



Economic Commission for Africa



Economic Policy Research Center

Pro-Poor Growth Strategies in Africa

Financing for pro-poor Health Policies:

An Inquiry into making financing
health policies work for the poor

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Introduction: A pro-poor approach for assessing the efficiency of public health financing

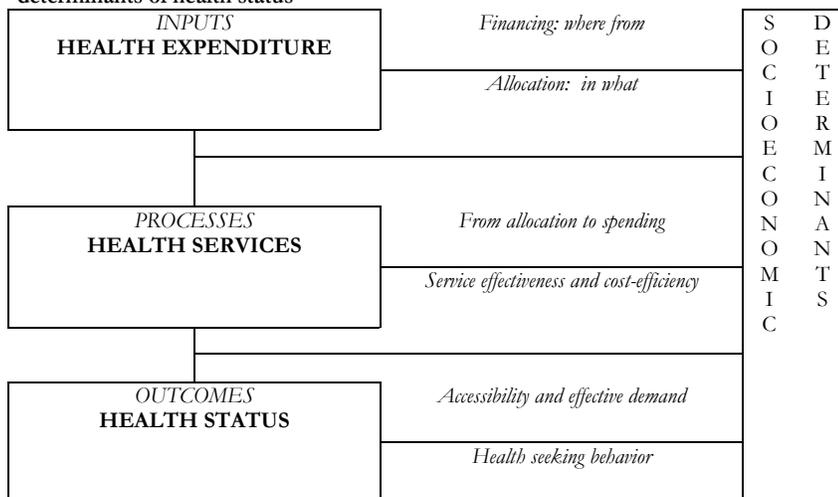
The purpose of this paper is to highlight and get deeper understanding of what kind of health policies is more beneficial for the poor. It aims at provoking discussion on the reach of health policies for the poor and the very poor, and the impact of public health policies on the overall poverty reduction strategy of the country. The paper should serve as a “discussion map” of the major factors determining pro-poor health policies to set up benchmarks for future agendas.

This paper does not aim to be an exhaustive review of the literature of all factors relating health and poverty. Rather, it picks on major aspects of policy that recent experiences have proved to be key in the relationship between health and poverty. It draws critically on the findings of previous work from the Economic and Social Policy Division, namely the forthcoming report “Scoring Leadership for Better Health: the Challenge of AIDS, TB and Malaria in Africa” (ECA/AU/UNAIDS 2003), and work of the DFID Health Systems Resource Centre.

Public health financing

The performance of public health policy can be analyzed looking at “the missing link in the chain”. Diagram 1 represents the public health policy chain. This chain is divided in two steps, from public health expenditures (inputs) to health services (processes), and from processes to improvements in health status (outcomes).

Diagram 1
Public health policy 2-steps chain and interrelations with the socio-economic determinants of health status

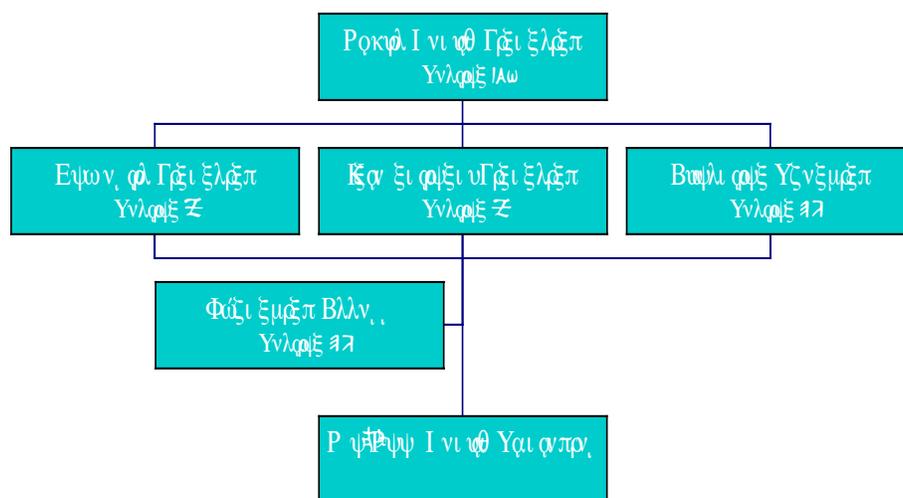


The hypothesis is that public health expenditure affects health services directly and health outcomes indirectly. There are many factors along the chain that determines the effective translation from public spending onto health outcomes. Health outcomes could be measured by reductions in mortality rates, increases in life expectancy, and even reductions in HIV infection rates.

The diagram also includes socio-economic factors all along the public health policy chain. Socio-economic factors determine the availability and allocation of funds, the performance of the public health system, and the final decision and accessibility by households. For example a highly educated population is more likely to respond to a preventive health campaign, and national priorities in poverty reduction are conducive for prioritization of health policies.

The focus of this paper is the first step in the chain, those issues dealing with financing and budgeting of health policies. Current developments within poverty reduction frameworks and health policies in Africa have raised key questions resulting in the need to re-visit and think through financial aspects from a pro-poor perspective. Sections 2 and 3 of the paper deal with issues of domestic and international financing respectively, and following section 4 looks at ways to improve the budget allocations to get better value for money. Finally, the actual improvement in health status will depend also on the rest of the health policy performance chain that is, on the actual spending on most cost-effective and affordable interventions and on the effective demand capacity of the beneficiaries, especially the poor. Therefore, section 5 of the paper will look briefly at key issues in service provision and demand function for effective access by the poor. See diagram 2:

Diagram 2
Linkages of the Sections in the Paper



Criteria for assessing the pro-poor impact of Health policies and financing systems

This paper looks at health systems that are beneficial to the poor. Although the concept of “pro-poor” is easy to understand, it is more difficult to establish measurable criteria to assess it. In this paper the analysis of the pro-poor impact of health policies is based on the understanding that, for a health system to be beneficial to the poor it needs to watch the following considerations:

- **How funds are raised-** It should ensure that the contribution to health services is in proportion to the ability to pay from different households or individuals so as not to restrict health-seeking behavior.
- **Allocation proportional to needs-** It should ensure that national health budgets are proportional to the health needs of the population, and in any case tackling the health burden of the very poor.
- **Respectful to financial restrictions-** The financing of the policy should not undermine complementary development objectives and it should not increase the debt dependency of the country.
- **Cost effective interventions-** It should always promote the most cost-efficient health interventions to maximize the scarce resources available.
- **Ensuring access-** It should ensure the final accessibility of services to the poor, taking into account all determining socioeconomic factors, including perceived quality, geographic access, and health seeking behavior.
- **Protection of the most vulnerable groups-** It should always safeguard the most vulnerable, particularly with respect to the financial shocks associated with severe illness and the geographic access to services, using subsidies, safety nets and compulsory resource allocations.

It is also important to make the distinction between the poor and the very poor. In many sub-Saharan countries, more than 50% of the population is living under 1\$ per day, the poverty threshold. The very poor are a small fraction of this group. This paper deals necessarily with both categories. Benefiting the majority, considered as poor, may in some cases be contradictory with the needs of the very poor. For example, an effective user fees system that raises health revenues and improves quality of care may be beneficial for the majority poor who can still pay for them, but may hinder access for the very poor who cannot afford it.

In addition, there is a strong geographical component in the vulnerability related to access to care within the sub-Saharan context, where a majority of the population live in rural areas and most health facilities, including the best ones, are located in the urban areas. The rural poor therefore tend to be more vulnerable in relation to health care. A person living on more than 1\$ per day but in a remote area of the country with no health facility nearby may not be able to pay for the

transport cost to the nearest hospital, and therefore will be more vulnerable in terms of health care. Thus, for health policies to be pro-poor, they need to consider all dimensions of poverty.

Section 1: Public health policy and poverty

1.1 Introduction

The contribution of health to human and economic development has been widely evidenced (HDR 1996, CMH 2001). Recent strategic developments such as the Millennium Development Goals (MDGs) and Poverty Reduction Strategies Papers (PRSPs) underscore the close contribution from health to development or from the lack of it to poverty. The relationship goes also the other way, where economic and social progress leads to improvements in health.

The provision of care is determined at every moment in time by a health production function formed by health knowledge and technical capacity relative to each disease and moment in time. In spite of the numerous advancements in science and technology, Africa has yet to reach the health production function frontier for our time. The high proportion of avoidable deaths¹ in African countries is shocking. Several factors are hindering African systems from fulfilling their potential. Health systems in Africa are characterized by the insufficiency, inequality, and inefficiency of resources and services. It is commonly argued (Social Summit Copenhagen, 1995) that great part of public health investment in less developed countries is spent in hospitals and expensive treatments that do not reach the majority of the population, and in particular the poor. From all the contributing factors, this paper focuses mainly on aspects related to the way health systems are financed, the way health resources are allocated in the national budget, and to a lesser extent, on the factors determining access by the poor.

