

Medicus Mundi International

Newsletter No. 67, Summer 2001

Introduction, Sake Rypkema

Balancing cost against accessible resources: art de cuisine without standard re

Types of mutual aid arrangements in sub-Saharan Africa: what place for health
Criel

User fees in private not-for-profit hospitals in Uganda, Adriano Cattaneo

Health Care Financing, Jos Dusseljee

Re: Follow-up of MMI/MMM partner consultation on contractual approach in Dar
Puls

How popular is health care? Adoption or rejection of PHC concepts in devel
how to move beyond mere participation, Marieke Verhallen

In memoriam Professor Vincent van Amelsfoort, Sake Rypkema

Introductory

Financing of health care services is on the move during the last two decades. In many countries free treatment was a rule, residue of the colonial times. The expectation that the State would act as the Big Brother, have been waved away. Paying for services is normal now, and it is clear that this existed for centuries or longer in Africa. Bamako was the turning point: pay as you get good quality. Many States were delighted for other reasons as well: the imposed high hospital expenses.

Two questions remain which have not been answered so far. Does quality really improve for the losers, not being able to call in when they are sick, because of having no means? And also: how can you safeguard the average patient from too high hospital expenses?

The Medicus Mundi conference on financing took place this time in Brussels and not in Geneva. The World Health Assembly ordinary was held in Geneva. Brussels because the UN conference on financing for developed countries was held at the same time there. So we met in Brussels and not in Geneva. As speakers were invited Medicus Mundi members, Dr Tom Puls (Medicus Mundi Belgium) who is the chair, Dr Bart Criel (Medicus Mundi Belgium) who is the chair of the systems at the Tropical Institute of Antwerp, Dr Cattaneo (Cuamm, Italy), epidemic research in Uganda, and Dr Jos Dusseljee (Cordaid), specialised in Hospital management. Presentations are here.

Contracting at district level between NGO health institutions and District has been a subject for discussion the last three years. Inside WHO it looks that the member states work towards a common subject. For MMI the main focus was and is the cooperation between the local NGO health institutions and the District. Be aware that MMI is not referring to International NGOs and central governments. Many partnerships are contracted at global level. The last years we focus on the district level in order to reach an integrated health care system, accessible and suitable for the common man. The Dar es Salam consultation 1999 and Conakry 1999 (MMI Newsletter No 65) had the intention to discuss and investigate what our local partners feel. A letter of the follow-up is published here.

The Memisa 75 years celebration was reported last year by introductory presentations and proceedings by Marieke Verhallen gives you a short overview of the proceedings.

Professor van Amelsfoort passed away, too early. He was for many years the intelli

guide at a distance for the Medicus Mundi projects. We owe him so much.

Sake Rypkema

Balancing cost against accessible resources: art de cuisine without standard re

by Dr. Tom Puls

Defining the service.

The basic questions Governments, providers of care, donors and target communities common in relation to health care are of course centered around such issues as type of way to provide them, quality, equal access, etc. But an overruling common denominator in such questions is the inevitable final question: How to make ends meet and how to do not just once with the help of lavish donor funding, but in a sustainable way within locally available resources.

Defining the business plan, knowing and controlling the cost..

On the one hand there are numerous studies, which demonstrate, that there is considerable variation in average cost e.g. for the provision of a basic minimum package of care at health centers in the same region in one country. This can often be attributed to such factors as overuse of consumables, greater efficiency of staff deployment, inefficient communication or more expensive transport, etc. Competition among providers is still a rare phenomenon. Also there is a tendency yet to look over the fence at the neighbours activities and there is hardly any pressure from outside to rationalise practice or budget utilisation at grass root level. Quality of care as a topic may generate some attention. But quality of administration appears to be interesting. Yet for the same service provided some centers in the same country may charge almost 4 times the fees to their visitors compared to another health center. The first will show up with far lower rates for utilisation and coverage as the other one. Both be working in the same type of communities in the same region of a given country. More quality of care might sometimes be even worse in the least cost/ effective one.

Already back in 1970 for students at the Royal Institute for the Tropics in Amsterdam a Resources Allocation Game was a popular training tool enabling participants to become aware of the importance of making the right budget allocation choices e.g. for staff deployment, equipment, transport, means of communication and other resources for the final outcome. Depending on the mix chosen the percentage of target coverage and per capita cost per service provided. Depending on the mix chosen the percentage of target coverage and per capita cost per service provided. Depending on the mix chosen healthcare could be provided to anything between 10% and 90% of the target community overall cost. Surely reality might show up with even more striking examples than the did! More experienced players as healthcare administrators are certainly among the best contributors to improve cost/benefit ratios in healthcare provision and towards achievement of making ends meet.

Identifying the sources and raising the resources.

10 -15 dollar is the amount we are looking at in the least developed countries as the minimum expenditure for health. In most of such extremely deprived -situations one should not expect that health appears not as the prime concern: Less than 10% out of a total average income of 100-150 dollars per year is reserved for it!

Yet, even such a small amount might be sufficient, provided it would indeed be very effectively used. Look for instance at average cost per capita for the running of a reasonably complete health care system in an average Ghanaian district of 100.000 inhabitants, having 1 million dollars effectively available for recurrent expenditure would in principle allow to achieve in principle relevant targets. However, such concentration of resources at one given level of health care and administration is hardly feasible. In most places, where total health care expenditure is assessed and estimated to equal 10 dollar per capita, the actual spending of the available resources is found to have taken place at many different levels including to a great extent- at the individual person. The latter type of expenditure is exemplified by the person pay

to go to the clinic, by the payment to the traditional healer to the bonesetter or to the market, or also by payment of the regular OPD-fee at the district hospital or the pre health Insurance.

On the other hand, out of tax money and other public revenues national or regional at most often also spending part of the available funds on the procurement of health meeting the cost of health care for the individual. Yet the total cash flow along this considerably smaller than the previously mentioned personal spending. Even so s care spending is far more visible and far more often discussed as a parameter for inte priority of health care in a given country. Over the past decades, most of the deve mainly newly independent states, displayed a trend towards centralisation of such p healthcare, whereas more recently, the reverse appears to be the case: Funds gener are more and more often allowed to be re utilised at the local or regional level again : priorities.

Moreover Governments are encouraged to decentralise their healthcare admini budget management. Even in -countries which are currently subscribing to a rather c Wide Approach, some of the donating external partners prefer still to collect their shar collective basket and to keep an eye on it till its final peripheral destination e.g. for health department or district.

Also those involved in the planning, in the procurement and in the provision of h raising the necessary budgets are not only confronted with a great variety in poss accessible sources, but they should also reckon with dynamic changes taking place than ever in the size and the durability of such resources.

In Uganda the mix of governmental subsidies plus revenues out offees, assuring a r cost recovery for the important network of private not for profit healthcare facilities, National healthcare system, was uprooted almost overnight by the Governments an healthcare would be provided free of charge to all citizens with immediate effec elections were more important in Uganda than the outcome of the previous leng dialogue on the issue.

