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**ORGANIZATION MONDIALE DE LA SANTE
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OFFICE OF THE WHO REPRESENTATIVE FOR UGANDA

**KAMPALA DECLARATION
ON FAIR AND SUSTAINABLE HEALTH FINANCING**

**Report from the Regional and Evidence based Workshop in
Kampala 23-25 November 2005**

**MOH Uganda, WHO, WB, Dfid, Save the Children UK,
UNICEF Southern Sudan, Belgian Embassy and
Belgian Technical Cooperation (BTC) and Sida**

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The Kampala Declaration on Fair and Sustainable Health Financing

We, the participants in the Evidence Based Workshop on Health Financing in Kampala, held between the 23^d and 25th November 2005, declare the following to be our common views of a way forward for the development of fair and sustainable health financing in low income countries:

1. Health is a fundamental human right, which must be supported by fair and sustainable health financing systems, based on equity and efficiency in promoting universal access to quality health care and protecting people, especially those living in poverty or in conflict areas, from financial risks and catastrophic health expenditures;
2. The transition of health systems to reach universal and equitable access to quality health care requires a sustainable financial resource base in meeting the health needs of the population, without causing impoverishment, and contributing to the attainment of national development goals and economic growth through improved health status;
3. The health financing system needs to be developed within the particular macroeconomic, socio-cultural and political context of each country. It should create balanced incentives with regard to equity, efficiency, sustainability and quality of care;
4. The collaboration between governments and development partners should follow internationally respected principles of the Paris Declaration of 2005 and thus ensure national ownership of the health development policies and processes, maximized use of limited resources and reduced transaction and management costs;
5. Donor financing needs gradually to be replaced with nationally mobilized resources in line with the Abuja Declaration to ensure sustainability and country ownership of the health development process;
6. Out of pocket spending on essential health care should be minimized, while governmental spending on health should be increased and the scope for prepayments expanded in line with WHA resolutions 58:31 and 58:33 with a view to avoiding impoverishment of households and moving towards universal coverage;
7. Governments should ensure efficient and equitable allocation and utilization of human and financial resources in the health sector;
8. Implementation of fair and sustainable health financing reforms, strategies and action plans should be based on the principles of accountability, transparency, non-discrimination and stakeholder participation;
9. All stakeholders should use evidence generated from the use of sound scientific methods in the development of health financing reforms and functions; and
10. The development partners should provide adequate financial and technical support for capacity building in fair and sustainable health financing at the regional and national levels.

As agreed by the participants
25th November 2005

FRAMEWORK FOR FAIR AND SUSTAINABLE HEALTH FINANCING IN AFRICA

EXECUTIVE SUMMARY

Fair and sustainable health financing in Africa focuses on providing support to countries, which are going to undertake health financing reforms. Existing African systems of taxation, social security institutions, fee structures, and organisation of medical service providers and insurers have all developed out of historical processes conditioned by experiences of nation-building, colonialism, global initiatives, labour movements, wars, communal and kinship patterns, and medical and technological change. Citizens already have developed beliefs and expectations regarding the proper ways to pay for health care and countries have established administrative mechanisms for revenue collection or fees. As all social arrangements, these can and do change, but not in simple unconstrained ways. Therefore, the costs and difficulties of altering social institutions and of creating new ones must be an integral part of any discussion about health financing policy.

The appropriateness of a fair and sustainable health financing policy in any particular country will depend on its specific history, institutions, culture, politics and economic resources. But the different means available should always be judged with regard to how well they are likely to achieve the goals of health, equity and efficient use of health care resources when evaluated in context.

The need for improved financial and technical support in implementing health-financing reforms in the African region is critical. Countries have been implementing health financing reforms for decades but the impact on health has been weak, today only a few African countries have high quality data on health spending. The use of evidence-based data will aid health policy formulation, implementation, management as well as monitoring and evaluation and research of health financing reforms. Attention has also to be paid to the organizational and legislative aspects of health financing reforms. It is hoped that the support to build health financing capacity in countries will be institutionalised such that countries will be able to implement, monitor and evaluate health financing reforms that protect people living in poverty from catastrophic health expenditures and promote efficient and high quality health care service provision leading to good health for all people in the countries.

This framework paper has been used as the major reference document during the workshop and has been developed in close collaboration between WHO/HQ, WHO/AFRO and WHO Country Office in Uganda. It is a synthesis of health-financing policy documents from WHO such as reports from the World Health Assembly, the Executive Board, Policy and Technical Briefs papers and reports from the Regional Committee for Africa and health financing policy experiences gained in the African Member States based on NHA data.¹

¹ For additional information, see WHO Health Financing website; http://www.who.int/health_financing

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LIST OF ACRONYMS AND ABBREVIATIONS

CCS	Country Cooperation Strategy
CMH	Commission on Macroeconomics and Health
EIP	Evidence and Information for Policy
FSHF	Fair and Sustainable Health Financing
GDP	Gross Domestic Product
HFP	Health Financing Policy
HPRS	Health and Poverty Reduction Strategies
HSPAI	Health Systems Performance Assessment Initiative
MDG	Millennium Development Goals
MoF	Ministry of Finance
MoH	Ministry of Health
NHA	National Health Accounts
OOPS	Out Of Pocket Spending
SWAp	Sector Wide Approach
USD	United States Dollar
WHO/AFRO	World Health Organization, Regional Office for Africa
WHR	World Health Report

1. INTRODUCTION

As stated in the WHO Constitution, the highest attainable standard of health is one of the fundamental rights of every human being to be enjoyed without distinction of race, religion, political belief, economic or social condition.² Successive WHO's declarations have given increasing emphasis to the need to mobilize sufficient resources for health systems in ways that are financially equitable and which assure health service access to all citizens regardless of economic circumstance. For example, as an integral part of implementing the Alma Ata Declaration, WHO began a series of studies and political initiatives to consider the role that health financing could and must play in supporting Health for All. A few years later, in 1981, the World Health Assembly passed a resolution that urged all its members to allocate adequate resources for health and, in particular, for primary health care and the supporting levels of the health system.³

The Alma Ata Declaration of 1978 and the World Health Declaration of 1998 both reaffirmed health as a fundamental human right. The United Nations Millennium Declaration and several other international agreements and commitments recognize the importance of equality in rights in all spheres of life.⁴ The State Parties to the International Covenant on Economic, Social and Cultural Rights also recognize the right of everyone to social security, including social insurance.⁵ In 1998, the World Health Assembly adopted an Annex to Article 23 of the World Health Declaration, which stated that WHO are committed to ethical concepts of equity, solidarity, and social justice and to the incorporation of a gender perspective into our strategies. WHO emphasises the importance of reducing social and economic inequities in improving the health of the whole population. WHO also ratified and elaborated on these priorities in its Corporate Strategy (CS) framework, which was even more explicit in its attention to health financing issues.⁶ This document identifies four strategic directions related to improving health with special emphasis on the health of the poor; promoting healthy lifestyles and environments; developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair, and frame enabling policies to assure that the health dimension is incorporated into all spheres of public policy. WHO's Regional Offices have also actively addressed questions regarding health system financing in a range of policy statements and studies regarding health financing. In May 2005 a resolution was adopted by the World Health Assembly⁷ again calling for increased national and international funding for health systems especially for maternal neonatal and child health while encouraging nations to move towards universal coverage by moving away from user fees to more prepayment and pooling mechanisms.

² Preamble to the Constitution of the World Health Organization, 1946.

³ WHA34.37, "Resources for Strategies for Health for All by the Year 2000", accompanied by a technical document, WHA A34/Tech.Disc./1. 30 March 1981.

⁴ Alma Ata Declaration, 1978; World Health Declaration 1998; United Nations Millennium Declaration 2000, and see for instance the Universal Declaration of Human Rights, 1948; the International Covenant on Economic, Social and Cultural Rights, 1966; and the Convention on the Elimination of All Forms of Discrimination against women.

⁵ Article 9, International Covenant on Economic, Social and Cultural Rights, 1966.

⁶ A Corporate Strategy for the WHO Secretariat: Report by the Director General. EB105/3. WHO December 1999.

⁷ WHA 58.31 "Working towards universal coverage of maternal, newborn and child health interventions". WHO May 2005.

Fair and sustainable health financing (FSHF) aims to make funds available, to ensure that all individuals have access to effective, efficient and high quality public health and personal health care.^{8,9,10} This means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so. The WHO Regional Committee for Africa, in its 49th Session noted that for health sector reforms to achieve their set goal of improving the health status of the population, they must first produce changes that will lead to health systems development and strengthening as prerequisites for improving the performance of health systems.¹¹ The Regional Committee called upon Member States to ensure that Government assumes leadership at every stage of the reform process and urged the Regional Director to develop a framework that will guide Member States in designing, implementing and evaluating their health sector reforms.

During the 52nd session of Regional Committee in Harare, Zimbabwe, Health Financing was discussed at a Round Table and Member States requested the Regional Director to provide support to issues on general health financing and also on social health insurance and to organize as soon as possible, a meeting bringing together financing experts so that they would identify the approaches most suited to the context of the countries of the Region¹². At the WHO 55 Regional Committee meeting for Africa in Maputo 2005 a special session was held to Ministers of Health and stakeholders to discuss fair and sustainable health financing.¹³

The aim of this document is to initiate the development of a health financing policy framework for the African Region that will support the Member States in developing sustainable and fair health financing strategic plans to be integrated in their national health plans to improve the Health MDG targets.

2. SITUATION ANALYSIS

2.1 Epidemiological and socio-economic context

The countries in the African region are facing huge disease burdens, especially HIV/AIDS, and excess premature mortality, scarce resources and low economic growth. The annual population growth rate diminishes with increasing income. The poorest countries have the lowest life expectancy and life expectancy increases with increasing income. The average life expectancy at birth is 50 years that can be compared with 74 years in the European region. Ill health contributes

⁸ Executive Board EB115/8, 115th Session 2 Provisional agenda item 4.5: Social health insurance. Report by the Secretariat. WHO December 2004.

⁹ WHA 115th Session EB115.R13, Agenda item 4.5 24: Sustainable health financing, universal coverage and social health insurance. WHO January 2005.

¹⁰ Fifty-Eight World Health Assembly WHA 58.33. Agenda item 13.16 25. Sustainable health financing, universal coverage and social health insurance. WHO May 2005.

¹¹ AFR/RC/49/R2: Health sector reform in the WHO African region: Status of implementation and perspectives.

¹² Health Financing. Being a Round Table 3 at the Fifty-second session of the WHO Regional Committee for Africa, 2002 (also in French and Portuguese).

¹³ Report of the special session – Sustainable health financing in Africa, Annex 16. The fifty-fifth session of the WHO Regional Committee for Africa. WHO Regional Office for Africa, Brazzaville August 2005.

significantly to poverty and low economic growth. The economic value of lost life years in 1999 due to AIDS was estimated to be 12% of the gross national product of sub-Saharan Africa. Average economic growth in malaria-free zones is at least 1% higher than in malaria-endemic areas.¹⁴ For every 10% increase in life expectancy at birth there is a corresponding rise in economic growth of at least 0.3%-0.4% per year. The probability for children of dying under five years is 182 in poorer countries and 58 per 1 000 live births in richer countries. In year 2000, 70% of the 10.7 million deaths that occurred in the African region resulted from the ten most common causes; among those HIV/AIDS, lower respiratory tract infection, malaria, diarrhoeal diseases and maternal and prenatal conditions alone accounted for 54% of the deaths and 51% of the disability-adjusted life years.⁵ This heavy burden of disease effects productivity, demography and education and have contributed significantly to Africa's chronically poor economic performance.¹⁵

Fifty-two percent of the countries in the African region are severely indebted and 20% are modestly indebted. The human poverty index for the region is 40% and the average of population living on less than one USD per day is 44%. It can also be noted that 47% of the population in the region lack access to adequate sanitation facilities; 40% lack access to safe drinking water; 40% of adults in the region are illiterate; primary school enrolment is 63% and secondary school enrolment is 21%¹⁶.

2.2 Health spending

The countries in the African region spend in average 5.7% of their gross domestic product on health, (almost the same amount as spent in 1995) which can be compared with the average of 8.2% for all countries worldwide. The total health expenditure per capita in the African region is the lowest in the world. It is almost 15 times lower than the global average and far away from the amounts spent in the European and American regions. The African countries spend in average USD 34 per capita that are regarded as the minimum government expenditure required for providing an essential health package of public health interventions. Thirty-five countries (76% of all countries in the region) spent less than USD 34 per capita. The proportion of governmental health spending of total government spending in the African regions is 8%.

Forty-four countries (96% of all) spent less than 15% of their national budgets on health. The few health resources available are often inequitably distributed and inefficiently managed. Geographic inequities persist in the distribution of resources, with urban areas having more resources than rural areas and tertiary level health facilities consuming more resources than primary level health facilities¹⁷.

¹⁴ Gallup J.L, Sachs JD. The economic burden of malaria. *American Journal of Tropical Medicine and Hygiene*, 2001; Jan-Feb; 64 (1-2 Suppl): 85-96.

¹⁵ Bloom DE, Sachs JD. Geography, demography, and economic growth in Africa, *Brookings Papers on Economic Activity*, 1998; 2: 207-95.

¹⁶ UNDP. *Human development report 2002*. New York, Oxford University Press.

¹⁷ Eastern and Southern African NHA Network. National Health Accounts in Eastern and Southern Africa: A comparative analysis. Unpublished report. Cape Town, South Africa, 2001.

The countries in the African region are mainly using eight alternative ways of collecting revenue to fund health care services. These are general tax revenue, earmarked taxes, social health insurance, private health insurance, community health financing, user fees (cost-sharing/cost-recovery), medical savings accounts and donor funds.

The private health expenditure amounts to be 56% of total health expenditures in year 2000. That is the second highest share of private health expenditures spent on health in the world; it is two times more than what is spent in the European region. The health systems of most African countries depend largely on household's direct out-of-pocket payments (averaged 28% of total health spending). The share of out of pocket spending and private health expenditures is significantly higher in the poorer countries compared to the richer countries. It has been found that user fees disadvantaged the poor¹⁸.

The governmental spending on health amounts to be 44% of total health expenditures. In average 35% of the total health expenditures come from general tax revenues that correspond to USD 12 per capita. During the last five years the general government health expenditures of total health expenditures increased marginally. The major part of that increase is explained by direct support from external resources; 6% of total health expenditures or USD 2 per capita. The poorest and most indebted countries rely heavily on external resources compared with the richer countries, 28% and 4% of total governmental health expenditures respectively.

Health insurance schemes seem to be a promising option by pooling risks and transferring unforeseeable health care costs to fixed premiums but there is some evidence that social health insurance or commercial insurance schemes alone cannot significantly contribute to increased coverage rates and access to health care; especially in rural and remote areas due to low household incomes, high transaction costs and market failure. Seventeen countries in the region (35% of all countries) are using some type of pre paid plans. The poorer countries use a significant lower share of prepaid plans as a proportion of private health expenditures compared to the richer countries. There has been almost no change in the use of prepaid plans in the region since 1995; they still remain on 44% of private health expenditures. Only seven countries in the region have introduced social health insurance schemes. The contribution from these schemes is 3% of the total health expenditures. During the last 10 years there has not been any major change in social health insurance spending as a proportion of general government health expenditures.

Several countries in the region have been implementing community-financing schemes, which partly could be explained by a reaction to adverse effects of user fees. The schemes are heavily influenced by contextual factors, and the revenues from the schemes have been small. The net impact of the schemes is inconclusive¹⁹ they have the potential to increase community participation and access to health care but struggle with small risk pools, adverse selection, failure to protect the poorest poor, dependency on subsidies, financial, managerial and

¹⁸ Gilson L. The lessons of user fee experience in Africa. In: Beattie, A. et al. (eds.), *Sustainable health care financing in Southern Africa*. Papers from an EDI health policy seminar held in Johannesburg, South Africa, June 1996. EDI learning resources series, Washington, D.C.

¹⁹ Preker AS, Carrin G, Dror D. et al. Effectiveness of community health financing in meeting the cost of illness. *Bulletin World Health Organisation*, 2002; 80 (2): 143-50.

sustainability problems. Some countries are implementing medical savings accounts but they have played a minor role in health financing in the region.

3. CHALLENGES

With increasing disease burden, low economic growth, huge informal sector, high unemployment, high levels of poverty, inequitable distribution of income, and weak public sector management, countries in the African region are facing the challenge of ensuring access to essential and quality health care services that are financed equitably.

The utmost challenges in the health care system that a large number of countries in this Region will have to overcome in developing viable and fair financing strategies include:

- i) Failure of establishing cost recovery safety net mechanisms in protecting the poor;
- ii) Lack of financial resources to produce good health for all;
- iii) Lack of human resources is a bottleneck in improving health system performance;
- iv) Inefficient use of available health resources providing equitable health care;
- v) Limited technical capacity to manage the complex health financing issues and also high turnover of health staff, managers, policymakers and planners mainly due to poor financial incentives;
- vi) Limited institutional capacity to facilitate the development and implementation of viable and fair financing strategies; and
- vii) Weak monitoring and analytical capacity; leading to evidence not being used for formulating health policy and taking decisions.