1.2 A case for investing in public health policies?

Although the public health system is normally characterised by inefficiency and inequity (Social Summit Copenhagen 1995), the nature of public goods and externalities associated to public health makes it absolutely necessary. Public health policy includes health care and also involves regulating the marketing and protecting equality. The intervention of the public sector is necessary to provide services, regulate, and offer a safety net for the poor. Health policy “embraces courses of action that affect the set of institutions, organisations, services and funding arrangements of the health care system. It goes beyond health services,

¹ Avoidable deaths are defined as the excess of the average death rate for the 0-5 age group in the low-and middle-income countries, of 88 per 1000, versus the level in the high-income countries, 9

however, and includes actions or intended actions by public, private and voluntary organisations that have an impact on health” (Walt 1994, p.41, in Zwi and Mills 1995, p.301). This paper focuses mainly on the public health care system which refers only to the care provision and protecting equality, and not to the regulation of the market or other functions.

An ongoing debate lies in the choice between public and private health services. The key question is how does health expenditure translate into better services (Filmer, Hammer, and Pritchett, 1998). Public sectors are commonly criticised for its inefficacy and inefficiency, *i.e.* hardly competent civil service, inappropriate incentive systems, or high levels of corruption (Tendler, 1998). On the other hand, Zwi and Mills argue that “there is little evidence that private is more effective, and even less evidence for less developed countries (LDCs). Besides, when private providers come into LDCs they act more freely leading to problems of cost inflation, and so on.” (1995, p.310-11)

Extremely important is the argument by Musgrove (1996) pointing to the existence of small but very important health-related activities, which need to be financed by the state. “These interventions appear to account for much of the impact of health spending on health improvements. They probably explain why public health expenditure is somewhat more effective than private expenditure in extending life expectancy.” (*idem*, p.2). These health activities requiring public financing are especially important at low-income levels, for both epidemiological and economic reasons. Thus, public financing appears to be particularly crucial for health in poor countries (Musgrove, 1996). For example, most of provision of services related to under-five survival is made by the public service because it is not profitable for the private sector. In this sense, the public service may be considered more effective on equitable issues rather than the private one, and more effective in reducing under-five mortality.

International organizations have also an important role in less developed countries in funding and providing technical support. Lafond (1994, in Zwi and Mills 1995, p.309) argues that “in the poorest countries, heavily reliant on external assistance, donor funds support primary and preventive care, while government funds support the hospital infrastructure.”

Besides, health services -whether public or private- play only a limited impact on health outcomes. Health, or well-being in its broad and more complete sense, is composed of many factors, such as security, lack of uncertainty, economic growth, education, and so on. As the integrative framework of Mosley and Chen (1984) explains for the analysis of child survival, all social and economic determinants (the “distal” determinants) of child mortality operate through a set of biological determinants (the “proximate” determinants) to affect a child’s probability of survival. Multivariate cross-country studies and panel data analysis actually show that socio-economic factors such as GDP or female education have

a stronger impact on health status than public health expenditure, to the extreme that some studies like Filmer and Pritchett (1997) found that income alone can explain most of the cross-national variation in child and infant mortality.

1.3 The hottest issue of the distribution of public expenditure

Health Ministries in Africa are facing a difficult decision. They need to expand and improve the quality of basic services, namely Primary Health Care (PHC), that are key cost-effective measures to avert a great deal of infant and maternal deaths. But at the same time, they have to react to new epidemics, mainly AIDS, and a strong resurgence of old ones, mainly tuberculosis and malaria. The exponential spread of these infectious diseases and their magnitude and impact on society, economy and governance capacity of countries are such that the cost of inaction would be much higher in the future: action is needed now. As a result African governments are facing this dual competing demands, between strengthening health systems and investing in vertical programmes for particular diseases. To satisfy both demands, maximization of the health production function is required. Adding extra funds to health budgets cannot do the work alone; it will not solve the problem of inefficiency of the system, but even more, it may not be feasible in a context of macroeconomic restrictions and capacity constraints, as will be shown later on.

In the African context of aiming strongly at pro-poor growth strategies, the need is to maximize public resources and increase the absorptive capacity for new resources. The re-consideration of the capacity to absorb new resources opens many challenges around foreign aid effectiveness and sustainability, and around the domestic capacity to increase revenues without hurting the income of the poor. This paper will raise these issues together with good examples in overcoming them in the continent. For results to be sustainable and not easily reversible, they need to come from better use of existing domestic resources through a more coherent allocation and implementation system.

1.4 International momentum for poverty reduction and investments in health

There has recently been a shift towards developing Poverty Reduction Strategy Papers (PRSPs) moving away from Structural Adjustment Programmes (SAPs). The resources saved through debt relief under the Heavily Indebted Poor Countries (HIPC) are channelled to reduce poverty through a country owned 3-year policy framework-the PRSP, provided the national PRSP is well-designed according to IMF and World Bank. With the same spirit, the Millennium Development Goals adopted by 189 nations in the Millennium Declaration in September 2000

are the result of a global effort and consensus to set up common goals to halve poverty by 2015 and improve well-being in a comprehensive sense.

There is a strong focus on critical importance of health and in particular, mainstreaming the major challenge of HIV/AIDS in the design of national strategies in order to achieve pro-poor growth and reach the MDG goals (PRSP-LG report 2001). Indeed, most African PRSPs, if not all, incorporate health issues in the poverty analysis. Nonetheless, this analysis has been regarded as weak and insufficient in most cases, as was emphasised in the PRSP-Learning Group² meeting that took place at ECA November 2001.

Currently massive –though not sufficient- amounts of money have been pledged for Africa to scale-up the responses to HIV/AIDS, TB and malaria, coming not only from debt relief but also from new initiatives such as the Global Fund and others. This is a positive sign and message of hope that funds will be available. But at the same time caution is necessary. Most of the funds have only been pledged, but the money is not coming in yet. Secondly, there are problems linked to receiving external aid, and in addition many African governments do not have the capacity (in terms of physical and human infrastructure) to absorb, manage, and use such high amounts of money in such a short time. And above all, if the health financial system is dysfunctional or there are big mismatches, increasing the amount of funds will increase the mismatch in the same proportion. What is needed in the first place is to get the financial and allocation systems right.

Section 2: Domestic financing and the poor: Tax based, user fees and insurances schemes

After excessive introduction of user fees since 1980s, the current focus is now on *“the need to move away from excessive reliance on out-of-pocket payment as a source of health financing towards a system which incorporates a greater element of risk pooling (for example through health insurance) and thus affords greater protection for the poor.”* (Bennett and Gilson 2001, p.1) Latin America for example is moving ahead in this direction. In the sub-Saharan context where the tax base is small and difficult to increase, there is limited capacity for increasing funds through taxation, or even to ensure that national funds are allocated to health. For this reason earmarking is likely to complement this system in ensuring funds are allocated to the desirable lines.

There are five principal financing mechanism in low-income countries (Bennett and Gilson 2001): **tax-based financing, user fees, social insurance financing, private insurance, and community-based insurance** Table 3.1 contains a schematic summary of the current tendencies in using and mixing these ap-

² PRSP-LG is an African Learning Group on the PRSP is convened by the ECA and brings together on an annual basis senior African policymakers and experts for candid discussions on how the PRSP process is unfolding in Africa

proaches and country examples. They impact on access by the poor in different ways, but most of all it is the combination of all of them that will determine the most appropriate design of a pro-poor health system. This section will review the effects of these financing mechanisms and their combinations upon the poor, based mainly on Bennett and Gilson (2001).

Table 2.1
Major trends in health care financing

Trend	Objectives	Countries reforming in this way
Introduce of increase User fees in tax-based systems	<ul style="list-style-type: none"> - Raise more revenues - Encourage more efficient use of resources - Create greater accountability to the consumer 	Many countries in Sub-saharan Africa
Introduce community-based health insurance in systems currently based on user fees and tax revenues	<ul style="list-style-type: none"> - Reduce financial barriers created by user fees - Encourage more efficient use of resources - Raise more revenues 	Large scale initiatives in Thailand, and Indonesia; numerous small scale efforts in many other countries e.g. Zambia, Tanzania, Uganda, India
Shifts from tax based to social health insurance type systems	<ul style="list-style-type: none"> - Create independent, sustainable source of health finance - Raise more revenues 	Thailand, many countries in the Former Soviet Union and Eastern Europe; proposed by not implemented elsewhere, e.g. Nigeria, Zimbabwe, Ghana
Consolidate multiple state insurance funds	<ul style="list-style-type: none"> - Increase equity and prevent tearing and fragmentation - Increase administrative efficiency 	Mexico, Colombia and other countries in Latin America

Source: (Bennett and Gilson 2001, p.1)

2.1 Tax-based financing

In tax-based systems, *“health services are paid for out of general government revenue such as income tax, corporate tax, value added tax, import duties, etc. There may be especial earmarked taxes for health care”* (Bennett and Gilson 2001, p.5). Presently over 65 percent of current health expenditure is tax funded (CMH 2001), and there is little potential for increasing tax financed health spending.

