Initiatives in Health Care Financing: Lessons Learned

HHRAA/DDM East/Southern Africa Regional Workshop Proceedings

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Our appreciation goes out to all of the workshop participants for the enthusiasm, candor, insight, and commitment they brought to the proceedings and discussions. In addition, DDM would like to thank those participants from East Africa -- Ethiopia, Kenya, and Uganda -- who shared their own country experiences and perspectives and all of the many other participants from various international and collaborating agencies.

Our thanks to the Ministry of Health (MOH) of Zimbabwe and USAID/Harare who served as country hosts for the workshop. We are especially grateful for the support given to us by our staff, without which this workshop would not have been possible, and for the input which many colleagues provided in the development of the workshop agenda. DDM would also like to thank the Partnerships for Health Reform (PHR) Project for contributing preparatory documents, completing the workshop proceedings, and for providing additional logistical support. Finally, we greatly appreciate the local workshop organizing staff for all of their hard work which contributed so much to the success of the workshop.

Executive Summary

During the past several years, in response to African policy and decision makers, USAID's Bureau for Africa, through its Health and Human Resource Analysis for Africa (HHRAA) project, has commissioned several sets of comparative case studies on hospital autonomy, resource mobilization, means testing (equity), and decentralization in the health sector. The Data for Decision Making (DDM) Project, the BASICS Project, and the World Health Organization (WHO) conducted studies in each of these four areas in various countries. In order to disseminate and discuss findings and lessons learned from these studies, along with methodological and implementation guidelines developed by DDM, BASICS, and WHO, HHRAA sponsored this East/Southern Africa regional workshop entitled "Initiatives in Health Financing: Lessons Learned" which was held in Harare, Zimbabwe from May 26-29, 1997.

The workshop format included discussion panels and small group fora with speakers presenting conceptual frameworks and study results, and country representatives sharing their experiences and identifying needs related to health care financing reform. Participating countries included Botswana, Ghana, Malawi, Mozambique, South Africa, Zambia, and Zimbabwe. Additional representatives from Ethiopia, Kenya, and Uganda shared their own country experiences and also benefited from the exchange of ideas with their regional neighbors. Representatives from ministries of health, ministries of finance, hospitals and other facilities, universities, international and collaborating agencies, USAID and other donor agencies, and local NGOs were invited.

Plenary sessions included: presentations on financing, resource mobilization issues, decentralization, and National Health Accounts; presentations of national country strategies from East and Southern Africa; and discussion panels. Conceptual frameworks, case study results, and country experiences were presented and discussed for the benefit of the entire group. Discussions following these presentations indicated that many of the countries represented at the workshop faced similar constraints and much was learned from the sharing of experiences. Specific issues which were raised concerned political constraints in reforming health care systems, collaboration with the private sector, the need for better information and monitoring, the role of human resources and capacity building, and the importance of consensus building for success. Both the plenary presentations and subsequent discussions served as the basis for discussions in the concurrent sessions. Representatives from countries with implementation experience provided useful insights and lessons to colleagues in the adoption and implementation of their health financing strategies. Since the participating countries were at different stages of debating, planning, and/or implementing health financing reforms, countries in earlier stages of reform gained valuable information and insight from these presentation and discussion sessions.

In addition to attendance in the plenary sessions, participants were requested to choose one topic group to attend for the duration of the workshop:

- hospital autonomy;
- health insurance; or
- equity -- protecting access of the poor to health services under user fee systems.

Participants selected a topic group and remained with that group for five break-out sessions, during which speakers presented conceptual frameworks and study results, and country representatives shared their experiences and identified needs related to health care financing reform specific to the topic area. In-depth discussions attempted to define terms, identify key issues, develop policy options, and determine strategies for implementation.

Finally, participants were asked to present their country's planned activities and potential needs for technical assistance in the future in the areas of hospital autonomy, insurance, and/or equity. What stood out as most encouraging from the country presentations was that in each country these areas had been identified as priority issues and much planning in these topic areas had already taken place. Workshop topics were thus relevant to participant experiences and information needs. These sessions also illustrated the diversity of solutions that have been undertaken in the region to address the many challenges that health sector reform poses and revealed the participants' needs for future technical assistance in three main areas:

- Continued exchange of information and experiences through study tours, south-south collaboration, and other fora which provide opportunities for the exchange of ideas and networking;
- Institutional capacity building and training; and,
- Situational analyses and further research to inform the health sector reform process.

According to participant evaluations, the workshop was a success, both in terms of expanding participants' knowledge of health financing, as well as in identifying concrete strategies that African countries have found successful in implementing health care financing reform and improving the organization and management of health services. The technical presentations, country case studies, and subsequent discussions enabled participants to leave the workshop with enhanced knowledge about the lessons that have been learned in health financing reform and to look forward to possible future regional collaboration.

1.0 Introduction

The purpose of this report is to provide highlights of the East/Southern Africa Regional Workshop “Initiatives in Health Financing: Lessons Learned” held May 26-29, 1997 in Harare, Zimbabwe. It is intended to document workshop proceedings, with emphasis placed on key issues, proposals to address these issues, and strategies aimed at enhancing and/or facilitating regional collaboration identified by the participants. Thus, this report provides both a record participants can use for future follow-up activities, as well as a summary of the workshop’s approaches and conclusions.

1.1 Background

During the past several years, in response to African policy and decision makers, USAID’s Bureau for Africa, through its Health and Human Resource Analysis for Africa (HHRAA) project, has commissioned several sets of comparative case studies on hospital autonomy, resource mobilization, means testing (equity), and decentralization in the health sector. The Data for Decision Making (DDM) Project, the BASICS Project, and the World Health Organization (WHO) conducted studies in each of these four areas in various countries. In all, twenty-three studies were conducted; seventeen studies in thirteen different countries in Africa and six studies in non-African settings.

Studies Commisssioned by HHRAA

Study	***Country***	***Organization***
Hospital Autonomy	India, Indonesia, Ghana, Zimbabwe, Kenya	DDM - Harvard
Resource Mobilization	Sri Lanka, Bolivia, Senegal, Zimbabwe, Côte d’Ivoire	DDM - Harvard
Means Testing	Kenya, Guinea, Ecuador, Indonesia, Tanzania	BASICS
Decentralization	Botswana, Burkina Faso, Ghana, Kenya, Mali, South Africa, Tunisia, Uganda, Zambia	WHO

These case studies examined experiences and approaches that have been undertaken in countries seeking to improve health care systems, design national reform strategies and insurance schemes, grant greater autonomy to health facilities, implement mechanisms to protect the poor, and decentralize the health sector. They were designed to provide empirical data on health reform and financing activities in the African setting to assess current practices and guide future reform efforts. For each topic, research efforts attempted to:

- Describe different approaches which have been taken in various countries;
- Analyze factors which contributed to successful implementation of reform strategies; and,
- Formulate a set of guidelines to support the design of reform strategies and to guide implementation.

In order to disseminate and discuss findings, lessons learned, and implementation guidelines from these studies and to share experiences within the region, HHRAA sponsored this workshop with specific emphasis on: hospital autonomy, health insurance (as a tool to mobilize resources), and equity issues related to the protection of poor and vulnerable populations. Discussion of the need for reform to be linked to a coherent national health strategy, including presentations on decentralization in the health sector and National Health Accounts (a vital tool to inform policy makers), provided a broader framework for examination of the issues.

Prior to the workshop, at the request of DDM, the Partnerships for Health Reform (PHR) Project drafted situational analyses of health sector services and health financing in the eight countries that were expected to participate in the workshop. These analyses were intended to serve as background materials at the workshop to inform participating countries of health financing trends and issues in other countries in their region [McEuen, 1997].