To overcome the above-mentioned constraints, countries also need to collect empirical evidence on economic, social, cultural, political, epidemiological context, health financing system and health outcome before embarking on health financing reforms.

4. CONCEPTUAL APPROACH TO HEALTH FINANCING

4.1 Stewardship and health

Health financing systems have to be properly assessed in light of their impact on the main goals of the health systems of which they are a part. WHO has developed precise definitions for three major and intrinsic goals of any health system: health status of the population, responsiveness, and fairness of financial contributions. Health financing affects all of the goals in complex ways; therefore, it is necessary to have a comprehensive framework of analysis so that advising changes in one element of health financing takes into consideration the full range of consequences.

WHR 2000 provides a framework for analysing the role of financing in the overall health system. It describes the context within which the financing function operates and the channels through which it affects the health system's performance in terms of health, responsiveness and fairness in financial contributions. Financing is one of four major functions of any health system. The others are Resource Generation, Service Provision, and Stewardship. It is important to note that Stewardship is a function that creates the framework within which the other functions operate. In this regard, a health financing policy is itself directed toward informing good stewardship and oversight of the health financing function, taking into account the channels by which health financing influences health system performance.

To ensure that individuals have access to health services, three interrelated functions of health system financing are crucial: revenue collection, pooling of resources, and purchasing of interventions. The main challenges are to put in place the necessary technical, organisational and institutional arrangements so that such interactions will protect people financially the fairest way possible, and to set incentives for providers that will motivate them to increase health and improve the responsiveness of the system. The three health functions are often integrated in many health systems.

4.2 Collection of health funds

Collections of health funds focuses attentions on the different ways funds enter the health system; taxes, payroll contributions, insurance premiums, co-payments, direct fees and external funding. It is important to recall that the choice of a particular financing source has implications for all three health system goals through the way it influences equity, effectiveness of services, and mobilisation of funds. Each source implies a different collection process, different pattern of responsibility and accountability for the use of funds, differing degrees of progress, different ways of allocating resources to services, and different relationships between the population and providers in delivering health care services.

General government taxes

General government taxes are collected from individuals and firms and are commonly used to fund health services. This form of funding is generally considered to be efficient and equitable. However, it depends largely on national macroeconomic performance and competing demands from other sectors, the size of the tax base and human and institutional capacity of the government to collect taxes.

Earmarked taxes

Earmarked taxes can be used in funding health care services. Sin taxes like those on alcohol or tobacco can also be effective in reducing the demand for harmful substances by raising the price closer to its true social costs, thus increasing the price for the consumers. They might be inequitable by imposing an additional tax on the poor who are the largest consumers of those products.

Social health insurance

Social health insurance is a system that involves mandatory contributions by individuals and employers. This type of arrangement is advantageous because it does not force individuals into catastrophic health expenditure, such as using up all their resources, borrowing or drawing upon households and extended family networks as does the direct-out-of pocket payment mechanism.

It can be an effective way of generating resources for. In a situation where social health insurance is not universal, it can have a negative impact on equity and provision of health care services, in the sense that it tends often to create a two-tier system: one for the insured and the other for the uninsured, providing high-tech health services for the insured, resulting in high costs. Taxation and payroll deductions for social insurance will be more or less successful at raising funds for health depending on the effectiveness of domestic tax policies, rates of tax evasion, and the responsible levels of government.

Private health insurance

This type of insurance scheme covers either the formal sector alone or is operated on a voluntary basis. Large amounts of funds can be raised through private insurance. It works well in a situation where there is a large formal sector. People who face lower risks of ill health are less likely to voluntarily enrol in health insurance plans and more likely to not enrol when costs of coverage increase. Those who face higher risks of ill health are likely to choose more generous insurance plans when given the option. In a few cases, this behaviour has made it impossible to financially sustain more generous insurance plans in the face of competition from more restrictive plans. Insured people tend to use more health services than those with less coverage or those with no insurance at all. It is however inequitable due to its capacity for ‘adverse selection’²⁰ and ‘moral hazard behaviour’²¹. Government can reduce adverse selection by subsidizing those who cannot afford the premiums while ‘moral hazard’ can be reduced through co-payments.

Direct out-of-pocket spending (OOPS)

OOPS, especially user fees are commonly used together with other health fund collection instruments. Together with choice of price setting they all have different implications on provider and consumers with respect of efficiency and equity. If no exemption mechanisms for the poor are introduced together with user fees they will discriminate the poor by creating barriers of access to health care and even push households into catastrophic health spending. Efforts to replace out-of-pocket spending with prepayment have to grapple with the different behaviours exhibited by households with respect to paying at time of service compared to their willingness to join prepaid plans.

Community health insurance

Community health insurance schemes, such as the *mutuelles* in the Francophone countries, can be efficient to collect funds for non-salary costs, especially at primary health care level, and they can reduce catastrophic expenditures for the poorest. However, they contain problems of coverage, membership across different ethnic grouping, management capacity and inadequacy of resources for services provision, because the premiums are low.

²⁰ Adverse selection is a particular type of imperfect information between consumers and providers. An example is where the patient knows more about his/her potential for illness and may be able to hide this information from the insurer. Those persons with great risk will demand more coverage, while those with lower risk may opt not to be insured. This has an effect of increasing the average risk of those remaining insured, and as a result premiums rise.

²¹ Moral hazard is where the attitudes of consumers and providers of health care change because the full cost of health care is being reimbursed. The incentive to adopt healthier styles is diminished and over-utilization of health care services may occur.

Medical savings accounts

These accounts are used by individuals to save money for health in separate personal bank accounts to finance health care when need arises. The accounts can guarantee access to medical care services when need arises. However, they can fail to cover low probability and high costs for health care and can only be viable where there is an economy where the propensity to save is high.

External funding

External funding includes grants and loans to the government by international and local organizations. These offset government shortfalls in revenue and play a significant role in financing capital expenditures, essential drugs and supplies, human and institutional strengthening and some health programs. However, this financing mechanism is unsustainable and can exacerbate inequities as donor preferences might be at variance with those of governments. In addition, the resources are contingent on many conditions which often lead to delays in the implementation of activities, giving a more or less false impression of weak absorptive capacity of the countries. Over-dependence on external funding can thwart implementation of national health plans

4.3 Pooling of health funds

Pooling focuses attention on how the health financing sources are mixed together and allocated to different uses in a way that shares the burden of financing between different subgroups of the population; the sick and healthy, old and young, rich and poor. Pooling emphasises the element of sharing risks that takes place explicitly in insurance schemes but is also meant to bring attention to the implicit risk sharing that takes place in public tax-based schemes.

Analysis of pooling is key to understanding that someone always bears the risk that health service demands may exceed available resources. Insurance agencies manage the funds they have collected to address the financial risk they bear for such demands, and in some systems will shift the risk onto patients by denying care. But government health services also implicitly manage these risks, through agreeing tacitly to macroeconomic constraints such as reducing finance deficits, overworking staff, or denying or delaying care for patients (rationing by using queues and waiting lists). Thus, different forms of pooling have implications for the degree of risk sharing in the population and for who bears and manages those risks. However, there are problems in deciding optimal pooling; whether there should be one or many pools, each pooling variant having its advantages and disadvantages.

4.4 Purchasing of health care services

The efficiency and equitability of the health financing system is heavily influenced by the way health services are purchased. Purchasing is the process through which revenues that have been collected and pooled are allocated to providers to deliver a set of interventions to groups of individuals. This sub function is meant to be useful in bringing attention to understanding how funds are allocated across different inputs and uses within integrated health systems. In cases with separate financing and provision, the effectiveness and equity will be affected by whether or not purchasers are active and strategic in getting the best value for money. In systems with integrated financing and provision, accountability, administrative capacity, and budget allocation mechanisms will be critical factors in the process.

This ranges from budgeting to contracts between purchasers and independent providers and even individual transactions between clients and providers. Purchasing arrangements generate strong incentives that can alter access, quality, utilization, coverage, productivity of health providers, and allocation across interventions.

Strategic purchasing aims to serve the population with the best health care interventions or health benefit packages available from the best providers by using the best payment mechanisms and contracting arrangements in order to use the mobilized health funds as efficiently and equitably as possible. Different kinds of active purchasing can be undertaken within a wide range of health financing systems, but in all cases, they focus attention by the financing agent and the medical providers on the desired results. Strategic purchasing includes such approaches as paying bonuses for performance, some degree of capitation to share financial risk with providers; creating new oversight mechanisms such as local health boards; collecting and disseminating information about service quality of different providers and benchmarking; as well as competitive and selective contracting.

There are different options available in choosing an optimal purchasing strategy:

- i) Contracting is where the providers agree to provide health care services according to conditions put forward by the purchaser. There are several types of contracting arrangements, which creates different incentives for purchasers;
- ii) Capitation requires that the purchaser contracts with providers for maintaining health of each affiliated person in return for payment per person. Capitation has an advantage of extending services to the underserved population groups or delivering specific services such as health promotion and prevention of ill health. Health professionals tend to provide fewer services when they are paid by capitation. However, there is need for prior setting of prices for inputs, outputs and outcomes, which are not easy to determine due to limited information;
- iii) Budgeting is a payment of a particular sum that covers the total cost of health care services delivered during a given period of time. Though administratively simple, it requires administrative capacity to ensure that funds are used efficiently, distributed equitably and managed well. It also gives little incentive for improving and monitoring quality of care;
- iv) A salary system is based on a labour contract between the purchaser and the provider. The employee works on time basis and receives payments for the time at disposal regardless of number of patients treated or improvements in health;
- v) Fee per visit means that the patient pays a fee each time he visits a health facility. The fee usually covers consultation, laboratory services and drugs etc. It is a simple system to administer but discouraged frequent visits by the patients;
- vi) Fee for service requires paying for each provided health services or goods received retrospectively. Quality of care is generally high; it could increase provision of under-utilised care but also encourage overprovision of care, hence leading to cost escalation. A

disadvantage of this system includes greater managerial requirements in billing and collection procedures;

- vii) Fee per episode of illness requires paying for each episode of illness irrespective of the number of consultations, tests and drugs etc. However, a main disadvantage of this system is that it encourages overuse of the health services on the demand side and undersupply on the provider side (moral hazard);
- viii) The system with a capitation fee paid by the patient means that the patient usually pays a lump sum amount at the beginning of each time period, which gives him access to a defined package of services for the entire period. It is an administrative simple system but creates moral hazard problem and does not give any signals for better allocation of resources; and
- ix) Case based payment is payment based on a single individual case rather than a single treatment. Case based payments are used in paying family physicians, specialists, dentists, hospitals or health centres. The payment could be based on a single flat rate per case. This payment is easy to operate but fails to differentiate between treatments. The payment could also be based on a more sophisticated system that allows a higher degree of differentiation of treatments such as diagnosis-related groups (DRGs).

4.5 Priority health interventions

Guided by national health policies countries have developed minimum health care packages of priority health interventions to be delivered to the population. In general, the prioritized health interventions to be delivered can be categorized into four major groups: Health Promotion, Disease Prevention and Community Health Initiatives; Maternal and Child Health; Prevention and Control of Communicable Diseases; and Prevention and Control of Non Communicable Diseases.

Health Promotion, Disease Prevention and Community Health Initiatives

- i) Health Promotion and Education
- ii) Environmental Health
- iii) Control of Diarrhoeal Diseases
- iv) School Health
- v) Epidemic Disaster Prevention, Preparedness and Response
- vi) Occupational Health

Maternal and Child Health

- i) Sexual Reproductive Health and Rights
- ii) Newborn Health and Survival
- iii) Management of Common Childhood Illness
- iv) Expanded Programme on Immunization
- v) Nutrition

Prevention and Control of Communicable Diseases

- i) STI/HIV/AIDS
- ii) Tuberculosis

- iii) Malaria,
- iv) Diseases targeted for eradication and/or elimination

Prevention and Control of Non Communicable Diseases

- i) Non-Communicable Diseases
- ii) Injuries, Disabilities and Rehabilitative Health
- iii) Gender Based Violence
- iv) Mental health & Control of Substance Abuse
- v) Integrated Essential Clinical Care
- vi) Oral Health
- vii) Palliative Care

5. GUIDING PRINCIPLES, OBJECTIVES AND STRATEGIC DIRECTIONS

5.1 Guiding principles

In order to achieve the targets of the Regional Health For All Policy for the 21 Century²² and Millennium Development Goals (MDGs), there is an urgent need to support the countries in the region in their efforts in reforming the health sector and in particular understanding of health financing reforms. This is so because the way health systems are financed have profound effect on household access to health care and thus on their health.²³ It is necessary to find sustainable health financing strategies for the region that would mobilize adequate and sustainable resources and reduce inequities and inefficiencies in health financing and health services delivery.^{10, 24 25}

The purpose of developing a fair and sustainable health financing policy framework for the African Region is to contribute to better health, especially for people living in poverty, through improvements in the way health systems are financed. The framework can contribute to this end by supporting countries' efforts to reform their health financing policies in ways that have been demonstrated to promote equitable financing, access to appropriate health services, and fair opportunities so as to enjoy the right to the highest attainable standards of health among their populations. Governments have a responsibility to ensure that maximum available resources are directed to and used for protection of health, and to aggressively take targeted steps towards the full realization of the right to health.²⁶

Financing affects the health system's effectiveness and efficiency. For example, health-financing mechanisms influence the allocation of funds across health service levels, geographical zones, inputs, diseases and preventive measures. They also influence the productivity of health services by whether or not they assure reliable, timely, and adequate funds and accountability for being

²² AFR/RC50/8 Rev.1: Health for All Policy for the 21st Century in the African Region: Agenda 2002.

²³ Murray CJL, Knaul F, Musgrove P, Xu K, Kawabata K (2001): Defining and measuring fairness in financial contribution to the health system. Geneva: WHO (GPE Discussion Paper No. 24).

²⁴ WHO/HSF/HFP. Achieving universal health coverage: Developing the health financing system. Technical briefs for policy makers, number 1, 2005.

²⁵ WHO/HSF/HFP. Designing health financing systems to reduce catastrophic health expenditure. Technical briefs for policy makers, number 2, 2005.

²⁶ Commitment made by state parties to the Convention on Economic, Social and Cultural Rights, 1966.

well applied. Services are also affected by how prices and wages are negotiated or set, and whether payments are related to inputs, outputs or outcomes. Financing mechanisms are not the only factors influencing the efficiency of allocation across services and the efficiency with which resources are applied, but it is a very important one. To the extent that the financing function improves efficiency, it makes it possible for the health system to provide more equitable access across the population to more services of higher quality.

Financing also affects equity and non-discrimination; whether or not people can enjoy good health and obtain necessary health services irrespective of their income, ethnicity, gender or other social distinction. It directly affects how fair the financial burden is distributed between households and socio-economic groups, which depend on such things as whether payments are made through insurance premiums, taxes, co-payments, or fees; the mechanisms for cross-subsidisation and for pooling risk; and whether access to services is conditional on payments. But financing will also affect equity more broadly, and sometimes more significantly, by influencing the quantity, quality, and efficiency with which those funds are transformed into appropriate health services for the entire population with regard to need.

A fair and sustainable health financing system should support the development of an effective and inclusive health system of good quality for all. Health financing strategies should be based on principles of accountability, transparency, non-discrimination and participation. There are four key criteria constituting a fair and sustainable health financing strategy, namely; effectiveness, efficiency, equity and sustainability:

- i) Effectiveness: The financing mechanism should have the potential to make a significant difference in closing the financing gap;
- ii) Efficiency: The financing mechanism should raise funds without incurring sizeable administrative costs and it should allow for allocation of funds to high priority health needs to tackle the nations burden of disease;
- iii) Equity: The financing mechanism should reduce the risk of poor households facing catastrophic health care costs and it should allow for the cross subsidisation of the poor and vulnerable by healthy and wealthy sectors of society as well as allow universal access to health care; and
- iv) Sustainability: The financing mechanism should be relied upon to provide sustained and predictable funds for the foreseeable future.

Choice and implementation of health financing reforms should be guided by relevant evidence on current levels of health spending, sources and uses of those funds; economic viability analyses of various financing options; health policy analysis, legal analysis; socio-political environment analysis, among others. Information used for planning and allocation of resources to health policies, programmes and services information should be disaggregated by sex. In distribution of resources the most vulnerable groups should be identified and given specific consideration. Financing options should be assessed for their impact of both women and men, and strategies devised to prevent any negative impact.

5.2 Objectives

The basic premise is that WHO should encourage and support changes in national health financing policies that fulfil the following objectives:

- i) Reduce financial obstacles to health service access, particularly among the poor;
- ii) Reduce the risk that households will face catastrophic health expenditures due to ill health or injury;
- iii) Mobilise sufficient financial resources to support adequate health systems, including external aid to the lowest income countries where needs far outweigh available domestic resources;
- iv) Provide incentives for effective and efficient provision of good quality and appropriate health services; and
- v) Achieve good governance, transparency and accountability.