External aid, provided on a regional basis may lead temporarily to a completely pattern of health care provision, than what is found as a routine elsewhere in the same

Cultural differences and differences in economic potential between regions of the s play a decisive role in the feasibility and level of direct cost sharing on the part c communities served. In Ghana in some remote rural districts, in spite of their relati income levels, communities actively demanded and paid for Meningitis immunisator people to rid themselves of this recurrent epidemic.

In some countries, like Congo (DR), Kenya and even Senegal, State funding for healt negligible nowadays in comparison with cost sharing per treatment by the indi collectively by an insurance company or co operative insurance scheme.

It will be clear from the above brief summary, that measures to make ends meet in he should focus just as well on rationalisation of use of already available budgets and ways to mobilise local resources (whether at individuallevel, community level or from same time it also clarifies, that there cannot be devised a type of a blueprint for im economic viability of health services in general. Depending on a great variety of circumstances, the current cost effectiveness of the system or institution involved, context, etc. the health economist, having a keen eye for public interest as well outcome for all the measures to be proposed, will probably have work like talented Cf rather than as a wholesaler of coca cola and fanta. Even if in some of the healthca products to be offered are a bit more defined (e.g. minimum package of care; exte care) still the way in which it/they are being achieved can vary considerably v repercussions for outcome or client satisfaction. At most one could think of maki possible points of interest to consider and possible measures one could attempt to t monitoring the effects after each individual measure taken. Even if at a given time it w the mix of measures to enhance resource mobilisation as well as to improve budget to the optimum, changing habits of clients, the arrival of competing providers, econ changes will require the mix to be reviewed and adapted frequently to keep

developments. If not, either the institutional viability will suffer or the utilisation and he will be affected.

In view of these latter findings the following points might be raised and worthwhile to detail:

- 1) Without proper (but even so appropriate) analytical bookkeeping and reporting, the sustainability of health services and healthcare institutions will remain an illusive goal.
- 2) In the absence of a transparent financial report and a clear plan of operations, recruitment support should not be granted.
- 3) It is an urgent matter to review the guidelines for annual hospital reports and to edit a separate document the guidelines for making a plan of operations for monitoring recruitment and for reporting and analysis of the data reported.
- 4) It is essential for healthcare institutions to have access to health economists to optimise their cost-effectiveness.
- 5) Consumers are so much aware of cost of health care provision, that there can be a correlation between perceived cost-effectiveness and:
 - effective utilisation
 - willingness to pay a share in the cost directly and in particular indirectly via prepayment or local insurance schemes.
- 6) The contractual approach (whether contracting in or contracting out) makes good analytical bookkeeping and cost-effectiveness analysis all the more necessary.
- 7) Decentralisation of health service administration and budgets will lead to survival in this context not necessarily the providers with the best medical results but with the clearest financial picture.
- 8) Given the fact, that training for health institution administration and for health economists come by in developing countries the creation of such courses should be facilitated in (OPEN FOR DEBATE).

Types of mutual aid arrangements in sub-Saharan Africa: what place for health insurance?

by Dr. Bart Criel

Introduction

In recent years there has been an increasing interest in the development of health insurance in sub-Saharan Africa. The financial crisis haunting African public health care systems has contributed to this evolution. Initially, in the sixties, free health care was a constitutional principle: health care systems were supposed to be entirely tax-financed. This rapidly proved untenable. The international economic crisis in the seventies had dramatic effects on the government budget allocated to health. 'Free care' became a myth: at the end of the day patients were forced to buy (expensive) drugs in the private sector because drugs were scarce in the public sector. Governments had to come up with under-the-table fees for underpaid (and sometimes unpaid) health workers.

A pragmatic response to this situation was the introduction in the 1970's and 1980's of 'out-of-pocket' payments by the patient at the time and point of use. Today, this policy of user payments - i.e. user fees - has become a fact of life in the whole of Africa. This has been legitimised through the *Bamako Initiative* of the World Health Organisation and UNICEF. In some successes where fees were used to improve the quality of public health care, for instance the availability of essential drugs. This has been extensively documented in the case of countries like Guinea and Benin (Levy-Bruhl *et al.* 1997).

Nevertheless, the disadvantages of user fees are clear, certainly when they are too high - which is the case in many African countries. They decrease the access to health services for certain population groups and they can even lead to total exclusion in situations where the need is seasonal as in many rural African communities. Insurance systems are therefore an interesting option that can also contribute to the solidarity within the community.

In this paper I will attempt to clarify the health insurance debate in Africa which might improve the insight into European health insurance systems, which are too often taken for granted. First I would like to introduce a typology of collective arrangements for mutual aid with systems based on insurance and where solidarity is an important underlying value. I will conclude with a discussion of the current dynamic of locally developed, voluntary health insurance systems.

Types of mutual aid mechanisms

In developing countries in general and in sub-Saharan Africa in particular, a number of mutual aid mechanisms designed to face individual risks have been developed. These risks include life cycle events like birth, death but also illness. In this discussion we shall focus on the insurance mechanisms that can be made in this variety of mutual aid arrangements depending on the presence or absence of insurance (see table 1)

The International Labour Office (ILO) defines insurance as: "the reduction or elimination of an uncertain risk of loss for the individual or household, by combining a larger number of individuals or households who are included in a common fund that makes good the loss of one member" (ILO, 1996). Insurance implies the possibility of a discrepancy between the initial investment (i.e. the costs for the insured) and the eventual result (i.e. the personal loss suffered by the subscriber). This frequently occurs in practice. From a financial point of view, insurance means that there will always be winners and losers: everybody pays in to compensate the loss suffered by some. Hence, the insurance principle differs from the reciprocity principle where the expected outputs are more or less equivalent to the inputs.

Insurance can be paired to varying degrees of solidarity. Solidarity can be defined as "a sense of awareness of unity and a willingness to bear its consequences" (Dunning, 1992). In the case of insurance this means the (implicit) acceptance that the size of the personal return may be smaller than the initial investment. In the case of mandatory insurance systems, as they exist in many countries, this unequal relationship is imposed on people by law. Solidarity is then imposed and is nevertheless reversible. Whether it is reversed or not depends on the political and social decisions that society makes.

Table 1. Mutual aid mechanisms for individual health risks

without insurance	with insurance
<ul style="list-style-type: none"> ● Systems of family and clan solidarity: moral obligation to help ● Informal systems of mutual aid (endogenous associative movements, <i>tontines</i> or ROSCA's): expectation of reciprocity ● Systems based on an act of prepayment without sharing of risks with others 	<ul style="list-style-type: none"> ● Mandatory health insurance systems managed by the State (the <i>Bismarck</i> model): insurance and solidarity ● Voluntary health insurance systems: <ul style="list-style-type: none"> ● with a private finality: insurance without solidarity ● with a public finality: insurance and solidarity

Mutual aid mechanisms without insurance

Family and clan solidarity is based on the moral obligation—in informal, but nevertheless effective, systems of mutual aid help family members. These systems of mutual aid are selective since those who do not belong to the family, clan or ethnic group cannot benefit from the aid. This help can be, and indeed is, very valuable.

range of events that is not, and does not have to be, explicitly defined. The 'coverage' beyond troublesome events like illnesses or accidents, and includes happy events like feasts.

