Medicus Mundi International
Newsletter No. 67, Summer 2001

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In memoriam Professor Vincent van Amelsfoort, Sake Rypkema

Introductory

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

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

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

Contracting at district level between NGO health institutions and District has been a s
the last three years. Inside WHO it looks that the member states work towards a
subject. For MMI the main focus was and is the cooperation between the local NGO
and the District. Be aware that MMI is not referring to International NGOs and central
many partnerships are contracted at global level. The last years. We focus to th
district level in order to reach a integrated health care system, accessible and s
common man. The Dar es Salam consultation 1999 and Conakry 1999 (MMI Newslet
tention to discuss and investigate what our local partners feel. A letter of the follow
published here.

The Memisa 75 years celebration was reported last year by introductory presentations
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*

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**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 typical way to provide them, quality, equal access, etc. But an overruling common denominator of such questions is the inevitable final question: How to make ends meet and how to do it 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 consistency in average cost e.g. for the provision of a basic minimum package of care at health care facilities in the same region in one country. This can often be attributed to such factors as overconsumables, greater efficiency of staff deployment, inefficient communication or more 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 care as a topic may generate some attention. But quality of administration alone can interest. Yet for the same service provided some centers in the same country may cost and 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 be working in the same type of communities in the same region of a given country. 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 Resources Allocation Game was a popular training tool enabling participants to become familiar with 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 of coverage and per capita cost per service provided. Depending on the mix chose healthcare could be provided to anything between 10% and 90% of the target community, the 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 most contributing to improve cost/benefit ratios in healthcare provision and towards achieving 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 expenditure for health. In most of such extremely deprived situations one should not expect 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 important for instance at average cost per capita for the running of a reasonably cost-effective system in an average Ghanaian district of 100.000 inhabitants, having 1 milliard of health care expenditure for recurrent expenditure would in principle allow to achieve relevant targets. However, such concentration of resources at one given level of health care might be insufficient, 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 average Ghanaian individual person. The latter type of expenditure is exemplified by the person pay for...
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 almost 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 devi mainly newly independent states, displayed a trend towards centralisation of such 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 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 sam Cultural differences and differences in economic potential between regions of the s play 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 relat income levels, communities actively demanded and paid for Meningitis immunisation 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 Ct 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 w 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 m 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, acl 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, recu support should not be granted.

3) It is an urgent matter to review the guidelines for annual hospital reports and to ed informative in making a plan of operations for monitoring recu and for reporting and analysis of the data reported.

4) It is essential for healthcare institutions to have access to health economist and optimise their cost-effectiveness.

5) Consumers are so much aware of cost of health care provision, that there can correlation between perceived cost-effectiveness and:
   - effective utilisation
   - willingness to pay a share in the cost directly and in particular indirectly via pre or local insurance schemes.

6) The contractual approach (whether contracting in or contracting out) makes grot 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 cle

8) Given the fact, that training for heath institution administration and for health economy in developing countries the creation of such courses should be facilitated in (OPEN FOR DEBATE).

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

by Dr. Bart Criel

Introduction

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

A pragmatic response to this situation was the introduction in the 1970's and 'out-of-pocket' payments by the patient at the time and point of use. Today, this policy is frequently seen - 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, to 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 high - which is the case in many African countries. They decrease the access to healthcare for population groups and can even lead to total exclusion in situations where the seasonal is 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 treated as homogeneous. First I would like to introduce a typology of collective arrangements for mutual aid within insurance systems based on insurance and where solidarity is an important underlying value. I then will make 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 mechanisms for mutual aid have been developed. These risks include cycle events like birth, death but also illness. In this discussion we shall focus on the individual risks that can be made in this variety of mutual aid arrangements depending on the presence of insurance (see table 1).

The International Labour Office (ILO) defines insurance as: "the reduction or elimination of the 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 costs for the insured and the eventual result (i.e. the personal investment for 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 for the loss suffered by some. Hence, the insurance principle differs from the reciprocity principle for which the expected outputs are more or less equivalent.