5.3 Strategic directions

Following ten strategic directions have been identified to support countries in establishing fair and sustainable health financing:

- i) Improve equity and efficiency in allocation and utilization of existing health care resources;
- ii) Try to define what could be a feasible per annum amount to spend on health with respect to health outcomes. The Abuja benchmark is to reach is 15 % of public spending;
- iii) Mobilize financial and sustainable resources efficiently by using appropriate revenue collection methods;
- iv) Increase governmental expenditures to fund health care as far as possible;
- v) Minimise large net out-of-pocket spending on health, such as user fees, to protect households from catastrophic levels of health expenditures;
- vi) Introduce or strengthen prepaid plans such as national social health insurance or publicly subsidised services;
- vii) Examine whether community social health insurance could be used as a complement to other health financing options;
- viii) Improve the use of donor funds, by following internationally respected principles of the Paris declaration of 2005 of Alignment and Harmonization and thus allow for national ownership of health and maximized use of limited resources, reduced transaction costs and improved accountability;

- ix) Use a mix of health financing sources and payments mechanisms to health care providers that will create balanced incentives with regard to equity, efficiency, productivity and quality of care; and
- x) Ensure that all health interventions implemented strengthen the regular health system.

6. IMPLEMENTATION

6.1 Contextual approach

The importance of health institutions, epidemiological, economic, social, cultural and political context is extremely evident. It is necessary to take full advantage of successful local institutions and mimic their successful strategies if possible. It is also necessary to attend to the process of health financing reforms and their related transitions because such reforms require changes in institutions, management, accountability mechanisms and population behaviours that take time and resources.

Health care systems are necessarily shaped by the politics of their countries, and cannot be understood or altered without taking this fact into account. The emphasis given to different health system goals, the relative importance assigned to health, and the assignment of responsibilities for health care between individuals, families, and society, are all influenced by domestic political factors. People who use health care services, medical professionals, insurance institutions, employers, and unions are among the prominent groups that take a particular interest in public policy toward health financing. It is necessary to combine the political processes of governance and collective decision-making with the widespread recognition that public policy must play a significant role in guiding the health system. Therefore, the design of sustainable health financing reforms in any particular context should not only recognise political influences, but explicitly address and take advantage of the opportunities presented by political debate and governance.

With due respect to the evidence demonstrating that no single health financing system has proven superior in attaining the goals of equity, health and responsiveness, and that recommendations for any particular country must take into account how particular proposals will operate in that particular context. Sustainable health financing will affect equity, effectiveness and amount of funds mobilised for health because of the interrelationships between financing and the resource generation, provision, and stewardship functions of the health system. Consequently, there is no single "right" health financing system and health financing policies should always be judged with regard to how well they are likely to achieve goals of equity, health and responsiveness within the specific historical, institutional, cultural, political, and economic context.

The implementation of health financing reforms should be guided by relevant evidence on current levels of health spending, sources and uses of those funds; economic viability analyses of various financing options; health policy analysis, legal analysis; and socio-political environment analysis. It is important to build capacity in health financing in countries by providing training and technical assistance to countries and support technical experts that have problem solving expertise as well as support to health economics in training institutions in the region.

However, there is relatively little empirical evidence of systematic assessments of how the health-financing function affects equity, effectiveness or mobilization of funds. The implementation of the health financing information system National Health Accounts (NHA)²⁷ will enable support in formulation, development, implementation, monitoring, evaluation and research of health financing reforms and promote stakeholder collaboration, consensus building, good governance, transparency and accountability. NHA has been designed specifically to be a policy tool for improving the capacity of health sector policy makers and planners to manage their health systems. The NHA methodology can easily be understood and interpreted by all policymakers, including those without economic backgrounds. This allows decision makers to understand how health resources are used in health system, to review allocation patterns, assess the efficiency of the current resource use, and to evaluate impact of health care reform. It also allows for comparison of health system at different points in time, and comparisons of one country to another's health system with others. Such information allows policymakers to better tailor the needs of their population.²⁸

6.2 Main activities

The following main health financings activities have been identified in implementing health-financing strategies:

- i) Sensitizing health policy makers and planners on need of country specific health financing options;
- ii) Developing country specific health financing strategies in close collaboration with stakeholders in countries;
- iii) Integrating the Millennium Development Goals (MDGs) with the Poverty Reduction Strategy Paper (PRSP) and Commission of Macroeconomics and Health (CMH) and frameworks;
- iv) Integrating health financing country strategies into national strategic health plans, following internationally respected principles of the Paris Declaration of 2005 of Alignment and Harmonization. e.g. Sector Wide Approaches (SWAp);
- v) Developing and providing guidelines in health financing;
- vi) Providing training and technical assistance;
- vii) Providing support to training institutions in health economics; and
- viii) Implementing National Health Accounts (NHA).

²⁷ WB, WHO and USAID. Guide to producing National Health Accounts (NHA) with special applications to low and middle-income countries. WHO, Geneva 2003.

²⁸ Proposed Strategy to Support National Health Accounts (NHA) in the African Region. Consensus Document from NHA Partners Meeting in Nairobi, Kenya 2002. AFRO Brazzaville, Congo 2002. (also in French and Portuguese)

6.3 Key factors in implementation

Enabling factors

- i) Strong political commitment;
- ii) Good governance, transparency and accountability; participation, non-discrimination
- iii) Proper management, monitoring and evaluation;
- iv) Active partnership, coordination and collaboration between government, agencies, donors and research institutions; and
- v) Adequate financial and technical support.

Constraining factors

- i) High disease burden and excess of premature mortality
- ii) Low economic growth and high levels of poverty;
- iii) Huge informal sector, high unemployment and narrow tax base;
- iv) Lack of human resources in health care;
- v) Limited technical and managerial capacity in health care system; and
- vi) Limited evidence based data available for analysis.

7. TECHNICAL SUPPORT TO COUNTRIES

7.1 Justification

It is necessary that health-financing reforms are fair and equitable. The reforms have also to promote high quality care, effective, and efficient health care provision in an equitable way. Governments have to take the leadership in health in collaboration with all stakeholders in health care system. Good governance, transparency and accountability are of utmost importance. Several African member states have requested special support in implementing national social health insurance schemes and community health insurance schemes.

There is no single health financing formula that has been proven to be superior in reforming health financing systems. A given health financing strategy will affect quality, effectiveness, equity in resource mobilization and health service provision and population health quite different from other strategies. Each country has to take into account how different health financing strategies will operate in that particular country context. The effects will depend on countries specific historical, institutional, cultural, legal political and socio-economic context.

7.2 Capacity building

The capacity building in health financing to countries could be provided by the use of three complementary stage model:

- i) Self-help by using national experts;
- ii) Assistance via regional institutions; and
- iii) International assistance.

In each of these stages the national counterparts should be involved or trained to assume a policy and technical role. Main activities at country level are technical assistance implementing health-financing reforms, sensitising meetings, seminars, hearings, training workshops and courses for stakeholders in health care. It is important to provide consultants to countries in analysing the health care system, designing, developing and proposing health financing strategies and appropriate measures of implementation, monitoring, evaluation and research.

Partnerships

The support to countries implies increased collaboration between governments, international agencies and NGOs in health care in to provide support to countries in designing, developing, implementing, monitoring and evaluating health financing reforms. Hence, there is great need for donors to coordinate their efforts related to health financing.

Health policy information and dissemination at regional and country level

Health policy information and dissemination of information aims to increase the usefulness of health financing data as a tool for health policy making and encompasses activities such as holding briefing sessions and meetings for government policymakers, donors nongovernmental organizations staff on the relevance of the need of health financing reforms for policy development, implementation, monitoring and evaluation of health sector reforms. It will also involve publications and dissemination of health financing work in order to build competence in the region and inform health policy makers.

Financial and technical support at regional level

Provision of courses at regional level, including the development of course materials, providing courses on a regular basis to technical personnel in government, donor agencies, nongovernmental organizations and training institutions within countries and at sub-region level have to be strengthened. Training institutions should also be encompassed to incorporate NHA and health financing in their curriculum. The courses would be most relevant to all countries planning to undertake health-financing studies in order to build a sustainable local critical mass of practitioners through the international support. In the long run the courses should be offered in MPH, economics, health economics, health financing and management training. Workshop activities are also important, especially when there is health-financing data available for different years or from different countries. Given these data, it is possible to make comparative analysis of country findings, discuss methods, data quality, results and implications on health financing policy.

Financial and technical support at country level

There is limited technical capacity in the region for undertaking relevant analyses in support of health financing reforms. The current support to countries has mainly been developing of tools for monitoring and evaluation, support to policy and plan formulation, support to assessment processes, exchange of documentation and limited training. The development of health financing reforms are complex processes which differ from country to country and encompassing broad areas such as: design of reforms, situation analyses, policy plans; implementation with selection of interventions, management, budgeting, financing, stewardships and governance, provision of care and human resources etc; monitoring and evaluation such as triggers and indicators for monitoring and appropriate mechanisms for gathering data.

In order to undertake health financing reforms in countries by using evidence based data for health financing policy formulation, following actions have to be reinforced: strengthening national and health information systems such as National Health Accounts (NHA); strengthening the organization of health system including contracting; strengthening district health systems operational ability and assessment procedures; strengthening human resources development especially for priority programs such as HIV/AIDS, malaria and TB etc.

Establishment of mechanisms for institutionalisation of health financing reforms

The institutionalisation of health financing reforms in countries is a core issue in the region. There is need for increased technical, human and organizational capacity in countries. Among the mechanisms for institutionalisation, training institutions, especially in health economics and health financing will play an important role. That includes the strengthening of NHA and promotion of evaluation, training and research, especially in collaboration with stakeholders.

8. RESPONSIBILITIES

8.1 Countries

Countries should state ownership and commitment for implementation of health financing priority actions and should translate the priority actions into realistic national action plans and appropriate operational plans. Countries should also undertake advocacy and translate political commitment into action in order to ensure adequate allocation of financial and human resources and ensure that the undertaking of health financing reforms are part of national health development plans from the planning stage to evaluation and research.

Countries should establish mechanisms that will allow for dialogue between the Ministries of Health, Education, Finance and other health related ministries, the private sector, non governmental organizations, training institutions, health professionals and professional associations from the very early stages of planning of activities in order to ensure ownership and optimal contribution of stakeholders.

It is important to create teams at country level in order to make the capacity building of health financing at country level sustainable. The teams have to develop close relationships to health policy makers and technical professionals in the country and establish a long-term collaboration between MoH, MoF, training institutions and national authorities such as statistical bureaus, other stakeholders in health system, donors and external partners.

The main tasks for countries are to:

- Develop viable and fair and sustainable health financing policies, strategies and action plans and health financing reforms;
- Develop and maintain links between to MoH, MoF, national authorities, universities, other stakeholders in health system, WHO, donors and external partners;
- Provide a basis for coordinated support to country capacity building of health financing;
- Assume ownership of health financing activities and designate national experts in appropriate councils and organizations to assist in the implementation of health financing reforms;
- Produce evidence-based information to analyse health financing reforms;
- Conduct health financing studies;
- Commit resources to health financing;
- Use evidence-based health financing information for health policy;
- Incorporation of a genuine health financing content into strategic national health plans;
- Play an active role in health financing networks;
- Coordinate donor support to the country activities.

8.2 WHO

HQ plays an important role in strengthening the member states capacity for improving health-financing reforms. The major responsibilities are to:

- Provide technical and financial support for capacity building (e.g., training/workshops, course materials, studies, data analysis and dissemination, and technical cooperation networks) at regional level;
- Assist in capacity building and make available the necessary resources especially financial resources to countries;
- Identify and brief consultants to provide support to Member States;
- Provide guidelines, tools and instruments for data collection and analysis;
- Provide support for undertaking studies in countries;
- Provide support in implementing health financing reforms;
- Facilitate comparative studies and research;
- Production of policy and conceptual documents and methodological development;
- Assist in research, technical support and advocacy actions;
- Support WHO Regional Office for Africa and Country Offices in financial resource mobilization; and
- Play an active role in health financing networks.

WHO Regional Office for Africa (AFRO) will be responsible for coordinating the activities in the African region, in collaboration with countries, training institutions, other partners, HQ and WHO country offices. The main tasks for are to:

- Sensitise Regional Advisors and WRs on the importance of building capacity in health financing;
- Expand and improve collaboration in health financing network in the region;

- Coordination of technical cooperation in the implementation of health financing reforms;
- Identify and brief consultants to provide support to countries;
- Assist in the implementation of health financing reforms;
- Coordinate information exchange mechanisms for countries to share experiences and to define priorities in future development;
- Strengthen national capacity building in health financing through workshops;
- Provide seed funding for undertaking studies;
- Provide briefing/sensitising meetings for health policy makers and technical professionals;
- Train of WR staff, policy makers and technical professionals in countries;
- Strengthen country capacities particularly MOH in the development and implementation of health financing strategies;
- Support countries in the generation and use of data to monitor and evaluate the implementation of health financing reforms;
- Facilitate comparative studies, evaluation and research;
- Assist in providing health financing policies and strategies for the African region; and
- Assist in strengthening health financing that will improve health of people living in poverty.

The role of WHO country offices in strengthening the Member States capacity for improving health-financing reforms is of utmost importance. The country office and especially the focal point, WR-HEC will facilitate activities between AFRO and the country team. The major responsibilities are to:

- Assist governments to foster efficient pro-poor health financing policies and contribute to sustained economic growth and human development
- Sensitise policy-makers in countries;
- Create an enabling environment within which health financing activities can take place;
- Play a pro-active role in national health financing among stakeholders in health care;
- Build national and local capacities;
- Update need of country support;
- Assist in implementing health financing strategies and priority actions in countries; and
- Facilitate comparative studies, evaluation and research.

8.3 Other development partners

Local development partners, donors and multilateral agencies should support countries in resource mobilization, capacity building, brokering but also respect the countries ownerships of the health financing reform process. The main tasks for partners are to:

- Provide financial and technical support in undertaking health sector reforms in countries;
- Provide support to sensitising meetings, seminars, hearings, training workshops and courses for stakeholders in health care;
- Provide financial and technical support for undertaking health financing studies and research;
- Support reviews and dissemination of best practice cases;
- Facilitate comparative studies, evaluation and research;
- Play an active role in health financing networks; and

- Support to training institutions in collaboration with MOH.

8.4 Training institutions

The capacity of national, sub regional and regional health training institutions should be built to ensure that a critical mass of staff with appropriate skills is produced which would be involved in health financing activities. Training programs and practice should put special emphasis on building capacity and training within health economics, especially on health financing. The main tasks for the training institutions are to:

- Provide training, seminars, workshops and courses for stakeholders in health care;
- Provide training and course material;
- Provide support in development and implementation of health financing reforms;
- Play an active role in health economic and health financing networks;
- Provide technical expertise in health financing studies;
- Facilitate comparative studies;
- Provide research in health financing; and
- Disseminate findings through scientific publications.

9. MONITORING, EVALUATION AND RESEARCH

9.1 Monitoring and evaluation

Monitoring and evaluation of the process and impact of regional and country-level activities should be conducted regularly in a comprehensive and participative manner, which would allow all partners to join their effort in the process. The WHO together with collaborating partners will oversee the implementation of health financing activities with annual reviews. Reports will be produced and disseminated to countries and partners involved in the networks in the region.

In order to improve the implementation of fair and sustainable health financing activities in the region, it is necessary to collect quality NHA data over time and carry out evaluations based on a minimum set of measurable indicators that reflects expected outcomes. Reliable input, process, output and outcome indicators for monitoring and evaluation with respect to health financing; collection, pooling, purchasing and health system performance and fairness indicators have to be developed.

9.2 Research

It is necessary to build a strong evidence base for research of the health financing function in collaboration with training institutions, national authorities and development partners. Such future studies could focus on analysing the effects of different health financing options on health, especially the poor and health system performance, contextual factors, challenges, prepayment schemes and how providers and households respond to different payment mechanisms as well as on efficiency, effectiveness and equity in health care service provision. Collection of high quality data such as NHA and household data have to be improved. Such future studies should focus on analysing:

- Effects of different health financing mechanisms on health system performance;
- Effects of health financing mechanisms on health, especially the of poor;
- Effects of contextual factors influence on health financing and health outcomes;
- Measuring effectiveness, efficiency and equity of health financing under different systems;
- Alternative prepayment schemes;
- How providers and households respond to mixes of payment mechanisms; and

9.3 Success factors for support

The successful support to health financing activities will be dependent upon:

- The vision decision-makers may have in regard to health financing activities;
- The level of political involvement and commitment;
- The recognition of evidence based data as a basis for health financing policy analysis;
- The sharing of responsibilities between all concerned, internal and external actors;
- The availability of efficient monitoring mechanisms for financial resources;
- The proper management, monitoring and evaluation of proposed activities; and
- Adequate financial and technical support.