It is argued that tax-based financing can be pro-poor as it tends to be progressive, avoids the use of out-of pocket payment, and thus provides a protection from the financial restrictions coming from large care costs (Bennett and Gilson 2001). On the other hand, this way of financing is criticized because often funds are biased towards hospitals in main cities, where the allocation of funds is decided and the majority of the constituency lives. In addition, evidence has shown that in settings where the formal sector is small, indirect taxes are more used than direct ones, and indirect taxes are less progressive and may even become regressive (*idem*). While evidence on the progressive nature is mixed, there seems to be a

consensus that in comparison to other systems, tax-based funding is relatively more progressive.

Evidence has shown, however, that allocations through this system are often biased against the poor, resulting in poor quality facilities offered to the poor, that are not exactly free as costs of transport need to be covered privately. There is strong evidence showing that in these cases of perceived low quality services, the poor would prefer to use alternative systems such as private provision of care and traditional healers, or not at all. This results in hospital services being used mainly by the income-able population and the ones living in the urban areas where hospitals are located.

2.2 User fees financing

“In the user fees system patients pay directly, according to a set tariff, for the health care services they use. There is no insurance element or mutual support. This is the most common way of paying for privately provided services in developing countries and is also used as a component of financing for public sector services” (Bennett and Gilson 2001, p.5). The out of pocket share is high on average for low-income countries and accounts for 50-70 per cent of total health expenditure though varies greatly (Musgrove and Zeramndini 2001, Bennett and Gilson 2001). In 1995, 28 out of the 37 African countries studied in a World Bank survey had introduced user-fees in government health facilities (Nolan and Turbat 1995 in Arhin-Tenkorang 2001). However, much of the out-of-pocket fees are spent in urban areas for non-essential services (Bennett and Gilson 2001).

User fees are commonly regarded as the most “anti-poor” financing system, as it prevents the poor from using the services that they cannot pay for. This situation has been repeated in Africa continually especially after the introduction of Structural Adjustment Programmes (SAPs) in 1980s when cost recovery schemes were introduced. In particular the problem was that the collection of pocket payment did not translate into an improvement of the health facilities (where the fees were collected) in most cases. Generally although the fee is significant for the individual, especially if poor, the total revenue raised is low at the aggregated level. In Ghana where hospital fees were introduced as part of the government’s Economic Recovery Programme with the target of raising 15% of recurrent budget, only 1-12% cost recovery ratios had been sustained and with the trade off of declining use of health facilities mostly in rural areas (Arhin-Tenkorang 2001).

Although the general trend stands, counter arguments could also be raised. This system could effectively work for the poor provided certain conditions are met. The fees could be translated into improvements in staff and facilities and thus more incentives for poor people to use the services. Even more, the fees collected in urban centers could be reallocated towards the rural poor. This is a clear

case where improvements in participatory institutions and accountable administration would probably lead to ensuring more beneficial outcomes for the poor.

The feasibility of making out-of-pocket payment work for the poor will depend on the proper design and implementation of the scheme, especially if governance issues as well as the combined utilization with other systems and exceptions mechanisms for the very poor are considered. For example experiences in Kenya where more attention has been drawn on appropriateness and implementation show how user fees may bring benefits to the poor. In areas with low average income it will naturally be difficult to make this system work for the poor. Similarly, where the mechanisms to ensure equitable redistribution of revenues are not put in place, or exceptions for the very poor are not common, the pro-poor potential of this system is not likely to succeed.

Box 2.1
Moving away from user fees in Uganda

User fees for primary health care services were prevalent in Uganda since late 1980s as a fiscal austerity effort. It has been strongly argued by civil society that (CSRC 2000 in Nyamugasira and Rowden 2002) that the perception of the fees was mixed; economically better-off regions would see them more positively while the rest would see them as a burden. President Museveni made a political issue of it and eliminated them in 2001. Immediately after demand increased sharply and remained high but diminished when drugs supplies decreased (*idem*). All in all, it has been argued that the revenue generated by the recovery schemes created additional constraints on access to quality services by the poor, particularly in rural areas (SAPRIN 2001 in Nyamugasira and Rowden 2002). The Government reports pointed to 40% increase in attendance for outpatients and 48 to 63% increases for DPT immunizations (Weissman 2003). To the question of how much revenue was lost by not charging fees, opinions are mixed.

Social insurance schemes have also been considered, but do not seem to be a feasible option in the short and medium-term in providing sufficient health financing resources, according to “A Feasibility Analysis of Social Health Insurance in Uganda” (Berman and Hsiao 2000). The conclusion of the study is towards a cautious movement with small pilot programmes (Yates interview in Nyamugasira and Rowden 2002). In 2001 the Ugandan Government was moving towards developing a package of free basic health care services.

Source: Nyamugasira and Rowden (2002) and Weissman (2003)

2.3 Social Insurance

When financing through social insurance, “health services are paid for through contributions to a health fund. The most common basis for contributions is the payroll, with both employer and employee commonly paying a percentage of salary. The health fund is usually independent of government but works within a tight framework of regulations. Premiums are linked to the average cost of care for the individual. Hence there are explicit cross-subsidies from the healthy to the less healthy. In general, membership of social health insurance schemes is mandatory, although for certain groups (such as self-employed) it might be voluntary” (Bennett and Gilson 2001, p.5).

The core principles of social insurance include considerations for the poor in terms of reducing risk and mutual support and transfer of resources. However when applied in practice, especially in context with small formal sectors, this system may end up being used only by the better off with the poor being excluded. Even more if the government is trying to expand the use of social insurance and therefore subsidizes them initially in several forms, the requirements are too high for the poor and the very poor to participate and benefit from these subsidies. In addition, as pointed by Bennett and Gilson (2001), in a context of limited human and technical capital, the pool of resources by the insurance may attract the best medical resources available away from public health systems.

2.4 Community-based insurance

“As for community health insurance, premiums are commonly set according to the risk faced by the average member of the community i.e. there is no distinction in premiums between high and low risk groups. However, unlike social health insurance schemes enrolment is generally voluntary and not linked to employment status. Funds are held by a private non-profit entity”(Bennett and Gilson 2001, p.5).

As contained in figure 3.1, community based insurance arose as a reaction to mitigate the impact of user fees. Thus, where user fees had been implemented often the community felt the need to pool resources to mitigate financial shocks between the sick and the poor and over time. Being community-based, the common practice is that it also covers those outside formal sector employment, as opposed to social health insurance.

The evidence has proved community based-insurance to work pretty well for the majority of the population, including the poor. However, doubts arise for the effect on the very poor who require special concessions and may in some cases be left out from exceptions or special benefits by the community or the government. It is also argued that governments must play a role in distributing benefits among schemes when the community-based insurance is the primary source of health revenues.

2.5 Private insurance

In private insurance systems “people pay premiums related to the expected cost of providing services to them. Thus people who are in high health risk groups pay more, and those at low risk pay less. Cross-subsidy between people with different risks of ill health is limited. Membership of a private insurance scheme is usually voluntary. The insurance fund is held by a private (frequently for-profit) company” (Bennett and Gilson 2001, p.5).

If community-based insurance may not be pro-poor, private insurance is even less so, being a privilege for those with stable income. This is largely absent in low and middle-income countries, although exceptions exist. In South Africa and Zimbabwe the large income disparities have allowed higher income groups to use private health insurance. Indeed, it is argued that the use of private insurance may free the public systems from expensive non-essential demands (related to high-income groups) and thus having a positive impact on health budgets. However, because private insurance is closely linked to the most affluent population, issues of political governance may not facilitate that the very poor benefit from the design of this scheme.

Box 2.2

Private insurance and risk pooling in South Africa

The case of the development of private insurance in South Africa can be taken as a “best practice” case of public-private partnership and devising a scheme which diverts from payment on delivery and therefore diminishes risk of falling into poverty.

In 1994 a private health care industry accounted for 61% of health care providing the needs for only 20% of the affluent part of society. Cost escalation in the private sector exceeded inflation during the 80s and 90s. The private sector responded by limiting benefits, increasing co-payments, accelerating exclusion of high-risk members. The Government’s response was (Medical Schemes Act, 2000) to define minimum packages along:

1. Community rating. Premiums can vary according to family size and income and risk and age criteria were prohibited.
2. Guaranteed access. No one who can afford can be excluded.
3. Increased pool risking. Caps on the permissible contributions through individual medical savings account will ensure contribution flows into the common risk pool.
4. Promoting lifetime coverage. Community rating will be combined with penalties for late coverage and encourage affordable lifetime subscription.
5. Prescribed minimum benefits. Every medical scheme must guarantee to cover the full cost of a specified list of conditions and procedures.

