

# health systems

communicating international development research

## Financing mental health services in low and middle income countries

**M**ental illness accounts for at least 12 percent of the global burden of disease. It impacts on social services, housing, education and criminal justice systems. Providing access to effective mental health services may be highly cost-effective. But what is the best way to finance them?

Severe and chronic mental health problems are linked to unemployment and low income. So those most in need are often least able to access services. How can countries correct this inequity? A study by the London School of Economics explores the impact of different financing arrangements on the efficient and equitable use of mental health services.

Through a literature review and 12 country case studies, the researchers examine four broad methods of financing health care: out-of-pocket payments, private health insurance, social health insurance and taxation. They report that:

- Out-of-pocket payments are the main method of financing mental health care in 40 percent of low income countries. But service benefits are distributed according to ability to pay, giving inequitable access to care. So service use falls below socially efficient levels.
  - Private health insurance, mostly bought by employers for individuals, has three problems: it often excludes mental health benefits due to their chronic nature and high cost; those without jobs have limited access; and providers may refuse to insure pre-existing conditions.
  - Under social health insurance (mandatory wage-related contributions, usually shared between employee and employer, and kept separate from other taxes) people with mental health disorders are not financially penalised. But eligibility is based on contributions and often limited to those in formal employment, excluding many with mental illness.
  - Tax-based systems provide universal coverage in theory but in many poorer countries they cannot cover even basic health care for the whole population. So the quality and distribution of services makes access difficult in practice, especially for poor rural communities.
- Whatever the source, if there is no government commitment to allocate the

money according to need, access to mental health services will remain limited. The researchers outline possible strategies for policymakers to improve access, including:

- regulating private health insurance to require life-time cover or open enrolment, set premiums or define minimum benefits
- applying means testing and exempting lower income groups from charges
- using charges applied to higher income groups to cross-subsidise services for poor people
- pooling financing across a population and offering coverage regardless of risk to remove adverse financial consequences of accessing services.

The researchers conclude that reform of financing mechanisms alone is unlikely to be enough to tackle the burden of mental health problems. Future approaches should consider issues outside the health sector, including the stigma related to mental illness, that stop many from accessing services.

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'Financing mental health services in low- and middle-income countries', *Health Policy and Planning* 21(3), pages 171-182, by Anna Dixon, David McDaid, Martin Knapp and Claire Curran, 2006

## Managing and financing health services during conflict in the DRC

**O**ne of the greatest humanitarian management dilemmas in chronic crisis situations is the trade-off between subsidised care, which improves public health, and raising fees, which can help economic sustainability but may also lead to exclusion of the poorest people.

The Democratic Republic of the Congo (DRC) suffers from extremely high mortality rates, armed violence and a weak public health system with no support from central government. Health clinics are largely self-financing. Patients must pay for consultations and drugs.

Researchers looked at the work of three non-governmental organisations (NGOs) in the eastern DRC between 2001 and 2005. The researchers focused on efforts to improve standards of the health services and increase their use.

They studied financial documents,

interviewed patients and staff, and observed the NGOs in action. The three NGOs have different approaches to caring for the poorest patients. One organisation, the International Rescue Committee (IRC), provided poor people with coupons for care. Clinics were then reimbursed for their treatment. The other two organisations, Malteser and ASRAMES, provided free treatment for poor people, but had no set criteria or formal systems in place.

The study found that:

- The three NGOs had different pricing structures to accommodate adults and children or urban and rural residents.
- IRC clinics were in a smaller stable area, allowing them to provide more regular supplies of drugs.
- IRC supervisors visited the clinics on a weekly basis while Malteser and ASRAMES staff visited less frequently.
- For two of the organisations (IRC and Asrames) revenue covered up to 46 percent of a clinic's running costs. However, if poor people were treated free of charge, as in the case of the IRC supported clinics, the clinic's income only covered 16 percent of its outgoings. More people would use the clinics if drug supplies were regular, the clinic staff were

well supervised and health care was free for poor people. Clinics need to receive drugs free of charge along with other subsidies if they are to pay staff wages and meet running costs. In a period of crisis increasing access to health care must take priority over trying to recover costs, NGOs need to:

- put in place a formal system which reimburses the clinic for the care it has provided free of charge
- find methods to ensure clinics are stocked with regular supplies of essential drugs
- agree on a fee structure and compare usage rates in coordination with other organisations, including national health authorities
- provide local supervisors who can spend more time at the clinics.

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'NGO management and health care financing approaches in the Eastern Democratic Republic of the Congo', *Global Public Health* 1(2), pages 157-172, by Dennis Dijkzeul and Caroline Lynch, 2006

# Maternal health in sub-Saharan Africa

## Tackling the skills shortage

**S**ub-Saharan Africa has the worst rate of maternal ill-health in the world. Maternal deaths occur partly because health systems are inadequately staffed to deal effectively with birth complications. How can human resources be managed better to ensure that all women, especially in poor, rural areas, can access good quality maternal health care?

