, i.e. to consider the revenue that would actually be available for health service provision once the costs of collecting and administering revenue have been taken into account. Administrative efficiency is thus also an important consideration when evaluating the overall efficiency of a particular financing mechanism. In addition, the potential for evasion of payment should be considered to obtain a realistic estimate of anticipated revenues.

Efficiency criteria also include the long-term reliability and stability of a particular source of finance. This would include considerations such as the extent to which a financing source is dependent on political decisions (e.g. allocations from general tax revenue) or on the consumption of particular goods (e.g. taxes on tobacco products which may be dedicated to funding health budgets).

## **Displacement effects**

When a new financing source or the expansion of an existing one is being evaluated, it is important to establish whether revenue from another source will be displaced, i.e. to identify the net *additional* revenue. The primary objective of health care financing reform within a country may not be to generate extra funds, but rather to *change* the financing mechanism as a means of achieving other objectives (e.g. improving resource allocation patterns). The displacement effects may thus be positive or negative depending on the efficiency and equity characteristics of the new or expanding source relative to the one it is partially or entirely displacing.

## **Equity**

Two key questions should be asked when evaluating the equity implications of health care financing alternatives, namely "Who pays?" and "Who benefits?"

With respect to the issue of who bears the burden of financing, the focus in the health economics literature has been on evaluating vertical equity. Vertical equity requires that individuals with different ability to pay should make appropriately dissimilar payments for health care. Alternative health care financing mechanisms are usually evaluated in terms of their degree of progressivity (i.e. the extent to which payments for health care rise or fall as a proportion of a person's income as his or her income rises).

The issue of the beneficiaries of health care is related to the effect of the financing mechanism on health service utilisation and provision (discussed below).

### **Impact on utilisation of health services**

Different financing mechanisms will provide different incentives in terms of health service utilisation. A financing source that relieves households of some or all of the costs of health services may result in excessive utilisation of such services. Conversely, certain financing mechanisms will adversely affect access to health services and constrain utilisation.

### **Impact on service provision**

Financing sources also influence the supply of health care. They may promote the provision of curative rather than preventive services (e.g. private insurance), they may favour capital rather than recurrent expenditure (e.g. foreign loans and aid) and they may influence the level of technology and type of health personnel employed (e.g. private insurance tends to promote 'high-tech', doctor-centred medical practice).

### Comparison of key alternative health care financing mechanisms

Financing mechanism	Efficiency	Displacement effects	Equity
General tax revenue	<ul style="list-style-type: none"> <li>• Usually most important source of health care finance</li> <li>• Relatively efficient</li> <li>• Collection costs low relative to revenue</li> <li>• Relatively stable, but dependent on political decisions</li> </ul>	<ul style="list-style-type: none"> <li>• Leaves potential private funding sources untapped (if health services completely tax funded)</li> </ul>	<ul style="list-style-type: none"> <li>• Tends to be progressive overall</li> <li>• Depends on progressivity of each tax and the combination of taxes (direct taxes tend to be progressive, while indirect taxes tend to be regressive)</li> </ul>
Dedicated taxes	<ul style="list-style-type: none"> <li>• Relatively efficient</li> <li>• Earmarked for health services</li> <li>• Revenue can fluctuate (if linked to consumption of certain goods)</li> </ul>	<ul style="list-style-type: none"> <li>• Tend to displace general tax revenue</li> </ul>	<ul style="list-style-type: none"> <li>• Tend to be regressive (most consumption taxes regressive, with the exception of luxury goods)</li> </ul>
User fees	<ul style="list-style-type: none"> <li>• Complementary source</li> <li>• Tends to have relatively low revenue generating potential, particularly if reliant on out-of-pocket payments as opposed to targeting the insured</li> <li>• High collection and administration costs</li> </ul>	<ul style="list-style-type: none"> <li>• Tend to displace general tax revenue</li> </ul>	<ul style="list-style-type: none"> <li>• Tend to be highly regressive</li> <li>• Adversely affects health service access of the poorest (can be minimised through <i>effective</i> exemption mechanisms and/or offset by significant and sustained improvements in quality of health services)</li> </ul>
Pre-paid community schemes	<ul style="list-style-type: none"> <li>• Complementary source</li> <li>• Tends to have relatively low revenue generating potential</li> <li>• Collection and administration costs not excessive</li> </ul>	<ul style="list-style-type: none"> <li>• Replace or reduce user fee revenue</li> <li>• Minimal tax revenue displacement</li> </ul>	<ul style="list-style-type: none"> <li>• Tend to be regressive (burden of financing placed on rural poor)</li> <li>• May reduce costs of health services for individuals if service quality (especially drug availability) improves</li> </ul>
Social health insurance	<ul style="list-style-type: none"> <li>• Can generate significant revenue (depends on size of formal sector and income levels)</li> <li>• Administrative costs can be relatively high</li> </ul>	<ul style="list-style-type: none"> <li>• May displace general tax revenue</li> <li>• Tends to displace voluntary private insurance</li> </ul>	<ul style="list-style-type: none"> <li>• Degree of progressivity varies (depends on extent to which contribution structure is income-related, and level of upper limit)</li> <li>• Can improve equity <i>within</i> insured group</li> <li>• Financing burden usually on formally employed</li> <li>• Creates a two-tier system</li> <li>• Public sector resources <i>may</i> be released, which can be targeted to improving services for non-insured</li> </ul>