Source: WHO Report 2000 in ECA/AU/UNAIDS/WHO (2003)

2.6 Which health financing system is more ‘pro-poor’?

As Bennett and Gilson concluded (2002, p. 20), *“It does not make sense to assess whether or not a single financing mechanism is pro-poor; such an assessment must be carried out with respect to the complete mix of financing mechanisms and their interaction with resource allocation approaches and organizational contexts.”*

For example, whereas user fees are commonly disregarded for preventing poor people from using health services, they could also be beneficial for the poor if they are invested in better quality of services and redirect revenues from urban hospitals to the rural poor. However, the problem lies at the planning and implementation level by the lack of consideration of the policy with a predominantly pro-poor approach. Arhin-Tenkorang (2001b) argues that the design and performance of community health insurance schemes may be improved by considering data on willingness to pay and expected costs, and by facilitating transactions by formal agents in informal environments.

Nowadays efforts in Africa are to move away from user fees and invest more on community-based and social insurance schemes, as a mean to reach and protect the majority of the poor. Although moving in the right direction, the need remains to ensure the protection of the very poor in the design and implementation of the schemes. Because of the non-universal coverage of insurance of any kind, it is often the case that the poor and very poor tend to be left-out and thus it will further the health gap between the poor and the rest of the population. Strengthening more participatory and accountable institutions is expected to address this problem. The Community Health Fund (CHF) established in several districts of Tanzania exemplifies a scheme that is affordable to the majority of the population while including exemptions mechanisms. It combines three financing mechanisms: user fees, insurance contributions, and matching subsidies from the government and it is governed at the district level but also coordinated from the Ministry of Health (Arhin-Tenkorang 2001b).

Finally, the adequate design of the financing system is hindered by lack of information of who is paying the services and what kind of services, and thus a bias assessment of the capacity to pay of the population. To deal with it, South Africa, for example, has started the exclusion of some employment-related members that are generally well-off, from the base population when formulating the allocation of public funds. However, this requires good quality data on population and health related, often not available, even more on time, for most African countries.

Section 3: Mobilising external resources

3.1 What external resources are needed and what are the trends?

Because of the limited extent to which domestic resources can be reached, and the need for additional financial resources to fight rising epidemics, external resources are necessary, and need to be effectively disbursed. CMH (2001) calculated that out of the extra funds needed to combat AIDS, TB, and malaria, US\$ 2.2 – 2.4 billion needed to come from external grants and concessional lending. Whereas financing public health sector budgets from total identifiable ODA is 7% in low income countries, it is up to 12% for Sub-Saharan Africa on average (Roberts 2003); in 2000, ODA commitments explicitly earmarked \$2.6 billion to be added to national health budgets (Roberts 2003).

How much is international aid being increased? There is a general feeling of scepticism in African countries about the recycling of aid instead of an actual increment in aid. In addition, even when extra resources are mobilised from outside to increment health budgets, there is the danger that public expenditure planners may compensate for this increment by reducing domestic allocations. Therefore, even if aid is earmarked for health, it may not lead to an increment in expenditure.

With respect to HIPC Debt Initiative, there is ongoing debate on (a) to what extent it is releasing funds, and (b) to what extent these funds are, and should be, invested in health policies. The IMF, in a paper prepared for the Commission on Macroeconomics and Health (CMH), estimated that allocations from HIPC released funds to health sector outlays are expected to increase by an average of 0.4% point of GDP between 1999-2001 (Gupta *et al* 2001). The allocations at the time of the study (1999) showed that HIPC allocations for health care remained low, with only 8.5 % of total government outlays in HIPC devoted to health. This is relatively small, taking into consideration that HIPC countries tend to spend less on health care than other low-income countries. This was 1.8% of GDP in HIPC countries that are eligible for PRGF compared to 2.6% of GDP in low-income countries in 1998. HIPC resources have to be distributed within the competing demands for poverty reduction activities. It is claimed that some of them may have a stronger impact within the overall poverty reduction framework, such as education, improvements in water and sanitation, rather than health services alone.

The international concern of rising epidemics has also created a positive momentum in terms of mobilising new sources. Several new initiatives have been created to mobilise extra funds to tackle AIDS, TB, and malaria, such as *the Global Fund to fight AIDS, Tuberculosis and Malaria*, *Roll Back Malaria Partnership* and *Bill and Melinda Gates Foundation*. The Global Fund is a new approach to international health

financing, that exemplifies the extraordinary intentions and mobilisation and efforts at the international and domestic levels to effectively and quickly channel funds to these diseases³.

However, these initiatives, including the Global Fund, are just disease-specific funds that may even disestablish national health budgets. Rather, what is needed is not to lose track of strengthening overall health systems as a necessary condition. Not only to enhance health services, but even to enable vertical programmes to work, as recommended by the report “Scoring Leadership for Better Health: the Challenge of AIDS, TB and Malaria in Africa” (ECA/AU/UNAIDS 2003).

3.2 Constraints of international side: Unpredictability and conditionalities⁴

A key problem linked to external resource mobilization is conflicting conditionalities attached to donor funding. The politics of international aid have an influence on the operations of national institutions as well as on crucial social and political dimensions, limiting effective national leadership. Aid effectiveness varies from country to country depending on the robustness of national policies and the tightness and feasibility of conditions attached.

The unpredictability and conditionalities attached to overseas development assistance present a major constraint to effective interventions against diseases in Africa. More often than not, recipient countries are unable to predict the availability (or even the amount) of donor contributions. Conditionality of donors’ support may take several forms, structural reforms, macroeconomic conditions, areas and ways of intervention, including geographical areas. For example, the linkage of aid to district projects can be a problem if this does not reflect the country’s needs (Pearson 2002). This can be avoided if project-support is substituted by donors budget support, as for example in Uganda, where “central allocations to districts receiving large inputs from NGOs and donors were reduced as a means of promoting greater equity in overall resource flows” (Pearson p. 10).

³ The Global Fund relies on local ownership of the planning and managing of the resources, based on newly created institutions, mainly the Country Co-ordinating Mechanism (CCM) and the Principal Recipient (PR). However, despite the efforts in designing a sustainable and participatory system as a new way of materializing international aid, the Global Fund is going through delicate moments that put in danger its existence. Serious difficulties to maintain the funds pledge and need do once more raise the need for international partners to maintain their promises. As of April 30, 2003 progress on Round 1 of proposals includes signed agreements with 29 of the 37 countries with approved proposals, for a total of US\$367 million, of which initial disbursements for 25 countries, amounting for US\$20 million. Round 2 was also signed and the deadline for submissions of proposals for Round 3 ended last May 31. Half of the funds are used for purchasing of drugs and commodities, and half are used for infrastructure and training, and 60% of the funds are allocated in Africa (Global Fund Observer 2003).

⁴ From ‘Scoring Leadership for Better Health’ (ECA/AU/UNAIDS 2003)

Both conditionality and lack of predictability have a negative effect on the expenditure planning processes. For example, for countries where donor budget support is high such as Mozambique (60-70 percent), and Ghana (40 percent), the availability and timeliness of information on donor contribution is critical. Notwithstanding this, Ghana is an interesting example of how donor budget support is managed in an efficient manner, in terms of ownership and coordination.

Box 3.1
Donor Budget Support: the case of Ghana

African leaders have proposed in NEPAD that donor finances should be channeled through country budgets, returning ownership of resources to the countries themselves. In connection with NEPAD, the government of Ghana has established a multi-donor budgetary support programme. The aim of the programme is to support the Ghana poverty reduction strategy (GPRS) by:

- Consolidating high real economic growth through the support of economic reforms and sound economic policies
- Providing financial contributions for increased allocations to priority sectors for poverty reduction
- Creating an enabling environment for sector wide approaches by addressing key issues, thus laying the basis for more efficient and effective public service delivery.

The innovative budget support programme requires that donors reorient their approach to make sure that overall assistance matches country needs and capacities. Just as country ownership of poverty reduction strategies is meaningless without capacity, so is having institutional arrangements without the capacity to implement them. That is why capacity-and capacity development-will determine the pace of moving forward as well as strong institutional arrangements.

The government of Ghana and the development partners participating in the programme have agreed to focus on five key reform areas that are considered of great importance for the success of the GPRS. These areas range from public finance to public sector reform and governance. Regular dialogue, monitoring and audits are considered critical for continued development partner commitment to the programme. Regular monitoring reports from the government will be in a standard format and will include quarterly reports on, inter alia, macroeconomic indicators as well as progress in the implementation of GPRS. The programme is open to all development partners but only the ADB, Canada, the EU Commission, The Netherlands, The UK, USAID and the World Bank have signed so far.

Source: 'Scoring Leadership for Better Health' (ECA/AU/UNAIDS 2003) and Government of Ghana and official sources.

3.3 Towards budget approach, MTEFs and SWAPs

There is currently a shift in international aid to move from programme-linked aid towards supporting national budgets, leaving the country to make the decision regarding the distribution of the funds. In the mid 1990s, sector-wide approaches (SWAPs) became the sought form of support by donors as a response to the fragmentation of aid. Even more comprehensive is the budget support system, that pools together the whole national budget increasing the ownership in the decisions by the national government, even more than SWAPs (Roberts 2003).

The development of budget support programmes, MTEFs, and SWAPs, increases the coherence and systematic planning capacity of national budgets and policies. They have proved to increase the capacity of management of funds as well as the management of national accounts. They also improve the relationship with donors, provided that budget management is done in a transparent and efficient way.