Insurance can be paired to varying degrees of solidarity. Solidarity can be defined as an awareness of unity and a willingness to bear its consequences" (Dunning, 1992). Insurance this means the (implicit) acceptance that the size of the personal return will be less 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 reversed, but is nevertheless reversible. Whether it is reversed or not depends on the political decision that society makes.

<table>
<thead>
<tr>
<th>Table 1. Mutual aid mechanisms for individual health risks</th>
</tr>
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<tbody>
<tr>
<td><strong>without insurance</strong></td>
</tr>
<tr>
<td>- Systems of family and clan solidarity: moral obligation to help</td>
</tr>
<tr>
<td>- Informal systems of mutual aid (endogenous associative movements, tontines or ROSCA's): expectation of reciprocity</td>
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<tr>
<td>- Systems based on an act of prepayment without sharing of risks with others</td>
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Mutual aid mechanisms without insurance

Family and clan solidarity is based on the moral obligation—informal, but nevertheless enforceable—helping 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
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 even' feasts.

Next to traditional family solidarity systems, there exist in Africa a rapidly growing list of associative movements, which play an important role in the domain of mutual aid. These 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 associate, or according to the nature of the services the association provides (F Romainville & Loveva 1999).

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

The tontine is one type of associative movement that constitutes a widespread aid at whole of Africa. In the English literature tontines are called Rotating Savings and Credit (ROSCAs). These arrangements are not insurance systems, but rather informal (yet r systems. Usually a tontine consists of a limited group of people who have something for instance a same profession) or who are acquainted in one or the other way. Each regular payments to a common pool (the ‘pot') which is then in turn allotted to participants. The investment, usually financial, is in principle in balance with the e benefit. Tontines are usually created in order to generate a small capital that is in business, or that is used to purchase a particular costly good. The functioning of tontines is a characteristic for many of these endoge movements, is fulfilled. Tontines are rarely mobilised to cover health care expenses 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, is made in advance to a health care provider or health care ins consultation of the health care provider, this prepaid amount is gradually debited - consultation fees charged - until the total amount is consumed. This system is actually usually organised to pre-finance the costs of fairly predictable health care costs, under-five consultations. Prepayment is, nevertheless, an interesting option because purchasing health care at a time when money is indeed available in the household is 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 1 there is a distinction to be made between on the one hand the model of mandatory especially the Bismarck-model as it exists in different European countries, and voluntary systems on the other.

Systems of mandatory or compulsory health insurance do exist in most African cou cases they were established in the last years of the colonial rule or in the first ye 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 particularly civil servants. This population group consists of a small minority, rarely than a few percent of the total population, and often already relatively privileged w rural households living from subsistence agriculture. It seems unlikely, in short or e that the range of such systems will show a significant boost. Many African countries are under pressure from the World Bank, in structural adjustment programmes, where elements is to reduce the number of civil servants.
A possible extension of these health insurance systems to the rural population, or to the informal sector, requires efficient and effective administrative and managerial capacity at 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 the national 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 (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 premium linked to the magnitude of the individual health risk and are independent of the family income. 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 gene 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 and the second consists of protecting the family capital - savings and/or other goods - in the face of health care: in other words avoiding a family from being thrown into poverty because of health 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 very different from a German citizen, although the health care in the United Kingdom is mainly tax-financed while in Germany is financed through earmarked social security contributions paid by both employers and employees.

