Role-Play

MOBILISING RESOURCES IN A RURAL, LOW-INCOME COUNTRY CONTEXT

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OBJECTIVES

In this role-play you will:

- Critically examine resource mobilisation alternatives for the health sector, on the basis of theory and country experience;
- Gain a detailed understanding of the advantages and disadvantages of alternative resource mobilisation strategies (tax-financing, user fees, community-based health insurance (CBHI), mandatory health insurance).

THE PROBLEM

The government of a low-income country has recognised that the problems facing its health sector require that policies on financing health care be re-considered, recognising that alternative approaches must be rooted in the prevailing context.

National context:

- GDP per capita	US$ 1,850 per year (approx.)
- Rate of annual real GDP growth	3.5%
- General government expenditure as % of GDP	20%
- General government revenue as a % GDP	18%
- Taxes on income, profits and capital gains as a % of total revenue	20%
- Taxes on goods and services as % of total revenue	25%
- Taxes on trade and transactions as % of total revenue	25%
- Grants and other revenue as % of total revenue	30%
- Government health expenditure as % of total government expenditure	8%
- Infant mortality rate (IMR)	60/1,000
- Maternal mortality rate	350/100,000
- Life expectancy at birth	58 years
- Population growth rate	2.6%
- Urban population as % of total population	25%
- % labour force in formal employment	20%

The health system:

Ministry of Health services consist of specialist hospitals in the main cities, general hospitals in the district headquarters, health centres and clinics in rural areas. The aim of the Ministry of Health is to provide health care accessible to the entire population. Services are currently financed from general taxation and are provided free of charge at the primary health care level, while small user fees are charged for other services at the district level, such as inpatient services at district hospitals. Ministry of Health hospitals in the main cities have a few private wards for those willing to pay cost-recovery fees.

Private medical practitioners and clinics are located in the main cities. Many private and parastatal enterprises provide health insurance cover for their employees either through a non-profit insurance agency or by a direct arrangement with medical practitioners and private hospital wards. The health insurance covers the cost of treatment in the Ministry of Health's private wards. In addition, the great majority of patients attending private medical practitioners pay the fees themselves.

Mission operated health facilities primarily consist of hospitals located in rural areas. Mission health facilities operate with funds from overseas donations, such as country donor support or from religious organizations, small grants from government, as well as income raised through user charges. The user charges at mission health facilities are higher compared to Ministry of Health facilities to cover their costs.

Current problems:

The Ministry of Health has advised the Government that in its view, the main problems of the health system are:

- Ministry of Health services are very crowded (bed occupancy rate in excess of 100%; outpatient services overloaded with patients). The Ministry of Health considers that many of the outpatient attendances are for very minor complaints.

- Ministry of Health services are very short of doctors and nurses. Newly qualified doctors do two years' government service and then many leave to set up in the private sector where they can earn more money. Nurses are also attracted by the higher pay in private sector clinics. The private sector has been growing steadily and is expected to continue growing.

- Ministry of Health services are accessible to about 70% of the rural population. Clinics based in villages provide the backbone of the system, providing basic curative and MCH/FP services. The facility of first referral is the health centre, with in-patient capacity. However, the services provided by these facilities are characterised by low quality - such as drug supply problems,

equipment shortages and unmaintained buildings. Staff are de-motivated, sometimes absent and often rude to patients. Although some village health workers have been trained, few are active.

- The Ministry of Health is allowed only a very small annual budget increase in real terms (i.e. after the effects of inflation have been taken into account), and this is inadequate for any major development of the services.

- Mission health facilities are underutilized due to the higher fees. Because mission facilities and public facilities often do not co-exist in the same geographical area, poorer households either travel long distances to obtain (free or cheaper) care at public health facilities, or pay the higher fees at mission facilities.

In addition, the Government is aware that civil servants are agitating to be provided with health insurance coverage similar to that available to many of their private sector colleagues.

ROLE PLAY CONTEXT AND TASKS

A government commission has been established to consider alternative health financing options and advise the government on appropriate policy development.

The Ministry of Health has advised the commission that sectoral problems could be tackled by some combination of four approaches:

1. It could be argued that additional government revenue should be allocated to the health sector, in recognition of its important role in social development.

2. User charges could be levied at health centres and hospitals for outpatient visits in order to raise revenue and restrict outpatient demand to people with more urgent health care needs. A proportion of fee revenue would be retained at the point of collection to be used for service improvements.

3. Community financing mechanisms can contribute to setting up a village-level primary health care system that is largely self-financing. Mechanisms may include user fees at the point of use, or some form of pre-payment such as community-based health insurance schemes. Appropriate management and accountability systems would be established.

4. A social insurance scheme could be introduced to replace existing private insurance, extend coverage to civil servants and as many other groups as possible, and increase the availability of funds

for urban health care. Both public and private sectors would be able to provide care for people covered by social insurance.

The commission has asked interest groups representative of the wider community to consider, from their own perspectives, the advantages and disadvantages of these options. These groups include:

1. Combined committee of doctors and nurses professional associations;
2. Representative organisation of rural villagers;
3. Civil servants union (including non-health care professionals);
4. Representatives of mission operated health facilities;
5. Private practitioners.

Each of these groups is asked to:

- Review current evidence concerning the options for mobilising additional resources (each group will receive a resource pack containing key articles for each resource mobilisation option);
- Define their preferred package of financing reforms, possibly combining several of the specific options;
- Consider issues that are not only related to revenue collection (e.g. efficiency, equity, ease of collection), but also (risk) pooling mechanisms.
- Prepare a 10 minute presentation describing and, most importantly, justifying their preference.

After hearing their arguments the commission, acting as an arbitrator in consideration of the national interest, will decide which option(s) to recommend to cabinet, and give reasons for that decision and provide a full outline of the relevant package of reforms.