ANNEX 1: BACKGROUND DOCUMENT FOR THE REGIONAL WORKSHOP ON FAIR AND SUSTAINABLE HEALTH FINANCING

1. INTRODUCTION

Successive WHO's declarations have given increasing emphasis to the need to mobilize sufficient resources for health systems in ways that are sustainable and financially equitable and which assure health service access to all citizens regardless of economic circumstance. For example, as an integral part of implementing the Alma Ata Declaration, WHO began a series of studies and political initiatives to consider the role that health financing could and must play in supporting Health for All. A few years later, in 1981, the World Health Assembly passed a resolution that urged all its members to allocate adequate resources for health and, in particular, for primary health care and the supporting levels of the health system.²⁹ In May 2005 a resolution was adopted by the World Health Assembly³⁰ again calling for increased national and international funding for health systems especially for maternal neonatal and child health while encouraging nations to move towards universal coverage by moving away from user fees to more prepayment and pooling mechanisms.

Fair and sustainable health financing (FSHF) aims to make funds available, to ensure that all individuals have access to effective, efficient and high quality public health and personal health care.^{31,32,33} This means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so. WHO has also pointed out in the strategic agendas for the Country Cooperation Strategy framework that health financing is a priority challenge within the Health Development Systems.³⁴

Member States have requested WHO to provide support to issues on general health financing and also on social health insurance and to bring together health financing experts so that they would identify the approaches most suited to the context of the countries of the African Region.³⁵ At the

²⁹ WHA 34.37, "Resources for Strategies for Health for All by the Year 2000", accompanied by a technical document, WHA A34/Tech.Disc./1 (WHO March 1981).

³⁰ WHA 58.31 "Working towards universal coverage of maternal, newborn and child health interventions". WHO May 2005.

³¹ Executive Board EB115/8, 115th Session 2 Provisional agenda item 4.5: Social health insurance. Report by the Secretariat. WHO December 2004.

³² WHA 115th Session EB115.R13, Agenda item 4.5 24: Sustainable health financing, universal coverage and social health insurance. WHO January 2005

³³ Fifty-Eight World Health Assembly WHA 58.33. Agenda item 13.16 25. Sustainable health financing, universal coverage and social health insurance. WHO May 2005.

³⁴ A Corporate Strategy for the WHO Secretariat: Report by the Director General. EB105/3. WHO December 1999.

³⁵ Health Financing. Being a Round Table 3 at the fifty-second session of the WHO Regional Committee for Africa. WHO Regional Office for Africa, Brazzaville 2002 (also in French and Portuguese).

WHO 55 Regional Committee meeting for Africa in Maputo a special session was held to brief Ministers of Health and stakeholders on fair and sustainable health financing.³⁶

2. JUSTIFICATION AND OBJECTIVES

2.1 Justification

The current challenges facing Africa such as the huge excess in premature deaths, the escalating poverty levels, underdevelopment including regional fragmentation, international marginalisation, extreme donor dependence and macroeconomic constraints on public spending need huge investments in human development to boost poverty eradication, economic growth, welfare and health for all.

In order to reach the targets set by national poverty reduction strategies (PRSPs), health plans and the UN Millennium Declaration Goals (MDGs) all stakeholders in health systems have to discuss on how the health care systems could be strengthened by building capacity in health policy development, planning, implementation, management, monitoring and evaluation of health sector development. It is of greatest importance that countries in the region develop viable and fair health financing policies and strategies guiding health system reforms. The utmost health financing constraints in African health care are:

- i) Failure of establishing cost recovery safety net mechanisms in protecting the poor;
- ii) Lack of financial resources to produce good health for all;
- iii) Lack of human resources is a major bottleneck in improving health system performance;
- iv) Inefficient use of available health resources providing equitable health care;
- v) Limited technical capacity to manage the complex health financing issues and also high turnover of health staff, managers, policymakers and planners mainly due to poor financial incentives;
- vi) Limited institutional capacity to facilitate the development and implementation of viable and fair financing strategies; and
- vii) Weak monitoring and analytical capacity; leading to evidence not being used for formulating health policy and taking decisions.

2.2 General Objective

The general objective of the workshop was to disseminate evidence based information and share experiences from countries in the East African Sub Region on fair and sustainable health financing mechanisms being used in closing the financial gap to achieve the MDG targets.

³⁶ Report of the special session – Sustainable health financing in Africa, Annex 16. The fifty-fifth session of the WHO Regional Committee for Africa. WHO Regional Office for Africa Brazzaville, August 2005.

2.3 Specific Objectives

- i) Increase the understanding of the challenges facing developing countries in improving fair and sustainable health financing in the context of national priorities, international commitments and macro economic constraints;
- ii) Increase the understanding of FSHF concepts such as; protecting the poor from catastrophic health spending; pooling of risks by the use of prepayments, guaranteeing equal access to effective and efficient high quality health care in order to achieve financial protection and good health for all citizens;
- iii) Increase the understanding of different FSHF mechanisms used in Africa such as; user fees, social and community health insurance, tax funded health care, donor funding and effective and efficient allocation and disbursements of funds. The degree of fairness and sustainability will be discussed against the criteria of effectiveness, efficiency, equity and sustainability:
 - Effectiveness; whether the mechanism has the potential to make a significant difference in closing the financing gap;
 - Efficiency; whether the mechanism raises funds without incurring sizeable administrative costs and whether the mechanism allows for allocation of funds to high priority health needs to tackle the nations burden of disease;
 - Equity; whether the mechanism reduces the risk of poor households facing catastrophic health care costs and whether the mechanism allows for the cross subsidisation of the poor and vulnerable by healthy and wealthy sectors of society as well as universal access to health care;
 - Sustainability; whether the financing mechanism be relied upon to provide sustained and predictable funds for the foreseeable future;
- iv) Increase the understanding of the relevance of using different FSHF instruments in policy development, planning and implementation of health financing reforms; and

2.4 Expected Outcomes

- i) Knowledge about the challenges facing countries in improving fair and sustainable health financing;
- ii) Knowledge about FSHF concepts and options increased
- iii) Knowledge about the relevance of using FSHF instruments in policy development, planning and implementation of health financing reforms and effective and efficient allocation and disbursements of funds;
- iv) Commitment from participants to use equitable, effective and efficient FSHF instruments; and

- v) Knowledge about support needed to develop FSHF policies and strategies and action plans together with civil society in implementing FSHF.

3. FOLLOW-UP

3.1 Short-Term

Finalisation and dissemination of the FSHF recommendations made to participants.

3.2 Medium-Term

- i) Support to governments and agencies to include FSHF in their health financing agendas and work plans.
- ii) Support to countries in developing and implementing FSHF reforms in collaboration between governments, bi- and multilateral agencies and NGOs.

3.3 Long-Term

- i) Continued support to countries.
- ii) Organization of a FSHF follow up workshop.

4. DATE AND VENUE

4.1 Date: 23-25 November 2005

4.2 Venue: Speke Resort and Country Lodge, located on the shores of Lake Victoria in Munyonyo, Kampala, Uganda

5. WORKING LANGUAGE

The workshop was conducted in English.

6. PARTICIPANTS

Participants from Ethiopia, Kenya, Southern Sudan, Rwanda, Tanzania and Uganda attended the workshop; Health Policy Makers, Senior Technical Officials, Representatives from WHO Country Offices, Health Economists/Public Health Specialists from Academic Institutions, Directors/Managers Health Insurance organizations and from Tax Funded health care, Participants from Health Consumer Organisations and Civil Society/Community Based Organization; and participants from Development partners/Donors in health.

7. METHODS OF WORK

Plenary presentations: keynote addresses, best practices cases; panel discussions and report writing. The case reports were based on African experiences in health financing. Rapporteurs were facilitating the writing of proposed conclusions and recommendations made during the workshop.

8. DOCUMENTS

8.1 Working documents

i) Workshop statement, the Kampala Declaration on Fair and Sustainable Health Financing.

ii) Group work notes:

- Out of pocket spending and user fees;
- Social health insurance;
- Community based health insurance;
- Tax funded health care;
- Efficient allocation and disbursements of funds; and
- Donor funding.

8.2 Reference documents

i) Major guide: Framework for fair and sustainable health financing in Africa. WHO, November 2005.

ii) Presentations and related documents.

9. ADMINISTRATIVE ARRANGEMENTS

The workshop was organized by WHO (HQ, AFRO, WCO Uganda) in close collaboration with WB, MOH and Development Partners.

Steering Committee

The members of the Steering Committee represented MOH and MOFPED, WHO, World Bank, Save the Children UK, UNICEF Southern Sudan, Sida, Dfid, Belgian Embassy & Belgian Technical Cooperation (BTC), Health Consumer Organization, IPH and EPRC Makerere University Kampala.

Secretariat

The secretariat was hosted by WCO Uganda with support from MOH Uganda.

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ANNEX 2: OVERVIEW OF PRESENTATIONS AND GROUP WORK

1. INTRODUCTION TO THE WORKSHOP

Dr. Peter Okwero, Health Specialist, World Bank Uganda

Fair and sustainable health financing focuses on the different mechanisms by which money is mobilized and allocated to fund health sector activities for the household to benefit. Examples of important questions are: how much funding is available; who bears the financial burden; who controls the funds; whether risks can be pooled, whether costs can be controlled, who has access to health care; who is protected from impoverishment from catastrophic medical payments and what is the impact on the health status of the population.

In Africa many problems hinder access to health care with a large percentage of the populations unable due to difficulties ranging from high costs for access to health care, limited revenue potential from public sources, especially taxation which is below the targeted Abuja rates for Africa. Although there is a pronounced recognition of the importance of health (MDGs) and donor funding still remains low. Health sector funding basically depends on taxation and prepayment mechanisms and user fees and donor dependence. To use out-of-pocket payments across countries that are already impoverished is one way of denying the population access to health care. Increased costs are also brought about by the high burden of disease and adoption of new technologies (ARVs, ACTs vaccines etc). Countries have in all efforts tried to use reforms but have been rather unsuccessful and not met desired goals. In the end most health financing decisions remain implicit.

The general objective of the workshop was to provide an opportunity for key stakeholders to share evidenced based experiences on fair and sustainable health financing. The specific objectives were to increase the understanding of the different health financing modalities; experiences from countries in ensuring fair and sustainable financing; out-of-pocket payments; risk pooling as well as coming up with measures to protect poor households from catastrophic health spending taking into account equity, efficiency, sustainability and accountability.

Participants were expected to come out of the workshop with improved understanding of application of different financing modalities. They were also expected to recognize the impoverishing effects of different health financing approaches including measures to mitigate them. In addition, participants were also expected to improve articulation of fair and sustainable financing concepts in the development of health financing policies and strategies; and were encouraged to be more explicit during policy formulation.

2. THE ROLE OF THE MACROECONOMIC FRAMEWORK IN ACHIEVING THE MDGS

Mr. Peter Allum, IMF Representative Uganda

The macro-economic considerations in promoting health financing depend on policy changes and the choice of policy options. When the macroeconomics of health care is discussed, “fiscal

space” is a term commonly used. This can be translated as: Do we have enough resources to finance health care, given other budget priorities? Countries are encouraged to focus on the current level of health care funding in dollars per capita, or perhaps as a percentage of GDP to target a given level of funding. This could be based on the cost of achieving the MDGs or the amount to achieve other sectoral targets. This would then imply a funding gap, to be closed over a period of time. Options for closing the funding gap includes higher levels of donor funding, additional domestic revenue mobilization, and efficient budget reallocation in favour of the health sector or faster economic growth.

A major concern is “the predictability of donor funding and whether governments should reject donor funds when availed”. There is always a problem of predictability of donor commitments which in turn affects funding levels. Governments are encouraged to take up donor funding, and at the same time use external reserves that they could rely on in case of abrupt cancellation of donor funding. This is the case of the other sectors too, but perhaps particularly critical for health. From the donor perspective, funding often is the responsibility of parliaments, which work with a time frame of only one or two years. Tradeoffs between predictability, conditionality, and aid effectiveness have to be understood if health programs are to be managed for results. There should be an option of reducing funding when programs are not delivering expected results but such conditionality comes at the cost of predictability. How the trade offs are to be resolved was another question.

Strengthening domestic revenue mobilization could also provide additional resources for healthcare for many countries in Africa. For instance, in Uganda revenue collections currently amounts to only about 13% of GDP, and finances just over one-half of the total budget. Although this figure was up from the 7% range in the early 1990s, it is still low by international standards, and even by the standards of Sub-Saharan Africa. The IMF recommends that countries should aim at a minimum revenue effort of 15% of GDP. The foundation for effective taxation rests with good tax administration. For instance in Uganda, the IMF has been working with the Uganda Revenue Authority to implement a program launched at the beginning of this year to strengthen tax administration. It appears to be bearing fruit, and is expected to yield more resources to fund priority programs but it will take a number of years for tax administration to be fully effective.

In Sub Saharan Africa the overall per capita health care spending among countries is found to be low, leaving very limited scope to meet national/MDG targets for health. The high population growth rate and effects of HIV/AIDS coupled with a growing demand for health services especially in public services makes up some of the challenges. In addition issues related to resource constraints to service delivery, the need for strong macroeconomic performance amidst the very slow growth of economies and limited domestic revenue sources are some of the challenges.

Donor project funding exhibits the tendency of falling below expectations, which can not always be fully compensated by most government in Africa. In addition inadequate staffing levels equivalent to only about 84% of existing positions are filled. The persistent insufficient resources for drugs and equipment with no clear mode of resource allocation/purchasing modalities to improve health outcomes are listed as some of the challenges. Other challenges include; how to allocate available funds efficiently and effectively and yet equitably at relatively low transaction costs raise challenges to the health sector. For example, global initiatives and resource priorities

may not be consistent with national priorities and sometimes bypass national systems. Issues related to accountability and NGO funding plus localization of resources together with governments' lack of a clear commitment to implementing poverty reduction & service delivery programmes are also big challenges.

The manner of donor funding and whether it should be provided to a common pool of budget support; pledged to a basket that supports the health sector; or be dedicated to health projects with choices influenced by many factors is another challenge. Governments have affordable medium term investment/expenditure plans but strong government institutions/processes to ensure accountability required for increased budget support are lacking making it difficult to assess health systems performance with respect to efficiency, effectiveness and ensuring equitable distribution of resources. There is a need to look at absorptive capacity issues such as organizational/managerial weaknesses to reduce the impact of additional resources.

Policy solutions that are offered include suggestions of using donor inflows to pay for public imports. By spending on items like ARV drugs and mosquito bed nets, Uganda would avoid domestic inflation and also ease pressure on the exchange rate. This was found to have many limitations of not being feasible as a general approach. Many programs require a high domestic spending component including expenditure on wages and salaries, accommodation and transport. Procurement processes could be rewritten to down play in order to obtain value-for-money. For example, the focus on sourcing goods and services not forgetting cases of stationary and furniture could be purchased locally. For ARV drugs, the answer is clear, as there are no local alternatives. But where local alternatives exist, the local producers should always be given a chance. This approach would also reduce greatly the administration costs. Promoting imports through trade liberalization offers better prospects for avoiding the inflationary and exchange rate effects of donor inflows. Several options are available; first, import tariffs could be determined at the level of the EAC and a program of EAC-wide tariff cuts would ease exchange rate pressures in all three countries. Since these reforms would imply some loss in tax revenues, they would need to be carefully implemented and backed up by measures to strengthen other sources of tax revenue.

Uganda has some options for domestic liberalization; this would include improving the transport system, to cut freight costs and streamlining the bureaucratic burden imposed by regulations associated with customs inspection and clearance. The resulting higher import bill and larger trade deficit would mop up donor foreign currency inflows, reducing their impact on the local market.

By trying to maintain competitiveness and at the same time entirely avoid currency appreciation, the best policy approach is to ensure that a portion of donor inflows are used to fund investments that support domestic productivity, leaving firms better able to cope with the currency appreciation. Investment priorities would typically include key infrastructure, such as power and roads, and institutions critical to the business climate, such as the land and property registries, and the tax authorities. Again the idea is to achieve an appropriate balance between social spending and investments in competitiveness, productivity and growth.

3. FAIR AND SUSTAINABLE HEALTH FINANCING IN AFRICA

Dr. Dick Jonsson, WHO Uganda

African countries have requested WHO to provide support to fair and sustainable health financing and to identify the approaches most suited to the context of the countries of the African Region. Successive WHO declarations and resolutions have also given increasing emphasis to the need of that support to achieve the health MDGs and other national health priorities. At the WHO 55th Regional Committee Meeting for Africa in Maputo 2005, ministers of health and development partners discussed Fair and Sustainable Health Financing (FSHF) as a means to reach universal access to health care.

Africa is facing huge excess premature mortality and most of the Health MDG targets are still not met. For instance more than 50 percent of the countries in the African region are severely indebted, big informal sector and high unemployment still exists. In addition, there are high levels of poverty, inequitable distribution of income and the human poverty index is 40% with 44% of population living on less than one USD per day. Such heavy burdens of disease have contributed significantly to Africa's chronically poor economic performance. The distribution of income is also inequitable, 40% of the population lack access to safe drinking water, 40% of adults in the region are illiterate with primary school enrolment of 63% and 21% secondary school enrolment. 47% of the population in the region lack access to adequate sanitation facilities.