**Voluntary health insurance pursuing a public objective**

There is great need to structure the great variety of locally developed voluntary health care insurance schemes. Creese and Bennett (1997) recently made a very interesting attempt at classification of voluntary insurance schemes mainly focuses on schemes developed in the UK. The authors handle two variables: first, the identity of the systems’ management (the provider, the 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 schemes are distinguished. A first type where there is coverage of ‘high’ risks (e.g. a hospital admission) and that usually is run by a community-based structure. The hospital owns and/or runs the scheme. A second type is one that especially covers ‘low’ risks (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 classify the heterogeneous lot of voluntary insurance schemes. Other variables that seem useful include:

i. The scale of the target population. This variable matters for at least two reasons: the population tends to be inversely related to the potential for the community involvement in the scheme’s management. Second, a larger population allows for economies of scale contributing to the scheme’s efficiency and effectiveness.

ii. The degree of overlap of the population targeted by the insurance scheme and covered by existing functional entities of health care providers (e.g. a hospital admissions department) and the eventual destination of the funds (i.e. the care provider). Organisation can play a more or less active role—beyond merely channelling the funds to the insurers or buyers) deliberately uses his financial power to obtain efficient and effective care (Kutzin 1998). The expression ‘from payer to player’ is an adequate description 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 the ‘provider-driven’ or technocratic model. The major features of these two models are summarized in Table 2.

**The mutualistic model**

In the mutualistic model a members association (a ‘Mutual Health Organisation’ or MHO) acts as a purchaser between the payer and the provider (see Figure 1). The raison d’être of the insurer (or purchaser) lies in the defence of the interests that 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 the members 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 (1993) note the difference between more ‘traditional’ associations of mutual aid and MHOs precisely lies in the decision-making process. In traditional systems, there is obligation to mobilize resources; in MHOs, however, there is a commitment (often explicit) to achieve results. In MHOs, however, there is a commitment (often explicit) to achieve results, i.e., to provide certain types and amounts of care at an agreed price.

The operation of such an intermediary structure obviously accounts for additional transaction costs, but through this structure an improvement in efficiency can—albeit in theory—be obtained from the health care providers. Such savings can serve as a kind of “counter-force” to the health care services. Whether or not this actually achieved, mainly depends on the objectives pursued and on the managerial capacity of the insurer.

Recent research indicated that a dynamic of mutual insurance systems exists in Africa (Evrard & Bationo, 1993), even though this “mutualism” is recent and poorly structured (Brouillet, 1997, Atim et al., 1998). Sometimes one distinguishes corporative and non-corporative mutualistic associations (Criel, 1999). The first type is aimed at a more homogeneous group of individuals and their relatives, who share a same professional identity: e.g., the Mutuelle des Travailleurs de l’Education et de la Culture (MUTEC) in France, which serves 10,000 people. The non-corporative type is aimed at a more mixed and heterogeneous group of people regarding professional activity, but which as a group shares other characteristics: e.g., the mutualistic associations has until now rarely been studied in a systematic way (Atim, 1999).

Today, this mutualistic dynamic enjoys important technical and institutional support. African initiatives, however, (still) struggle with problems in the institutional design and management system. The financial viability of African mutualistic associations remains on the whole lack of economies of scale. The underlying social dynamic that (supposedly) makes mutualistic associations has until now rarely been studied in a systematic way (Atim, 1999).

**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 is also the insurer.
Such an institutional construction bears a resemblance to the HMO model (HMO: Maintenance Organisation) that is widespread in the United States. In Africa this situations where the District Management Team is responsible for the organisational management of an insurance system. The target population is then the population for which the team 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 scheme developed in 1986 in the Bwamanda district in the Democratic Republic of Congo (1997) is a well-documented example of this model. An important limitation of this model is the lack of a 'counter-force' to the health services. The risk that the health professionals might dominate the decision-making process is real indeed. This was clearly illustrated in the case of the Bwamanda scheme.