1.2 Workshop Setting

1.2.1 Workshop Participants

Workshop participants included nearly 60 representatives from ministries of health, ministries of finance, hospitals and other facilities, universities, international and collaborating agencies, USAID and other donor agencies, and local NGOs. Although the workshop focused on health financing issues in the Southern Africa region, Ghana was invited to participate as an Anglophone country which had more in common with the systems of this region than with those of its Francophone neighbors. In addition, representatives from East Africa (specifically Ethiopia, Kenya, and Uganda), acting as resource persons, shared their experiences and lessons learned with the group. In all, ten African countries were represented, including Botswana, Ethiopia, Ghana, Kenya, Malawi, Mozambique, South Africa, Uganda, Zambia, and Zimbabwe. Representatives from Angola were also invited but were unable to attend. Participation of representatives from USAID, WHO, and other donor and collaborating agencies (CAs) enhanced collaboration among all policy makers and actors working in the health sector, and provided additional opportunities for networking and regional collaboration.

1.2.2 Workshop Objectives

The main purpose of this regional workshop was for participants to review existing and new research data from the perspective of their own experiences, and to identify pertinent health care financing reform strategies from their discussion. Primary objectives of the workshop were to:

- Review, disseminate, and discuss findings of the comparative case studies on hospital autonomy, resource mobilization, equity issues, and decentralization conducted by DDM, BASICS, and WHO;
- Provide an opportunity for country representatives to share experiences among themselves, help foster future regional collaboration, and begin discussion on developing policy options to expand relevant health care financing strategies in their country and/or region;
- Discuss available and potential choices of strategies for reform in health care financing, management, and delivery appropriate to participating countries, focusing on practical implementation problems;
- Present the concept of a comprehensive national health care financing strategy, including issues related to the design and use of National Health Accounts; and,
- Identify needs for technical assistance, regional networks, and other forms of assistance.

1.2.3 Workshop Format

The format of this workshop was designed in response to requests from African policy and decision makers for workshops to focus less on "what" needs to be done and more on "how" to do it, and to focus less on presentations and more on discussion and exchange among participants. The innovative design of the workshop devoted more time to fewer topics and allowed participants to gain a broad overview of key issues while permitting them to address one particular interest area in more depth through a series of small working groups. The workshop structure allowed participants to establish commonalities, share lessons learned and collective expertise, identify key issues and approaches, and develop proposals for future reform.

The workshop consisted of:

- *Plenary Sessions* -- Plenary sessions included presentations on trends and issues in health care financing, resource mobilization issues, decentralization, and National Health Accounts; presentations of national country strategies from East and Southern Africa; and discussion panels. Conceptual frameworks, case study results, and country experiences were presented and discussed for the benefit of the entire group.

- *Concurrent Sessions* -- In addition to attendance in the plenary sessions, participants were asked to choose a topic group to attend for the duration of the workshop:

  --hospital autonomy;
  --health insurance; or
  --equity -- protecting access of the poor to health services under user fee systems.

  Participants selected a topic group and remained with that group through five break-out sessions. These small group fora were designed to be participatory with speakers briefly presenting conceptual frameworks and study results and country representatives sharing their experiences and identifying needs related to health care financing reform specific to the topic area. In-depth discussions helped to define terms, identify key issues, develop policy options to address these issues, and determine strategies for implementation.

- *"Make-up" Sessions* -- "Make-up" sessions were held on each topic area to provide participants the opportunity to receive a broad overview of the topic area sessions which they did not attend. For example, participants who attended concurrent sessions on the topic of health insurance could take part in "make-up" discussion sessions on hospital autonomy and equity.

- *Plenary Review and Discussion* -- At the end of the concurrent sessions, participants in each of the three areas -- hospital autonomy, health insurance, and equity -- reported back to the plenary session on the issues, policy options, and implementation strategies identified through their group work.

- *Country Team Meetings* -- A final break-out session dividing participants into country teams was designed to present the country's planned activities for the future, identify country-specific needs for technical and donor assistance, and suggest ways to enhance regional collaboration.

The workshop agenda is included below. A more detailed workshop agenda that includes the names of all the presenters is attached as Appendix 2.

Workshop Agenda

<table>
<tr><th colspan="3">Day 1: Monday, May 26</th></tr>
<tr><th>Session</th><th>Topic</th><th>Presenters</th></tr>
<tr><td>9:00 - 10:00</td><td>Opening Session</td><td>Welcoming Remarks</td></tr>
<tr><td>Plenary Session I

10:30 - 12:00</td><td>Overview of Health Financing Trends and Issues in Region</td><td>Introduction to Workshop
Health Sector Reform in Africa
Resource Mobilization Studies</td></tr>
<tr><td>Plenary Session II

1:30 - 3:00</td><td>Country Experiences in Developing National Health Care Financing Strategies</td><td>Ethiopia, Kenya, Uganda</td></tr>
<tr><td>Plenary Session III

3:30 - 5:00</td><td>Health Care Financing Strategies: Southern African Perspectives</td><td>Zambia, Malawi</td></tr>
<tr><th colspan="3">Day 2: Tuesday, May 27</th></tr>
<tr><td>Plenary Session IV

8:30 - 10:00</td><td>Decentralization in the Health Sector

[Introduction and Sign-up for Concurrent Sessions]</td><td>South Africa, Ghana, Uganda</td></tr>
<tr><td colspan="3">NOTE: Concurrent sessions begin here. Each session has three groups: a) health insurance, b) hospital autonomy, and c) equity. Participants should join one group and stay with that group throughout the concurrent sessions.</td></tr>
<tr><td rowspan="3">Concurrent I

10:30 - 12:00</td><td>A. Social Health Insurance</td><td>Kenya, Tanzania, South Africa</td></tr>
<tr><td>B. Hospital Autonomy: Lessons Learned</td><td>Malawi, Ghana</td></tr>
<tr><td>C. Key Concepts and Critical Elements of Equity</td><td></td></tr>
<tr><td rowspan="3">Concurrent II

1:00 - 2:30</td><td>A. Planning for Social Health Insurance</td><td>Zimbabwe</td></tr>
<tr><td>B. MOH and the Autonomous Hospital: The Government Perspective</td><td>Ghana</td></tr>
<tr><td>C. Common Experiences: What Affects the Effectiveness of Protection</td><td></td></tr>
<tr><td rowspan="3">Concurrent III

3:00 - 4:30</td><td>A. Innovative Health Financing Mechanisms: The Experience of Medical Aid Societies</td><td>Zimbabwe, Zambia</td></tr>
<tr><td>B. MOH and the Autonomous Hospital: The Hospital Perspective</td><td>Kenya, Zimbabwe, Ghana</td></tr>
<tr><td>C. Equity: Policy and Management Issues</td><td></td></tr>
<tr><td>Plenary Session V

5:00 - 6:30</td><td>National Health Accounts: Applications and Methods</td><td>International, South Africa</td></tr>
</table>

Day 3: Wednesday, May 28		
Concurrent IV 9:00 - 10:30	A. Planning for Private Indemnity Insurance	South Africa
	B. Implementing Hospital Autonomy	Kenya
	C. Equity: Group Work: Developing Practical Applied Guidelines and Solutions	
Concurrent V 11:00 - 12:30	A. Insurance Working Group - Proposals for Further Action	
	B. Hospital Autonomy Working Group - Proposals for Further Action	
	C. Equity Working Group - Proposals for Further Action	
1:30 - 3:00	MAKE-UP Session 1: Groups learn about and discuss one of the topics they did not attend	
3:30 - 5:00	MAKE-UP Session 2: Groups learn about and discuss the other topic they did not attend	
Day 4: Thursday, May 29		
Plenary Session VI 9:00 - 10:30	Report to Plenary from Three Groups on Key Issues, Needs, Proposals (with discussion following each presentation)	
11:00 - 12:30	Country Group Work to Develop Proposals for Future In-country Strategies and Areas for Regional Collaborations	
Plenary Session VII 1:30 - 3:00	Report on Group Work and Discussion	Country representatives from Botswana, Ghana, Kenya, Malawi, Mozambique, South Africa, Zambia, Zimbabwe, and Uganda
3:00 - 3:30	Closing	

1.3 Participant Evaluations

According to participant evaluations, the workshop format allowed participants to get a broad picture of several issues while further investigating a single issue in greater depth. The majority of participants found the concurrent session format extremely useful, adding that the small size of the groups encouraged participation and fostered more effective discussion and exchange of experiences. Several participants felt that each topic area warranted a separate workshop, especially since most participants were interested in all three of the topic areas.