The total expenditure on health for African countries is on average 5.7% of their GDP on health, the same as in 1995. It can be compared with 8.2% for all countries worldwide. 35 countries (76% of all) spend less than USD 34 per capita on health. This is regarded minimum for providing an essential health care package. The proportion of governmental health spending of total government spending is 8% for 44 countries. 96% of all countries in the region spend less than 15% (Abuja benchmark) of national budgets on health. Private health expenditure amounts to be 56% of total health expenditure, two times higher than in Europe.

The health systems of most African countries depend largely on household's direct out-of-pocket payments averaged at 28% of total health spending. Government spending on health is 44% of the total health expenditure, yet the poorest and most indebted countries rely heavily on external resources; amounting to be 28% of total governmental health expenditure. Few countries in the region have introduced social health insurance schemes; corresponding to 3% of the total health expenditure. Several countries in the region have been implementing community health insurance schemes and some medical savings accounts, seventeen 17 countries in the region, 35% of all, are using some type of pre paid plans.

The outstanding challenges for fair and sustainable health financing in Africa are brought about by the failure of establishing cost recovery safety net mechanisms in protecting the poor. There is currently a general lack of financial resources to produce good health for all given that low income countries have a small revenue base to generate domestic resources. Inefficient use of available health resources and lack of human resources are major bottlenecks in achieving efficient health care in Sub Saharan Africa. A major concern is the high turnover of health staff, mainly due to poor financial incentives and weak management capacity hamper the provision of essential and quality health care services. In addition limited technical capacity to manage

complex health financing and equity issues; weak monitoring and analytical capacity and evidence not being used in health policy making and management are huge challenges to the health sector.

Contextually, there is need to recognize the importance of the country's epidemiology, health care structure and capacity of the health system, macroeconomic constraints and socioeconomic conditions as well as the cultural values for countries in designing fair and sustainable health financing policies and strategies. Countries should also make proper use of evidence based information as far as possible when analysing current levels of health spending, sources and the use of those sources (NHA data). Fair and sustainable health financing entails economic viability analyses of various financing options, health policy analysis, legal analysis and analysis of socio-political environments.

Fair and Sustainable Health Financing (FSHF) policies and strategies should be developed with reference to National Health Policies and Strategies, Millennium Development Goals (MDGs) and Poverty Reduction Strategy Paper (PRSP) frameworks. Collaboration between governments and development partners should follow the Paris Declaration of 2005 of Alignment and Harmonization, a Sector Wide Approach (SWAp) might be used. There is need for strong political commitment, acceptability to clients, professionals, politicians, collaboration partners and the general public not forgetting proper management, monitoring and evaluation. Good governance, transparency and accountability active partnership, coordination and collaboration between governments, development partners, training and research institutions are all important for adequate financial and technical support.

Fair and sustainable health financing ensures equal access to health care and gives financial protection and reduces the risk that households will face catastrophic health expenditures. This is done by way of cross subsidisation of the poor and vulnerable by healthy and wealthy sectors of society. It aids in minimizing large out-of-pocket spending on health, such as user fees and introduction/strengthen of prepaid plans such as health insurance, taxation and publicly subsidised services. FSHF can play an important role in improving equity and efficiency in allocation, access to and utilization of existing health care resources. In addition, fair and sustainable health financing implies increased external and domestic funding to benefit the poor and mobilize domestic resources by using efficient revenue collection methods. It also implies optimal use of different financing sources and payments mechanisms to create balanced incentives for health providers with regard to equity, efficiency, productivity and quality of health care delivery.

4. OUT-OF-POCKET SPENDING AND USER FEES

4.1 Out of pocket spending and catastrophic health expenditure

Dr. Ke Xu, WHO/HQ Geneva

Out-Of-Pocket Spending (OOPS) are those payments made by patients at the point of receiving health care. It includes payments made to both public user fees and private facilities. At early stage of reaching universal coverage, countries rely heavily on OOPS. A survey conducted on the

components of Health Expenditure (AFRO) indicates OOPS as widely used means of health financing in many African countries.

Globally, OOPS comes with impacts that deserve mentioning; 1.3 billion people do not have access to effective and affordable health care, 150 million people face catastrophic health spending and 100 million people are pushed under the poverty line. Many countries rely on OOPS to finance their health systems. Funds available for health care are scarce, government health expenditure as a percentage of total government expenditure is insufficient; for instance in the WHO AFRO region 4 countries were found with government spending on 15% of total government spending, 17 countries were spending between 10 and 15%, 25 countries 10% and 22 countries in Africa spend less than 50% of government spending on health compared with the 15% target in the Abuja declaration. External resources are increasing, but still limited and voluntary based private prepayment schemes are in very small scales of less than 10% of total health expenditure in 142 countries globally and less than 10% in 31 countries in WHO AFRO region.

The countries in Africa could move forward through raising more funds and spending efficiently by; improved efficiency in domestic revenue collection; increased allocation from ministries of finance through comprehensive planning; use of sector wide approaches and political negotiation; increased predictability of external flows and; using existing resources efficiently. Other measures suggested includes reducing OOPS and increasing reliance on prepayment through tax-based system, compulsory or voluntary insurance and community based insurance schemes, but also by efficient use of funds. While encouraging various prepayment schemes, African countries could develop long term strategies to increase coverage. This could be done by making sure that the providers of external funds channel them through risk pooling mechanisms, and to strengthen and give support for building institutions. People should have access to essential interventions when need for universal coverage arises, without the risks of financial catastrophe or impoverishment. The important question is how to efficiently collect the needed money for providing essential health services without causing financial burden to the patients, particularly the poor.

4.2 User fees and ability to pay in Africa

Dr. Sophie Witter, Save the Children UK, London

User fees were introduced during the economic problems of 1970s & 1980s in Africa when the continent suffered problems of dwindling funding and quality in public health sector resulting into growth of informal payments. This was followed by the 1987 agenda for reform and the structural adjustment program paradigm of shift by donors.

User fees are official/formal direct payments by users, at time of seeking medical care. That is, legally mandated, with rules on retention, use and management of funds. User fees can be based on a flat-rate or being variable, the latter being the most common aiming for full or partial cost recovery on national or local schemes. User fees were originally introduced as claims to increase efficiency and equity by: reducing 'frivolous demand', increasing revenue through low price elasticity of demand since health service is a necessity commodity, increasing quality and coverage of public sector, and later on, as incentive to join risk-pooling schemes. Surveys carried

out in 33 out of 37 African countries in 1993 showed that most of the user fees were introduced since 1990. That survey found that 20 out of 24 DFID priority countries had fees at primary level and 23 at secondary level. 75% of the WB projects in SSA in 1998 included user fees as condition of loans. 80-100% of private payments were out of pocket and private payments made up 60-70% of total on average. Studies in Democratic Republic Congo and China showed much higher use of user fees in 'privatised' services.

The value of the revenues generated were reduced by transaction costs of 40-60% of revenue; also eroded by poor banking facilities; inflation; and embezzlement. In some cases funds were reinvested, leading to increased quality and utilisation, but often gains were not realised otherwise. Ability and willingness to pay were too low as well as inadequate revenue not retained by facilities. In addition; funds from user fees were not reinvested to benefit the poor clients and revenues were often offset by declining budgets and poor accountability for funds.

Health care utilisation, measured by out patient visits, in Africa is as low as 0.25-0.4 visits per person per year, with common reductions of 40-50% due to introduction of user fees. The result is a vicious circle of low willingness to pay/ability to pay; low revenue; low quality; low utilisation etc. Where demand for health care was found to be already suppressed by high access costs, uncertainty about prices and seasonal variation in income lead to increased inefficiency. The supply induced demand (e.g. poly-pharmacy, high rates of caesareans) called for a need for cost containment measures to demand for private and informal health facilities, which in many cases gave substandard quality of care.

The impact of user fees on the health status was not so commonly measured, but some studies on delivery fees in Zimbabwe and Nigeria indicated a drop in deliveries in facilities and mortality rates of mothers and babies due to the introduction of user fees. High health bills were reported to be responsible for 250,000 deaths of children under 5 which could be averted each year if 20 African countries removed user fees. Another study on malaria in Gambia showed that the number of deaths rose with increased costs of insecticides.

On equity of health care, willingness and ability to pay were even lower in complex emergencies. Rural/urban differences still exist in Africa, and in some societies women, children and the elderly were the most discriminated.

Evidence on ability to pay from studies by SC in East and Central Africa showed that on average 30% of the population failed to treat themselves; 27 % carried out self-treatments; and on average 21% of those seeking treatment could not pay. Lack of money was cited as a main problem in most of the areas of Burundi, evidence showed that non-consultation rates for poor groups doubled that of richer ones. In addition poor households sought care for fewer family members than rich households and were less likely to go for a second visit and more likely to visit pharmacies or a traditional healer.

Still on ability to pay, evidence from Tanzania showed the relationship of the number of episodes of treatment related to the wealth of family. This was averaging to be between 2 persons per year for the poor households; 3 persons for medium income households and 4 for wealthier households. Worse still, for chronic illness: 54% of families with chronic illness were found not taking treatment and there was a growth in 'medical jailings'. Overall, 30-60% were reported

having failed to gain access to health care due to poverty, and in some areas, access was reduced for the poor. For instance in Rwanda, 30% were treated in 2003; only 10-15% in 2005. And in Gatonde, Rwanda, the poor would have to spend 60% of total income to treat all of their household illnesses.

In Burundi the poor households often spent 3 times as much as the rich and they spent 21% of their income compared with 6% spent by the rich. Despite this, the rich can spend more in absolute terms to a tune of 2-3 times in Tanzania and Khartoum; and 5 times more in Burundi. In addition, for a single episode, poor people sometimes were charged more than the rich for lower quality health services. There were reports of discrimination, in part related to user fees. The consequences related to paying for treatment included debt, reducing consumption, switching to cheaper foods, borrowing, selling assets, mortgaging crops, and increasing labour hours. In Ethiopia, 20% of families reported sending children to work in the fields to pay for health bills. All of these could contribute to long term poverty.

In-depth interviews with families affected by HIV/AIDs and TB in Tanzania illustrated the high direct and indirect costs of chronic illness and how they were linked to impoverishment. In Ethiopia for instance, two out of three of households were using risky coping strategies. While in Burundi 18% of the poor households had no coping strategies at all. These issues are compounded by conflict and natural disasters. Exemptions in health care could provide an answer to the plight of the poor and in turn would solve the numerous problems in health care delivery. These come with difficulties of providing revenue for providers in the name of protecting the poor, identifying eligible people for exemption, lack of information for clients and insufficient funding to reimburse providers. Other problems cited in the study were stigma from the users, fear of differential treatment, nepotism, the high rates of poverty and the impact of decentralisation.

A user fee is a sub-optimal payment mechanism by most health financing criteria providing at best 'sustainable inequity'. It is a sign of under development: rich countries have developed risk-sharing mechanisms. The poverty which exacerbates the negative features of user fees is also to a large extent the cause of their existence. All countries were encouraged to look for ways of removing and reducing user fees for essential health care, including drugs. This would be a major pro-poor measure, though many access costs remain (travel, food, accommodation etc. This shift in international policy requires international efforts to increase resources for health and improve their management.

4.3 Abolition of user fees in Uganda

Dr. Juliet Nabyonga, WHO Uganda

Implementation of the policy on abolition of user fees was based on voices of the poor in the Uganda Poverty Action Plan (UPAP), and health was cited as a major cause of poverty and user fees in health as a major hindrance to seeking care. In addition, there was a government feeling that there was no significant contribution of funds from user fees to improving the quality of services.

There were high poverty levels of 35% of the Ugandan population in 2000 and no significant revenue raised from health facilities (estimated at only 10Bn Shs); in addition health facilities were poorly managed. Therefore charging user fees at point of getting health service was seen to be an ineffective financing mechanism. In 2003 38% of the population was living below poverty line. There was low utilization of services in face of poor health indices, excluding the poor from accessing services and general lack of a functional exemption system.

Effective March 2001 user fees were abolished in all government lower level units and a dual system of service was introduced in public hospitals. This was after a study in which health was cited as a major cause of poverty and user fees in health units as a major hindrance to seeking care. Government responded by supplementing the health budget by 1 billion Uganda Shillings (approximately 0.03 USD per capita). Government funding to the sector increased steadily from 124.23 Bn Shs in 2000/01 to 219.56 in 2004/05 and increased the health workers salary. Funding to lower levels increased from 44% in 2000/01 to 54% in 2004/05 as well as the flexibility in use of HUMC. The expenditure on drugs was increased to a tune of 0.8 US\$ per capita 2000/01 to 1.2 in 2002/03 and to be 1.6 US\$ in 2005/06. Protected funding equivalent to 50% of primary health care at health centre level and 40% at hospital level was realized in the same year. The Local Government Decentralization Act of 1997 allowed districts to levy fees for services delivered and fees decided upon locally. In addition, there was no policy back up from the centre and no significant contribution to improving quality of services. Results from utilization of services surveys showed a widely felt use of stimulating community participation.

Qualitative findings from studies by UPAP 2002, MoFPED, MoH and WHO 2005 indicate preference of government health units because of free services; seeking health care more since abolition of user fees. A survey on whether cost hampers people from seeking medical care on inpatients services; and utilization of preventive services showed that antenatal clinic remained fairly constant in public facilities after abolition. Women were utilizing services more than men both before and after the policy change. The highest increase in utilization was noted to be higher among the above 5 age group as a percentage change in utilization over 2000.

Concerning quality, issues like the kind of drugs used; chloroquine and cotrimoxazole were found to be commonly used in outpatient care. There was an increasing average of annual drugs receipts since 2000 to 2003, although stock outs were found to be slightly improving probably because of the still persisting per capita expenditure on drugs which was low, US\$ 1.6 per capita. The impact of the policy on health expenditures showed significant decline in average household expenditure on health from about US\$ 3.5 per month in 1999 to about US\$ 2.2 in 2002.

The removal of user fees resulted in increased utilization of public services more so by the poor calling for a need for system wide improvements required to sustain the increased utilization. The high demand for health care led to congestion, drugs being used up very fast and increased workload for health workers. There was need for sustained community participation in utilization of preventive services and compound understanding of issues especially concerning utilization of services by women and children under 5 years. Sustained increases in utilization can only be achieved if wider measures to improve service quality were also implemented.

4.4. Group discussions

OOPS and user fees are not effective especially at macro level, but at a micro-level they might help to raise some funds to keep health centre services running. In Ethiopia for instance, at micro level OOPS rose up to 10%. While in Rwanda 33% of health budget was realised locally by utilisation with 15% contributed through community insurance and more than 25% through OOPS. In Tanzania OOPS made up 5% of macro level recurrent expenditure but the micro level support is important. In Uganda the contribution was found to be too small for being effective, the poor could not pay to access services. For instance, no staffs were hired to collect these charges. Multiple collection points would result in wasting clinic staff time and higher collection costs with a significant leakage. Management committees took decisions, which led to inefficiency. For example in Tanzania, no staffs were hired, and there were guidelines on what they were able to spend their user fee money on hence regarded to be efficient. While in Ethiopia no extra staff was taken on either, but the collections were not retained at facility level so OOPS were not efficient at that level. The same thing happened in Kenya and Rwanda. In Rwanda OOPS and user fees only covered a small percentage of the total health sector costs. Generally, OPS and user fee schemes are not effective in Africa as they do not cover an appropriate level of costs and do not meet the priority needs of the people.

Out of pocket spending were seen not to be equitable since the poor are excluded and therefore not sustainable especially at macro level though it was possible at micro level. It might be sustainable at the facility level but not at the household point of view. The major challenges of these mechanisms were that they were found inequitable, inefficient, ineffective and unsustainable as they send more people into poverty. Additionally, safety nets (waivers and exemptions) have failed because there is no cross subsidy from rich to poor. Other challenges ranged from political institutional challenges complicated by issues of human resource capacity and economic constraints like the difficulties of managing the funds.

OOPS should be used with care most likely as a transitory scheme and therefore temporary. The need to have standardized guidelines and management systems to involve the communities and civil societies in the decisions on issues which affect them like accountability and good governance was realised.

Countries should implement WHA resolution 58.31 (signed by 189 countries). By formulating a legal framework with clear indication of what services, exemptions and waivers cover. There is a need to separate the clinical role from the administrative role for health workers as the demand for health services increases. There is also a need for more funds to be made available for health care, maybe from taxes collected. It was agreed that health is a human right and that it is the government's responsibility to take on the role of stewardship in ensuring good health for all.

5. COMMUNITY HEALTH INSURANCE

5.1 The role of community health insurance in health financing

Prof. Bart Criel, Institute of Tropical Medicine Antwerp

Community Health Insurance (CHI) is a way of health care financing based on insurance and solidarity. It is increasing in popularity particularly in West Africa where more than 600 initiatives are operating today. Community health insurance has the potential to overcome some of the well-known limitations of user fees and to substantially contribute to improvement of people's access to quality health care. Many health system policy makers and planners in the Sub Saharan Africa show an increasing interest in CHI. However, the implementation and functioning of CHI are complex matters.