**Table 2. The major features of both models.**

<table>
<thead>
<tr>
<th>Mutualistic or participatory model</th>
<th>Provider-driven or technocratic model</th>
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</thead>
<tbody>
<tr>
<td>Generally small scaled</td>
<td>Usually larger scale</td>
</tr>
<tr>
<td>Social selectivity of target</td>
<td>Less social selectivity</td>
</tr>
<tr>
<td>population</td>
<td>Predominance of top-down planning</td>
</tr>
<tr>
<td>Predominance of bottom-up planning</td>
<td>Management by health professionals</td>
</tr>
<tr>
<td>Management by member organisation</td>
<td>Usually overlap with functional</td>
</tr>
<tr>
<td>Rarely overlap with functional</td>
<td>entity of health care delivery</td>
</tr>
<tr>
<td>entity of health care delivery</td>
<td>Provider is insurer</td>
</tr>
<tr>
<td>Intermediary structure between</td>
<td>Health care provider is financial</td>
</tr>
<tr>
<td>payer and provider</td>
<td>risk-bearer</td>
</tr>
<tr>
<td>Mutual Health Organisation is</td>
<td></td>
</tr>
<tr>
<td>financial risk-bearer</td>
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</table>

**Conclusion**

The different arrangements discussed cover a range going from very informal systems (see figure 3). This overview, however, has a major limitation. It presents a cross-sectional view—of what is there today in Africa. It actually positions these different systems non-historical, and thus static perspective. Figure 3 indeed mentions mutual health care well as centrally managed and mandatory social health insurance systems. Both systems are independent of each other. This is not the case when we look at European social history. The dynamic of European mutual health organisations gradually developed over several decades and with increasing government support, into nation-wide mandatory health insurance systems. Hence the arrow in figure 3. One system co-exists with the 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.**
Obviously there are intermediate forms between the two above-mentioned models of insurance. Such an intermediary model is not only possible, it is perhaps even desirable, to indeed reconcile the transparency and participatory potential of the mutualistic model with the effectiveness and efficiency of the more large-scale provider-driven technocratic model. A better synthesis between people's priorities on the one hand and the technical knowledge and expertise of professionals on the other could be achieved. This is only possible if there is a clear framework and understanding between both partners.

This intermediary model seems coherent with the philosophy of Primary Health Care as it was advocated more than 20 years ago by the World Health Organisation in Alma Ata (WHO 1978). Primary Health Care indeed advocated consumer participation in the management of the health system as well as the pursuit of an optimal accessibility of the health services.

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**User fees in private non-for-profit hospitals in Uganda**

by Dr. Adriano Cattaneo

A research carried out in ten hospitals by:

- Joseph Amone, Hospital Administrator, Kitgum Hospital, Kitgum, Uganda
- Salome Asio, Double Registered Nurse Midwife, Moroto Hospital, Moroto, Uganda
- Adriano Cattaneo, Unit for Health Services Research and International Cooperation l'Infanzia, Trieste, Italy
- Annet Kakinda Kweyatulira, Hospital Management Programme, Ugandan Martyrs Nkozi, Uganda
- Anna Macaluso, Unit for Health Services Research and International Cooperation l'Infanzia, Trieste, Italy
- Gavino Maciocco, International College for Health Cooperation in Developing Countries, Padova, Italy
- Maurice Mukokoma, Hospital Management Programme, Ugandan Martyrs University, Uganda

on behalf of the Uganda Catholic Medical Bureau, in July and August 2000. Co authored by Dr. Adriano Cattaneo, Unit for Health Services Research and International Cooperation l'Infanzia, Via dell'Istria 65/1, 34137 Trieste, Italy; phone +39 040 3785 236; fax +39 040 3785 235; e-mail cattaneo@burlo.trieste.it

**Summary**
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 structure of user fees, their predictability, their effects on the use of health services, and the levels of payers' compliance. The aim of this research was to offer a tool for a rational structuring and management of user fees private-non-for-profit hospitals in Uganda Catholic Medical Bureau (UCMB).

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

The ten hospitals were different in terms of size, staff and volume of activities; 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 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 to 1893 million Ush; five hospitals (Kisubi, Comboni, Naggalama, Ibanda and Rutooro) derived more than 30% of their revenue from user fees, while the other hospitals represented less than 30% of the total revenue.

