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Health systems financing: putting together the “back office”

Lola Dare, Anne Reeler

Strengthening healthcare systems has been identified as central to Africa achieving global and regional development targets, including the millennium development goals. Lola Dare and Anne Reeler present case studies on issues that can contribute to improved integration and lead to better performance of health systems in Africa

As Africa attempts to achieve ambitious millennium development goals, many critical challenges confront healthcare systems. In advancing towards these goals, African countries need to review and reform their healthcare delivery systems, and they need to devise innovative approaches to deal with daunting problems.^{1,2} Development of healthcare systems and improvement in health outcomes, based on investment in programmes focusing on specific diseases, continues to fragment health systems, leaving the basic infrastructure weak and incapable of delivering equitable, broad based services. There has been much discussion about integrating the primary, secondary, and tertiary tiers of the health system (the “front page”) but inadequate attention has been paid to identifying and strengthening the actions that are required to deliver the basic package of care (the “back office”) at each level of care.

Low income countries in Africa face the daunting challenge of improving the performance of their healthcare systems, upgrading their health services to a level that will enable them to deliver services that are effective, efficient, and equitable. They need to build up capacity in a systematic manner, but financial and other constraints make it impossible for them to reproduce exactly the models from affluent developed countries. This paper identifies the main components of the back office that need to be developed and integrated to improve the performance of health systems and strengthen the delivery of healthcare services (box 1), and includes examples of the issues that arise.

Physical components

The physical components of the back office include the infrastructure and capital equipment. The needs and challenges of the physical components are illustrated by an example from Tanzania.

The rehabilitation of the Muhimbili National Hospital is currently being undertaken by a public-private partnership involving Abbott Laboratories and the government of Tanzania. The aim is to facilitate delivery of high quality care by improving the hospital's capacity for diagnostics, teaching, and research, in addition to strengthening its capacity to serve as a referral centre. The key areas for intervention are the introduction of an effective management system that addresses financial sustainability, human resources, and improvement of infrastructure, as well as an upgrade of the hospital's capacity to deploy information and communication technology for record keeping and patient care. The initiative includes the strengthening of regional hospitals by introducing integrated voluntary counselling and testing and a

focus on the referral system. The lessons learnt from this project could inform other initiatives aimed at strengthening health systems and tertiary care structures in sub-Saharan Africa.³

Management

Each healthcare facility requires an efficient process for generating and using evidence in policy making, implementing services, managing procurement and distribution, organising logistics and maintaining equipment, using human resources appropriately, and efficient financial management.

Procurement and distribution

Health facilities in Africa often fail to obtain value for money in their investments in capital equipment and consumables because of a limited definition of process for efficient procurement and distribution. National standards and bulk purchasing would provide economies of scale and make it easier to maintain capital equipment such as refrigerators and x ray machines. Similarly, national guidelines on procurement and distribution would enable the health facilities to obtain the most cost effective drugs and ensure that drugs are distributed equitably.

Procurement of drugs

Many methods have been tried to scale up access to drugs for developing countries, including large scale donations of drugs to governments, centralised procurement, reduced prices for developing countries, and supplying generic drugs. Innovative approaches that enable non-profit health institutions to apply over the internet for free or low cost drugs have also been piloted. In one public-private partnership project, the donating pharmaceutical company ships the drugs directly to the successful applicant. Changing the requirements that all actions be processed through the government, and setting technical standards for recipients of donated drugs, made it possible to increase substantially the number of mother-child pairs covered by programmes for prevention of mother to child transmission of HIV. Furthermore, government accreditation of the facilities and a higher degree of accountability greatly reduced drug deviations and other abuses.⁴

The procurement policy should also deal with the requirements for logistic support—for example, transportation for field staff, communications by telephone, and information technology support for data collection and processing and electronic communications. A common error is failure to provide for the complementary inputs that are required for successful operations. For example, when planning to purchase drugs

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Box 1: Components of the “back office”**Physical**

- *Infrastructure*—Strengthening the basic infrastructure of healthcare facilities is vital to the capacity to deliver care on a broad basis
- *Equipment*—Selective inputs from vertical programmes lead to imbalance in the various elements of the infrastructure
- *Maintenance*—Common problems are the failure to make adequate arrangements for maintenance of buildings and fittings and the failure to establish servicing contracts for capital equipment¹⁷

Management

- *Generation and application of evidence*—Evidence from biomedical research and from national and central health information systems should be complemented by data collected from each facility. This can provide useful insights into the performance of the facility
- *Procurement and distribution*—Cost effective investment in equipment and supplies requires careful correlation of other components of the back office
- *Human resource management*—The challenge is to ensure a balanced investment in human resources and supportive services so as to optimise the working conditions and improve efficient delivery of care
- *Sustainable financing*—Sustainable financing of health care will require that governments are able to predict and support healthcare programmes from both domestic and external resource flows while servicing its debt obligations and additional borrowing that may be required to bridge health budget gaps

Relationships

- *Stewardship and leadership development*—Stewardship is an essential function of the health system which influences its other functions and assures that health system goals of equity, efficiency, and improvement in health outcomes are achieved. Each facility should consciously identify its role in fulfilling the stewardship role through integration and cohesion of the components of the back office
- *Role of development partners*—Well placed foreign aid can help to close the financing gap, but it must be well managed to ensure that it does not distort national priorities
- *Health education and communications*—Each facility should develop a communications strategy that facilitates two-way communication between the staff and the communities that they serve
- *Community mobilisation and empowerment*—The involvement of relevant stakeholders, including communities and civil society organisations, can enhance the performance and impact of health service delivery units in each tier

and vaccines, managers should ensure adequate supplies of syringes, needles, and gloves.