Participant evaluations also indicated that the workshop was a success, both in terms of expanding participants' knowledge of health financing, as well as in identifying concrete strategies that African countries have found successful in implementing financing reforms and improving the organization and management of health services. The technical presentations, country case studies, and subsequent discussions enabled participants to leave the workshop with enhanced knowledge about the lessons that have been learned in health financing reform and pitfalls to avoid in implementing health reform activities. Participants were also able to look forward to possible future regional collaboration.

2.0 Summary of Plenary Sessions

The workshop opened with a plenary session to welcome participants. The workshop's convener, Dr. Peter Berman, Director of the DDM Project at the Harvard School of Public Health, welcomed participants and explained the objectives and format of the workshop. Welcoming remarks were also made by Mr. Oscar Picazo, Regional Health Finance Advisor from REDSO/ESA and Dr. Abraham Bekele, Senior Health, Economic, and Finance Advisor from USAID/Bureau for Africa. The workshop was officially opened by the U.S. Ambassador to Zimbabwe, the Honorable Johnnie Carson.

2.1 Plenary Session I -- Overview of Health Financing Trends and Issues in The Region

This first plenary session provided participants with an overview of health financing trends and issues in the region through two presentations. The first presentation was by Dr. Charlotte Leighton, Technical Director of the PHR Project, who began the session with an overview of health sector reform in Africa. Dr. Leighton's presentation discussed health sector reform policies, typical reform goals, processes, common obstacles to reform, and strategies used to overcome these obstacles. Health insurance and broader packages of reforms, including resource mobilization, resource reallocation, and sectoral reorganization, were also discussed. The presentation offered lessons learned from several country case studies to provide participants with concrete examples of the typical obstacles faced in the design and implementation of health sector reform and successful strategies that have been used to overcome these obstacles.

A second presentation on resource mobilization was given by Dr. Peter Berman. This presentation discussed key conclusions and lessons learned from the five DDM case studies on resource mobilization (see bibliography) and examined the design and implementation of national resource mobilization strategies. National strategies require that countries have an understanding of their current and past financing patterns, estimate resource needs and set realistic goals, assess the feasibility of different strategies, assess political implications, and then build consensus. Advantages and disadvantages of specific resource mobilization mechanisms such as health insurance, medical aid schemes, community-based financing schemes, and user fee systems were also discussed. An interesting finding that was presented was that the level of total resources allocated for health was not necessarily a predictor of health performance. For example, Sri Lanka was cited as a high performing health system with very low levels of allocated resources.

2.2 Plenary Session II -- Country Experiences in Developing National Health Care Financing Strategies

The second and third plenary sessions, chaired by Dr. Eyitayo Lambo, WHO/AFRO, were designed to explore country experiences in developing national health care financing strategies. In the second session, after a brief introduction to the session by Dr. Lambo, Dr. Beletu Woldesenbet, Dr. Dan Kraushaar, and Dr. Francis Mwesigye, working in Ethiopia, Kenya, and Uganda, respectively, shared their experiences in developing national health care financing strategies. In all three presentations, political challenges and constraints in implementing national health care financing strategies were addressed, and creative solutions to these obstacles and other lessons learned were shared.

Ethiopia: Dr. Woldesenbet, Chairperson of Ethiopia's Health Care Financing Study Team, presented the sequence of events leading to the development of their national health

care financing strategy, including preparatory work, study tours, data and situation analysis, identifying key issues, choosing potential financing options, identifying organizational mechanisms for implementation, prioritizing activities, convening a national policy workshop, and establishing a national policy committee.

Kenya: Dr. Kraushaar, USAID REDSO/ESA, presented some general observations about national health care financing strategies and then discussed Kenya's national strategy. Results of the implementation of Kenya's health care financing reform over the period 1993-97 presented a mixed picture -- funding for primary health care increased but not in real terms, cost sharing revenue was low but remains an important source of financing, and funding for curative care remains high. Despite this, the number of private providers has increased largely due to the National Health Insurance Fund (NHIF) and the health care financing strategy has influenced the national development plan and related legislation.

Uganda: Dr. Mwesigye, Ministry of Health (MOH) Uganda, presented Uganda's health care financing strategy. As a result of the implementation of the strategy, the MOH has increased health expenditure from 4% to 7%, revenue has been retained at the facility level and pumped back into primary health care, equity has been improved through the development of informal means testing criteria, and quality assurance has been improved through stricter monitoring of drugs. However, Dr. Mwesigye pointed out that the strategy has not been free of drawbacks -- doctors are still providing private services after hours to supplement their low pay, pilferage of drugs and supplies remains high, informal user fees are often charged for services, and standard treatment guidelines, although widely distributed, are not usually used.

2.3 Plenary Session III -- Health Care Financing Strategies: Southern African Perspectives

The third plenary session, also chaired by Dr. Lambo, focused on national health care financing strategies in southern Africa, specifically in Malawi and Zambia. It provided an additional opportunity for participants to relate their country's experiences with health care financing strategies from the southern African perspective. Each described the work accomplished in their country and their experiences reflected various levels of planning and progress.

Zambia: Mr. Felix Chindele from Zambia's MOH discussed the progress of health sector reforms in Zambia, including efforts focused on the mobilization of resources, the use of health boards, and the need to create an enabling environment to enhance the effectiveness of health boards in providing health services.

Malawi: Mr. Z.D. Chikhosi from the Ministry of Finance in Malawi described Malawi's health financing experience from a political and historic perspective, and discussed the objectives and strategies of health financing in Malawi along with several implementation challenges that the reform strategy is currently facing . Mr. Oscar Picazo of REDSO/ESA further contributed to the discussion on Malawi's health care financing strategies by providing background on the existing system, and by suggesting sectoral reform in the areas of resource mobilization, efficiency improvements, and ministerial reorganization.

2.4 Plenary Session IV -- Decentralization in The Health Sector

A plenary session on health sector decentralization, moderated by Mr. Alex Ross of USAID/Bureau for Africa, was held in order to share country experiences in the decentralization planning and implementation process, explore the forms and processes of decentralization, identify and understand what enhances or impedes progress and implementation of decentralization, and discuss guidelines to assist local decision makers in the formulation of decentralization-related policies and evaluation efforts. Country presentations were made on decentralization experiences in South Africa, Ghana, and Uganda.

South Africa: Dr. Peter Milligan, Deputy Permanent Secretary, Eastern Cape Province Department of Health (DOH), presented South Africa's efforts to decentralize the health sector to the provincial level as mandated by a new constitution. Among the key issues facing South Africa at this time are: the development of districts (including governance, regional role, management capacity issues), resource allocation methods and how to ensure equity and financial management, civil reform-related issues, the interaction of legal frameworks and decentralization, and the development of the private sector.

Ghana: Dr. Emmanuel Mensah, Director, Institutional Care Division, MOH, presented Ghana's ten year experience in health sector decentralization and the development of an administratively separate Ghanian Health Service (GHS). Some key features of the GHS are that the personnnel are now split from the MOH, the GHS will use a performance-based contract funding system with districts, and where the teaching hospitals will be autonomous and answerable only to the MOH. Dr. Mensah noted that the decentralization process was inevitable and that its success will depend on good management and a political will to sanction poor performers and reward achievers.