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

As a consequence, high or increasing user fees are associated with reduced utilization of health services. An upward adjustment of user fees is always associated with reduced utilization rebounds when the fees are decreased. The assignment of delegating the Government is a mechanism that could foster equity in access, if properly used. How to be sufficient if maintained at the current level.

Three hundred and three outpatients and 102 inpatients were interviewed during the survey. The hospitals for common problems, such as fever, pain and cough in outpatient clinics, 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 prescribed to outpatients was 2.7, and about 25% of patients received more than the median fee paid by outpatients was around 3,000 Ush, but some patients paid more than 20,000 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 referred that they were so reduced treatment, drugs in particular, in previous occasions.

The cost of care for users is not limited to hospital fees. Non-hospital cost includes the loss of income due to illness and care-seeking, and cost of care-seeking elsewhere. 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 particular 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 it is responsible, in particular, the most vulnerable groups: children, pregnant women, 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, financially accessible (with low user fees) to all the socio-economic strata of the population, the most vulnerable groups, cannot use them; clearly, these hospitals are not delivering their mission.
- the hospitals in the second group (B) have user fees so high that a substantial population, the most vulnerable groups, cannot use them; clearly, these hospitals are not delivering their mission.

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

<table>
<thead>
<tr>
<th>Variables</th>
<th>Group A</th>
<th>Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td>User fees range:</td>
<td>in Uganda Shillings:</td>
<td>in Uganda S</td>
</tr>
<tr>
<td>Outpatients</td>
<td>447 – 1,690</td>
<td>3,126 – 7,0</td>
</tr>
<tr>
<td>Inpatients</td>
<td>2,493 – 1,613</td>
<td>26,081 – 4,1</td>
</tr>
<tr>
<td>User fees structure</td>
<td>mainly flat rates</td>
<td>fees for ser</td>
</tr>
<tr>
<td>Fee for a paediatric admission (malaria)</td>
<td>1,500 – 2,400</td>
<td>12,000 – 2,7</td>
</tr>
<tr>
<td>Bed occupancy rate</td>
<td>86% - 95%</td>
<td>23% - 38%</td>
</tr>
<tr>
<td>Paediatric admissions as percentage of total admissions</td>
<td>47% - 60%</td>
<td>29% - 37%</td>
</tr>
<tr>
<td>User fees collection as percentage of annual running cost</td>
<td>9.5% - 24.5%</td>
<td>73.9% - 87.3</td>
</tr>
<tr>
<td>Government financial contribution as percentage of annual running cost</td>
<td>13.6% - 25.9%</td>
<td>3.3% - 25.2</td>
</tr>
<tr>
<td>External aid</td>
<td>Substantial, continuous and well structured</td>
<td>From very existent</td>
</tr>
<tr>
<td>Administration and management</td>
<td>Good management, good keeping of service and financial records</td>
<td>Poor management, poor keeping of financial records</td>
</tr>
<tr>
<td>Attention paid to equity and accessibility</td>
<td>User fees consciously set and structured to ensure equity and accessibility</td>
<td>Little conc and access</td>
</tr>
</tbody>
</table>

\(^a\) data available for two hospitals only

The user fees system is inequitable by its own nature. It makes the patients bear the cost and it makes the poor pay proportionally more than the rich. For this reason,
introduction and testing, in Uganda, of alternative models of health services for pre-payment and progressive contributions. To this respect, the World Health Organis:

"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 health services"

In any case, as regrettable as it is, user fees are likely to remain the most common form of financing 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 Hospital

- Our study strongly suggests that, above this threshold, the fees seriously complicate financial accessibility of the services. They become an insurmountable barrier for a large portion of the population.
- Some of the hospitals studied have succeeded in keeping user fees revenue within 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 could become stronger.
- At the same time, we are convinced that other external donors, both private and public, must urgently intervene to guarantee the financial accessibility of these hospitals to a large portion 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 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 the services, but also to be conscious of the real cost of the services delivered and to keep a record 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 conditions (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. This will avoid penalising those affected by serious diseases.
- It will also minimise the risk of over-prescription of drugs and services, sometimes resulting in "bribe for services".