Next to traditional family solidarity systems, there exist in Africa a rapidly growing lot of associative movements, which play an important role in the domain of mutual aid. They may gather people beyond kinship relations, they intervene in a wide range of (positive) events, and they contribute to the creation and reinforcement of social networks. These movements can be classified according to the social features of the people that they associate, or according to the nature of the services the association provides (Fassin & Romainville & Loveva 1999).

Many of these endogenous mutual aid systems have a strong focus on deceased members (sometimes encounters disapproval from young people who question the emphasis on the living). Few of these associations, however, intervene substantially in the domain of health care. According to Sylla Moussa (personal communication) this precisely constitutes a justification for the introduction of exogenous insurance-based mutual aid systems that fill that gap by covering the expenses in the domain of health care.

The *tontine* is one type of associative movement that constitutes a widespread aid arrangement in the whole of Africa. In the English literature *tontines* are called Rotating Savings and Credit Societies (ROSCAs). These arrangements are not insurance systems, but rather informal (yet regular) systems. Usually a *tontine* consists of a limited group of people who have something in common (for instance a same profession) or who are acquainted in one or the other way. Each member makes regular payments to a common pool (the 'pot') which is then in turn allotted to the participants. The investment, usually financial, is in principle in balance with the expected benefit. *Tontines* are usually created in order to generate a small capital that is intended for a business, or that is used to purchase a particular costly good. The functioning of *tontines* is based on members' expectation of reciprocity, characteristic for many of these endogenous movements, is fulfilled. *Tontines* are rarely mobilised to cover health care expenses which are difficult to determine and plan ahead.

In the case of prepayment systems (sometimes called *abonnement* in the French jargon, see Galland *et al.* 1997), a certain payment, sometimes on an individual basis, sometimes on a family basis, is made in advance to a health care provider or health care insurance. In consultation of the health care provider, this prepaid amount is gradually debited - until the total amount is consumed. This system is actually usually organised to pre-finance the costs of fairly predictable health care costs, such as under-five consultations. Prepayment is, nevertheless, an interesting option for purchasing health care at a time when money is indeed available in the household. Prepayment, however, is limited by the fact that expensive events, like a hospital admission, are difficult to pre-finance. Moreover, in such systems the risk is generally shared among a small group of people (a family for instance).

Mutual aid mechanisms with insurance

In this section I would like to elaborate on aid arrangements based upon insurance. In the first place there is a distinction to be made between on the one hand the model of mandatory health insurance, especially the Bismarck-model as it exists in different European countries, and voluntary health insurance systems on the other.

Systems of mandatory or compulsory health insurance do exist in most African countries. In many cases they were established in the last years of the colonial rule or in the first years after the independence of the young African states. This *Bismarckian* health insurance model, imported (European) model, introduced in countries with a totally different social background. In reality these systems have proved to reach only a fragment of the population, particularly civil servants. This population group consists of a small minority, rarely more than a few percent of the total population, and often already relatively privileged within the rural households living from subsistence agriculture. It seems unlikely, in short or long term, that the range of such systems will show a significant boost. Many African countries are currently under pressure from the World Bank, in structural adjustment programmes, where one of the elements is to *reduce* the number of civil servants.

A possible extension of these health insurance systems to the rural population, or to in the informal sector, requires efficient and effective administrative and managerial governmental level. Today, such a capacity is unfortunately not readily available in sub-Saharan African countries. Moreover, it is highly questionable whether the government enjoys sufficient popular credibility for the organisation and management of a social health insurance system. Hence there is a generally recognised necessity to develop new models of health insurance that focus on reaching the unsalaried population (G Jacquier 1999).

Within the category of voluntary health insurance systems a distinction can be made between those driven by a public or private rationale respectively. In the latter case, insurance premiums are linked to the magnitude of the individual health risk and are independent of the family income. This affects the equity of these payments. A majority of the African population would therefore be excluded from participation in such private health insurance initiatives. For a more detailed discussion of the distinction between public and private rationale in health care delivery in general, we refer to work done by Giusti & colleagues (1997). From hereon, we shall further focus on systems pursuing a public finality.

First of all, it is useful to point to the important distinction between health insurance as a function and health insurance as an institutional set-up (Kutzin, 1998). Kutzin attributes two functions to health insurance. The first one consists of ensuring accessibility to the health care delivery system. The second consists of protecting the family capital - savings and/or other goods - in the event of health care: in other words avoiding a family from being thrown into poverty because of health care expenditure. Health insurance as a function is an end in itself; this is not the case for health insurance as an institutional arrangement. From this perspective a British citizen would be more like a German citizen, although the health care in the United Kingdom is mainly tax-financed while in Germany it is financed through earmarked social security contributions paid by both employees and employers.

Voluntary health insurance pursuing a public objective

There is great need to structure the great variety of locally developed voluntary health insurance schemes. Creese and Bennett (1997) recently made a very interesting attempt at the classification of voluntary insurance schemes mainly focusing on schemes developed in Africa. The authors handle two variables: first, the identity of the systems' management (state, community, a co-operative society, a non-governmental organisation, etc.); second, the nature of the risks being covered: on the one hand, rare high-cost events, on the other frequent but low-cost events. On the basis of these two variables two insurance types are distinguished. A first type where there is coverage of 'high' risks (e.g. a hospital admission) where the hospital owns and/or runs the scheme. A second type is one that especially covers low-cost events (e.g. first line consultations) and that usually is run by a community-based structure.