Accurately forecasting the drugs needed is difficult. For example, the Axios database of 350 institutions in 81 developing countries (www.axios-group.com) shows that applicants frequently overestimate the quantity of drugs that the health system can deliver. Forecasts, based on epidemiological data on HIV prevalence alone, far exceeded the capacity of the healthcare facilities from Axios programmes to deliver. Some of the facilities that requested and obtained donated drugs used only about 10% within a year.⁵ Had all relevant components of the back office been well developed and integrated, the donation programme would have been supported by enhanced diagnostic and distribution services.

Financial management

The back office mobilises financial resources and manages funds. The financing of health care in African countries remains difficult and often contentious. Given the limited resources available in most African countries, free healthcare programmes and social protection strategies remain inequitable and are not

sustainable. Health care provided by the public sector is constrained by annual health budgets ranging from less than \$20 per capita in parts of sub-Saharan Africa to about \$50 per capita in the more affluent countries of southern and northern Africa. Various mechanisms have been devised to increase health resources. Prepayment schemes and health insurance schemes are having varying degrees of success; organising and managing health insurance schemes is especially difficult in countries where reliable records are not available. Many countries have implemented user fees and have established revolving funds for specific services and programmes. Such funds may be a rational response to a specific need, but having many revolving funds operating outside the financial management system of the central administration may prove overwhelming. Similarly, centrally administered accounts focused on specific diseases make it difficult to coordinate investments in the public health sector and to track donors' contributions and manage public-private partnerships. Health funds should be integrated into a financial management system for each facility and ultimately for the healthcare system. One solution has been to introduce “basket funds” where donors contribute a sum of money that is not earmarked for any particular programme. This has resulted in challenges of accountability and transparency, however, and may not serve longer term needs for equitable and sustainable financing.⁶

Sustainable financing of health care requires that governments are able to predict and support their healthcare programmes from both domestic and external resource flows while servicing their debt obligations and any additional borrowing that may be required to bridge health budget gaps.⁷ This will require that countries are better able to harness resource flows for health from other sectors, and the effective integration of health budgeting into poverty reduction strategy papers and medium term expenditure frameworks. Increasing integration of health into comprehensive economic development and financial management strategies could provide national health financing mechanisms that could encourage development partners to move towards sector wide approaches and direct support for government health budgets.⁸

Relationships

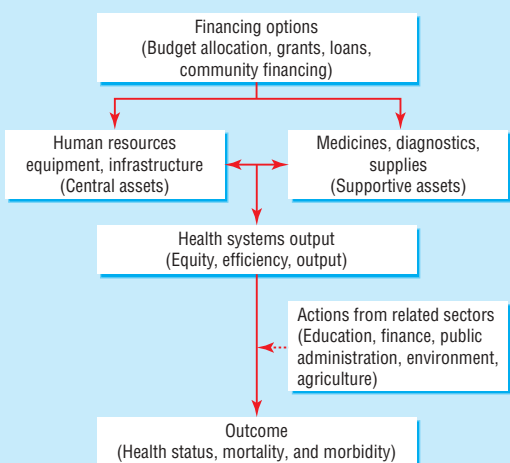
Each health facility must establish mechanisms for developing and maintaining relationships with relevant groups and programmes. Stewardship represents the relationship of the healthcare managers with the national health system and other public sectors. Relationships with communities and foreign development partners can be nurtured through effective communications systems.

Stewardship

The world health report for 2000 identifies stewardship as an essential function of the health system.⁹ Stewardship influences the other functions of the system and assures that goals of equity, efficiency, and improvement in health outcomes are achieved. Stewardship has been identified as a “function of government responsible for the welfare of the population,

Box 2: Ondo state health plan (Linking Health and Development)

In Nigeria, an innovative and incremental health systems development plan is being implemented in Ondo state. The plan identifies both reform and performance improvement issues in the health sector and presents a reform programme for the health sector in the context of a broad development programme including poverty alleviation, economic development, and education. The innovative changes are guided by reviews that include diagnostic surveys of the physical infrastructure, human resources, financial procedures, and other features of the health services. These have helped to identify the modifications required to improve efficiency, effectiveness, and cost effectiveness. The framework for response presents human resources, infrastructure, and equipment as the central assets for health systems development, with other elements of the back office (management of medicines, diagnostics, and supplies) as supportive assets within a framework that balances financial flows between these two assets.