6. To promote a rational referral system within the different levels of health units by linking the hospitals of the same region and by implementing a system of partial exemptions.

- Our study suggests that the period elapsing between the onset of a disease and hospital admission averages one month. During this time, patients visit an excessive number of "health care providers", most of them private for profit.
- This event became more common in the last few years because of the chaotic and unregulated 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 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 but referred to the lowest level health units for which Matany is the referral institution;
- patients coming from districts other than Moroto.

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**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 Baron was concentrating on the financing side.

Due to the positions I have been holding in the last few years, I have had only limited opportunities to involve myself intensively with (the financial management of) health institutions, field work or research. Considering the fact that another speaker will discuss in more detail a study concerning the situation at a number of Ugandan hospitals, I will share some observations with you, especially the general in terms.

**Current View**

During the last two decades institutions are increasingly challenged to provide services of sufficient quality at acceptable costs, to meet more and harder demands from the side of donors, the government, the private sector and the public. Providing services of sufficient quality is essential but not enough to sustain a viable 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; 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 respect health-related actions only
3. A less stable economical environment with
- reduced, suppressed an 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 economic decline for years, with in addition growing economical 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 as 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 off late point at financial hardship in church related hos 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 i requires an open well designed account system, which meets following criteria:

1. It allows for refined differentiation of recurrent expenditure and income according to subcategories: e.g. personnel cost, divided in salaries, allowances, gratuities
2. It allows for distinction of expenditure and income according to department or a specific 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 project accounts.
4. It allows for adequate registration of debtors (e.g. patients discharged after signature) and creditors (e.g. suppliers).

In order to design such a system, expertise needs to be made available, the use of 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 project is designed, so that a maximum of standardisation is achieved.

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

**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 a optimum balance between expenditure and income. Although, financial survival is not achieved is hardly done.
Accounts only are not enough. Information concerning the utilisation of an institution provided too. In this way one can match financial data with utilisation data and come to an 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, the accounts of three hospitals, to find remarkable differences in the two major cost-items in comparison of the number of patients per day: cost of personnel and cost of medical supplies, usually accounting for the recurrent expenditure or more. In the most expensive institution government regulations as far as coverage of wards by qualified nurses during full shifts concerned. In the other institution night coverage matched actual patient load. The cost of drugs varied according to habits (against standardised conditions of Joint medical Stores, or using communal storage offering discounts to the buyers), according to the pricing system (all-inclusive rates 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 critical care like "wet production units", trainings, optimal stock keeping. Institutions may co-operate to 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 already run at a low cost. Quick comparison of the running cost of a number of hospitals gives an impression that the cost may even less than $2 per capita, i.e. the number of people directly depend on the cost of 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 more so since at present one tends to compromise on quality of care. Staff levels are not high, competence levels are often at a bare minimum, salaries are low, (and are low too, etc. Most institutions have starved themselves to the maximum they can.

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 complete and well-designed fee system preferably in combination with an insurance system. Making economical disparity among potential patients, e.g. by differentiating the quality of care (giving up the equity principle in essential health services) one may increase income. One may not escape to note that due to poverty in general and the impact of HIV/AIDS in particular. The income of institutions out of patients themselves is limited.

Economic analysis may assist a lot to find the optimum, but there is need for a warning tendency to make ends meet leads to the demand for cost coverage of all different aspects of an institution. This is bookkeeper mentality which suits well a business corporation. For a not-for-profit health institution which seeks to offer acceptable quality services again, one must not consider the cost of care provided. The break-even demand is not a goal in itself. A pricing system should not just be regarded a system using for maximum public health income, but should be considered as a tool too to allow for a maximum public health income, but should be considered as a tool to allow for a maximum public health income.