Uganda: Drs. Prosper Tumusiime, Ministry of Local Government (MLG), and Francis Mwesigye, Ministry of Health, then presented their experience in Uganda where a legal framework for decentralization has been developed and is beginning to be implemented. Uganda's decentralization is led by the MLG and the delivery of health services are the dual responsibility of the MOH and the local councils. Among the key issues presented were the need to develop alternative sources of health funding for districts, minimum national health standards, and local level capacity, and to encourage the development of the private sector.

Dr. Tom Bossert, DDM, responded to the presentations by making a few remarks. He stressed the need for governments and stakeholders to fully understand *why* decentralization was taking place, to fully plan and develop capacity for implementing decentralization, and to develop and implement a monitoring and evaluation system to track the implementation of decentralization and its impact, as well as to take mid-course corrective measures if necessary.

2.5 Plenary Session V -- National Health Accounts: Applications and Methods

This plenary session, chaired by Dr. Emmanuel Mensah of the MOH in Ghana, included presentations on National Health Accounts (NHA) by Dr. Peter Berman and Dr. Di McIntyre of the University of Cape Town Medical School, South Africa.

Dr. Berman introduced the concept of NHA, discussed its multiple uses, and provided an overview of how NHA can be used as a tool to enable policy development, simulation, planning, and evaluation of health sector reform strategies. In his presentation he reviewed experiences in India, Egypt, Mexico, and the Philippines, as examples of areas where NHA data was used for different

purposes, such as informing the development of national health insurance proposals, monitoring changes under decentralization, tracking national health expenditures, monitoring growth of the private sector, and determining resource allocation based on disease burden and priority interventions. The presentation stressed the importance of building local capacities to implement NHA and got participants thinking about the possibility of building NHA regional and international networks to facilitate reform processes.

Dr. McIntyre then presented the process and results of the South African experience in conducting a health expenditure review (HER) which essentially contained the same elements as the NHA methodology. This session afforded participants the opportunity to learn about the benefits of budget tracking mechanisms in the context of South Africa, and furthered their understanding of the practical applications of NHA and how such a tool might be used in their respective countries. Key issues included how HER assisted in restructuring health sector priorities, developing policies, promoting resource redistribution and addressing inefficiencies. Key lessons learned included the necessity to have local control, participation and ownership over the process and product.

3.0 Issues Emerging From Plenary Session Discussions

The discussions following the plenary session presentations indicated that many of the countries represented at the workshop faced similar problems and much was learned from the sharing of experiences. Both the plenary presentations and subsequent discussions served as the basis for discussion in the concurrent sessions. Representatives from countries with implementation experience provided useful insights and lessons to colleagues in the adoption and implementation of their health financing strategies. Since the participating countries were at different stages of debating, planning, and/or implementing health financing reforms, countries in earlier as well as relatively advanced stages of reform gained valuable information and insight from the plenary sessions and subsequent discussions. Several key issues which emerged from discussions following each plenary session are included below.

3.1 Political Challenges and Constraints in Reforming Health Care

Workshop participants shared their experiences and their country's financing strategies in addressing political challenges and constraints that might hinder health care reform in Africa. Issues discussed included the following:

- How does the political cycle (e.g., elections) affect the design, implementation, and hence success, of health sector reform?
- What are possible approaches to managing political challenges and constraints, and creating demand for reform?
- What is the best way to take advantage of political "windows of opportunity"?
- Do the proposed health care reforms fit into a current political agenda?
- Do research studies support the argument for reform and convince policy makers of their importance?

A clever strategy used in Ethiopia to overcome political constraints to health care reform was to call for a national debate on the health care strategy and include legislators and other government officials in the meeting, effectively combining the political and policy processes. Although the issues above could not be answered readily, all participants agreed that some level of consensus building among all stakeholders, including policy makers, was necessary before health reform could be effectively implemented.

3.2 Decentralization

Several issues were raised after the plenary session presentation on decentralization including:

- How does decentralization affect other areas of the health sector reform process?
- Has consideration been given to the definition of decentralization? What is the purpose or goal of decentralization efforts?
- What should be the pace of decentralization?

One of the discussants noted that the presentation and discussion of decentralization had omitted the goals of decentralization initiatives, such as improved equity, improved efficiency of use of

limited resources, improved quality of care, and ensured financing for health service provision. It was agreed that these goals were important to keep in mind since they might also serve as criteria upon which decentralization efforts could be evaluated.

On the issue of pacing of decentralization efforts, discussion focused on whether decentralization was better implemented rapidly or in a slow and methodical manner. Questions were raised about what the minimum preparations were in order for decentralization to take place and be successful. For instance, it seemed that political support was necessary in all cases to implement decentralization but perhaps waiting to build institutional capacity at local levels before decentralizing might delay the process indefinitely. Once a legal and political framework is in place, however, a mandate to build local institutional capacity would exist.

Additional issues raised during the discussion on decentralization included: the importance of the clear delineation of roles, responsibilities, and authorities, especially for newly devolved districts or local authorities and for the ministries; and, the issue of control of the hiring and firing of personnel at the facility level. The latter issue is crucial to decentralization efforts in all countries in sub-Saharan Africa because health workers' salaries usually account for the majority of health care expenditures.

3.3 Generating Resources With User Fees

There are many merits and risks associated with the implementation of user fees, but most participants at this workshop supported the necessity of them as long as they are associated with strategies to protect the poor and vulnerable groups. The fact that the retention of revenue at the facility level has resulted in improvements in quality of care is also contributing to support for user fees as a method of resource mobilization and cost recovery. Most participants agreed that the recent global debate and trend toward discouraging user fees may be premature. They postulated that user fee systems seemed to work in African settings on the condition that exemption systems for vulnerable populations were included. Participants also stressed that revenue should be invested in the facility and earmarked for improved quality of care that was country-specific and appropriate.

It was also noted that user fees should be designed to fit into the context of a comprehensive national health care strategy. User fees are vital to the introduction of any type of insurance scheme. And lastly, participants urged that informal user fees need to be examined and stopped. It was recommended that mechanisms to discourage charging of informal fees should be discussed and designed.

3.4 Human Resources and Capacity Building

As mentioned in the decentralization section above, human resources are critical to the implementation and success of a decentralization reform strategy. Several countries have already undertaken manpower assessments and developed related strategic plans (e.g. Malawi). In other countries, further research to assess manpower and capacity at local levels (i.e. provincial and district levels) is needed before undertaking any decentralization planning. But participants from Uganda warned that decentralization cannot be delayed in order to build capacity because this may delay decentralization indefinitely.

3.5 Information For Planning and Monitoring

Several participants asked if health care systems could be reformed effectively without reliable data about the current state of the system. Many participants felt that their countries needed to better analyze their health systems before further changes or reforms were undertaken. A better understanding of the strengths and weaknesses of the system could then be used to advocate for the types of changes needed or the type of mechanism to be utilized.

After the presentations on National Health Accounts, attendees asked specific questions related primarily to data collection methodology, the cost of completing NHA, and other NHA modalities. Participants expressed genuine interest in the topic as a mechanism to better understand their own health systems and to better inform policy makers and planners. Many delegates were interested in having such an activity take place in their countries.

3.6 Role of The Private Sector

Participants expressed a strong need to explore public and private sector collaboration as an important mechanism with the potential for significant resource mobilization for health service delivery. One strategy suggested was to focus on determining the role and scope of the private sector and then building strategies to best utilize it. It was noted that in Uganda, however, limited manpower at the MOH discouraged a thorough assessment of the private sector. It was hoped, though, that by better understanding private sector services, the overall level of services could be maintained but with funding and service delivery shifted from public to private sources. The remaining public funding could then be allocated to primary health care.

In addition, a representative from Ethiopia found that “private wings” within public facilities function more effectively than having separate private facilities which may directly compete with public institutions. In the latter situation, it was argued that public hospitals might lose credibility and high quality personnel and supplies to the private facilities.