The essence of Medium-term expenditure framework (MTEF) is to *“provide a fiscal framework in which revenue receipts are realistically projected on the basis of forecast growth and non-revenue receipts on the basis of aid agreements and prospects for domestic and external market borrowing, which are themselves based on the country’s debt situation and macroeconomics stabilization requirements”* (Roberts 2003 p. 66) revenues and non-revenues. MTEFs provide a better planning policy instrument based on a three-year rolling plan. There is improved predictability on reducing the resource gap between forecast and actual revenue, but this also requires timely information.

However, MTEF cannot incorporate funds not pledged earlier in the budgeting cycle; particularly considering donor support, which may be too high. Also, the process of MTEF, to be effective, needs sufficient information on revenue and expenditure from all sources and if donor funds are not available then such a practice is incompatible with the MTEF process.

In budget support, earmarking of health areas is sometimes used. Within the current situation of rising epidemics in sub-Saharan Africa this earmarking could help to ensure funds are allocated to the health budget, moving away from historical allocation of resources and adapting to new priorities. However, there are also the risks of returning to conditional aid and narrowing assistance to vertical programmes. Uganda is a prime example in this regard. As has been pointed out by the Rwandan Minister of Finance (ADB symposium 2003), “Earmarking to health should be considered as an exception, not the rule”.

Box 3.2

Medium-Term Expenditure Framework

The Medium-Term Expenditure Frameworks were introduced in order to solve countries' budget problems. However, experience suggests that developing a successful MTEF is not easy. In fact, there are few established medium-term frameworks. The existing ones, especially in the developing world, have been recently implemented and are still evolving. Some lessons show that there are dangers in applying MTEF as an appropriate response to budget problems.

In Malawi, for instance, where an MTEF had been introduced since 1995, questions were raised on the lack of synchronisation between the approved budgets and the actual release of funds. Therefore, the challenge is not only strengthening public financial management in order to ensure that scarce resources are being used to achieve priorities. The real challenge in developing an MTEF is also to introduce a level of predictability in budget allocation so as to close the gap between budget demands and available resources. Experience in OECD countries on the other hand, indicates that stringent conditions are a pre-requisite to realising full benefits from medium-term frameworks. Some of these conditions are unlikely to be fulfilled in most developing countries.

However, even the basic acceptance of the principles of a medium-term budgeting may improve the appropriateness of sector budgets. This is a substantial gain for many developing countries where ad hoc spending cuts in budget implementation are often caused by the gaps between stated policies and actual resources. Improvements in the costing of policies and programmes will take longer to achieve, because they require a strong information base and are impossible to deliver without the full involvement of the sectors concerned. Therefore, successful budget reforms depend on national and sectoral policies that are clear, affordable and realistic. Finally, MTEF is definitely not a panacea. Its success largely depends on the ability to identify the real and most urgent priorities.

Source: 'Scoring Leadership for Better Health' (ECA/AU/UNAIDS 2003) and World Bank (2000)

3.4 Consistency of health expending with macro-economic policies and national budget

The need for macro-economic stability may present a further constraint on national governments to increase domestic spending on health. This is particularly related to additional funding through overseas development assistance and the existence of medium-term expenditure ceilings. For instance, Uganda, which has moved away from the project approach to the sector-wide and budget sup-

port approach, was almost unable to access a grant from the Global Fund because of this ceiling to health spending (see Box 5.2). Uganda is not a unique case. Tanzania has also experienced a similar situation to that of Uganda with the Global Fund, and other countries such as Mozambique are feared to suffer from the same constraints.

Box 3.3

Macro-economic stability constraints over health: the case of Uganda

Uganda has committed itself to the Abuja declaration, which calls for an increase in health sector spending to 15 percent of GDP. This commitment is currently in conflict with spending limits set in the Medium-Term Expenditure Framework, which restricts health sector spending to \$107 million for financial year 2002 – 2003. The Ministry of Finance tried, therefore, to decline a grant towards the Ministry of Health from the Global Fund to fight AIDS, TB and Malaria to spend on HIV programs over the next three years.

The Ministry of Finance argued that increasing health expenditure beyond the limit of \$107m for that financial year could raise inflation and destabilise the country's economy. Therefore, the acceptance of the grant could only be equal to a reduction in domestic spending. Finance Minister Gerald Sendaula said: *"We should not just be told 'funds are available, take it up.' If we handle our economy that way we will have problems."*

However, health officials argued that in setting a health expenditure limit of \$107 million, the Ministry of Finance has fixed a ceiling below the floor, in other words lower than it should. An official from the Ministry said: *"We have to get this ceiling constructed in a more conventional manner, above the floor."* In this case, the goal of macroeconomic stability takes precedence over the health of the nation.

Uganda has been shown as an example to follow by being one of the pioneers in achieving a PRSP and the lending attached to it. Their process leading to their PRSP has been regarded as a best practice in terms of participation and ownership. However, the resistance of the Ministry of Finance (MoF) to accept the grant of the Global fund has caused controversy between the poverty reduction strategies and the macroeconomic requirements, as highlighted in the study "New Strategies, Old Loans" published in April 2002 by Nyamugasira and Rowden. After two weeks of tight negotiations, the Ministry of Finance agreed to accept the grant of the Global Fund and thus agreed to increase the health spending. In the words of the Permanent Secretary in the MoF, Chris Kassami, "The worst effect we have on the economy is AIDS, so anything that fights AIDS is good for the economy". The questions to be answered now are to what extent has this money caused trouble for Uganda's economy and to what extent it has benefited in terms of health care and poverty reduction.

Source: Lancet, (2002) in 'Scoring Leadership for Better Health' (ECA/AU/UNAIDS 2003) and Nyamugasira and Rowden (2002)

The question remaining is how much and how fast can Governments increase their health spending without damaging the stability of their economies. Uganda had increased significantly its proportion of the national budget, from 6% to 9% between November 2000 and June 2001, and it was aiming to increase it to 15% as set up by the AU in Abuja Summit 2001 (*idem*). However, this increase had

not been translated immediately into improvements in the efficient use of resources within each sector, whereas relative prices increased. Indeed, the quality of services had not improved and had worsened in some regions, one of the reasons being the increase in the number of health facilities with their associated costs.

Similar case to Uganda has been reported in Tanzania, as reported by the Global Fund Observer (GFO 2 2003), *“Two days before the Global Fund was due to sign a grant agreement with Tanzania on 22 November for a \$12 million grant for malaria prevention, the Tanzanian Finance Ministry insisted that it, rather than the nation’s malaria control programme, would handle the funds. The Global Fund immediately canceled the signing, not so much because such an approach is unacceptable, but because it is different from what the Tanzania CCM had proposed and agreed”*.

In this case, the agreement has to happen not only between Ministries of Health and Finance, but also between MoF and the CCM, which add an extra complication to the decision-making process. The response by the Tanzanian MoF was, *“We are concerned that the mechanism of aid delivery proposed by the Global funds Against AIDS, TB, and malaria has the potential of undermining government accountability and (negating) all efforts made so far to improve development partnership and aid effectiveness”*. (GFO 2 2003) Finally, an agreement was reached and signed on 30 November 2002.

Uganda and Tanzania are not isolated cases of pressure from fiscal discipline over health demands. As was mentioned earlier, it is often the case that if extra funds are allocated through specific initiatives or through earmarking of aid towards health budget, expenditure planners may compensate by reducing other domestic sources not to alter the initial calculations. However, these moving budget lines crash with the tenants of the Global Fund that grants must lead to additional expenditure.

There are several macroeconomic concerns to higher expenditures for health. First, it may spark inflation in the economy. Second, the incoming dollars may appreciate the local currency, thereby hindering national exports. Third, when aid is given as a loan and not a grant, it worsens the debt sustainability. A final concern is the absorptive capacity of the country to utilise increasing funds in the short run, and linked to this the argument that after health expenditures have been increased, improvements on health outcomes should be shown first before asking for more resources.

On the other hand, counter arguments are also numerous. As pointed out by the Ministry of Health in Uganda (idem, p. 38) *“a large portion of the donor monies are given in hard currencies and are never actually exchanged into Uganda shillings, and instead are used to purchase drugs and equipment in international markets.”* In addition, some time needs to pass before health expenditure translates into better services and into better health outcomes ultimately, as necessary

for evaluating the impact of any other policy. In relation to debt sustainability, when aid is given as a grant, the ratio is not altered in a direct way (though there may be indirect effects).

Remaining questions include which increase would be acceptable (non inflationary) and which one not? And how to determine the absorptive capacity of a country? Sound economic calculations need to be made explicit and country by country. General or hypothetical estimations could otherwise lead to big opportunity losses. In addition, decisions have to be made in consideration with other key changes. For example, Nyamugasira and Rowden (2002) also argued that in the new loans to the Ugandan government, price increases in clean water as a result of privatization directives from PRSC were not considered, and thus considerations were not made on how this may undermine the health-related poverty-reduction goals of the PRSP.