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

One may stress the need for training of these administrative oriented health professionals. At the non-governmental church related side in the eastern Africa region some 10 master and degree level trainings. However (as I understand from a head consultant who visited most of these institutions), their standards are not always too demanding or do not cooperate but survive in isolation, there is limited exchange with institutions trainings do not always succeed in attracting the most promising students, and who from certain that talented persons survive in the at times managerial hardships of the health care system.

Definitely there is need to look more careful in the kind of health care management training.
contribute to the optimum balance between economic and public health performance.

In order to so one needs to connect expenditure and income data to statistics which 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 in has not been updated to match current requirements. The guidelines for hospital re; the early eighties was an essential step forward. Scores of mainly expat staff utiliti 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 i no standardised reporting system for activities related to CBHC, AIDS (prevention/hoi available. We may continue referring the demands on financial reporting, managemer 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 incre: 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 pro standardisation on national level.

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**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 e issue of public/private partnership in healthcare provision through a contractua co-sponsoring organisations were Memisa Medicus Mundi (called CORDAID sinc 1999)and Medicus Mundi International. WHO had been closely associated in prepari Dar es Salaam as well as with the preparation of a similar meeting in Conakry fo countries. In both meetings WHO played an active role in the clarification of th Contractual Approach in public/private partnership.

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

Heartened by the support and constructive contributions offered to the resolution pr Dar es Salaam and Conakry meetings, and following the advice of WHO headquarter among a number of interested member states, the Chad delegation undertook th
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 argu 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 f 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 c this matter jointly with the Chad delegation and with the secretariat of WHO in Genev:

In this context it should be mentioned that we have commissioned a study, currently i 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 expl for her new policy regarding (personnel) technical assistance, which had been the s 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, striv policies and activities based on their experiences and use the same experiences t and improved practices. As representatives of the civil society NGOs should governs accountable for their policies and actions.

Professor Mercenier reviewed the lack of integration of the PHC concept in health (
practices. His main conclusions were that a number of aspects have been underestimated: these range from the complexity of the concept itself to 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 to conclude that the failing cultural integration entails the lack of accessibility. First important cultural gap: PHC implies scientific rationality and social acceptability but 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 complex—conceptually because the biomedical perspective is dominant;—historically because modern medicine evolved, from within, in the north, while it has 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 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 'cheaper' and that it requires new professional role models including adapted and training.

Dr. El Tom first of all placed developments in PHC in the perspective of internal economic developments and then reviewed the present position of the main stake care: 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 stake should define its role more clearly and complementary to the others.

Mr. Adams, WHO, presented the contractual approach as a promising new tool for services. With respect to the present day challenges facing health care provision stimulates goal orientation, fairness, responsiveness to legitimate needs and respect for the changing internal and external environment mean that governments can and must assume to provide health care on their own. New and diverse types of interaction between stakeholders 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 strengths contracting between government and private parties. Compared to the other tools contracting between government and private parties is 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 11 bishops, various health secretaries from episcopal conferences, rep Cordaid-Memisa, Misereor, Cafod, Stichting Porticus, Medicus Mundi International an 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 intention to empower the poor and towards improving the health care status and health care sector. Based on the principles of solidarity and human rights the representatives 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 as well as 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
actors as well as within their interactions. The call for clearly focused close 

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 bi 

will be available through the Memisa secretariat, PO Box 16440, 2500 BK The Hague

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**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 Tí 

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 f 

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 Fac 

controversial decision to close down his Institute when he left the university on pen 

remaining activities were transferred to the policlinic for tropical diseases and the labc 

parasitology.

We remember him as a very engaged tropical doctor, with a broad minded but str 

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 f 

*Sake Rypkema*