Many of the issues that were raised in discussions during plenary sessions arose from actual experiences in planning and implementing reform. While these policy issues were raised, specific action recommendations were not made. Rather, the workshop emphasized the identification of issues which need to be addressed and these issues influenced the next steps outlined by country representatives at the end of the workshop.

4.0 Workshop Findings: Summary of Concurrent Sessions

The following sections present highlights of the results of the work completed by participants during the concurrent sessions. Findings from concurrent sessions on the three issue areas were summarized in a plenary session by rapporteurs selected from country participants in each group and are described below. Ms. Oratile Modukanele of Botswana presented the findings from the sessions on hospital autonomy, Ms. Gillian Moalosi of Botswana presented findings from the insurance sessions, and Mr. Fabion Chitopo from Zimbabwe presented findings from the sessions on equity issues. This plenary session was chaired by Dr. Woldesenbet of Ethiopia and included a brief question and comment period after each presentation. Issues raised during the discussion periods have been added to each section.

4.1 Hospital Autonomy

An increasing number of countries in Africa are experimenting with new strategies to increase hospital autonomy and improve performance of public hospitals. These countries have attempted to make public hospitals function more efficiently and effectively by granting them increased financial and administrative autonomy under continued governmental ownership. DDM country case studies found that the degrees of actual hospital autonomy vary greatly by country and by facility (see Table 1 below). Most attempts to increase hospital autonomy include granting increased financial decision making to the facility and the retention of user fees at the point where they are collected.

It is widely expected that greater hospital autonomy can lead to significant gains in efficiency, effectiveness, and public accountability. Increased autonomy may also result in improved quality of care through better consumer responsiveness, optimal employment of hospital staff, improvements in staff performance and attitude through incentives, and increased availability of drugs and equipment. In addition to gains in available resources, efficiency, public accountability, and quality of care, hospital autonomy may contribute to raising universal health status and increasing equity. Due to stagnant or diminishing public resources for overall health care delivery, and because primary and preventive health care are largely viewed as more cost-effective than hospital-level curative care, MOH reform strategies are, at a minimum, trying to avoid further increases in the level of public funds for hospitals through measures to increase hospital efficiency and cost containment. Resources previously ear-marked for hospitals can then be used more effectively at the primary health care facilities.

Table 1: The Nature and Extent of Hospital Autonomy in Five Countries

Policy and Management Functions	*Extent of Autonomy*				
	Low Autonomy	*Some Autonomy*			*High Autonomy*
Strategic Management	Kenya, Zimbabwe	Indonesia	Ghana, India		
Administration		Zimbabwe, Ghana, Kenya	India, Indonesia		
Procurement	Ghana	Kenya, Zimbabwe, Indonesia		India	
Financial Management		Ghana, Zimbabwe	Kenya, Indonesia	India	
Human Resource Management	Ghana	India, Indonesia, Zimbabwe, Kenya			

4.1.1 Objectives

Several objectives for the concurrent sessions on hospital autonomy were defined prior to the first session and then were modified according to the participants' interests. The main objectives of the concurrent sessions on hospital autonomy included:

- Describing different approaches taken in different parts of the world toward improving public hospital performance through increasing hospital autonomy;
- Analyzing the factors that contribute to successful implementation of a strategy to increase hospital autonomy; and,
- Formulating a set of guidelines which can be used by national governments to improve hospital performance by increasing autonomy.

4.1.2 Key Issues

The concurrent sessions on hospital autonomy began with a presentation of findings from five case studies performed by DDM in Ghana, India, Indonesia, Kenya, and Zimbabwe. The cases presented highlighted the variation among countries in the extent and impact of autonomy in the hospitals studied (see Table 2 below). Hospital functions within the identified domains of strategic management, administration, procurement, financial management, and human resource management demonstrated levels of autonomy along a continuum from low to high. Most hospitals were able to exercise some autonomy in most hospital functions; some exercised only limited autonomy, especially in terms of strategic management, procurement, and human resource management; while no board demonstrated characteristics of a higher level of autonomy. The difficulties encountered in implementing hospital autonomy policy identified in the five case studies included bureaucratic resistance, legal barriers, political interference, and uncertain commitment -- all factors which make the process toward greater hospital autonomy a slow one.

Table 2: The Impact of Hospital Autonomy as Reported in The DDM Case Studies

Evaluative Criteria	***Level of Impact***			
	Adverse Impact	***No Change***	***Some Improvement***	***Substantial Improvement***
1. Efficiency		Zimbabwe, Ghana	India, Indonesia, Kenya	
2. Quality and Public Satisfaction		Kenya, Zimbabwe	India, Indonesia, Ghana	
3. Accountability	Zimbabwe	India, Ghana, Kenya, Indonesia		
4. Equity	Zimbabwe, Ghana, Indonesia	India, Kenya		
5. Resource Mobilization			Ghana, India, Indonesia, Kenya, Zimbabwe	

Over the course of the five sessions, representatives from Botswana, Ghana, Kenya, Malawi, South Africa, Uganda, and Zambia shared their own countries' experiences with the initiation and

implementation of hospital autonomy policies. Presenters from teaching hospitals in Kenya, Ghana, and Zimbabwe discussed with the group the challenges of implementing policies that grant autonomy to hospitals. So far in these countries, autonomy has been granted only to teaching hospitals at the central level. The group discussed the implications of granting autonomy at the district and local level primary and secondary level hospitals. The group also focused attention on the composition of the administrative hospital boards and the extent to which this reflects both autonomy from the central health ministry as well as the ministry's retaining influence of them through the selection of board members.

The group was able to reach some consensus about the direction in which to proceed with strategies for hospital autonomy implementation. Participants also concluded that granting hospitals more autonomy is not an easy process, but one that needs a lot of support and time to implement. Many of the group members expressed interest in receiving more guidelines on how to implement increased hospital autonomy. The group agreed that hospitals could benefit in some of the following ways. New resources should be mobilized through efforts to raise funds at the hospital level; but efforts should also be made to effectively utilize government subsidies and protect primary health care services. Hospitals would also benefit from greater control of human resources at the hospital level but with some assurance that there were incentive mechanisms in place in the case of rural area and small hospitals, so that career path opportunities may attract qualified staff. Greater separation of government from the board would benefit hospitals; to accomplish this, especially in the case of primary and secondary hospitals, community participation in the selection of board members and capacity-building in technical and managerial fields will be very important. Hospitals would also benefit from increased procurement capacity at the hospital level.

4.1.3 Proposals To Address Issues

The group recommended that countries where a successful autonomous hospital model already exists at the level of the teaching hospital should expand to the district level and proceed with the support and shared experience from teaching hospitals. In countries where there is not yet a successful autonomous hospital model to follow, implementation should begin at the central teaching hospital level once a legal support framework has been designed and implemented. The group agreed that shared country experiences would be useful both in developing policy to be passed as law and implementing autonomy policy once the legal autonomy-granting framework has been established. It was acknowledged that experience with hospital autonomy in Africa to date has had limited success and that significant new efforts would be needed to obtain the desired benefits from autonomy.

4.1.4 Discussion

Ms. Modukanele presented the group work on hospital autonomy and then she and other members of her group fielded questions.

- The first question asked was what the group meant when it recommended community participation in hospital boards. Some group discussion about the importance of having a board representative that could offer community perspective and display coordination between hospitals and the community took place. Despite the difficulties in ensuring community participation on hospital boards, having a representative might improve the hospital's responsiveness to consumers.

- Another important issue raised and discussed was who has the responsibility to select hospital board members. Often the MOH is given the responsibility but the process becomes too political, members are not often appointed on the basis of expertise, and many of the objectives of hospital autonomy are defeated. An important part of planning for hospital autonomy is to decide how to elect board members to ensure maximum effectiveness. One participant

suggested that the plan define broad categories of membership, e.g. for a teaching hospital, the board may consist of a university representative, a ministry representative, a community representative, and a representative from the city council.