Different models of CHI exist, with important variations in terms of design, management structures, objectives and quality of performance. The major CHI designs are; the Provider-Based Model (PBM) and the Community Based Model (CBM). The Community Based Model is common in West Africa and PBM in East Africa. While operating CHI schemes, values and principles that under pin the Mutual Health Organizations (MHO's) actions as: mutual help and solidarity, a non-for-profit purpose and participation of the scheme managers and members in the decision-making process should be adhered to.

In Europe, for instance, social health insurance schemes started at the end of the 19th Century with small schemes in context of high politicisation and organisation of workers amidst industrialisation. This was found to be different from the African agrarian society and therefore cannot take the same trend. African societies were commended and encouraged to keep open and take in experiences from all models. Lessons may also be learnt by comparing the evolving nature of schemes in developing countries like West Africa and developed countries.

The impact of community health insurance is looked at in five dimensional frameworks:

1. A health dimensional path upholds at CHI to facilitate access to health care (increase utilisation, reduce delays, improve compliance).
2. A social protection dimension shows the contribution of CHI in protecting households' income plus assets and prevents iatrogenic poverty.
3. A financial dimension constitutes CHI as a stable source of revenue for providers facing less unpaid bills.
4. A socio-political dimension depicts CHI as an apprenticeship process of social solidarity and as an organized counter-power to health professionals leading to more responsive health service, more democracy in health, and eventually better quality of care.
5. In addition, a local health systems dimension sees CHI as a policy instrument for district management teams to steer the health seeking behaviour and the flow of patients in the local health system.

A SWOT analysis of the strengths, weaknesses, opportunities and threats of CHI on basis of empirical evidence showed the need to recognize that CHI was about more than only financing. It is also a model of organization and empowerment of health services' users in their interaction with the providers. Of the strengths of CHI cited were; access to useful health care for the insured improved performance and social dynamics of any country important to cement it. In West Africa

such dynamics have helped to integrate CHI in local health systems. The Weaknesses of CHI include limited enrolment, small-sized schemes, high transaction costs, and problematic financial robustness and of importance is that CHI is not an option for the poorest. Opportunities for CHI however are; it can nascent dynamic of federations and unions of CHI schemes including re-insurance mechanisms. And the threats were that; the complexity of CHI is always underestimated and donors/development organisations always looking for rapid results.

Available evidence on the effectiveness of CHI in closing the financing gap at the macro-level so far is very limited. And at the micro-level effectiveness varies from scheme to scheme. For efficiency, considerable transaction costs and thus limited efficiency, except for some forms of highly rationalized provider-based CHI schemes in Bwamanda scheme in DR Congo.

As far as equity is concerned the CHI system of community rating implies cross-subsidy between patients with different health status thus some element of horizontal equity and no element of vertical equity. Community health insurance was seen as not an option for the poorest – unless premiums are paid by somebody else in form of subsidies in local solidarity mechanisms. The sustainability of the schemes also varies; some schemes have existed now for more than 10 years while many others have limited life span because of financial and/or managerial problems.

Another lens to look at CHI and financing is the health financing function of the health system. Three sub functions in the health financing function exist namely: revenue collection, fund pooling plus purchasing. Today the contribution of CHI remains modest, but CHI seemed an effective institutional entry point to larger pooling arrangements. Risk and fund pooling were found to be still limited because of small size of CHI member population. Strategic purchasing remained rare but increasing awareness of its importance is also vital. The enabling/constraining factors to CHI development include; quality of care, trust, ability to pay through presence of subsidies, information, designing scheme's to fit in local health context, issues of managerial capacity and political support (e.g. legal framework).

Community health insurance could be used to cover essential services excluded in the existing system, cover transport costs to health facilities or a pool of funds in PNFP system for essential drugs. There is need to recognize that CHI is a complex social, technical and managerial operation that needs a great deal of time to develop. Community health insurance is about spending money in a context of multiple and pressing household needs, risk-sharing and solidarity, trust and quality of care. In addition there is a need to educate clients of CHI to recognize and appreciate principles of social Health Insurance and that CHI is more than only financing. It is also a model of organization and empowerment of health services' users in their interaction with the providers. Community health insurance is also about accountability of providers, transparency of management and democracy in decision-making in health. All in all community health insurance may not be a solution for the poorest because they have no money to pay the premiums meaning somebody some where else needs to pay for them. Effective CHI implies need for subsidies and eventually integration of CHI systems and SHI systems. It is always important to start small and then eventually expand.

5.2 Community based health insurance in Rwanda

Mr. Dukundane Emmanuel, MOH Rwanda

The health situation in Rwanda before the introduction of Community Based Health Insurance (CBHI) depicted very poor characteristics with high under five mortality and maternal mortality rates, high fertility rate and low life expectancy. The primary causes of morbidity were malaria, respiratory infections and diarrhoeal diseases coupled with low utilisation of health services and a general lack of human resources. There were no medical doctors in health centres, where 80% of consultations are made, and where there are only 220 Rwandan and 54 foreign doctors in the public system. Financial access was cited as one of the major barrier to health with 0.4 consultations for every 2-3 episodes of grave illness per annum. Many more health conditions called for health centres to be exclusively financed by cost recovery.

Against such a background, in the 1960s the government of the Republic of Rwanda constitutionalized initiatives with the character of health insurance based in the communities. In 1999 the community based mutualism initiatives were re-launched. And by 2003 an approach by the Rwandan government and its partners on strong promotion of the CBHI was started. This was further strengthened and extended through sensitisation of leaders and institution of legal framework in 2005. The government of Rwanda is now carrying out Performance Based Contracting (PBC) of health services under community health financing initiatives and results from such an initiative has yielded remarkable results.

PBC in Rwanda operates under the following characteristics; an output based system in which provision of quality services is rewarded basing on the assumption that outputs produced create a health impact. Payments are made on measurable and verifiable indicators requiring substantial means of verification of output in terms of quantity, professional quality, patient satisfaction and cost to ensure efficiency through creation of incentives to provide quality services.

Evidence from PBC in Rwanda is used to provide fair and sustainable health services showed remarkable improvements. For instance health workers involved in the scheme have showed strong commitment and high motivation since incentives paid are related to their production. Health workers also consider themselves as partners since supervision by the district level became regular and beneficial to the health workers. PBC has improved the health indicators both in quantity and in quality by involving the community in addressing their health problems.

Strong results were reflected in improved service provision, a decreased financial burden and increased quality of care. The government of Rwanda has plans of extending PBC to the rest of the country. A national coordination mechanism was put in place involving all partners, e.g. through basket funding was necessary. Progress towards MDGs could be accelerated, but requires substantial investments in health. The achievement of the MDGs would require an increase in resources invested in health, since as the health status of population affects its productivity.

5.3 Group discussions

It was agreed that the effectiveness of CHI depends on a number of factors depending on the design and model/approach used. The compulsory form was found to be better in closing the financial gap. For instance, experience from Tanzania showed that this mechanism is effective and that it is potentially viable in future. At micro household level, still not much difference was shown though potential contributors. At micro level and health facility level CHI is effective but not effective at macro level. Still expertise from Tanzania and Rwanda had observations which showed that in both levels they are doing fine.

When verifying how efficient CHI was, the majority opinion showed that it was more expensive during initiation. For instance the compulsory comprehensive CHI was cheaper as compared to the voluntary one and allocation of funds to higher priority health needs could be better achieved with the compulsory and comprehensive community health insurance. The system in Tanzania showed that CHI is efficient given that it was built on the district structures and a provider based approach which exhibits less administrative additional costs. With the community based approach, efficiency depends greatly on the number of members (enrolments) since the larger the group the greater the economies of scale and in the end less administrative costs. However, on the side of choice of service, the community based approach is more efficient as members choose the package of service (benefit package) unlike the provider based approach.

The equity of CHI can be depicted along various forms of voluntary to compulsory solidarity based CHIs. The sustainability of CHI would exist for the compulsory solidarity based as compared to the voluntary one and the challenge cited included: a) Selecting the most practical CHI system based on the objectives conditions of a given country; b) Universality of CHI; c) Trustworthiness and; d) Skills development in management of CHI e.g. creating re-insurance and networking.

The major lessons learned were that successful implementation of CHI required a combination of CHI activities with income generating activities (such as the viable Bwamanda scheme in DR Congo). In addition basing the CHI initiative on a local coping mechanism was found to be vital. Others were the large membership pre-requirements to ensure sustainability and need for clear regulation, legislation and by-laws. Re-insurance systems are also important. Community health insurance generally needs a certain level of income to ensure continuity of contribution.

The solidarity compulsory type seems to be the best type of CHI although it should operate under basic regulations for proper functioning of CHI. There should be political and government commitment and involvement and generally a practice of re-insurance system - always forgotten by most countries in Africa. Others included improving management, good governance, accountability, and transparency. There should be clear legislations, by-laws, rules and operation manuals. In addition a need for a supervising body and capacity building in form of training, contracting and sub-contracting for transparency, involvement of stakeholders and technical support from other partners.

CHIs could work in a mixed system mainly in case of a large scale compulsory system. This is a big challenge however to make, it is a complement to the other systems. On the other hand, governments could give free cards to cover the gaps not covered by the CHI, while still

promoting CHIs. Other issues are how to include the very poor and what to do if the system breaks. Community involvement should be given priority in this system. Small is not always good and so the need to involve larger numbers of people.

6. SOCIAL HEALTH INSURANCE

6.1 The role of social health insurance

Dr. Tuoyo Okorosobo, Representative of WHO Regional Office for Africa, Congo

Social Health Insurance (SHI) is a system for financing health care through contributions to an insurance fund that operates within a tight framework of government regulation. A key characteristic of a social health insurance fund is compulsory membership & contribution by employers required by law to deduct a certain percentage of each employee's monthly wage for health to be paid to a social insurance fund. Employers are also required to make a contribution on behalf of the employee, workers, self-employed, enterprises and government could also pay contributions into a social health insurance fund. In addition worker's salary is the base for workers' and enterprises' contributions which are either flat or based on estimated income.

Contributions are also based on member's ability-to-pay instead of actuarial risk government. Contributions also might be paid for those without ability to pay, e.g. severely disabled, unemployed, casual workers, low- income earners, informal sector workers, the retired, or the poor. SHI schemes could either be made up of multiple risk pools/multiple funds, or a single risk pool/single fund. Of importance, all insured members are entitled to same benefit package and the scheme either owns its own provider networks or works with accredited public and private health care providers or uses a combination of both. Additionally, functions like registration, collection of contributions, contracting and reimbursement of service providers may be contracted out. SHI may be performed by a government corporation, NGO say sickness funds, or a system of closely regulated private health insurers.

SHI comes with advantages of members paying predictable premiums when they are healthy to cover unpredictable costs when sick. Equity of members is enhanced through the richer (healthier) members cross-subsidizing the poorer (unhealthier) members through risk pooling. The premiums are income-related but benefits are provided according to need and tries as much as possible to avoid exclusion of the poorest & most vulnerable. Social health insurance inhibits adverse selection and cream skinning and premiums are earmarked as health resources and therefore are unlikely to be diverted to other purposes.

When starting a social health insurance scheme, it is important to strengthen the safety nets (exemption and waiver mechanisms) within the existing health financing system to ensure that the vulnerable population groups and the poor financially challenged are adequately protected. It is also crucial to gather, archive, disseminate and utilize the evidence required to guide the decision of introducing SHI or not. Countries that currently have SHI took on average 70 years between the first laws related to health insurance to reach universal coverage. Once a decision has been made to introduce SHI, it is necessary to move cautiously in a phased and carefully monitored manner, e.g. starting with groups with formal employment. Equally important is to

define a clear and coherent SHI strategy, the timeline for coverage, benefit package, beneficiaries & contributors, sources of contributions, fund(s), provider payment, organizational & administrative framework, etc. The necessity of drafting a SHI law and strengthen administrative, managerial, legal and institutional capacities plus technical and perceived quality of public, mission and private facilities have to be acknowledged. It is also vital to build a broad consensus for SHI among all the key stakeholders and sensitize the general public.

Vertical equity refers to the fairness of distribution of health services and health care, while horizontal equity entails persons or households of the same ability to pay (ATP) make the same payments for health care and vertical equity - persons or households of unequal ability to pay make appropriately dissimilar payments for health care. The extent to which social health insurance is equitable depends on: progressiveness of personal income in the tax system; and whether the relationship between ATP and payments to SHI are progressive, i.e. those with greater ATP pay proportionately more.

The World Health Assembly (WHA) Resolution 58.33 on sustainable health financing, universal coverage and social health insurance encourages countries to achieve universal coverage of cost-effective quality health care and financial protection of the poor. Countries which would like to achieve these goals have to develop a health financing policy and a comprehensive health financing strategic plan with a clear roadmap of how the country plan to transit from the current health financing state dominated by inequitable, catastrophic and impoverishing direct out-of-pocket payments to a scenario of universal coverage. Countries have to decide for themselves on how to get to the visionary state of universal coverage, i.e. whether through SHI, NHS based on taxes or other combinations of different financing mechanisms.

6.2 Social health insurance in Kenya

Dr. Humphrey Karamagi, WHO Kenya

In Kenya, the Social Health Insurance Plan started way back in 1994 being implemented through a health policy framework paper. Following the reduction of funds to the health sector to as low as less than \$ 4 per capita and high out-of-pocket spending (OOPS) on health. This created a need to explore other financing mechanisms to reduce OOPS and increase sector funding and, including social health insurance. Social health insurance could be looked at as a key source of funds to the health sector. Before this policy the Kenyan health sector had different sources of funding including government funding, donors, local foundations and private companies through private not for profit institutions. There existed a health financing gap in the sector that the social health insurance fund is trying to reduce.

The 2002 elections saw historical events for Kenya with a clamour to oust KANU which had been in power for 40 years and responsible for mismanagement of the economy. All parties in 2002 elections included the social insurance framework in their manifestos. National Rainbow Coalition (NARC) government came to power in 2003 and converted the then existing National Health Insurance Fund (NHIF) into the National Social Health Insurance Fund and introduced the Economic Recovery Strategy Paper as a working paper. Another taskforce was formed to develop a Strategy and Sessional Paper composed of key stakeholders constituted in 2000 to develop concept paper. The Task Force findings included government allocations unlikely to

increase in the short-run, where OOPS acted as a barrier to access health care and contributes to declining health status. In addition the taskforce recommended a need to review the financing framework for the health sector.

A household survey estimated the demand for health, utilisation and expenditure on health services carried out in 2003. Results from the survey also showed per capita utilization of 1.92 visits per year, adjusted estimated demand for health for the sick but who never sought care was 23% and the expected increase in demand was 30%. The per capita utilization of out patient services was 3 visits per year and it was estimated that 2 percent of Kenyans get admitted with low used 4% admission rate for an average of 7 days. The survey further established the cost of an outpatient visit/inpatient day in mission hospitals. Mission hospitals were used because they were considered to be efficient and effective by public with 90% cost recovery.

The developed countries have not perfected their schemes after long years of practice. For example Japan and UK took 36 yrs between while the fast track Republic of Korea took 12 years but in a period of extra ordinary economic growth. What is most important is the persistent move towards a mature SHI system requiring regular adjustments. The government of Kenya agreed to phase membership and benefits in a gradual informal sector uptake, starting with inpatients and outpatients after three months. The informal sector was to contribute 4% and formal sector 2.9% of salary and a match from employers when the target will be met even after many years. Assuming providers were to accept the proposed rebates the fund would generate surplus if the current government allocations to health sector targets the poor, vulnerable groups and essential programmes focusing on MDGs.

In Kenya, once adequate consultation was done a strategy paper was presented to Cabinet and approval given to prepare a sessional paper. The sessional paper was approved by parliament and the attorney general prepared a draft Bill which was then passed by parliament in all three readings. The president of Kenya refused to assent the Bill because earlier on it was agreed that the implementation to be phased and remove the compulsory nature of membership or contributions.

6.3 Group discussions

Social Health Insurance (SHI) may be effective but it is only partially filling the health financing gap. A significant percentage of the population in Africa is in the informal sector and civil servants have low salaries and therefore low contributions expected. The Tanzanian experience shows a limited coverage of the members of the family up to 4 persons. SHI has the potential to make a difference in closing the financing gap, but will definitely take time, given the social economic characteristics of countries in Sub Saharan Africa. The extent to which SHI can meet the basic package still remains a challenge as premiums are small. In Tanzania for instance, private health facilities cover their costs through SHI; while public facilities use user fees to meet their full costs implying that efficiency depends on the local context and administrative system put in place. However SHI can lead to cost escalation and high cost interventions. In Kenya for example, the administration costs were double the costs for the benefit package.

Social health insurance could be efficient in regard to administrative cost and priority health needs depending largely on the economies of scale and membership base (coverage and contribution level). In the principles underlying SHI, benefits are expected to depend on allocation/priority needs. In Tanzania the SHI is included in the budget and district health plan. Funds collected for SHI at central level are disbursed to districts for SHI expenditures. However, in Burundi funds are collected at central level and were not disbursed to districts, consequently district health teams had to offset these costs somewhere else in budget. The bureaucracy in reimbursement in some instances and weak system which delay and can result into disrupted and poor service provision are common challenges. There is a need to develop system capacity in financial management, needs assessment, prioritisation, budget forecasting and guidelines for priority needs/activities/minimum standards.