The state is also effectively deploying health education and advocacy as critical elements to promote partnership with end users, the community, and the private sector. This process engages political processes to translate new concepts and plans into official policy.^{18 19}

and concerned about the trust and legitimacy with which its activities are viewed by the citizenry.¹⁰ Its key dimensions in the health sector are broad and include protecting the interest of the public by doing what is right; making public goods and social assets equitably accessible to the population; maintaining and improving resources for the benefit of the population; establishing the best and fairest health system possible; defining health vision and direction of health policy; exerting influence through regulation and advocacy in addition to collecting; disseminating and using information. The overall stewardship goals of the national health system consist of contributions from individual healthcare delivery facilities. The leadership in each facility must work with its staff and other stakeholders in defining the facility's role in stewardship and their specific contribution to the national effort.

Role of development partners

In reviews of the national government's responsibility for stewardship, the behaviour and performance of

development partners deserve close attention. The substantial financial aid that they provide can help to close the funding gap in operating health services in African countries—but they may be tempted to operate independently of national goals and strategies. A common criticism of development partners is that their activities impede service coordination.¹¹ In the worst cases, partners impose their will on national governments, and their vertically managed programmes distort national priorities. Development partners themselves have been critically reviewing their own performance,¹² and in some cases national authorities have questioned the performance of their foreign aid agency.¹³ One mechanism for reducing this risk is for the national government and its foreign partners to subscribe and to adhere strictly to a sector-wide approach that is truly country owned and led.

Learning and practice

Strengthening the back office aims at cohesion and integration of the components. It calls for leadership that has a clear vision about the overall goals of the health unit in the context of national goals and strategies. The leadership must also share the vision with the health workforce and relevant stakeholders.

Some developing countries—notably Chile, Sri Lanka, China, and Cuba—have devised and managed highly successful health programmes with the limited resources available to them. Their models for achieving good health at low cost have provided examples for other countries. Sri Lanka, for example, achieved a dramatic fall in maternal mortality over a relatively short period through strengthening community based services and the emergency obstetric services at the first referral hospitals.^{14 15} Ouallam, one of the poorest districts in Niger, developed a combination of diverse initiatives to facilitate effective access of its 250 000 inhabitants to health services. Refurbishment of seven dysfunctional health centres and the local hospital led to improved quality and uptake of health services.¹⁶

States within African countries are responding to the need to strengthen the back office and to link these actions to broader socioeconomic development (box 2). Although the implementation of each component of the back office is deceptively simple, it is difficult to put the package together in a way that achieves cohesion and integration. Each programme that attempts to strengthen the back office, especially in low income African countries, is treading an experimental course; it is a learning process for which there are few indicative role models.

Conclusion

Health authorities in Africa ought to pay more attention to broad based, balanced strengthening of healthcare facilities. For the optimal performance of health systems in Africa, all the key components of the back office must function together. Development partners and some African governments have tended to neglect investment in health systems. Funds are usually earmarked for programmes focused on specific diseases, neglecting the basic infrastructure and healthcare facilities. With the renewed interest of the international community in alleviating poverty and promoting development in Africa, and with the

Summary points

Strengthened and performing health systems remain critical to achieving health related millennium development goals in Africa

This will require increased integration and investment in various components of the “back office” by both national governments and their development partners

The lessons and experiences relevant to policy and programming need to be harnessed and shared

availability of considerable international funding for HIV treatment, substantial resources should be directed to strengthening the back office.

Contributors and sources: LD is a community physician and epidemiologist who has worked on health systems development and strengthening in Africa for over 15 years, with experience in the design of community managed primary care programmes that harness both public and private healthcare resources to improve service delivery. She is also the executive secretary of a pan-African partnership, the African Council for Sustainable Health Development (ACOSHED). AR is a medical anthropologist with more than 20 years of field experience in the design and implementation of health system programmes and the underlying private-public partnerships. She has also worked for the Action Program on Essential Drugs at WHO, as programme officer at the United Nations Economic and Social Council for Asia and Pacific, and at UNAIDS in Geneva.

Competing interests: None declared.

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Removing user fees for primary care in Africa: the need for careful action

Lucy Gilson, Di McIntyre

Current calls for the removal of user fees respond to evidence of their regressive impacts and their role in enhancing social exclusion—but removal must be carefully managed because this action may have negative impacts on the wider health system

User fees are once again a topic of hot policy debate in Africa. They were introduced relatively recently in many countries (box 1), but the current call is for their removal, particularly at primary care level.² As analysts who have consistently argued against user fees, we broadly support this call. However, we recognise that this action cannot be introduced overnight and, if weakly implemented, may exacerbate the problems facing African health systems. We outline both why we believe African countries should move away from user fees, and what actions should accompany their removal to ensure that this policy change strengthens rather than undermines healthcare provision. Our suggestions are based on the experience of countries such as South Africa and Uganda that have already removed

some or all fees, as well as wider experience of policy change.

Why should fees be removed?

User fees are the most regressive form of healthcare financing available; they contribute to the unaffordable cost burdens imposed on poor households; and they represent one facet of the social exclusion experienced by these households.

Out of pocket payments (which include user fees at public sector facilities) are more regressive than any other method of financing health care, capturing a higher proportion of income among poor households than wealthier ones.³ Thus, simply on the basis of the

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