Nevertheless, concerns are raised on the way these expenditure ceilings are set. Are these “ceilings” to social expenditure made by national governments by choice or in order to satisfy international financial institutions? For example, in the case of Uganda, some opinions point at the IMF as the “*architect of the low ceiling*” (Doroothy Hyuha, Chairperson of the Parliamentary Committee on Social Services, in the Lancet 2002).

Macroeconomic stabilization is key for sound government and thus should be given priority because it is good for national economies and it is believed as such by the Ministry of Finance. It should not be an imposed condition from the outside; conditionalities distort the strategic selection of the most appropriate choices. Especially in countries undergoing PRS processes, these “ceilings” to social expending should be shown explicitly under the same process of transparency and ownership claimed in the PRSPs. There are social choices made under economic decisions that need to be openly explained and agreed in the PRSPs and in line with the pro-poor approach sought by the country.

A good example in doing this is the country of Rwanda. The Rwandan Ministry of Finance in collaboration with DFID undertook a study in 2002 on the “Impact of increases in public expenditure on poverty in Rwanda”. This study is part of a larger series of Poverty and Social Impact Analysis (PSIA) that aims to provide evidence-based policy options for poverty reduction. DFID and World Bank have undertaken studies in six countries each (twelve in total). The optimal allocation and additional expenditure under PRSPs is based on three possible scenarios, which allow for modeling policy options under a small macroeconomic consistency model (see box 3.4).

Box 3.4
**Assessment of the impact on poverty and macroeconomic stability
of increasing health spending – the case of Rwanda**

The Rwandan Ministry of Finance, in collaboration with DFID, undertook in 2002 the study “*Impact of increases in public expenditure on poverty in Rwanda*” (2003b). This study is part of a larger Poverty and Social Impact Analysis (PSIA) that aims to provide evidence-based policy options for poverty reduction. Although the study is still in progress, the results are extremely enlightening on how to reconcile macroeconomic stability with health provision priorities.

The study assesses the impact of increases in expenditure in the PRSPs priority areas on poverty, on overall and sectoral growth, and on environmental sustainability and political stability. It points at the need for multiple scenarios including different kinds of risk and a different credit term in order to model resource flows in the medium and long term. Using these scenarios it argues that financing the priority areas under the Rwandan PRSPs requires necessary additional foreign aid (justified mainly by a post-conflict situation) and that there is no need for Rwanda to cap grants. The study concludes that Rwanda can productively absorb and use more aid, provided that both government and donors focus on the priorities for poverty-reduction and that resources are adequately flexible.

In relation to the health sector, the study concludes that expansion of bednets to prevent malaria can lead to dramatic reductions in child mortality, and thus, malaria programs can have a good return if well implemented. It highlights the need for HIV/AIDS prevention and treatment. However the effectiveness of further expenditure depends on whether it will be spent within a well-developed national strategy for combating the disease.

The macro aspects of increasing public spending and its implications for growth need to be looked at within the country’s context. Post-conflict countries are regarded as having more aid absorptive capacity, and where PRSPs involve better-defined prioritisation of resources and more flexible aid modalities, returns to aid may still remain high.

Source: Mckinnon *et al.* (2003a and 2003b)

3.5 Conclusions

As was raised in the Experts Meeting of the African Ministers of Finance Conference, Addis Ababa 29-30 May 2003, the non-sustainability of funds suggests that the way to tackle the health needs for African countries may not rely on these promises from international partners, but rather the solution may lie ‘in house’.

The dangers attached to conditional aid may supersede their benefits. Thus, budget support systems that respect national ownership, provided accountable

decision-making process have been proved, should be enhanced. In so doing, there are some preconditions that need to be met to ensure the final success. Two key issues relate to the technical capacity to introduce the reforms and maintain systems of regular monitoring, and to put in place institutional arrangements to ensure the allocation of funds is achieved as desired.

Moving towards more sustainable and predictable fiscal frameworks and aid absorption systems, such as budget support and MTEFs, have proved to be successful in increasing ownership and efficient allocation of resources, in addition to enhancing security and an optimal investment environment. Furthermore, it is the way to ensure that progress made is not easily reversible, but that it is built on sustainable frameworks for future action.

In cases where epidemics are rising, earmarking of public resources or aid for health could be beneficial to adapt to the changing needs. However, this should be considered the exception, not the rule. What is more, the burden of the HIV/AIDS epidemic in many African countries is such that new institutions to deal with it have been created with autonomy over funds and implementation of programmes, outside the regular budget, as in the case of Malawi (Roberts 2003). It is important to be aware of the 'fungibility' of funds, and ensure that additions to public expenditure finally mean a top up of funds, and are not misused by reductions in other lines of the budget.

Having a limited capacity for raising funds domestically through fees or social health insurance schemes, the options left are national budget or donor support. Recently fiscal restrictions to expanding health expenditures seemed to focus the debate on deflationary policies having priority over increasing access to health. But further than that, the debate lies on how fast to increase the budget of the Health Ministry, a much more complex issue. The solution to what level of spending is non-inflationary is difficult without more precise information. Decisions are difficult to take when the estimations change for different actors⁵.

Looking at how these decisions were taken is the first step for getting priorities right. Lessons learnt from the Uganda experience call for the need to open the information and debate to public forums such as the PRSP. African countries should take the examples of Uganda and Tanzania as an early warning. The concerns raised are relevant to most governments in the continent, especially those expecting a quick and increasing inflow of funds to tackle the 'priority diseases' of AIDS, TB, and malaria.

⁵ Whereas the World Bank calls for a \$13-15 health spending per head, the Commission on Macroeconomics and Health called in 2001 for about \$34 per head taking into account the links between health and poverty (CMH 2001). The Ugandan Ministry of Health Sector was calling for about \$28 health expenditure per person.

Section 4: Improving value for money: The needs-based approach

The re-allocation of resources can be both internal, within the Ministry of Health, and external, within the overall national budget. Both of them are relevant to this paper, as both directly shape the extent to which the design of national budgets and policies is more or less favourable to the poor and the very poor. If the national budget allocation is done based on merely incremental approaches of previous budgets, it is likely to miss the new and changing health needs and opportunities in treatments, and thus not be the most efficient choice. In addition, budget allocations are highly political. The final outcome will be based on negotiations and a political compromise, and thus the stronger the voices of the poor, the more likely it is that their interests will be included. Bearing this in mind, a systematic approach to ensure that resource allocation is beneficial to the poor as the one offered by the needs-based approach is an imperative.

4.1 Needs-based approach

The most logical system to allocate health resources would derive from the formula of health needs and efficiency of policies, however, this is not the case. Health allocations in African countries show a huge imbalance between needs and resources. For example, the most deadly diseases in Africa are communicable diseases, most of them relatively cheap to treat. Nonetheless, they receive less attention (funds) than other non-communicable but more prominent diseases in urban sectors.

A best practice case is given by the study undertaken in some districts of Tanzania. In Morogoro and Rufiji, two rural districts, surveys were done to compute a “burden of disease” it was found that the amount spent by local authorities bore no relation to the harm that the disease made. Malaria accounted for 30% of life lost in Morogoro but only 5% of health budget. Based on these findings, health workers were given policy instruments, technically an algorithm, with which to treat disease burden and calculate pertaining costs. The results were immediate with infant mortality rates falling by 28% between 1999 and 2000 and under 5 mortality rates dropping by 14% in Rufiji. (Economist 2002).

Thus, through some form of benefit incidence the efficiency, in terms of allocation and in terms of improved health outcomes, was achieved. This Tanzania Essential Health Intervention (TEHIP) is a best practice case in better health expenditures. Although it is just a pilot project, it achieved not only higher budget efficiency but also successful partnership since a substantial part of the project is financed through CIDA-Canadian Cooperation.

4.2 Scaling-up the needs-based approach: Steps and issues

The procedure to put this approach in practice does not seem to demand extraordinary financial or human resources. The basic principles in using this approach are to maximise the health outcomes for the majority of the population, weighting for cost-effectiveness of interventions and extra costs determined by the context, and subject to ensuring access to the most vulnerable populations. Figure 5.1 covers this procedure.

Figure 4.1
Basic steps for implementing a needs-based approach to allocation of health budgets

STEP 1	List and priorities health needs of the population
STEP 2	Identify most cost-efficient interventions, if \$1 was going to be invested, what are the mortality and morbidity levels avoided by intervention?
STEP 3	Take into account additional costs, such as delivery cost and opportunity cost of inaction.
STEP 4	Identify the groups expected to be excluded from accessing these interventions, and formulate policy options to compensate for this.
STEP 5	Monitoring and evaluation systems should be continuous so that changes in needs and resources are identified promptly.