## APPENDIX B: KEY ISSUES ARISING FROM RESOURCE MOBILISATION ROLE PLAY

### Introduction

- Country context:
  - ◆ Budget deficit
  - ◆ Low economic growth
  - ◆ Poor health status
- Goals of reform:
  - ◆ Equity, efficiency and sustainability
  - ◆ Improve access to health care, especially in rural areas
  - ◆ Improve quality of care in public sector
  - ◆ Explicitly indicate the role of the private health sector

### Financing mechanisms

#### Existing financing

- General tax revenue:
  - ◆ Need to reduce budget deficit, so must increase taxes and/or reduce government expenditure. While it may be feasible to increase income taxes slightly, one needs to recognise that there will be limited scope for increasing budget allocations to the health sector, unless resources are allocated away from another sector.
  - ◆ However, it may be feasible to use existing resources more:
    - Efficiently (especially by improving allocative efficiency and shifting resources to lower levels of care; and by improving efficiency of drug procurement, distribution and use); and
    - Equity such as by using a needs-based formula to guide the allocation of public sector resources between geographic areas.

#### Key new financing mechanisms

- Prioritise the development of community based pre-payment schemes (better to pay in advance rather than have to face high costs at time of use), but need to avoid problems of:
  - ◆ Adverse selection (could be addressed by only allowing people to join the scheme once a year and by encouraging households rather than individuals to join); and
  - ◆ Moral hazard (could be addressed by promoting community ownership of the scheme and thus appropriate use).
- User fees could be implemented for those who do not belong to a pre-payment scheme, to serve as an incentive for community members to join the scheme. It may also be feasible to implement a 'by-pass' fee (i.e. charge those who go directly to higher level hospitals without referral) to encourage use of primary care services as the point of first contact.
- Cross-cutting issues of relevance to user fees and pre-payment schemes:
  - ◆ Exemption mechanisms — there need to be clear, explicit exemption criteria (to protect vulnerable groups and ensure equity in access to services) and people need

- to be made aware of the exemption criteria.
  - ◆ Fee and pre-payment levels need to be appropriate in relation to each other (e.g. pre-payment charge should be less than fee per service x average number of health care visits in one year).
  - ◆ Revenue retention at facility level is an important incentive for revenue generation, but there may need to be guidelines on the use of retained revenue. The allocation of government resources to individual facilities should take into account different abilities of geographic areas to raise funds through fees and pre-payment.
  - ◆ Local control of revenue generation schemes should be encouraged.
  - ◆ There could be other initiatives to foster community ownership (e.g. get community to give their time and skills to maintaining the local health facility).
  - ◆ It may be useful to pilot these schemes first, to identify appropriate national implementation strategies.
  - ◆ It may be useful if the community has a say in what specific financing mechanism(s) are adopted in their community (e.g. between fees and pre-payment).
- Social Health Insurance:
    - ◆ This may be a useful strategy for improving risk pooling between existing private insurance organisations and for bringing in other private formal sector workers.
    - ◆ Coverage of civil servants by a SHI requires further detailed consideration, particularly to determine if the costs to government of contributions to SHI on behalf of civil servants exceed or are lower than the benefits of covering civil servants (e.g. reduced use of public facilities by civil servants or when public facilities are used, the costs are fully covered).

## **Delivery issues**

- Strengthen decentralisation initiatives (there is a strong relationship between decentralisation and effective resource mobilisation through user fees and community pre-payment schemes).
- Improve quality of care in the public sector:
  - ◆ Improve retention of staff in public sector (possibly through limited private practice, although the potential adverse effects of this practice should be considered).
  - ◆ Improve distribution of staff, especially attracting staff to rural areas — could offer comprehensive incentive packages and/or increase the period of government service for those working in urban areas to 4 years compared with 2 years of service if willing to work in an underserved area.
  - ◆ Improve procurement, distribution and use of drugs.
- Private providers:
  - ◆ Engage more actively with NGOs.
  - ◆ Where there is an NGO facility in an area, public sector should not duplicate services but rather consider supporting the NGO:
    - NGO could collect and retain pre-payment contributions and fee payments; and
    - The public sector could provide additional support (e.g. supply of drugs, secondment of public sector staff).
- Private for-profit providers:
  - ◆ Continue as at present seeing patients either covered by insurance or willing to pay

- out-of-pocket.
- ◆ Strengthen regulation (particularly to ensure quality of care).
- ◆ Provide free preventive service supplies to promote provision of preventive services by private providers.
- Involve NGOs and other private providers in district health discussion groups to reduce duplication of services and promote integrated planning.

### **Strategies**

- Some areas of reform need more investigation and information (e.g. SHI) before final decisions can be made.
- Need to think carefully about implementation:
  - ◆ Capacity development needs must be identified and addressed;
  - ◆ Important to consider how to offset potential opposition to resource mobilisation changes;
  - ◆ There should be careful phasing of each reform (don't try to do everything at once);
  - ◆ Ensure implementors (managers and front-line workers) fully consulted and informed about financing reforms.