Concerning the equity of social health insurance, it is true for those within the system if the contributions are proportionate and if there are cross-subsidies within schemes - for services within package. It was concerted that investment of SHI funds into health centres have indirect benefits to non-members by improved service provision, urban/rural bias in service provision and quality of care for those within schemes. On this note SHI could be equitable within the pool but there was need to be supplemented by other funding sources to make it more equitable. The challenge of covering the poor and bringing together various pools and risk of creating dual systems with the poor receiving poor services exist. There are also several ways to address equity concerns that in most cases require political solidarity subsidies.

Social health insurance can be sustainable if designed to capture the formal sector because of revenue predictability which requires monitoring and cost containment procedures (e.g. accepted essential drugs mechanisms/treatment guidelines). Resources would be allocated to health depending on the interest of members though this will take time. On the other hand social health insurance has shortcomings; it does not always cover secondary and tertiary care forcing individuals to find other means of covering catastrophic costs. For example, in Tanzania co-payments amounts to be 15% for secondary/tertiary care. The form of package may not keep pace with new technologies and effective treatments to reduce disease burden e.g. ARVs not covered in the package. However, Rwanda & Zanzibar include ACTs in their SHI packages.

The challenges of such a system cited includes lack of capacity and effectiveness of the administrative systems, possible government interference and the lack of capacity to mobilize resources from the informal sector. In addition, cost escalation due to members increased demand for better health services, lack of proper network of health providers and quality of services to make the system work plus fear of government are other major challenges.

It is necessary to protect the poor from catastrophic costs of illness by using cross-subsidy mechanisms. Timely and efficient disbursement of funds from central to district levels and feedback to members on how funds are used as well as transparency are essential. Successful implementation of SHI requires strong and responsive systems of finance, management, HRM, procurement and continued efforts with monitoring & evaluation and cost analysis. It is important to put in place an appropriate regulatory and administrative framework; create and improve awareness; ensure SHI resources are additional and do not replace government funding. However, SHI is only an additional mechanism for health financing and does not necessary completely fill all health financing requirements.

Mixed funding from households, governments and donors have to be sustainable and there is a need to clearly address issues of uniform funding for the health facilities. In addition social health insurance can work and be sustainable if marginalized groups are included and only if issues concerning geographical location are addressed. It is important to focus on efficient management systems and good governance for clients to get quality health services worth the value of the money contributed in form of premiums. Social health insurance needs continuity and stewardship of government in contributing to health financing in the health sector, especially for the poor.

7. TAX FUNDED HEALTH CARE

7.1 Overview of tax funded health care system

Dr. Ke Xu, WHO Geneva

Broad options to health financing are distinguished as dominated by tax funded health care (TFHC) and social health insurance. Tax funded health care is therefore one of the broad options in reaching universal coverage. A TFHC approach is mainly based on revenue collections from direct tax taxes levied on individual income, corporate income and property. It also uses indirect tax revenue collections like VAT/sales tax, excise duties, import & export tax and other forms of taxes depending on the country at central and local levels. During the transition to universal coverage, various types of prepayment schemes need to be encouraged, so as to systematically enhance financial protection. The choice among TFHC, social health insurance or mix of financing mechanisms will be determined by a country's economic, political and social context.

In practice, the scale of TFHC varies dramatically around the world; but all countries have some of their health system funding coming from general taxation. For instance tax-based financing as a percentage of total health expenditure is for example 1% in Monaco to 99% in Kiribati. In the high income countries UK has its health system funded using tax based resources to a tune of 83% compared with 68% for Canada, Australia 68%, New Zealand 78%, Ireland 74% and Iceland 61%. In the Nordic countries Sweden has TFHC corresponding to 85 % of the total health spending compared with 60% for Finland, Norway 84% and Denmark 83%. This when compared with African countries and especially countries in the Sub Saharan region shows a marked difference. For example, TFHC in Niger is 49%, Rwanda 56%, Madagascar 55%, 53% in Tanzanian and 55 % for Uganda.

Tax funded health care has a potential to progressively raise funds, but does not guarantee progressive allocation of resources. It is a form of health funding source which is sustainable provided government revenue is stable and the priority of health is maintained on the political agenda. Additionally, it allows cross-subsidy from rich to poor; and healthy to ill. Tax funded health care allows universal access to basic care when geographical allocation of funds is balanced between urban and rural areas and when user chargers are minimal for the poor. However, tax funded health care comes with disadvantages of being regressive if the tax structure is regressive and less transparent and depends more on current political agenda. Funds may be concentrated on urban areas leading to dangers of inequity and high cost for accessing services by the rural population. In addition TFHC may only cover very limited services and in the end most

of the consumers are left dissatisfied. Results of research show that services of health system funded by government through tax funds could be of low quality, less choice and long waiting lists. In addition the services might also lag behind with respect to new technologies and that health staff could be unresponsive to patient needs.

Theoretically, TFHC can be a progressive health financing mechanism in raising funds and reaching people's needs but requires stable and growing government revenue as well as transparency in public health financing. In practice, its performance varies dramatically depending on a country's social, economic, political and cultural contexts. Therefore TFHC approach is only "one way" to finance health care. There is no basis, either theoretical or from practical experiences for suggesting that tax-based financing performs better, in terms of health financing functions, than social health insurance or the other way round.

7.2 Tax funded health care in SRI Lanka

Ms. Regina Keith, Save the Children UK

The health system in Sri Lanka started developing from 1926 when the joint curative and preventive services were emphasised. By 1930 the long term public expenditure support/ public health approach had evolved which later grew into a dense system of clinics & referral systems in 1945. The system also upheld maternal and child health care through household visits to encourage antenatal care and health centre delivery and by 1953, free public health care had been achieved. In 1968 a non-coercive mechanism for family planning services was started and later strengthened by the 1987 decentralisation policy and 1960 policy of government subsidizing the private health facilities.

By 2002 the government of Sri Lanka was proud of improved health indices with 94% of inpatient care through public system, 92% births at least in a health facility and 97% of under 5 years old children with community health care with a follow up on postnatal immunisation. Infant mortality rate (IMR) by 2002 was 14:1000 live births, CMR 15:1000 live births, and maternal mortality rate (MMR) was 0.2 per 100,000 live births. Life expectancy was 71 years for males and 75 for females in 2001 with a total fertility rate of 1.9 and importantly the overall achievements do not mask rural urban or gender disparities.

Various factors contributed to positive sustained health outcomes in Sri Lanka ranging from cultural, social and historical conditions specifically women's autonomy, relative equality and democratic system based on consensus. In addition the political will, use of pro poor policies plus a multi-sectoral approach health policy based on equity and efficiency in the health system. The multi-sectoral policy impact on health outcomes included the 1940 school expansion and 1947 free education. Improved literacy rates especially for women strong link between female education and reduction in health seeking behaviour and mortality figures for the education sector. Evidence from research showed that under 5 child mortality rates by educational level of mother as: no schooling-31.8 %, primary 33.3 %, secondary is 18.8 and the percentage of all as 13.8 and 20.8 for all levels. Other sectors that included water and sanitation and gender equality (lower son preference). The health sector in Sri-Lanka also participated in priority setting for food subsidies and set a standard for minimum rice consumption for poor. Above all the political will was vital at the implementation stage of every strategy. The study found a strong link

between women's education and health outcomes because educated women were better able to deal with children's illnesses and they were found more likely to take them to a health facility. In addition the study showed that women were more likely to follow advice from health service providers carefully and return medicines if they were not working and also more likely to seek health care for themselves when ill than men.

The public health care system in Sri Lanka is fairly equitable with an insurance mechanism for poor and complementarities between public and private sector. The Health system is efficient; it has strong demand for supply with most rural people live within 5 to 10 km of Public Health Facilities (PHF). The system provides free quality services taking into account the high impact access for the poor plus high utilisation and demand. Information and knowledge of services is supported by a mechanism of home visits and close PHF all maintained through political demand.

Improved efficiency was achieved through reduced unit costs supported by the fairly equitable and sustainable distribution of health facilities within reach of the rural poor financed through indirect taxation. Total annual public expenditure on health has averaged at less than 2% of GNP. Reduced unit costs obtained by efficient facility operation and increased staff productivity even without non financial incentives. Unlike other countries in Africa, private sector growth in Sri Lanka was discouraged through high quality PHF and staff career ladders. Sri Lanka also resorted to user fees or other public health financing mechanisms which restrict access to health care.

Sri Lanka also operates an insurance mechanism for poor allocating more funds in the total government budget for the health sector. For instance in just 2000, 60% of government spending was on hospitals and there exists high expenditure costs on maintaining high quality free in-patient services. The government in Sri Lanka rejected World Bank's advice to privatise in-patient services through cost benefit analysis because the poor were struggling to afford the costs of coping with illnesses. Therefore the policy implication was to ensure public sector delivery which represents social insurance for the poor. There was also a drive to the private sector to encourage a pro-poor redistributive effect.

Poverty Reduction Strategy Papers (PRSPs) developed through the World Bank has created a long term impact on public health care systems. The changing disease burdens also impacts on costs leading to depletion of human and financial resources making it difficult for the entire system to cope with new trends. Still, there are weak regulatory and managerial capacities of the frail public health status, malnutrition and poverty is prevalent. Sri Lanka needs to continue to support basic social services in their PRSPs and budget allocation as well as increased regulation of private sector. WHO/WB has to review the impact of DALY analysis on access to health for the poorest and global shift from economic to social model of health. Donors support other nations to implement Sri Lanka approach.

7.3 Group discussions

Tax funded health care services has a potential for closing the health financing gap although its effectiveness is doubted because of difficulties in lower income countries to mobilise resources due to the size and character of the tax base. Additionally, effectiveness of the tax funded health system depends on types of taxes used (income, VAT etc). Since income tax works for only those

who are formally employed such a system may not succeed in Africa where the largest proportion of population is not formally employed. There is also lack of clear legal, fiscal and institutional frameworks, which are needed for effective tax systems. Therefore there is a need to understand that implementing a tax funded healthcare system requires a clearly laid out long-term strategy.

Tax collection has some problems that constraint efficiency. For instance the large informal sector is an issue to consider and a constraining factor for efficiency of income tax collection for the health sector to benefit. In the interest of availing information, mapping data collection to determine tax levels and infrastructure may increase tax administrative costs making the entire system inefficient. Tax funded system takes time to develop and needs investment as well as monitoring and evaluation. It was noted that countries with significant natural resources have been able to implement a tax funded system more quickly than resource poor countries. The Sub Saharan countries require a strong tax base as well as powerful systems and frameworks to increase efficiency

In general, the tax funded health systems might not equitable when taxation is found to be too regressive to the very poor in society. Formal sector differences exist between urban and rural areas demanding generally higher investments in health in urban areas than rural. The sustainability of tax funded health care greatly depends on the opportunity to expand the tax base. African countries should work out means of increasing the tax base to promote benefits like value for money with respect to accountability transparency/visibility/feedback, quality of care, fair distribution and justice in tax system. The tax payers should be informed with equal opportunity through dialogue with community in changes of the taxes by public debate and not just imposed.

8. EFFICIENT ALLOCATION AND DISBURSEMENT OF FUNDS

8.1 Improved allocation and disbursement of funds

Dr. Mark Pearson, HLSP Institute, London

Different forms of health care financing exist but the overriding objective is to make funds available, as well as to set the right financial incentives for providers, to ensure that all individuals have financial access to effective public health and personal health care. Health financing further calls for efficient and equitable allocation of resources. It is important for any health system, to come up with health financing mechanisms that can potentially provide access to health care and protect the citizens against the risk of catastrophic health care expenditures.

The ability to administer a sufficiently skilled labour force with capacities in financial management, book keeping, banking and information processing has to be enhanced. Government have to provide strong stewardship at all levels and guide the process that would lead to efficient and equitable resource allocation.

8.2 Efficient allocation and disbursement of funds in Tanzania

Dr. Maximillian. Mapunda, WHO Tanzania

Resource allocation refers to how health activities/services are being funded. The funding may vary according to the following; levels of care, geographical areas, and health interventions. Resource allocation and improved disbursement were based on the context of resources being limited and therefore scarce, and a need to use them more carefully to optimize output. Health is one of the elements in the human rights calling for equity in health services financing and provision.

In order to address the aspects of equity in resource allocation, the allocation can be based on the agreed formula that takes care of different elements to achieve it. There are several criteria that can be considered. For example, Tanzania in 2004 included population 70%, poverty count 10%, vehicle route mileage 10% and under five mortality 10%. Previous allocations were based on the number of health facilities. The formula introduced in 2004 was supposed to apply for both personnel enrolment and other charges; however, it was started for other charges only. It has repercussions, since it has gainers and losers who should both be considered within the current investment portfolio and its consequences with this kind of allocation.

An example on a major efficiency concern is how to allocate resources towards preventive services proving to be more cost effective in the delivery of health services than hospital care. There was an unclear picture of the share of preventive services due to limited studies to determine technical efficiency exists, and evidenced by the trends in allocation by category of spending from financial year 2001 to financial year 2004.

For the first time in recent years, the overall actual expenditure matched the approved estimates in FY 2004. This is because of improved release of funds from the treasury. Some of the tools that may be helpful in monitoring resource allocation and public expenditure include public expenditure reviews, national health accounts (NHA) and health services costing and utilization studies.

8.3 Group discussions

It is not common to have effective and efficient allocation and disbursement of funds in public facilities and the sustainability was questioned. It's important for any system to set aside mechanisms for efficient allocation and disbursement of funds for health sector activities.

There is a need for a balance between and technical procurement procedures giving room for political priorities. In addition it is necessary to have an explicit formula for disbursement and allocation of funds say by use of unit cost formulas and formulas requiring tangible outputs like in the case of Uganda used by the MOF. In Tanzania for example several criteria were revised but the government considered taking only four of them.

If the different health financing mechanisms are to be sustainable, it is necessary to clearly address issues of uniform funding for health facilities especially in rural areas where the disadvantaged and marginalised people live. In addition efficient allocation of funds can work

and be sustained if communities are involved in all activities. It is important to put in place efficient management systems and good governance for clients to get quality services. Efficient allocations and disbursement of funds requires stewardship and a clear government policy on corruption and mismanagement of funds. Surprisingly, governments in Sub Saharan Africa where conditions and services are poor don't condemn a wide range of malpractices. Regular monitoring and evaluation and reporting are vital elements if different parties are going to contribute with sustainable funds to the health sector.

9. DONOR HEALTH FUNDING

9.1 Donor aid to the health sector

Mr. Paul Mpuga, Economist, WB Uganda

Health financing is inadequate in most African countries and this best explains why donor funding of the health budget has gained prominence since the 1990s. Aid commitments for health in LICs have greatly increased to US dollars 1.7 billion in 1990 to \$5.6 billion in 2003 of about \$2.56 per capita. The health sector aid to Africa's poor countries was \$3.8 billion. Generally there exists large dependence on aid for health expenditures with more than 250 agencies supporting health, nutrition and population sectors in Africa.

It is very important for countries in Africa to consider macroeconomic stability when advocating for increased donor funding. While expenditure needs in health and other sectors are wide, financing expansion has to consider the macroeconomic implications of proposed budgets. Sustained expansion of fiscal space and therefore increased expenditure in the health sector depend on the economic growth rate. Better policies, inter and intra-sector allocation and implementation are important for scaling up health care services within available resources. In addition strong budgetary and accountability processes are vital for yielding results.

Some improvements in health indicators in some countries exist even when other countries are lagging behind. For instance a small marked improvement in life-expectancy, infant/child mortality, nutrition and fertility in some countries exists. However, health indicators in Africa were still among the poorest in the world. Under-5 mortality is worsening in 18/38 countries and AIDS were cited responsible for 0.5-1.2% growth decline in Africa. Africa could be the only region that would not be able to meet MDGs until 2014. Where health is improving, the poor are not necessarily benefiting.

Current resources for health care in Africa are not certain. Many governments, donors, NGOs and the private sector are not very clear how much resources are going into the health sector. But it is clear that spending is far short of requirements to deliver basic health services. Health spending is low in SSA and other low developing countries with US\$ 13 per capita and \$71 in other developing countries and \$ 2,700 in developed countries! In 18 of Africa's poorest countries, per capita spending on health is only about \$ 4.50 of which \$ 2.40 is donor funded. Studies also showed that the poor countries need to increase health spending on \$ 30-48 by FY15 to meet the health MDGs. For instance Uganda's average national per capita spending on health is about US\$ 17; private US\$ 9.9; and government of Uganda's US\$ 3.9 and donors US\$ 3.3. This compares

poorly with \$ 28 per capita suggested in the Health Financing Strategy. Individuals bear a substantial proportion of the health care burden with households' out-of-pocket spending which accounts for about 60% of health expenditure.