The relevance of these two variables is beyond doubt, but they do not suffice to describe a heterogeneous lot of voluntary insurance schemes. Other variables that seem useful are:

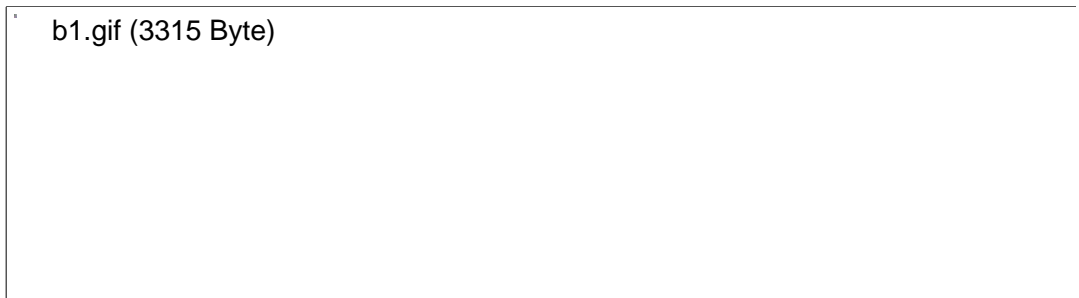
- i. The scale of the target population. This variable matters for at least two reasons: first, the scale of the population tends to be inversely related to the potential for the community to manage the scheme's management. Second, a larger population allows for economies of scale, thus contributing to the scheme's efficiency and effectiveness.
- ii. The degree of overlap of the population targeted by the insurance scheme and the population covered by existing functional entities of health care providers (e.g. a health district). A high degree of overlap then may constitute a lever to rationalise the pattern of health care delivery and the organisation in that very functional entity (for instance rationalising the referral system).
- iii. The existence (or not) of an intermediary institution in between the source of funds (i.e. households) and the eventual destination of the funds (i.e. the care provider). This intermediary organisation can play a more or less active role—beyond merely channelling funds—beyond merely channelling funds. In Anglo-Saxon literature this is called active purchasing, referring to the fact that the insurer or buyer deliberately uses his financial power to obtain efficient and high quality health care (Kutzin 1998). The expression 'from payer to player' is an adequate expression of this situation.

If one combines these different variables, one can distinguish two poles of voluntary systems: on the one hand the 'mutualistic' or participatory model, on the other 'provider-driven' or technocratic model. The major features of these two models are at table 2.

The mutualistic model

In the mutualistic model a members association (a 'Mutual Health Organisation' or MHO) acts as an intermediary structure between the source and the destination of funds (see figure 1).

Figure 1. The mutualistic model: a purchaser between payer and provider.



The *raison d'être* of the insurer (or purchaser) lies in the defence of the interests it represents. The mutualistic model is often part of a larger social dynamic where self-governance are important concerns. The insurer and the care providers confer with each other to negotiate the terms of the care that will be offered to the insured and define the financial package of benefits. These are then recorded in a contract. Evrard & Bationo (1999) distinguish a difference between more 'traditional' associations of mutual aid and MHOs precisely lies in the relationship established with the members. In traditional systems, there is an obligation to mobilise resources and an obligation to achieve *results*. In MHOs, however, there is a commitment (often expressed as a contract) to offer certain types and amounts of care at an agreed price.

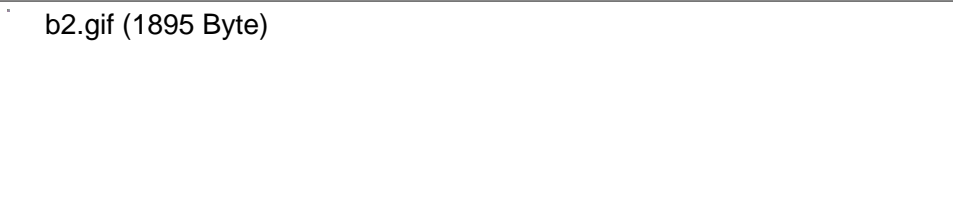
The operation of such an intermediary structure obviously accounts for additional costs in the system as a whole (transaction costs), but through this structure an improvement in efficiency can—at least in theory—be obtained from the health care providers. Such structures can serve as a kind of "counter-force" to the health care services. Whether or not this is achieved, mainly depends on the objectives pursued and on the managerial capacity of the intermediary.

Recent research indicated that a dynamic of mutual insurance systems exists in Africa, particularly in the French-speaking part (Centre National de l'Enfance 1997), even though this is often recent and poorly structured (Brouillet 1997, Atim *et al.* 1998). Sometimes one distinguishes between corporative and non-corporative mutualistic associations (Criel 1999). The first type involves individuals and their relatives, who share a same professional identity: e.g. the MUTEC stands for *Mutuelle des Travailleurs de l'Education et de la Culture* which involves about 10,000 people. The non-corporative type is aimed at a more mixed and heterogeneous group regarding professional activity, but which as a group shares other characteristics: for example, they live in the same neighbourhood or who are member of the same club/association or social movement. The corporative system usually has many more members than the non-corporative one as the latter often remains small-scaled, at most a few hundred people. This obviously affects the financial sustainability of the latter.

Today, this mutualistic dynamic enjoys important technical and institutional support. However, initiatives, however, (still) struggle with problems in the institutional design and management of the system. The financial viability of African mutualistic associations remains on the whole precarious due to the lack of economies of scale. The underlying social dynamic that (supposedly) motivates the formation of mutualistic associations has until now rarely been studied in a systematic way (Atim, 1998).

The provider-driven or technocratic model

This is also a voluntary health care insurance system without however an intermediary structure between the payer of funds and the health care provider (see figure 2): in other words the insurer is also the provider.



Such an institutional construction bears a resemblance to the HMO model (HMO : Maintenance Organisation) that is widespread in the United States. In Africa this r situations where the District Management Team is responsible for the organ management of an insurance system. The target population is then the population for is explicitly responsible for. It can be the population of the whole district or the popu 'area' of a health centre. Generally, the insured patients are then required to consult a provider. The health care provider is then the financial risk-bearer.

This model can substantially increase access to health care when the district team is finality and when it possesses the necessary managerial capacity. The insurance sy care developed in 1986 in the Bwamanda district in the Democratic Republic of Cong 1997) is a well-documented example of this model. An important limitation of this mo lack of a 'counter-force' to the health services. The risk that the health professionals the decision-making process is real indeed. This was clearly illustrated in the case (scheme.

Table 2. The major features of both models.

Mutualistic or participatory model	Provider-driven or technocratic model
<ul style="list-style-type: none"> ● Generally small scaled ● Social selectivity of target population ● Predominance of bottom-up planning ● Management by member organisation ● Rarely overlap with functional entity of health care delivery ● Intermediary structure between payer and provider ● Mutual Health Organisation is financial risk-bearer 	<ul style="list-style-type: none"> ● Usually larger scale ● Less social selectivity ● Predominance of top-down planning ● Management by health professionals ● Usually overlap with functional entity of health care delivery ● Provider is insurer ● Health care provider is financial risk-bearer

Conclusion

The different arrangements discussed cover a range going from very informal system ones (see figure 3). This overview, however, has a major limitation. It presents a cro *prevalence*—of what is there today in Africa. It actually positions these differe non-historical, and thus static perspective. Figure 3 indeed mentions mutual health well as centrally managed and mandatory social health insurance systems. Both sy Africa, although they are independent of each other. This is not the case whe European social history. The dynamic of European mutual health organisations gradu a period of several decades and with increasing government support, into nation-wide mandatory health insurance systems. Hence the arrow in figure 3. One system co historical outcome of the other. It is important indeed to be aware of these differences

Figure 3. Health care arrangements from an informal-formal point of view.