Figure 5.1 details the basic steps for implementing a needs-based approach. It assumes that this approach is not necessarily a pro-poor health approach, as pointed by Pearson (2002). For example, it is more expensive to provide health services in remote rural areas than in urban centres. However, for an intervention to be pro-poor the allocation needs to ensure that the most vulnerable will be protected. When this formula is applied, several issues are raised that policy-makers need to be aware of (Pearson 2002):

- Need of access to reliable and timely data, a major problem that prevents African Governments of using resource allocation formulas. The gaps of information systems go from the very basic population data, to disease specific and to more demanding information on particular sectors of the population such as the most vulnerable groups and in particular the very poor, often left-out even in national census.
- The choice of data may create 'perverse incentives'. For example, if death rates by disease are used to measure the health needs instead of illnesses cases, it may create an incentive not to treat the sick. Likewise self-reported morbidity measures may lead to biased results.
- From 'more essential' to 'less essential' needs- whether to exclude certain services that are more expensive and not considered that essential, therefore could be provided by private centres and not by public funding.

-
- Time requirement for re-allocation may break the process started, depending on the time of national budgeting, fix health costs, and political issues involved. Even within a MTEFs framework (3-5 years) there may be problems to sustain re-allocation commitments.
 - Where to start- in the short term it may be more feasible to allocate resources to health facilities needs, instead of to health outcomes. “*Although far from perfect, this approach begins the process of relating resources to needs*” (Pearson 2002, p. 14)
 - Need to review and formulate the allocation formula over time, as the parameters change, as well as to monitor the progress of the allocation. The process of shifting allocation criteria will rise the need for associated systems, such as information systems and financial guidelines, as in the case of Uganda and the allocation to mission hospitals.
 - Need to manage uncertainties and risks when budgeting. The risks are greater where population sizes are small, in these cases the most appropriate approach seems to be district-bases allocations. Cross-border flows need to be taken into account as well.

Experiences in implementing new resource allocation formula suggests that some preconditions should be met for the achievement of the desired result (Pearson 2002): data must be available, there needs to be supporting changes related to personnel and planning capacity and management, minimum capacity to regulate and monitor capital flows and ensuring their right allocation. Successful examples such as Tanzania suggest that it is possible to start this process even in settings with very limited resources. Some of these pre-conditions can be dealt with ad hoc solutions and creative strategies.

It is important to be aware that a needs approach per se may not favour the poor’s needs. For example, it is expected that promoting family planning and anti-natal care among rural and low-educated populations may take more time and cost than with urban and highly educated female populations. Nonetheless, the reasons why this approach has not been more widely promoted could be related to political issues and a tendency to maintain previous allocation approaches, rather than the technical complications incurred. In any case, examples such as the Tanzanian case proved not only its usefulness but also its feasibility to be relatively easily adopted even in resource limited settings.

Box 4.1
**Need to focus on cost-effective health intervention: Success
in scaling-up PMTCTs**

The Prevention from Mother to Child Transmission (PMTCT) has been identified as a top cost-effective intervention for it has proven efficacy and safety as well as improve access. The use of ARVs namely nevirapine and zidovudine, in infected expectant women has the potential of reducing the risk of mother-to-child transmission by 30-50 percent showed in clinical trials conducted in Uganda and Cote d'Ivoire⁶,

It is estimated that 40 percent of pregnant women in sub-Saharan Africa are infected with HIV. Studies have shown that in this group, without any form of intervention, there is 15-30 percent risk of mother-to-child transmission during pregnancy and delivery and an additional 10-20 percent risk of transmission during breast-feeding^{7,8}.

Despite this evidence, many countries in Africa have not adapted or replicated their use on a large scale. However, efforts have been made in some countries to expand PMTCT by integrating it into routine antenatal care and maternity services. This is already happening in Botswana, Cote d'Ivoire, Kenya, Rwanda, Uganda, Tanzania, Zambia, Zimbabwe, and in two provinces (Western Cape and KwaZulu Natal) of South Africa⁹. PMTCT programs are highly cost-effective and easy to apply interventions, even in resource-limited settings. It also brings about benefits from the synergies between the prevention and treatment sides, and therefore it is one of the most promising interventions to be successfully scaled-up.

Source: 'Scoring Leadership for Better Health' (ECA/AU/UNAIDS 2003)

⁶ Wiktor SZ, Ekpini E, Karon JM, et al. *Short-course oral zidovudine for prevention of mother-to-child transmission of HIV-1 in Abidjan, Cote d'Ivoire: a randomized trial.* Lancet. 1999; 353:781-785

⁷ De Cock KM *et al* (2000): Prevention of Mother –to-Child HIV Transmission in resource Poor Countries: Translating Research into Policy and Practice. JAMA 283(9): 1175 - 1182

⁸ N'duati R *et al* (2001): Effect of Breastfeeding on mortality among HIV-1 Infected women: A Randomized Trail. Lancet 357: 1651 - 5

⁹ UNAIDS Report (2002) *ibid.*

4.3 Focusing on the diseases of poor: Advocating for primary health care and “minimum packages”

“Reorientation of government efforts towards Primary Health Care (PHC) would bring both health gains and cost saving.”(Filmer, Hammer, and Pritchett 1998, p.3)

A major issue for enhancing the well being of the overall population and in particular of the poor and the very poor is the intra-sectoral allocation to Primary Health Care (PHC), rather than secondary or tertiary facilities. Primary Health Care is defined by what is not: *“PHC is neither secondary nor tertiary curative care, but all other activities related to health, from nutrition to sanitation. (...) PHC as composed of three (at least conceptually) distinct elements: simple curative care usually based in “primary” facilities, preventive activities aimed at health improvement especially those based on community health workers, and finally more traditional public health campaigns”* (Filmer, Hammer, and Pritchett 1998, p.3)¹⁰. Thus immunisations against infectious diseases and professional attendance of births are included in this category.

The focus given to PHC since the 1980s and 1990s started with the 1978 Health-for-All conference in Alma Ata. The main problem faced by this policy was that no resources, financial and personnel, were not sustained adequately, often leading towards rural hospitals lacking drugs, and bypassing inefficient public services towards private services. To address these problems, in 1987 the Bamako Initiative was launched by UNICEF and WHO. It promoted decentralisation of health management to local communities and cost recovery for outpatient care (Roberts 2003). Another key initiative in the same line and with great impact on health outcomes is the Expanded Programme of Immunisation.

More recently, the “Minimum package approach” is another attempt of targeting basic services in health. Promoted in World Development Report 1993, the minimum package approach selects key interventions according to “their relevance to current needs of the poor and because of their cost-effectiveness in terms of disability-adjusted life years (DALYs) saved”¹¹ (Roberts 2003 p. 56). This kind of approach has proved to be extremely useful especially for resource-limited settings. The annual cost per capita for delivering the package would be only \$12 (in 1990US\$). In addition, WHO has also proposed a key list of minimum interventions for AIDS, TB, and malaria in the recent Macroeconomic and Health Report (CMH and Roberts p. 56).

¹⁰ Another key concept together with PCH is MICE “medical intervention cost effectiveness”. The difference is that MICE refers more to technical effectiveness rather than basic allocation criteria. Hence, theoretically MICE interventions could occur in secondary or tertiary facilities, and in higher income countries where PHC is less relevant (Filmer, Hammer, and Pritchett 1998 p.4)

¹¹ Four were the major health policies selected by the World Bank to be included in the package, see Roberts 2003 page 56.

Ensuring a minimum essential package such as the indicated by Primary Health Care services, could help securing the re-allocation over time; the example of decentralization in Uganda is a best practice of how to make this work. Even when the specific purposes are seen to be fair and acceptable, this is not done without problems. First, pro-poor essential packages are vaguely defined. And second, even the expansion of PHC (an approximation of essential services) has not been done without problems and it has not always been effective for its purposes, due to several problems such as lack of reliable medicines, empty health centers, need for underpaid personnel working under very hard conditions, and so on.

Box 4.2
Towards an integrated agenda for prevention and treatment of HIV/AIDS

Three are the major stands of the struggle against HIV/AIDS: prevention, treatment, and mitigation of impact. While the mitigation of impact becomes a priority for countries with high and spread infection rates, prevention and treatment are needed already for most if not all sub-Saharan countries. Whereas the emphasis was first on prevention (both as a strategic decision and as the only affordable solution), the focus is being shift now towards treatment as it increasingly becomes affordable for selected populations in African countries and it is a priority for donors' agendas.

The benefits of therapy are significant, particularly in the reduction of morbidity and mortality in HIV-infected individuals. However, in Africa where an estimated 28.5 million out of the global estimates of 40 million people with HIV live, antiretroviral drugs have not been widely used because of the high costs and the delivery infrastructure needed¹². Under 60,000 have access to antiretroviral therapy, although the demand for antiretroviral therapy is increasing as more support is provided by various international initiatives.