4.2 Health Insurance

In studying resource mobilization in five countries, DDM found that health insurance was of increasing policy interest as a method of raising resources and, potentially, improving the supply and provision of health services. Health insurance is a mechanism for protecting families against the unexpected high costs of illness by sharing the risks of future costs among healthy and sick populations in the form of regular predictable payments. Proponents argue that people may be more willing to pay for health insurance rather than being heavily taxed or charged user fees. DDM research, however, indicated that only small percentages of the populations studied had any kind of health insurance and that insurance schemes currently do not contribute significant resources to total health care financing. Current insurance schemes also tend to cover mainly the more wealthy income groups or the formally employed, limiting the reach of such schemes into lower income or rural populations.

4.2.1 Objectives

Objectives of the concurrent sessions on health insurance were to:

- Review existing experiences with health insurance schemes in participating countries and the documented experience to date;
- Focus on social and private health insurance strategies in a number of different countries in terms of their effect on revenue generation, sustainability, and feasibility; and,
- Generate a set of proposals to address issues related to the design process which will assist in the formulation of health insurance schemes.

4.2.2 Key Issues

Dr. Dan Kraushaar and Mr. Oscar Picazo of REDSO/ESA co-facilitated this series of sessions focused on health insurance. Dr. Kraushaar first presented the Kenyan experience with national health insurance, and then explained Tanzania's proposed national health insurance strategy. Mr. Alex van den Heever of the Center for Health Policy in South Africa then followed with a presentation on South Africa's proposed social health insurance scheme. It became evident to all group members during these first few presentations that collectively they did not share a common understanding of the terminology used when speaking about health insurance related issues. This being the case, one of the first activities the group embarked on was defining terms so that they could then progress to more in-depth topical discussions.

In the next session the Zimbabwean participants, Mr. Simon Chihanga of the MOH, and Mr. Mathew Ncube of the National Social Security Authority, presented Zimbabwe's "pre-proposal" for social health insurance. The group then addressed innovative health financing mechanisms, specifically discussing the experience of medical aid societies. Dr. Hilda Mutayabarwa presented a lessons learned discussion on the demise of the Zambian medical aid society, and Mr. MacDonald Chaora presented an overview of Zimbabwe's successful experience with the CIMAS scheme. This session provided participants with valuable insights into the potential for both success and failure in the implementation of medical aid societies. Finally, Mr. van den Heever presented plans for private indemnity insurance in South Africa.

From the discussions which ensued from the above presentations, the insurance group identified the following key issues and proposals for addressing them. The majority of the countries represented in this group session were still in the process of exploring options and/or designing health insurance strategies. Hence, the key issues and proposals to address them presented below are related to the design process.

- Has the intended purpose of the health insurance scheme been identified? Specifically:
  - Why has this option been chosen?
  - Have the goals been clearly defined?
  - Will health insurance achieve these goals?
  - Are there other ways to achieve these goals?
  - Are the costs of the insurance scheme worth the expected results?
  - Is health insurance being integrated into a broader set of health sector reforms?
- Need for greater clarity of health insurance concepts and terminology.
- How much do we need to know about how health insurance may/will work before proceeding with implementation?
- What are the minimum technical questions that need to be answered? (e.g., benefit package, population coverage, premium amount, etc.)
- What are the main potential problems with health insurance that a proposal has to have some safeguards against? (e.g., adverse selection, moral hazard, cost escalation, etc.)
- What studies or technical recommendations need to be completed before implementation?
- What experiences can be learned from other countries?
- What should be the role of the private sector in national debates?
- How should the design process address issues related to HIV/AIDS in the African context?
- How do you manage the political process considering its role in the design, development, and implementation of health insurance schemes?

4.2.3 Proposals To Address Issues

In the final concurrent session on health insurance, group members defined several proposals to attempt to address the issues related to the design process that they had previously raised:

- Clarify goals and objectives of the proposed health insurance scheme;
- Have a "technical team" prepare studies and concrete proposals;
- Increase understanding of the structure of the health sector and the behavior of actors and stakeholders in the system through increased information gathering and research (e.g. situational analyses, household surveys, and provider surveys);
- Identify stakeholders affected by the proposed health insurance scheme (proponents and opponents), address issues raised by opponents and work to build consensus among all stakeholders through compromise;

- Use training and IEC to educate and inform stakeholders (i.e. seminars and technical sessions with practitioners and policy-makers, legislative staff training, briefings to standing committees in parliament, and public/consumer education);
- Assign the Minister of Health to assist in the management of the political process through an advocacy role and through education of politicians; and,
- Develop a schedule for the health insurance design process which includes ongoing monitoring and evaluation.

4.2.4 Discussion

Immediately following Ms. Moalosi's presentation to the plenary session, the floor was opened for questions and comments related to the health insurance issues raised by the group.

- One participant inquired whether there was an example of a developing country with a successful health insurance scheme. Egypt, Zimbabwe, South Africa, and Costa Rica were listed as developing countries which have tried various insurance schemes, with varying degrees of success. Yet policy makers were warned about unsuccessful examples as well and cautioned about risks of implementing poorly designed insurance schemes. Getting it wrong can be costly and difficult to reform once implemented.
- A second question raised the issue of enrolling HIV/AIDS patients in insurance and medical aid schemes. Responses suggested that perhaps schemes could offer limited coverage that would include visits to general practitioners and home-based care but not the high cost associated with the drugs required for treatment.
- A key implementation issue that was raised was the concept of developing a specific unit within the MOH to be responsible for the development and implementation of health insurance schemes. Many participants felt that, although the MOH supported such schemes, MOH staff was already too over committed to design and implement them. It was suggested that perhaps the MOH should not be responsible for designing the health insurance scheme but merely contract out the task under its supervision.

4.3 Equity -- Protecting Access of The Poor To Health Services Under User Fee Systems

Like insurance schemes, cost recovery through user fees is another response to declining revenue and growing demands on the health sector. Revenue collected can then be used to improve quality of health services to increase utilization rates and also to extend services to rural and under-served areas to increase access. User fees, in addition to increasing revenue, are also believed to promote equity. In order to ensure that user fees promote equity, only those who can afford to pay for services should be charged fees and those who cannot afford to pay should be subsidized or exempted.

Various mechanisms have been developed to protect poor and vulnerable populations from being denied health care due to an inability to pay user fees, including means testing, direct targeting, characteristic targeting, waivers, and exemptions. <u>Direct targeting</u> is the provision of free or reduced-price benefits to people who cannot pay because of low income, often using some form of <u>means testing</u> to determine how much people can afford and recommending that they receive fee <u>waivers</u>. In Africa, means testing usually occurs at the point of service delivery and rarely before the need for health care arises. Wage and tax records are often unavailable or non-existent in Africa. Facility administrators thus use their discretion to determine who is unable to pay fees, resulting in informal means testing that relies

on income proxies. Because of time constraints on facility administrators and doctors, pressure to waive fees for acquaintances, and unwillingness of staff to grant waivers because their facility needs additional revenue, eligibility for fee waivers may ultimately be determined in a less than systematic manner. Characteristic targeting is the provision of free or reduced-price benefits to people with certain attributes regardless of income level (e.g., certain contagious illnesses, services, or demographic and vulnerable groups, such as children). Under characteristic targeting exemptions are automatic within facilities to encourage certain people with certain characteristics to use certain health services.