User fees are used in private non-for-profit hospitals in Uganda as a way to finance services. They contribute an average of 50-60% of hospital revenues. But very little is known about the different structure of user fees, their predictability, their effects on the use of health services, or the levels of payers' compliance. The aim of this research was to offer a tool for a more rational structuring and management of user fees in private non-for-profit hospitals in Uganda. (Uganda Catholic Medical Bureau (UCMB)).

The survey has been conducted in a convenient sample of ten UCMB hospitals in ten regions of Uganda: Nkozi, Matany, Maracha, Angal, Kalongo, Ibanda, Comboni, Rubaga and Kisubi. Data were collected during site visits in five weeks by seven surveyors. The surveyors gathered and reviewed hospital documents; in addition, they interviewed hospital workers and users.

The ten hospitals were different in terms of size, staff and volume of activities; but inpatient efficiency showed also wide variations, being hospitals in the north of the country more efficient than those in the south. The annual expenditure of the ten hospitals ranged from 115 and 1717 million Ush in 1998/99; employment cost represented the largest portion followed by medical goods and services. The revenue, for the same financial year, ranged from 115 and 1893 million Ush; five hospitals (Kisubi, Comboni, Naggalama, Ibanda and Rubaga) received 50% of their revenue from user fees, while these represented less than 30% of the total revenue in the other hospitals.

Most hospitals adopt a system based on fee for service; very often users pay even for subsidised services such as antenatal care. In some hospitals, particularly in the north, some services are subsidised: care for common childhood illnesses, care for pregnancy and childbirth, and care for specific conditions. In all hospitals drugs for specific diseases (tuberculosis, STIs) are subsidised by the Government and are administered for free to patients; but in many hospitals some patients must pay for other services. Most patients with chronic conditions have to pay a fee. Only in one hospital the fee system is adjusted to favour a more rational use of health services in the district and sub-district. Few hospitals hold funds to help the poor; in general, the poor are exempted after some form of subjective judgement by members of the hospital management. Indigent patients tend to avoid private non-for-profit hospitals and prefer to seek care at other outlets, including government services.

As a consequence, high or increasing user fees are associated with reduced utilization of health services, as demonstrated in hospitals that produce regular annual reports on number of inpatient and outpatient activities. An upward adjustment of user fees is always associated with reduced utilization, which rebounds when the fees are decreased. The assignment of health services to the Government is a mechanism that could foster equity in access, if properly used. However, this mechanism will only be sufficient if maintained at the current level.

Three hundred and three outpatients and 102 inpatients were interviewed during the survey. The survey was using the hospitals for common problems, such as fever, pain and cough in outpatients, and chronic diseases, pregnancy and delivery in inpatients. One of the most important hospital fees, proportionally higher among outpatients, is the cost of drugs. The mean cost of drugs prescribed to outpatients was 2.7 million Ush, and about 25% of patients received more than 5 million Ush. The survey did not look at the quality of care or drug prescription, but the likelihood that a patient's treatment is justified is low.

The median fee paid by outpatients was around 3,000 Ush, but some patients paid up to 15 million Ush. There were wide variations among hospitals, with lower median fees in the north and higher in the south. The median fee paid by inpatients was slightly higher than 20,000 Ush, with a range from 10,000 to 150,000 Ush. Even for inpatients, hospitals in the south were more expensive than those in the north. The variability was higher for inpatients than for outpatients fees. Most users pay the fees; among those who did not pay (fully or partially), some were treated on credit, some were exempted (in most cases because they were members of the staff); only four outpatients and one inpatient did not pay at all because of indigence. Users referred that they were sorry they had to pay for reduced treatment, drugs in particular, in previous occasions.

The cost of care for users is not limited to hospital fees. Non hospital cost includes transport (loss of income due to illness and careseeking), and cost of careseeking elsewhere during an episode of illness. The median non hospital cost for outpatients was about 4,000 Ush;

13,000 Ush for outpatients. The major components of non hospital cost were travel and careseeking elsewhere or indirect cost in the south. To pay hospital fees and many patients had to borrow money or sell goods and property. Users find particularly hospital fees during the planting season and at the time of enrolling children at school clear that poor patients can hardly afford to use these hospitals; lack of money was the reason for seeking care elsewhere for the same episode of illness.

Recommendations

The mission of all Catholic Health Units is to serve the entire population of the area for which they are responsible, in particular, the most vulnerable groups: children, pregnant women, children and the poor in general. The research findings identified two groups of hospitals (Table):

- the hospitals in the first group (A) fulfil their mission, deliver good quality service which is financially accessible (with low user fees) to all the socio-economic strata of the population;
- the hospitals in the second group (B) have user fees so high that a substantial part of the population, the most vulnerable groups, cannot use them; clearly, these hospitals do not fulfil their mission.

Table: Relevant features concerning user fees levels, utilisation rates and management of two groups of hospitals (three hospitals have been considered for each group).

Variables	Group A	Group B
User fees range:	in Uganda Shillings:	in Uganda Shillings:
Outpatients	447 – 1,690	3,126 – 7,000
Inpatients	2,493 – 1,613	26,081 – 41,000
User fees structure	mainly flat rates	fees for services
Fee for a paediatric admission (malaria)	1,500 – 2,400	12,000 – 27,000
Bed occupancy rate	86% - 95%	23% - 38%
Paediatric admissions as percentage of total admissions	47% - 60%	29% - 37%
User fees collection as percentage of annual running cost	9.5% - 24.5%	73.9% - 87.5%
Government financial contribution as percentage of annual running cost	13.6% - 25.9%	3.3% - 25.2%
External aid	Substantial, continuous and well structured	From very few sources
Administration and management	Good management, good keeping of service and financial records	Poor management, poor keeping of financial records
Attention paid to equity and accessibility	User fees consciously set and structured to ensure equity and accessibility	Little concern for equity and accessibility

^a data available for two hospitals only

The user fees system is inequitable by its own nature. It makes the patients bear the cost of the services and it makes the poor pay proportionally more than the rich. For this reason, the system is not sustainable.

introduction and testing, in Uganda, of alternative models of health services for pre-payment and progressive contributions. To this respect, the World Health Organization states: *"A way health care is financed is perfectly fair if the ratio of total health contribution spending is identical for all households, independently of their income, their health status and the quality of health services"*

In any case, as regrettable as it is, user fees are likely to remain the most common financing mechanism for health services for a long time to come. For this reason, they must, at least, be administered and managed in line with a few basic principles of best practice:

1. To keep the user fees revenue below 20%-25% of the total recurrent budget of a health facility.

- Our study strongly suggests that, above this threshold, the fees seriously compromise the financial accessibility of the services. They become an insurmountable barrier for the poorest groups of the population.
- Some of the hospitals studied have succeeded in keeping user fees revenue well below the above-stated limits. They did so thanks to the "delegated funds" received from the government and to other external financial donations.
- We do hope that the current government policy in support of PNFP hospitals continues to become stronger.
- At the same time, we are convinced that other external donors, both private and public, should urgently intervene to guarantee the financial accessibility of these hospitals to a large part of the population.