Maternal death rates vary widely among sub-Saharan African countries, from Mauritius, which has around 24 maternal deaths per 100,000 live births, to Sierra Leone, with around 2,000 maternal deaths per 100,000. Sufficient skilled health providers are critical for the delivery of high quality maternal care, yet in sub-Saharan Africa the proportion of trained health staff to general population is so inadequate that the shortage is considered a crisis.

It is estimated that between one million and 1.4 million more doctors, midwives and nurses are needed in this region to supply the essential health services referred to in the Millennium Development Goals. If universal

coverage is to be achieved in the near future for maternal, newborn and child health, the World Health Organization stresses that the large shortages of health professionals with midwifery skills must be filled.

A study by the Nuffield Centre for International Health and Development (UK) reviews the evidence available to explore the implications of shortages of nurses, midwives and doctors for maternal health and health services in sub-Saharan Africa. It also looks at the unequal distribution of maternal health professionals among regions and among health facilities.

The research found that:

- A shortage of health professionals means that fewer health facilities are able to provide 24 hour emergency obstetric care.
- Health professionals are being lost to emigration and HIV and AIDS, and some leave public health facilities for private facilities or international health and development organisations.
- The understaffing of health facilities, especially in remote rural areas, decreases the availability of skilled birth attendants and emergency obstetric care.
- Due to understaffing, existing staff may have to cope with higher workloads and take on tasks for which they are not trained, resulting in increased job dissatisfaction.

Staff shortages and the poor distribution of maternal health professionals are not new problems in sub-Saharan Africa. However, in the past five years some health systems have lost a significant number of staff to emigration and AIDS. In order for the tide to be stemmed, the study makes the following recommendations:

- The number of health professionals with midwifery skills needs to be increased substantially in sub-Saharan Africa if the Millennium Development Goal on maternal health is to be achieved.
- An overall human resources policy must be developed to address the shortages, misdistribution and migration of maternal health professionals.
- Health sector reforms and macro-economic development policy must be revised and must focus on equity and boosting the role of the state.

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'The implications of shortages of health professionals for maternal health in sub-Saharan Africa', *Reproductive Health Matters* 14(27), pages 40-50, by Nancy Gerein et al, 2006

# NGOs take on health services in Afghanistan

**C**ontracts with non-governmental Organisations (NGOs) are seen as an effective way to expand services quickly in fragile states. NGOs currently provide most of Afghanistan's health services. Researchers from the London School of Hygiene and Tropical Medicine (UK) discuss the benefits, pitfalls and long-term implications of this approach.

'Fragile states' include some 40 countries affected by or emerging from conflict or otherwise unable to implement pro-poor policies. A successful pilot programme in Cambodia has encouraged the promotion of contracting out to NGOs in other weak health systems. In Afghanistan, the removal of the Taliban regime in 2001-2002 created new chances to tackle the country's poor health indicators. A joint mission of donors, largely influenced by the World Bank, proposed the use of non-state organisations as the main providers for a basic package of health services in Afghanistan.

Donors now fund contracts with NGOs worth over US\$140 million. Nominally, these cover around three quarters of the population, although not all people may have access to a facility. The remainder are under recent calls for proposals. Twenty-seven NGOs have contracts (17 international and 10 Afghan) lasting 12 to 36 months. They provide a basic package of care, including maternal and newborn health, child health and immunisation, public nutrition, communicable diseases and supply of essential drugs.

The researchers identify several advantages of contracting, such as:

- NGOs were already running most facilities and are experienced in the difficulties of delivering health services in unstable environments.
- The bulk of public health expertise in Afghanistan is within NGOs.
- NGOs may have financial and logistical backing from large international organisations.
- Their motivation is thought to be closer to public providers than the for-profit private sector, but with greater flexibility. They also highlight some areas of concern:
- Competition for contracts, which could improve efficiency and quality, is often lacking in remote areas. In addition, it may not be desirable to replace providers once they have built up local knowledge and networks.
- Contracts may be difficult to specify and monitor. However, in the Afghan case, performance is taken seriously, with different donors monitoring input, process or output indicators and providing different incentives.
- Management costs may wipe out efficiency gains. Extra costs from contracting include expatriate technical assistance and the need for external monitoring.
- Decentralisation to non-state providers means that health system fragmentation is very likely. There is no standard practice for user fees,

drug supply systems and use of community health workers. Variation between providers may lead to advances in service delivery, but also has implications for equity and efficiency.

- The capacity of NGOs to continue to scale-up and sustain quality services is unclear. NGOs may develop the same weaknesses as government delivery mechanisms if they grow bigger.
- Governments in fragile states often struggle to maintain legitimacy. Delivering health services and controlling health workers are seen as key state functions. As a government becomes better established, it may wish to resume control.

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