4.3.1 Objectives

Objectives of the concurrent sessions on protecting the poor under user fee systems were to:

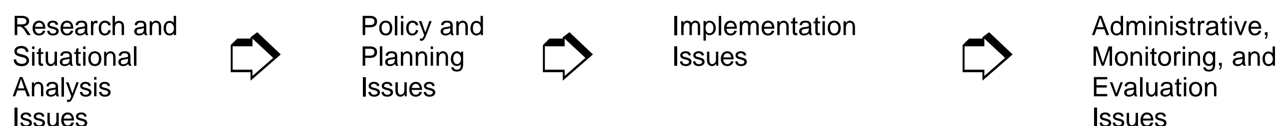
- Examine the provision of health care to the poor in participating countries;
- Analyze how governments in poor countries can exempt the poor fully or partially from increased health care costs given the need for health cost recovery; and,
- Provide guidelines for developing countries, with a special focus on sub-Saharan Africa, on the design and implementation of effective protection mechanisms to guarantee access to health care for the poor.

4.3.2 Key Issues

This series of concurrent sessions was designed to address the issue of ensuring access of the poor to health care services under user fee systems. Drs. William Newbrander and Peter Cross facilitated the sessions, while Mr. Fabion Chitopo of Zimbabwe acted as rapporteur. In all, five concurrent session were held in which participants successfully identified key equity issues, defined possible health care financing reform options to ensure access of the poor to health care services, and developed criteria to evaluate the various options.

The sessions were initiated by having country participants briefly describe user fee systems and related mechanisms to protect the poor that currently exist in each of their countries. This regional comparison was later summarized in a table to share with all workshop participants. In general, all countries participating in the group, Botswana, Ethiopia, Malawi, Mozambique, South Africa, Uganda, and Zimbabwe, had initiated some form of user fee system. Waiver systems were used in most countries, while all of the countries granted some type of exemption by either disease category, demographic group, geographic area, type of service, or level of care.

Next, key issues involved inensuring equity were indentified by the group and subsequently categorized by participants into four issue areas, including research issues, policy issues, implementation issues, and administrative issues. After each issue was categorized, a participant from South Africa pointed out that the categories selected by the group resembled the stages in reform planning, effectively defining the steps necessary to plan and implement a strategy to ensure access of the poor to health care services.



Issues identified by participants included the following:

- Research Issues
  - Does fee level affect user behavior?
  - What about "dependent syndrome"?
  - Do users comply with the system?
  - Do those who can afford to pay more do so through health levies?

- Policy Issues

  - How can the poor be identified?
  - Who should identify the poor?
  - Who should cover the cost of services for the poor and how?
  - Should the poor be held partially responsible for fees to avoid over-utilization of services?
  - How much revenue is retained by facilities and is it spent to subsidize the poor?
  - Are revenues reallocated to promote equity?
  - How and when should benchmarks be reviewed?
  - Are equity issues in other sectors considered?

- Implementation Issues

  - How are mechanisms to identify the poor defined and implemented?
  - How easy is it to identify and classify the poor?
  - What is the role of the head of the facility in identifying the poor?
  - How is income determined in the informal sector?
  - Is there a stigma attached to being classified as "poor"?
  - How transparent is the system? Are users aware of how revenues are spent?
  - Are users informed of fee levels and exemption options?
  - How can informal user fees be curtailed?

- Administrative Issues

  - How can waiver and exemption systems be monitored and evaluated?
  - How can the impact of waivers and exemptions on equity be assessed?
  - How expensive are cost recovery and means testing mechanisms?

4.3.3 Proposals To Address Issues

After key issues were identified and categorized, participants defined several options to improve equity under user fee systems. As pointed out by Dr. Newbrander, these options are not mutually exclusive, but rather can be combined to effectively ensure access of the poor to health services at all levels of care.

Options identified included:

- Direct targeting (income-based)

  - Means testing (formally determined)
  - Point of service determination
  - Credit (delayed application of waiver/community inducement)

- Characteristic targeting

  - By disease or illness
  - By group (demographic, employment, special)
  - By geographic areas
  - By services
  - By level of care

- Reallocation of financial resources

  - Fees collected
  - Within the central health budget

In the last concurrent session on equity issues, participants worked with the co-chairs to debate and develop criteria to evaluate the options to improve equity that were identified. Criteria were designed to be used to evaluate ongoing programs designed to ensure access of the poor to health care services, as well as to be used to plan the most cost-effective and successful future programs. The group envisioned using a matrix to roughly compare each option listed above against each criterion, but ultimately did not have time to complete this activity. The eight evaluation criteria that were developed included the following:

- Administrative Costs
- Effectiveness in Protecting the Poor (Minimization of Undercoverage)
- Prevention of Leakage
- Acceptability to Public and Community
- Promotion of Public Health Goals
- Consistency of Application of Waivers or Exemptions at Different Facilities
- Local Ownership of System and Revenue
- Minimization of Abuses of the System

4.3.4 Discussion

After the group's rapporteur, Mr. Chitopo, presented the above findings to the plenary session, several issues and questions were raised by participants.

- The issue of how to assess informal income, especially among farmers and non-wage earners in rural areas, was minimally discussed.

- One participant asked for a clarification of means testing and session co-chairs Newbrander and Cross explained that means testing was merely one mechanism to attempt to determine the ability of the patient to pay the fees.

- Another delegate stated that he felt no one should be denied health care. He suggested that a levy specifically earmarked for health care might be more effective than reallocating resources to ensure equity.

5.0 Next Steps

For the final plenary session of the workshop participants from the seven Southern African countries were asked to identify next steps and future directions in their respective countries relative to the topics discussed at the workshop. This included plans for in-country work, identification of areas where future technical assistance might be needed, and opportunities for regional cooperation and exchange. All of these steps were to be identified within the topic areas of the workshop, including:

- Hospital autonomy;
- Health insurance;
- Equity -- protecting access of the poor to health services under user fee systems;
- Decentralization; and,
- National health care financing strategies, including National Health Accounts as a planning tool.

Participants were asked to try to list at least four to five specific actions that would be most valuable to their country-level work. What stood out as perhaps most encouraging from the country presentations was that all countries are planning or implementing activities in these topic areas. The topics were thus relevant to participant experiences and information needs. The session provided participants with an opportunity to exchange ideas for future activities and to assist donors in planning for future collaboration. It also illustrated the diversity of solutions that have been undertaken in the region to address the many challenges that health sector reform poses.

The results of this exercise highlighted the participants' needs for future technical assistance in three main areas:

- Continued exchange of information and experiences, through study tours, south-south collaboration, and other fora which provide opportunities for the exchange of ideas and networking;

- Institutional capacity building and training; and,

- Situational analyses and further research to inform the health sector reform process.

Table 3 on the following page presents more country-specific next steps -- planned and ongoing activities -- in the five topic areas of the workshop outlined above for the six Southern African countries (and Ghana) that participated in the workshop. Suggestions for possible technical assistance are also included.

Dr. Abraham Bekele, Dr. Peter Berman, and Mr. Alex Ross closed the final session of the workshop on behalf of USAID and DDM. Participants were thanked for their frank and energetic contributions. Many participants also took the opportunity to express their appreciation to USAID and DDM for a useful and well-designed conference. All parties expressed their interest in and commitment to future collaboration.