2. To improve the quality of services.

- Some of the hospitals included in this study are poorly utilised not only because of high user fees, but also because their services are of poor quality. They are trapped in a vicious spiral: scarce funds - high fees - low utilisation – scarce funds - low quality of services.
- This trend will inevitably lead to their extinction. A potentially precious resource for the community would, then, be irreparably lost.

3. To improve the overall management of the hospital.

- In several of the hospitals studied, the scarcity of available resources was made worse by poor management.
- Improving hospital management does not only mean to improve the organisation of services; it also means to be conscious of the real cost of the services delivered and to keep accurate records of the financial flows.
- This will not only increase efficiency; it will make it easier to submit clear, sound and "palatable" requests to potential donors.

4. To implement and publicise a sound and clear exemption policy.

- Fees for children, pregnant women, elderly people, patients suffering from chronic diseases (e.g. tuberculosis, HIV-AIDS) should be strongly subsidized.

5. To adopt, as much as possible, flat fees for specific diseases.

- In this way, a patient will pay a fixed amount of money for the treatment of a given disease, irrespective of the amount and type of drugs received and of the length of admission, thus avoiding penalising those affected by serious diseases.
- It will also minimise the risk of over-prescription of drugs and services, sometimes due to high user fees for services.

6. To promote a rational referral system within the different levels of health units by introducing a system of partial exemptions.

- Our study suggests that the period elapsing between the onset of a disease and the patient's admission to hospital averages one month. During this time, patients visit an excessive number of "health care providers", most of them private for-profit providers.
- This event has become more common in the last few years because of the chaotic referral system and the proliferation of private for-profit "health care providers". In many cases these are ill qualified or abusive.

- This situation poses serious threats to the health of individuals and communities on them additional and unneeded expenses.
- One way to redress this trend is to strengthen and further integrate the district health systems. A clear path, from the lower levels of care to the highest ones, is advertised.
- To make it more relevant and acceptable to the users, it must be linked to a system of exemptions. A similar system is already used by Matany Hospital, in Moroto District. The hospital applies different and increasing levels of fees depending on where the patient comes from and whether they have been referred or not.
- Lower fees are applied to:
 - patients coming from the immediate catchment area of the hospital, for whom the nearest health unit;
 - patients coming from outside the immediate catchment area but referred to lower level health units for which Matany is the referral institution;
 - patients referred by other health units in Moroto District.
- Higher fees are applied to:
 - patients coming from outside the immediate catchment area of the hospital who have not been referred;
 - patients coming from districts other than Moroto.

Health Care Financing

by Jos Dusseljee, health sector coordinator, Cordaid

Introduction

I was asked to give a presentation on the costing side of health care, whereas Barbra was concentrating on the financing side.

Due to the positions I have been holding in the last few years, I have had only limited time to involve myself intensively with (the financial management of) health institutions, but I will be doing so in the future. Considering the fact that another speaker will discuss in more detail a study concerning the financial situation at a number of Ugandan hospitals, I will share some observations with you that are general in terms.

Current view

During the last two decades institutions are increasingly challenged to provide more services at a lower cost, to meet more and harder demands from the side of donors, the government and the public. Providing services of sufficient quality is essential but not enough to sustain a health system.

What's the current situation of health institutions in developing countries

1. A more political environment with developments like:

- health reforms (district "baskets")
- poverty reduction strategy papers
- sector wide approaches
- public private partnerships

2. a more complex environment from a Public health point of view

- HIV/AIDS problem, TB, malaria and other illnesses with a great interrelationship and a far going impact on the way in which the health system is utilized.
- Need for inter-sectoral collaboration, as the major health problems do not respond to health-related actions only

3. A less stable economical environment with

- reduced, suppressed and less reliable government funding
- no matching increase in unconditional aid/donor money
- more competitive environment with differentiated private services
- due to various reasons a growing number of poorer patients not able to meet financial requirements, like fees for medical services. Most Sub-Saharan economies have experienced economic decline for years, with in addition growing economic disparities with
- more costly treatments due to seriousness of medical problems (e.g. AIDS)

4. A altering donor environment with

- changing views on institutional health vis-à-vis empowerment of communities and general development in order to promote income generation
- greater insistence on value for donor money: i.e. tangible results

The consequences of all these developments are:

- financial hardships
- strain on quality
- underperformance in terms of utilisation/public health performance
- vicious circle between higher fees, lower utilisation, deficits

A number of evaluations of late point at financial hardship in church related hospitals scaling down in size (reducing nr. of beds) or in the width of their operations programmes).

Bart rightfully observed that in order to make ends meet, institutions hardly can expect patients to contribute financially. And this they should organise with vision.

What to do, seen from the cost side?

First of all to measure cost.

This recommendation seems obvious, however in practice it isn't. To measure cost properly requires an open well designed accounting system, which meets following criteria:

1. It allows for refined differentiation of recurrent expenditure and income according to and subcategories: e.g. personnel cost, divided in salaries, allowances, gratuities
2. It allows for distinction of expenditure and income according to department or activity. e.g. cost of the Mother and child health programme with static and mobile services, personnel cost, cost of essential drugs, transport, etc.
3. it allows for proper accounting of capital income and expenditure, as well as profit and loss accounts.
4. it allows for adequate registration of debtors (e.g. patients discharged after signing statement) and creditors (e.g. suppliers).

In order to design such a system, expertise needs to be made available, then a computerised system. No manual system may adequately (timely, efficiently, accurately) provide the required information.

Considering the scarcity of expertise, it is highly suggestible that a sort of national programme using software application is designed, so that a maximum of standardisation is achieved.

I worked in Kenya with a standardised system, which was followed almost blindly by Institutions. However after more than twenty years, the system does not meet modern requirements and does not make use of the fact that computers are already found in nearly all corners.

Suppose we do have an accounting system in place, what to do with it?

Again, although seemingly obvious, which it isn't in practice: *to analyse financial data* at an optimum balance between expenditure and income. Although, financial survival is not enough, a critical inspection whether an optimum balance is achieved is hardly done.

Accounts only are not enough. Information concerning the utilisation of an inst provided too. In this way one can *match financial data with utilisation data* and come to institutional cost benefit ratio.

Without going into much detail, even if the account system does not meet the mentioned comparison between institutions may already reveal a lot of information.

Some few years ago in Uganda I compared, using a sort of quick-and-dirty method, t of three hospitals, to find remarkable differences in the two major cost-items in compa load, i.e. cost of personnel and cost of medical supplies, usually accounting for thr recurrent expenditure or more. In the most expensive institution government regulatic as far as coverage of wards by qualified nurses during all shifts concerned. In the (and night coverage matched actual patient load. The cost of drugs varied accordi habits (against standardised conditions of Joint medical Stores, or using comm (offering discounts to the buyers), according to the pricing system (all-inclusive rates c on drugs), according to the prescription system, availability of protocols, etc.