Treatment is expensive because of more human resources requirements but specially because of prohibitive cost of medicines. However, we need to advocate for the use of ARVs in the health agendas, for it is the only way of cutting economic costs down. And this has proved efficient. In the last two years the prices of ARVs have decreased enormously, therefore making AIDS treatment more effective. Indeed, private companies have started to provide free ARVs to their employees (and family members too) that are infected, as it is proved to be cost-efficient for them. It would be more expensive to find and trained new employees for the same job that to treat the infected ones. Another case is the study in South Africa that shows that it is more expensive for the government to take care of orphans than it would be to care for the HIV infected mother through ARVs. As highlighted in the UNAIDS report 2002, prevention and treatment go hand by hand and the application of multifaceted approaches that combine prevention, care and support remains the main stay of the fight against HIV/AIDS.

Source: Adapted from 'Scoring Leadership for Better Health' (ECA/AU/UNAIDS 2003)

¹² UNAIDS Report (2002) ibid

Section 5: Final considerations: Expanding access for the poor

As it was shown in the chain that links the process from public spending to health outcomes (figure 1.1) at the beginning of this paper, there are other areas down the process that determine the final success of policy initiatives. These determinants appear after the budget allocation and its financing decisions have been taken, and therefore fall outside the scope and focus of this study. However, because the final outcome of financing policies will depend on these following links- and it is often the case that policy fails in the implementation side, the analysis of this paper need to be completed with the rest of the elements in the health policy performance diagram. These issues relate to three major questions:

- Have the health allocations actually been spent and translated into health infrastructure-services? From allocation to spending;
- Does that increase in capital -physical and human- provide more and better care? From health services to health outcomes; and
- Can citizens, specially the poor, access to those services? The demand-side of the equation.

The first and second questions relate in particular to the provision of health care, such as quality of services, cost-efficiency of interventions, restructuring of organisation, and so on. For example, even in the case that priority is put into PHC, the services provided may not be of good quality or perceived as such by the poor people. As a result they may prefer to go to other providers or not at all. The third question relates mainly to the demand capacity by the beneficiaries. Several barriers prevent the poor from using services, even in the case of free services: if the perceived quality is low, costs of time and transport, and informal charges for example (Bennett and Gilson 2002). Firstly they need to afford them. For example, the introduction of user fees has provoked remarkable decreases in the number of patients using health facilities, and in particular for the poorest ones (Yoder 1989, Mawabu 1995). Besides, we need to take into account people's health seeking behaviour. Anthropological studies explain how the actual demand of health services is embedded into a particular society. A common example is the non-acceptance of contraception methods due to religious beliefs or social understandings.

Much has been said about implementation of policies and effective demand capacity factors, and it is not the intention of this study to review them. This section highlights two key crosscutting issues to these three questions around how to make these services work for the poor, the impact of health sector reforms and more accountable institutions on the pro-poor approach.

5.1 Institutional health sector reforms

Decentralization processes are taking place all over the African continent. Decentralizing the national provision of care involves decentralization of the control of finances, rerouting funds to regional, district and community level programmes. The decentralization of funding should be accompanied by corresponding decentralization of resources and technical capacity to manage those resources. There seems to be a general sense that decentralization is likely to work for the poor, provided mechanisms to empower and hold the new institutions accountable are also put in place at the very beginning of the process.

A second key reform is given by the creation of National and Regional AIDS Councils (NACs and RACs) to take the lead and co-ordinate and mobilise against the AIDS epidemic. By 2002, 36 out of 44 countries that participated in the Abuja Summit, have a comprehensive national coordination mechanisms (ECA/AU/UNAIDS/WHO 2003). Despite the fact that they are key in sustaining and expanding the response against the epidemic, they have also brought about extra financial issues. The effectiveness of these councils is limited by their exclusion from budgetary processes, lack of legislative support and duplication of effort with other sectors involved in HIV/AIDS Control.

5.2 Promoting supportive institutions and good governance

On the governance side, health system performance is largely dependent on the adequacy and appropriateness of key institutions and decision-making processes. As was evident from the analysis of domestic financing approaches, the final impact of the financing system on the poor and the very poor will largely depend on the mechanisms and institutions put in place that ensure a representative and accountable decision-making process. The ultimate responsibility for the overall performance of a country's health system lies with government, which in turn should involve all sectors of society. Thus the diseases discussed in this report qualify for public financing and public provision, hence impelling national governments to address the constraints to leadership responses, created by ineffective health system.

Public expenditure management is also a major challenge in making government policies to work, and work for the poor. Here, also citizens can have their role in ensuring the final translation of budgets into expenditures, and the proper management of these expenditures. For example, the public expenditure public survey, as conducted in Uganda, served for making the education spending transparent and accountable, where people could enquire where has the money been spent.

5.3 Conclusions

As it has been pointed, lack of data on the health status and access to services specifically by the poor and the very poor is a major obstacle for adapting pro-poor health policies. DHS are the most complete source of health information for low-income countries. However, they do not include information on the wealth level of the households, and therefore they are not sufficient for an analysis of the situation of the poorest groups. Diamond, Matthews and Stephenson (2002) DHS suggest two ways to compensate for this uncompleted information. One is to add indicators of income/poverty to the ongoing surveys, so that future results will contain both income and health information. And second, to map health indicators of the DHS onto census information for populations/households. This will allow to link wealth and health information, in particular around household types. For example, the use of census can determine to what extent DHS has covered poor areas.

Section 6: Policy recommendations

Sufficient knowledge and evidence exists already on health strategies that are more conducive to improving the health of the very poor, as for example investment in free primary health care or the use of minimum packages. Nonetheless, despite all that has been written and said on reforming health systems in favour of primary care, health systems in most countries remain biased towards hospitals and curative medicine. Hospitals absorb 50-60 per cent of government recurrent health expenditure, and most of it goes to central hospitals. It is imperative that health budgets in Africa focus on minimum services for basic care and those cost-effective interventions that have proved to be cost effective and efficient in reaching the poor. Subsidies and exceptions should always be considered to ensure access by the very poor. At the same time, the health sector needs to build strong links with the institutions outside that are also key determinants of health status, such as the institutional environment and education.

To fulfill the health needs in Africa, especially those of the poor, both an increase in financial resources as well as maximizing the use of these resources are needed. In raising extra resources, both domestic and external sources have much to contribute. But in particular, national policies should focus first on the domestic ways of raising funds, rather than waiting for external and conditional money to come. Within the current context of pro-poor growth strategies, competing health demands and macroeconomic restrictions, only by achieving more efficient ways of financing and budget allocations can health care be expanded in a sustainable way.

Brave new thinking is required in order to be more strategic with regard to the possibilities for African countries to implement saving and investment activities through more creative strategies. Entry points have been identified in particular through risk-pooling initiatives. In mobilising domestic funds, evidence from other continents like Latin America and growing experience within the continent seem to point at risk-sharing practices, both community and social based, as the most feasible, sustainable, and promising way in the African context. Although moving in the right direction, the adoption of these schemes needs to be done with care. As the very poor tend to be left-out from risk pooling initiatives, it is important to ensure the protection of the very poor in the design and implementation of the insurance schemes.

Apart from this, there is a need to move from a general understanding of what are the health priorities of the poor towards teasing out what are the implications for strategic health policies within the context of poverty reduction. The imperative need to make systems respond to the AIDS epidemic has raised the need to re-visit the efficiency, absorptive capacity and trade-offs of international aid. Finance officers could pick this up as an opportunity to re-consider budgetary processes and stress long-term strategic approaches such as budget support or MTEFs. Moving from conditional aid to budget support strategies is decisive in making aid work within optimal planning systems. Budget support could also be accompanied by earmarking (money) for the health sector, especially in the transitional stages. Cases like those in Uganda have proved this to work.

Reflections on how to make public expenditure more efficient, leads to re-thinking of the effectiveness of aid and the way it is administered. There are strategic choices to be made, for example, between fiscal stability and health priorities. Calculations on ceilings to social expenditure, by IMF, World Bank, or national governments, need to be decided in the same spirit of openness, participation and national ownership of PRSP process. Accountability should not be just a requirement for national governments, but also has to come from international partners, who should open up debate on policy prescriptions, maximise choices that are not easily reversible, and enhance ownership of national strategies. The choices of public budget are not only financial allocations but also imply a social choice behind who will get access to which services or not.

Moreover, even with a zero-increase in health budgets, a substantial increase in benefits can be achieved with just a better allocation of the resources. Short and medium-term expenditure trends, if they are to be more cost-effective, must be allocated to the overall general improvement of living standards of the country correlating disease burden to expenditure allocations, while taking care of the specific new challenges of rising epidemics and the need to protect the poor. The pro-poor health strategy that emanates from these considerations starts with a needs-based approach. The needs-based approach has proved to be feasible, efficient, and cost-effective even in contexts where data availability is limited. Improvements in resource allocation can start through very simple initiatives and

their immediate results are very visible, as in the case of Tanzania. The final use of increasing and better allocation of health funds by the beneficiaries, and especially by those in greater need, will depend on their capacity to gain access to those services.

More ambitious policy-relevant outcomes will draw from new thinking on what the growth strategy should be within the presence of highly unsatisfactory health systems. What is needed as well, is to start re-thinking in a more creative way on how to address the impact of rising epidemics outside the health box, as for example promoting employment-orientated growth for the youth.

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