Table 3: Country Participant Plans and Areas For Future Technical Assistance

Country	*Health Care Financing Proposals*	*Hospital Autonomy*	*Equity*	*Insurance*	*Decentralization*
Botswana	Planned for in the National Development Plan.	Planned for in the National Development Plan.	Would like support to fund studies on topics such as poverty, manpower, setting priorities w/in MOH.	Planned for in the National Development Plan.	Planned for in the National Development Plan.
Ghana	Would like TA for NHA.	Need capacity building to enhance ability to manage and inform relevant civil servants; Need IEC to build political support	Need help in identifying the "poor."	Government to launch pilot scheme in 1998 but now concerned about it. Would like relevant info and training; continued regional exchange.	Would like support w/ seminars and workshops to inform public on decentralization; Need district level capacity building.
Malawi	Currently developing strategy.	In progress.	Need to review user fees system.	Plan to do situation analysis of health insurance (private).	Currently on-going process without clear direction. Need to choose model.
Mozambique	Soon to launch pilot cost-sharing program and update fee schedule.	Currently under discussion.	MOH has started to address imbalances; some vulnerable groups already protected.	Currently under discussion.	Developing training materials on effective management for local managers; decent. strategy under discussion.
South Africa	Need to coordinate, focus, and prioritize further research in this area. Need to put policy issues on the political agenda.	Strategy developed but no clear guidelines or strategy for implementation.	Need to evaluate impact of new policy which has abolished user fees for all PHC services.	Need to coordinate, focus, and prioritize further research in this area.	Need greater clarification on goals, roles, authorities of decentralization, how to measure decent. and governance issues, capacity building. Study tours, regional sharing of info/workshops.
Zambia	Draft policy document (legal Act) to be ratified this year. Would like TA for NHA.	Coordinated under Act which is currently under consideration. Would like TA to strengthen capacity (data, facilities management training).	Need TA for studies on innovative and alternative ways of protecting the poor, and determining who is "poor." Draft statute on user fees currently being debated.	Weakest area; Need TA to help in examining health insurance options.	In place.
Zimbabwe	Would like TA for NHA.	Need to strengthen capacity here to enhance autonomy in the future.	Would like to form steering committee to work on ensuring equity.	Current draft pre-proposal might be implemented after completion of a few more studies.	Currently underway; Need capacity building at decentralized units. Coordinate decent. strategy with health care finance.

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Appendix 2: Workshop Agenda

East/Southern Africa Regional Workshop
Initiatives in Health Financing: Lessons Learned
Harare, Zimbabwe
May 26-29, 1997

Day 1: Monday, May 26		
Session	**Topic**	**Presenters**
8:00 - 9:00	Registration	
9:00 - 10:00	Opening Session	Welcoming Remarks: *Oscar Picazo, REDSO/ESA* *Abraham Bekele, USAID/Bureau for Africa* *Peter Berman, Data for Decision Making Project (DDM), Harvard School of Public Health* Opening Statement: *Honorable Johnnie Carson, U.S. Ambassador*
10:00 - 10:30	Group Picture/Coffee Break	
10:30 - 12:00	Plenary Session I: Overview of Health Financing Trends and Issues in Region	Introduction to Workshop *Peter Berman, DDM* Health Sector Reform in Africa *Charlotte Leighton, Partnerships for Health Reform (PHR)* Resource Mobilization Studies *Peter Berman, DDM*
12:00 - 1:30	Lunch	
1:30 - 3:00	Plenary Session II: Country Experiences in Developing National Health Care Financing Strategies	Chair*: E. Lambo, WHO/AFRO* *Ethiopia - Beletu Woldesenbet, Alert Ethiopia* *Kenya - Dan Kraushaar, REDSO/ESA* *Uganda - Francis Mwesigye, MOH Uganda*
3:00 - 3:30	Coffee Break	
3:30 - 5:00	Plenary Session III: Health Care Financing Strategies: Southern African Perspectives	Chair: *E. Lambo, WHO/AFRO* *Zambia - F. Chindele, MOH Zambia* *Malawi - Z.D. Chikhosi, MOF Malawi* *Malawi - Oscar Picazo, REDSO/ESA*

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Initiatives in Health Financing: Lessons Learned

Day 2: Tuesday, May 27		
Session	**Topic**	**Presenters**
8:30 - 10:00	Plenary Session IV: Decentralization in the Health Sector Introduction and Sign-up for concurrent sessions	Moderator: *Alex Ross, USAID/Bureau for Africa* *South Africa - Peter Milligan* *Ghana - Emmanuel Mensah* *Uganda - Prosper Tumusiime* *Uganda - Francis Mwesigye* Respondent: *Tom Bossert, DDM*
10:00 - 10:30	Coffee Break	
NOTE: Concurrent sessions begin here. Each session has three groups: a) health insurance, b) hospital autonomy, and c) equity. Participants should join one group and stay with that group throughout the concurrent sessions.		
Concurrent I 10:30 - 12:00	A. Social Health Insurance: Kenya, Tanzania, South Africa	*Dan Kraushaar , REDSO/ESA* *South Africa - Alex van den Heever*
	B. Hospital Autonomy: Lessons Learned	*Peter Berman, DDM* *Malawi - D. Mbalame* *Ghana - A. Obuobi*
	C. Key Concepts and Critical Elements of Equity	*Bill Newbrander, MSH* *Peter Cross, MSH*
12:00 - 1:00	Lunch	
Concurrent II 1:00 - 2:30	A. Planning for Social Health Insurance in Zimbabwe	*Zimbabwe - Simon Chihanga* *Zimbabwe - Mathew Ncube*
	B. MOH and the Autonomous Hospital: The Government Perspective	*Ghana - Emmanuel Mensah*
	C. Common Experiences: What Affects the Effectiveness of Protection	
2:30 - 3:00	Coffee Break	
Concurrent III 3:00 - 4:30	A. Innovative Health Financing Mechanisms: The Experience of Medical Aid Societies	*Zimbabwe - MacDonald Chaora* *Zambia - Hilda Mutayabarwa*
	B. MOH and the Autonomous Hospital: The Hospital Perspective	*Kenya - A.K. Muita* *Zimbabwe - C. Maziwa* *Ghana - K.K. Pumpuni*
	C. Equity: Policy and Management Issues	*Bill Newbrander, MSH* *Peter Cross, MSH*
4:30 - 5:00	Coffee Break	
5:00 - 6:30	Plenary Session V: National Health Accounts: Applications and Methods	*Peter Berman, DDM* *South Africa - Di McIntyre*

Day 3: Wednesday, May 28		
Session	**Topic**	**Presenters**
Concurrent IV 9:00 - 10:30	A. Planning for Private Indemnity Insurance in South Africa	*South Africa - Alex van den Heever*
	B. Implementing Hospital Autonomy	*Tom Bossert, DDM* *Kenya - A.K. Muita*
	C. Equity: Group Work: Developing Practical Applied Guidelines and Solutions	*Bill Newbrander, MSH* *Peter Cross, MSH*
10:30 - 11:00	Coffee Break	
Concurrent V 11:00 - 12:30	A. Insurance Working Group - Proposals for Further Action	*Moderators: M. Chaora, Oscar Picazo*
	B. Hospital Autonomy Working Group - Proposals for Further Action	*Moderator: Tom Bossert*
	C. Equity Working Group - Proposals for Further Action	*Moderator: Bill Newbrander*
12:30 - 1:30	Lunch	
1:30 - 3:00	MAKE-UP Session 1: Groups learn about and discuss one of the topics they did not attend	*Resource persons*
3:00 - 3:30	Coffee Break	
3:30 - 5:00	MAKE-UP Session 2: Groups learn about and discuss the other topic they did not attend	*Resource persons*
6:00	Outing: Chapungu Village	

Initiatives in Health Financing: Lessons Learned
Harare, Zimbabwe
May 26-29, 1997

Day 4: Thursday, May 29		
Session	**Topic**	**Presenters**
9:00 - 10:30	Plenary Session VI: Report to Plenary from Three Groups on Key Issues, Needs, Proposals (with discussion following each presentation)	Chair: *Beletu Woldesenbet, Alert Ethiopia* *Hospital Autonomy: Dr. Modukanele, Botswana* *Social Insurance: Dr. Moalosi, Botswana* *Equity: Fabion Chipoto, Zimbabwe*
10:30 - 11:00	Coffee Break	
11:00 - 12:30	Country Group Work to Develop Proposals for Future In-country Strategies and Areas for Regional Collaborations	Chair: *Abraham Bekele*
12:30 - 1:30	Lunch	
1:30 - 3:00	Plenary Session VII: Report on Group Work and Discussion	*Country representatives from Botswana, Ghana, Kenya, Malawi, Mozambique, South Africa, Zambia, Zimbabwe, and Uganda*
3:00 - 3:30	Closing	

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