One may also support the role of an umbrella body in providing detailed analysis of c like "wet production units", trainings, optimal stock keeping. Institutions may co-op achieve economy of scale.

Despite the fact that I have no doubts on the opportunity to economize on the institutions by perhaps some 10% or more, I do wish to stress that institutions alread low cost. Quick comparison of the running cost of a number of hospitals gives an in may cost even less than \$ 2 per capita, i.e. the number of people directly depend care provided. The actual cost, as one study by the University of Nurnberg proved, is a number of subsidies and infra-structural cost are not taken into account. And the de even higher since at present one tends to compromise on quality of care. Staff lev speaking not high, competence levels are often at a bare minimum, salaries are low, (are low too, etc. Most institutions have starved themselves to the maximum they can p

In my view, *often more gains may be derived by a more optimal utilisation*, which adequate quality (according to subjective views of potential patients), a compe well-designed fee system preferably in combination with an insurance system. Making economical disparity among potential patients, e.g. by differentiating the quality of giving up the equity principle in essential health services) one may increase income. F escape to note that due to poverty in general and the impact of HIV/AIDS in partic income of an institutions out of patients themselves is limited.

Economic analysis may assist a lot to find the optimum, but there is need for a warni tendency to make ends meet leads to the demand for cost coverage of all different : by an institution. This is *bookkeeper mentality* which suits well a business cor not-for-profit health institution which seeks to offer acceptable quality services again not hinder accessibility to the poor and other deprived people. *The break-even dema is not a goal in itself.* A pricing system should not just be regarded a system use income, but should be considered as a tool too to allow for a maximum public health c

It is here that I plead for a *better understanding between the health professionals on i and administrators on the other hand side.* There is evidently a lack of understandir two groups of professionals which may hinder the realisation of the joint goal of o public health performance of an institution while breaking even financially.

One may stress the need for *training of these administrative oriented health professi way around.* At the none-governmental church related side in the eastern Africa regio some 10 master and degree level trainings. However (as I understand from a he; consultant who visited most of these institutions), their standards are not always too or not cooperate but survive in isolation, there is limited exchange with institutions trainings do not always succeed in attracting the most promising students, and whe from certain that talented persons survive in the at times managerial hardships of a health care system.

Definitely there is need to look more careful in the kind of heath care management tra

contribute to the optimum balance between economic and public health performance.

In order to do one needs to connect expenditure and income data to statistics which show the public health performance of the institution, i.e. to compare information on the services in comparison with the objectified needs in a defined catchment area.

Again I cannot help to note that important contributions to a *standardised health information system* has not been updated to match current requirements. The guidelines for hospital reporting in the early eighties was an essential step forward. Scores of mainly expat staff utilised leading to standardisation and allowing for maximum comparison. Despite the Antwerpen Institute to adapt the guidelines in the mid nineties, I cannot but observe reports are insufficient. Hardly or no use at all is made of computerised collection of data, no standardised reporting system for activities related to CBHC, AIDS (prevention/hospital care) is available. We may continue referring the demands on financial reporting, management of the environment, with new government systems in place, etc.

Medicus Mundi International: options for future involvement

Current issue:

Promoting public private mix through the "contractual approach"

This requires on the side of health institutions and their umbrella bodies an increase in health care management

MMI may possibly seek to involve itself with

- Design/promotion of standardised health information systems
- Design/promotion of standardised guidelines for annual reports
- Design/promotion of standards for health care management trainings
- Design/promotions of standards for qualifications of health institutions

MMI may be ideally situated to promote this kind of standardisation, or at least to promote standardisation on national level.

Re: Follow up of MMI/MMM partner consultation on contractual approach in Dar

Dr. Tom Puls, Brussels, 26th April 2001

Dear friends,

As you remember, you and/or your organisation participated in the meeting in Dar es Salaam on the issue of public/private partnership in healthcare provision through a contractual approach. Co-sponsoring organisations were Memisa Medicus Mundi (called CORDAID since 1999) and Medicus Mundi International. WHO had been closely associated in preparation of the meeting in Dar es Salaam as well as with the preparation of a similar meeting in Conakry for West African countries. In both meetings WHO played an active role in the clarification of the Contractual Approach in public/private partnership.

A key element during both meetings was the introduction of a first draft of a text for discussion and tabled during one of the coming World Health Assemblies. It was an indispensable opportunity to register ideas and to register comments and possible proposals for amendments/additions to the text. Moreover, since the concepts underlying the contractual approach were more fully understood in a number of countries the public-private communication was enhanced and efforts to develop a more formal collaboration were stepped up. As you might wonder what then happened after the proposed resolution, we felt we owe to you some explanation as to the follow-up. Medicus Mundi International has been giving to that initiative.

Heartened by the support and constructive contributions offered to the resolution proposed at the Dar es Salaam and Conakry meetings, and following the advice of WHO headquarters, among a number of interested member states, the Chad delegation undertook the following

of the draft resolution to the World Health Assembly. According to the internal rules, ask the Executive Board to put it on the agenda of the coming Assembly. Sadly possible agenda meeting was in January 2001. It was brought up on last day of the delegates of 24 countries took the floor and expressed a great interest in the argun lasted more than two and a half hours. It has been confirmed that all the stake HFA-Policy of WHO and the Policy of External Donors will profit by enforcing NGO-Health Care Providers, especially the not for profit ones. The proposed am included in an improved draft resolution and it has been decided to present it at the 109th session on January 2002.

We are convinced (and getting continuous support in this view,) that a resolution cal on member states to explore more actively and to enhance possibilities for public-p through a contractual approach, remains relevant and needed. Therefore we will co this matter jointly with the Chad delegation and with the secretariat of WHO in Geneva

In this context it should be mentioned that we have commissioned a study, currently a way, to inventorise existing forms of contractual public-private partnership in health the way in which these were achieved. The objective would be to develop guidelines f approach, in other words a publication (jointly by MMI and WHO) from which both r the private (not for profit) sector and Governmental officials can derive inspiration and to the basic elements to assure and to include in a strategy leading to more formal and increased integration of private networks in a National healthcare plan. We ar such a publication (expected: autumn 2001) will add momentum to the adoption, nex resolution by the World Health Assembly.

Dr. T. Puls
for Medicus Mundi International

Memisa Jubilee Congress, Rotterdam, 5th and 6th October 2000

'How popular is health care? Adoption or rejection of PHC concepts in developi how to move beyond mere participation'

by Mrs Marieke Verhallen, Policy Advisor NVTG

At the occasion of her seventy-fifth anniversary Memisa organised an international co the above question. The participants (about 350) consisted of representatives of part from all continents, representatives' of WHO and other multilateral organisations, medical anthropologists and health economists both from the north as from the south number of persons related in one way or another to the work of Memisa.