9.2 Donor aid to the health sector in Uganda

Mr. Claes Örtendahl, Sida Uganda

Donor funding to health will remain a dominant feature for the foreseeable time if we are to achieve the goal of 40 US dollars/capita to health. Thus the question of "by what means" is overwhelmingly important. For any country to qualify for any form of donor support the following features should be adhered to low volatility, high predictability coupled with high strategic congruence and low transaction costs. In addition a country should possess high ownership in any venture that is getting donor support and funding and therefore a call for high governance support and strong health outcome incentives for the health sector.

On the Ugandan scene there is low volatility coupled with high predictability and high strategic congruence. The transaction costs are still low as required by the donors and there exists high country ownership in all the projects in the health sector. In addition governance support is high and the health outcome incentives strong. There has been an increase in budget support till 2003 and GHI increasingly dominant thereafter. However the "donor support quality score" is developing negatively although budget support hailed and project support practiced. The Paris Declaration might be a turning point.

When problems of resource mobilization in donor countries and specific policy interests in donor countries exist then a country may not get the badly needed donor funds. In Uganda there is low absorptive capacity in government systems for health and lack of trust in government. In addition a country does not qualify to get donor funds if the above features for a country to qualify for donor support are reversed.

Good health is a basic necessity and human right and in Uganda today there exists large inequalities in access to health services and outcomes, by socio-economic status and location. The poor, vulnerable and those in the rural areas bear a disproportionately heavy burden of diseases and infant mortality; the poorest quintile is 1.8 times higher than the richest quintile; the prevalence of diseases - malaria, acute respiratory infection and diarrhoea is higher among children from poor families. Not all can pay for health care - failure to provide adequate services to the poor may result in significant negative externalities.

Although large positive externalities associated with good health, access to health services in Uganda is still very low; physical access is low with only 49 percent of the population having access to a health centre within a 5 km radius. The cost of sickness can be very high with about 30% of the population being sick in a month and about 1 in 5 of the sick do not consult due to either sickness being mild or as a result of cost and long distance to clinics. Additionally, over 7 workdays in a month are lost due to own sickness or of others in the household. Unfunded priorities in the health sector are in excess of Ush 100 billion. Modalities of donor financing in Uganda for health include budget support which became popular after 1997, and Uganda's PAF provides protection for poverty-reducing expenditures including health and also gives additional

confidence to donors. PAF health sector donors in Uganda include; UK, EU, Sweden, Belgium, Ireland, France, Italy, Denmark and Norway. The argument from Ministry of Finance Uganda has always been that donor projects are easily monitorable although donor funding through NGOs are not easily quantifiable. Global initiatives like are GFATM and US President's Emergency Fund for Aids Relief are some project sources of funds for the sector.

Funding for health care in Uganda is carried out the context of the Poverty Eradication Action plan (PEAP). In Financial Year 2005 health spending carried about Sh366 billion of which Sh150 billion were donor projects. Of recent, health care spending has gained prominence in budget allocations. The percentage of total health budget sector as has been increasing over time from 8% in the 1994/95 Financial Year to 11% in FY2004/05 expected at 15.9% by FY2014. However, health still takes a small percentage of total budget, 11% cf. and the figure per annum is 13%. In FY05, donor projects captured in MTEF funded about 40% of health sector budget with over 50% in the 1990s, 46% in FY04. There is an apparent decline in donor project funding due to increasing budget support though not easily captured! Donor projects in health accounted for about 15% of donor projects on the budget while donor projects account for about 80% of development spending in the health sector.

9.3 Health sector wide approach in Uganda

Dr. Francis Runumi, Commissioner of Planning, MOH Uganda

A sector wide approach (SWAp) could be defined as a sustained partnership led by national authorities, with the goal of achieving improvements in people's health in the context of a coherent sector, defined by an appropriate institutional structure and national financing programme through a collaborative programme of work, with established structures and processes for negotiating strategic and management issues, and reviewing sectoral performance against jointly agreed milestones and targets.

Uganda's health system, which had literally collapsed after many years of civil strife, had been characterized by heavy donor support and multiple projects. This support however did not translate into significant improvements in health outputs and outcomes – thus no improvements in people's health. Government and partners noted a lot of shortcomings in this type of support and hence agreed to introduce SWAp into the common basket whose shortcoming included:

1. Proliferation of projects, multiple reporting requirements, lack of coherence in donor support.
2. Distortion of spending priorities and leading to problems of sustainability, with limited scope for preparing comprehensive sectoral budgets.
3. Creation of parallel systems undermining organizational capacity building

The core elements and attributes of SWAp are that there should be an agreed policy framework & strategy, almost all donors sign and agree on a common/joint work program. There also exists a common management arrangement especially when it comes to issues concerning disbursement and accounting of funds plus reviewing performance. Sector wide approach also aims at streamlining government procedures with the government in "driver's seat".

The health SWAPs started way back between 1996/97 under the initiative of the government and especially the Ministry of Health and Development Partners mainly; WHO, WB, DFID, SIDA, Ireland AID and DANIDA. Partners felt the need to streamline the functioning of the sector. It came in shape through a series of consultative meetings and Joint Review missions namely - Sarova 99, Geneva 99, Kampala Oct 99, April 2000 and twice a year until October 2003. This was followed by development and consensus building for the National Health Policy (NHP) and Health Sector Strategic Plan (HSSP) in which Health Sub-Districts and Public-Private Partnerships in Health (PPPH) and Low Level Units were created. This was then followed by signing the Statement of Intent and the Memorandum of Understanding in April 2000 and launching of the National Health Policy (NHP) and Strategic Plan (HSSP) in August 2000.

The Health sector has registered significant progress with evidence from the eleven Joint Review and Medium Term Review Missions, all presented and discussed at the April 2003 JRM. Recently the sector launched the HSSP II at the 3rd National Health Assembly together with 11th Joint Review Mission. At such large gatherings that bring together Top Management Committees and members of the Health Policy Advisory Committee (HPAC) the sector sets its priorities, sector budget and planning process are carried out in Sector Working Group. In addition sector budget frame work papers (BFPs) and Local Government Budget Frame Work Papers (LGBFP), District and Programme Work-plan are also prepared.

SWAp also emphasizes central budget support as a preferred mode of funding for the health sector. Other funding modalities used (though not preferred) include district budget support and project funding. The later comes with advantages such as broad management of the sector, budget management and to a small extent efficient and equitable distribution of resources in the sector. Improved management entails having more information on what the sector needs to do with the available resources, increasing government management control and integration of vertical programmes. It also lays emphasis on the ability to implement policies at very low transaction costs and improved management capacity.

The budget process on the other hand is so involving and brings together sector working groups to start preparing budget framework paper in the context of the medium term expenditure framework (MTEF). This is then followed by local government budget workshops with participatory poverty assessment, and input and involvement of parliament. To improve efficiency greater percentages of funds are spent on HSSP inputs and allocations for district primary health care activities. For instance primary health care budget allocations have been on the increase from 14% in 99/00 to 42% in the year 2002/03, allocated using primary health care guidelines agreed with districts and calling for supervision and monitoring.

To improve equity in the health sector the Health Sector Strategic Plan (HSSP II) and the Uganda National Minimum Health Care Package were developed from a pro poor perspective. There is already a move to increase funding to district/PHC, especially rural lower level units treating mainly communicable diseases, child and maternal health. District budget allocations are weighed for poverty and health need factors and presently an increase in subsidies to NGO units.

The challenges of developing SWAp are:

1. Inadequate and stagnant amount of resources for the sector despite a costed programme of

work;

2. At implementation levels, at the district, private not for profit (PNFP) and the health sector and generally the government finds some challenges with the SWAP. First the sustainability of recurrent funding and the political (quasi-technical) captures not forgetting the World Bank and IMF's macroeconomic stability amidst national independence;
3. Some donors like USAID and UNFPA have not joined the common funding arrangements;
4. The resurgence of vertical funds under projects funded by GAVI, RBM, GFATM, GAIN, and GFEA etc. There is also the danger in providing an integrated package of services with lack of the necessary emphasis on some areas say reproductive health; and
5. In addition government staff capacity and attitudes like heavy work-load and changed way of work that is difficult to adapt. Building systems takes time especially when it requires working with many sectors on issues of good governance, corruption, procurement; human resources management and pay reform and payroll management.

The greatest challenge of developing a SWAp lies within the alignment of the national PEAP priorities with international priorities and goals like the Millennium Development Goals (MDGs) together with the stakeholders in healthcare. There is high turnover of donor staff including political and technical staff as well as government staff. The tendency by partners and government to unduly emphasize the process rather than the outputs like work-plans, reports and disbursement of funds has to be recognized. Ensuring acceptable level of financial management and room for improvement of supervision and monitoring are in several cases ignored if not forgotten. There is a foreseen danger of re-centralisation with donor interaction moving from the implementers to the sector level and budget determination between MOFPED and sectors.

Trust and openness, decreased transaction costs and frequency of HPAC and Joint Review Missions push the sector forward. There is a need for increased capacity of government to negotiate together with regular up-dates for new-comers help in achieving the long term SWAp objectives. This would play a great role in lobbying for increased funding for the sector and in the long run the targets formulae for the Health Financing Strategy will be achieved.

9.4. Group discussions

Funds from donor aid possess a potential to make significant contribution in closing the funding gap but the majority of donor opinions showed that it is not effective. Different governments in Africa especially in Sub Saharan Africa spend more funds on priority programs which in the end tends to be inflationary.

Donor project funding has a tendency of falling below expectations, which cannot be fully compensated by governments in Africa, and are therefore not efficient. In addition increased administrative costs, maintaining expatriates and paying consultants make the entire mechanisms

costly and sometimes taxes and bank charges are met by the recipient countries. The major challenge is how to allocate available funds efficiently, effectively and yet equitably at relatively low transaction costs to the health sector.

The predictability of donor project funding is critical especially if agreed targets are to be met. For many governments in Sub Saharan Africa donor funds cannot be relied upon as they can be turned on and off any time. There were problems foreseen with compensation of donor projects shortfalls necessary for harmonization of development partner programmes and processes important as they move along.

The persistent insufficiency of resources for procurement of drugs and equipment amidst vast inflows of funds with no clear mode of resource allocation/purchasing modalities to improve health outcomes have to be solved. Evidence from Uganda showed that, donor inflows are the single largest source of foreign exchange, ahead of even of exports. And this foreign currency is sold in the local market; it can appreciate the exchange rate, undermining the competitiveness of the export sector.

Donor inflows could offer considerable promise for creating the fiscal space needed to fund health and other priority programs, but is not sustainable in the long run. In addition equal emphasis should be given to strengthening domestic funding and tax administration and seeking savings in low priority outlays, especially public administration. These will be critical for developing countries to build a future exit strategy from donor dependence.

The Ministries of Finance and central country banks are right to have concerns about the macroeconomic challenges of managing donor inflows. When the economy is badly managed it could produce a cocktail of higher inflation, an uncompetitive exchange rate, and higher interest rates. Alignment of donor support to national processes and priorities is very important. Experience from Rwanda's GFATM showed that countries are free to reject donor funds for projects that do not rime with individual country priorities. In addition, countries should stop importing commodities where local alternatives exist. Examples are furniture, some drugs and stationery from local producers. This approach would also add to the reduction in administration costs.

Meanwhile, the issue of the "ceiling" still remained controversial. Different representatives of health insisted that there should be some flexibility in budget allocations for donor funds although finance ministries insist that for fiscal discipline and economic stability the sector ceilings must be maintained.

ANNEX 3. PROGRAM ON FAIR AND SUSTAINABLE HEALTH FINANCING IN EAST AFRICA, KAMPALA 2005

Arrival Day: Tuesday 22 November

19.00-21.00 **Registration**

Day 1: Programme agenda Wednesday 23 November

Note: We encourage you to be seated in time; the workshop will start 9.00 sharp

8.00-9.00 **Registration**

1. Opening ceremony Chair: Dr. Felicity Zawaira, WR a.i. Uganda

Master of ceremony: Dr. Francis Runumi, Commissioner of Planning MOH, Uganda

9.00-9.30 **Objectives and expected outcomes of the workshop:** Dr. Peter Okwero, Health Specialist, World Bank Uganda

9.30-9.45 **Welcome Address:** The need of improved health financing in Africa. Hon. Major General (Rtd), MP, Minister of Health, Jim Muhwezi, Uganda

9.45-10.30 **Coffee break, Group photo, Press briefing:** Dr. Francis Runumi, Commissioner of Planning MOH, Uganda

2. Introduction Chair: Dr. Felicity Zawaira, WR a.i. Uganda

10.30-10.50 **Session 1:** The role of the macroeconomic framework in achieving the MDGs. Mr. Peter Allum, IMF Representative Uganda

10.50-11.10 **Session 2:** Fair and sustainable health financing in Africa; challenges, enabling and constraining factors. Dr. Dick Jonsson, WHO Uganda

11.10-11.30 **Open discussion**

3. Out of pocket spending and user fees Chair: Dr. Felicity Zawaira, a.i. Uganda

11.30-11.50 **Session 3:** Out of pocket spending and catastrophic health expenditure. Dr. Ke Xu, WHO/HQ Geneva

11.50-12.10 **Session 4:** User fees and ability to pay. Dr. Sophie Witter, Save the Children UK, London

12.10-12.30 **Session 5:** Abolition of user fees in Uganda. Dr. Juliet Nabyonga, WHO Uganda

12.30-13.00 **Open discussion**

13.00-14.00 **Lunch**

14.00-15.00 **Group work 1:** Out of pocket spending and user fees

4. Community health insurance Chair: Dr. Emmanuel Humba, Director General, National Health Insurance Fund, Tanzania

15.00-15.20 **Session 6:** The role of community health insurance in health financing and local health care systems. Prof. Bart Criel, Institute of Tropical Medicine Antwerp

15.20-15.50 **Coffee break**

15.50-16.10 **Session 7:** Community health insurance in Rwanda. Mr. Dukundane Emmanuel, MOH Rwanda

16.10-16.40 **Open discussion**

Day 2: Programme agenda Thursday 24 November

4. Community health insurance, cont.

8.30-9.30 **Group work 2:** Community health insurance

5. Social health insurance Chair: Mr. Girma Seyoum, WHO Ethiopia

9.30-9.50 **Session 8:** The role of social health insurance. Dr. Tuoyo Okorosobo Representative of WHO Regional Office for Africa, Congo

- 9.50-10.10 **Session 9:** Social health insurance in Kenya. Dr. Humphrey Karamagi, WHO Kenya
- 10.10-10.30 **Session 10:** Social health insurance in Tanzania. Dr. Emmanuel Humba, Director General, National Health Insurance Fund, Tanzania
- 10.3-11.00** **Coffee break**
- 11.00-11.30 **Open discussion**
- 11.30-12.30 **Group work 3:** Social health insurance
- 12.30-13.30** **Lunch**

5. Tax funded health care Chair: Dr. Sophie Witter, Save the Children UK

- 13.30-13.50 **Session 11:** Tax-funded health care. Dr. Ke Xu, WHO Geneva
- 13.50-14.10 **Session 12:** Experiences from tax funded health care in Sri Lanka. Ms. Regina Keith Save the Children UK
- 14.30-15.00 **Open discussion**
- 15.00-16.00 **Group work 4:** Tax funded health care
- 16.00-16.30** **Coffee break**

7. Efficient allocation and disbursements of funds Chair: Dr. Samson Baba, MOH Southern Sudan

- 16.30-16.50 **Session 13:** Improved allocation and disbursements of funds. Dr. Mark Pearson, HLSP Institute, UK
- 16.50-17.10 **Session 14:** Experiences of improved allocation and disbursement of funds in Tanzania. Dr. Maximillian. Mapunda, WHO Tanzania
- 17.10-17.30 **Open discussion**
- 18.30-20.30** **Reception (Save the Children UK)**

Day 3: Programme agenda Friday 25 November

7. Efficient allocation and disbursements of funds, cont.

8.30-9.30 **Group work 5:** Efficient allocation and disbursements of funds

8. Donor health funding Chair: Dr. Ke Xu, WHO/HQ Geneva

9.30-9.50 **Session 15:** Donor aid to the health sector. Mr. Paul Mpuga, Economist, WB Uganda

9.50-10.10 **Session 16:** Sector Wide Approach (SWAp) in Uganda. Dr. Francis Runumi, Commissioner for Planning, MOH Uganda

10.10-10.30 **Session 17:** The future of donor support. Mr. Claes Örtendahl, Sida Uganda

10.30-11.00 Open discussion

11.00-11.30 **Coffee break**

11.30-12.30 **Group work 6:** Donor funding

12.30-13.30 **Lunch**

9. Way forward Chair: Dr. Tuoyo Okorosobo, Representative from WHO Regional Office for Africa, Congo

13.30-14.30 Conclusion of group work

14.30-15.30 Open discussion

15.30-16.00 Joint statement. Dr. Samson Baba, MOH Southern Sudan

16.00-17.00 **Coffee break and Press conference:** Dr. Francis Runumi, Commissioner of Planning MOH, Uganda

10. Closing of the workshop Chair: Dr. Melville George, WR Uganda

17.00-17.15 **Conclusions:** Dr. Melville George, WR Uganda

17.15-17.30 **Closing remarks:** Hon. Capt. Mike Mukula (M.P). Minister of State for Health (General Duties), MOH Uganda

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