Hans Kruijssen, director of Cordaid, the new catholic organisation for development aid that was formed by the merger of Bilance, Caritas Neerlandica and Memisa, ope by stressing that health is a prerequisite for development and therefore health care de be pursued. Referring to the national and international debates in developmen suggested that the main principles for adaptations in policy and implementation ownership and international solidarity.

Mrs Herfkens, the Netherlands Minister for Development Co-operation, first of all expli for her new policy regarding (personnel) technical assistance, which had been the su debate during the preceding weeks. Strengthening local ownership and commit refocusing on capacity building and institutional strengthening have to lead, in her vie personnel assistance, diversifying the forms of technical assistance and an improve sector wide approaches and programmes. Subsequently she reviewed the future development co-operation. As important players in their countries, in the north as we NGOs should be actively involved in the implementation of sector programmes, strive policies and activities based on their experiences and use the same experiences to and improved practices. As representatives of the civil society NGOs should governments accountable for their policies and actions.

Professor Mercenier reviewed the lack of integration of the PHC concept in health c

practices. His main conclusions were that a number of aspects have been underestimated: these range from the complexity of the concept itself to the methodological aspects. Of the latter the main stumbling blocks are: the lack of clear conditional priorities (determining the common ground between needs and demands the opposing principles of scientifically sound and socially acceptable), the late incomplete understanding of the health district concept, the lack of adequate use of research and, last but not least, the lack of attention to the change of attitude and the level of health care staff.

Professor Dormael assessed the failing of the PHC concept from the perspective of the cultural integration to conclude that the failing cultural integration entails the lack of accessibility. First important cultural gap: PHC implies scientific rationality and social acceptability but in most countries, is far from scientifically rational. This gap is exacerbated by the fact that culture considers lay expertise as irrelevant. Moreover, cultural integration is complicated -conceptually because the biomedical perspective is dominant;
-historically because modern medicine evolved, from within, in the north, while it has in the south thus breaking with the traditional medical systems, introducing technical characteristics and allowing staff to hide behind new identities;
-socially the obstacles stem from the increased social distance between patient and care provider and new social hierarchy among care providers placing a higher value on technicality and lowering moral among PHC providers.

To achieve cultural integration of PHC she pleaded for recognition that PHC is 'broader' and 'cheaper' and that it requires new professional role models including adapted training and continuing education.

Dr. El Tom first of all placed developments in PHC in the perspective of international economic developments and then reviewed the present position of the main stakeholders: governments, the population and the alliance of interested parties concerned with its health. He concluded that PHC should continue to be pursued but that each stakeholder should define its role more clearly and complementary to the others.

Mr. Adams, WHO, presented the contractual approach as a promising new tool for health care services. With respect to the present day challenges facing health care provision, the contractual approach stimulates goal orientation, fairness, responsiveness to legitimate needs and respect for the individual. The changing internal and external environment mean that governments can and should not assume to provide health care on their own. New and diverse types of interaction between partners are needed. The possible tools to realise these interactions each have their own strengths and weaknesses. On the basis of examples he reviewed the potential strength of contracting between government and private parties. Compared to the other tools contracting has the most potential to implement broad service oriented objectives, ensuring quality management of sub sectors of the health system. Careful implementation should enable us to find out whether this theoretical promise can be realised.

The last presentation read by *dr. Bro. Daniele Giusti*, concerned the statement of the Conference of 11 bishops, various health secretaries from episcopal conferences, representatives of Cordaid-Memisa, Misereor, Cafod, Stichting Porticus, Medicus Mundi International and others, held during the preceding days. This statement is of great importance as it expresses the commitment, of the catholic church in the represented countries and its promise of empowerment of the poor and towards improving the health care status and health care services. Based on the principles of solidarity and human rights the representatives expressed their commitment to the realisation of the full range of the healing ministry including a more active role in HIV/AIDS, to improve the structures and institutions involved in health care provision, to empower the persons working in them, to improve professional practice and to engage in partnerships with the principle stakeholders at the various levels of involvement and improved effectiveness.

Workshops were held to discuss the vision and possible roles of the (church-related) state sector and Cordaid with respect to the subjects:
-persisting obstacles to universal health care utilisation;
-failing integration of health care in the local cultural setting;
-structuring public/private partnerships.

The plenary presentations showed that the obstacles, though complex, are definable and can be addressed.

actors as well as within their interactions. The call for clearly focused close c predominant together with the recognition of the need, for all parties, to increase their new and better ways to involve the communities and users of health services implementation and evaluation.

Dr. Hafdan Mahler, who commented on the feedback from the workshops, pointed concept stood for the empowerment of people. As such it still is valid but to succeed model, that was made of the concept, has to be revised. He stressed the need for co for the poor, a role he thinks the church-related health care providers should retain a closer collaboration between public and private should be envisaged not only to impr and quality of services but also to improve equity and community participation by adv from within the system. This latter goal should also inspire the cooperation of the pri sector in the Sector Wide Approach for health as well as in contracting.

In conclusion the discussions in the working groups and the plenary in fact confirm renewed commitment of the church and as such the appropriateness of the statem representatives. The proceedings of the congress including the statement from the bis will be available through the Memisa secretariat, PO Box 16440, 2500 BK The Hague

In Memoriam Professor Vincent van Amelsfoort

On April 13, 2001, Professor van Amelsfoort passed away in 's-Hertogenbosch, the was 69 years of age. Professor van Amelsfoort was a pioneer in the field of medical public health care. He worked as a tropical doctor in New Guinea, Nigeria and Tz inspired many students in his capacity as Professor in Health Care in Developing University of Nijmegen.

He has had a great impact on the quality of training and coaching of Medicus M cooperation with Medicus Mundi he supported the internships for medical students i Mundi related hospitals in Tanzania, Ghana and Lesotho. Over 300 interns participate during his professorate until 1986. Very original was his way of postgraduate training annual reports of our hospitals. The professional contacts based on those reviews quality of work of the Medicus Mundi doctors. He developed therefor the first ho system, the so called "van Amelsfoort Forms". This was later developed into the Guid Reports by Dr Hamel and Kok of his Institute. The guidelines were accredited I Medicus Mundi International.

Professor van Amelsfoort Institute Medical Care in the Developing World of the Unive was unique in Europe in the way that it presented in teaching, research and s spectrum of medical care in the third world within the total framework of the social, po and cultural context. It was hard for him and Medicus Mundi that the medical Fact controversial decision to close down his Institute when he left the university on pens remaining activities were transferred to the policlinic for tropical diseases and the labo parasitology.

We remember him as a very engaged tropical doctor, with a broad minded but strc was straightforward in correcting the policy of some bishops who imposed in his vie decrees on their mission hospitals. His heart stayed in Africa.

He left something of real value behind him. Dutch Medicus Mundi doctors will never fc

Sake Rypkema