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Implementing funding modalities for free access: The case for a "purchasing fund system" to cover medical care

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Since 2006, abolition of user fees at the point of service delivery for care and drugs has been one of the pillars of the public health approach proposed by the WHO for scaling up access to medical treatment and care for PLWHA in low-income countries (Gilks *et al*., 2006). However, provisions to define the modalities for implementing this recommendation have not been made. This absence of directives has led to numerous concerns, and even reluctance, among public health programme directors in low-income countries, raising questions about the economic feasibility of such a decision and how to implement a policy that supports free access to HIV/AIDS-specific care and services.

Moving from the provision of free drugs to the provision of complete free care requires the implementation of effective and sustainable funding management. There is a danger that free access without secure and properly functioning funding will quickly work against the desired objectives. The negative side effects of a poorly-run free access policy—breaks in supply, lower service quality, under-the-counter payments—have frequently been described in the economic and public health literature.

In Senegal, several studies have analysed the funding of the national AIDS treatment programme (Ciss *et al*., 2002; Vinard *et al*., 2003), the programme's financial accessibility (Lanièce *et al*., 2003) and the evaluation of extra-ARV costs for patients (Canestri *et al*., 2004). They have demonstrated the inefficiency and drawbacks of payment systems, as well as the benefits—particularly in treatment adherence—of complete free medical treatment. A 2006 study, presented in this book (cf. chapter 13), concluded that complete free access for all medical treatment would be a sustainable expense for the State budget and could easily be covered without disrupting the 2007–2011 funding plan.

In 2007, following these studies, we explored the various avenues through which the decision to provide complete free access to care for PLWHA integrated into the country's public health system could be implemented. This chapter summarises the results of that study. In the first part, we describe and analyse the various alternatives for funding medical care for PLWHA, while taking into account the existing systems for free access to other medical payments or social actors (ex. childbirth, the poor, seniors). In the second part, we present a detailed reflection on the implementation of a "purchasing fund" system—a system that appears to be the most effective for guaranteeing feasibility and sustainability.

A short history of the Senegalese System

In Senegal, patients are charged for public health care services, regardless of the health care structure (rural or urban health centre, regional or national hospital). Only a few medical conditions and services, and care offered to certain social categories are provided for free. Hence, drugs for tuberculosis or leprosy have been distributed free of charge since the colonial era; those who are categorised as “poor” receive free access to care in all of the country’s health structures; in 2005, an experimental initiative in the country’s poorest regions led to free childbirth in health centres and caesareans in hospitals; and in 2006, a national plan to ensure free health care for people over the age of 60 was initiated (Sesame Plan). In 2007, other initiatives were being studied, and the implementation of systems that provide free care became a much-discussed issue, well beyond that of HIV/AIDS.

In the HIV/AIDS domain, ARVs have been subsidised since the national programme’s inception, making them more readily available to people with low purchasing power. These subsidies varied between 50% and 95% of treatment costs, and a complete subsidy was granted to those who were most destitute or who met various social criteria (e.g. PLWHA association members) (Desclaux *et al.*, 2003). The payment amounts had been lowered several times before December 2003, when free access to ARV drugs was announced for all patients living in the country regardless of therapeutic regimen (first- or second-line). Furthermore, HIV testing is free in all of the country’s public health structures. CD4 lymphocyte counts and treatment for certain opportunistic infections (anti-tuberculosis and oral, genital and neuro-meningeal antifungal agents; Cotrimoxazole) are also offered free of charge. The Ministry of Health has also provided various non-specific drugs (antibiotics, anti-inflammatories, iron, etc.), though this has been sporadic, depending on its supply. Hence, medical care is not totally free, since patients must pay for consultations, complementary exams (biological exams other than CD4 counts and medical imaging), hospitalisation and drugs other than those cited.

In practice, many actors involved in medical care for PLWHA have set up procedures to limit patient payments, and these have even resulted in complete free care. These initiatives derive from: the CNLS (National Council for the Fight Against AIDS) through, for example, contributing biological analysis equipment to health structures; the Ministry of Health itself (via the Division for the Fight Against AIDS and STIs), which provides reagents and drugs; health structure (health centre or hospital) directors, who decide not to bill PLWHA for medical consultations; and various associations and national or foreign NGOs who cover all or part of health expenses for PLWHA. These initiatives rely on various funding sources—international (the Global Fund), national, private and public. Hence, medical care for PLWHA is often free or partially free. However, throughout the country as a whole, this free access varies considerably from one region to another, given the timing and depending on the geographical areas and domains of intervention of the various actors. Variability in distribution creates gaps that oblige patients to still pay for part of their care.

Given this context, this study, which aims to compare the merits of different modes of implementation of “free access”, is based on an analysis of the activity and funding of four district health centres (Bignona, Ziguinchor, Thiés and Mbour) and two regional hospitals (Thiés and Ziguinchor). In-depth interviews were conducted with various administrators and health professionals in charge of public structures and administrator associations. Their accounts and those of support organs were studied. These results are not included here since our objective is not to present monographs but to explore fundamental problems.

This sample does not systematically represent Senegalese health structures. However, it gives a rather complete idea of the variety of situations by including structures with high levels of support (from NGOs, projects and community financing schemes) and others that are only supported by the State. The pros and cons of the various situations were then discussed in detail within the relevant services from the Ministry of Health and with health directors from various donors.

The content of the debate has been particularly rich because this study was carried out at a critical moment, when health officials at the highest level were engaged in an overall reflection on the subject. This stemmed in particular from the implementation of a programme that provided free care for seniors and conducted work on social protection in rural settings[1] and a UNFPA evaluation of the policy for free childbirth.

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[1] - Agro-Sylvo-Pastoral Policy Law and a Ministry of Agriculture working group.

There is a wide variety of funding modalities for the different elements of PLWHA care in Senegal. It is therefore possible to compare the advantages and disadvantages of these modalities and to analyse their potential with regard to scaling up HIV/AIDS care.

Five possible types of funding

In fact, five possible types of funding exist, which we shall analyse individually: provision in-kind of products necessary for the consumption of free services; provision of equipment to enable other revenues to compensate for losses created by free access; increased public budgetary allocations; care specifically for the poor, and reimbursement for free services by a third party.

- **Funding by supplying products**

After several years of a relatively complex payment system, the Senegalese authorities announced free access to ARV drugs in public structures. This choice was justified by the specificity, high cost and limited number of these products. A supply system was created that was channelled through the Fann Hospital pharmacy; from there, supply was integrated into the national public distribution system for pharmaceutical products (National Supply Pharmacy and Regional Pharmacies). Studies have shown that difficulties in scaling up in the country's different regions resulted more from problems in monitoring these supplies and managing drug stocks than from funding needs (Collard and Taverne, 2005; Diouf, 2007).

This free supply system functions relatively well for drugs as specific as ARVs or anti-tuberculosis drugs. The problems are relatively more complex when treating opportunistic infections, because of the variety of drugs that must be managed. Moreover, the experience has been less positive for kits to offset free childbirth in terms of their definition, cost and transport (Ndiaye and Dieme, 2007).

Logistical problems

Thanks to funding from the State or international donors, drug donations for opportunistic infections have been distributed in recent years.[2] They are significant, but do not cover the entire need. The contributions are decided at the central level on the basis of available funding rather than the needs of the health structures.

Depending on the health structure, these contributions require specific management by the recipients. Sometimes, these drugs are found in consultation units, sometimes in the office cabinet of a health-centre social worker, sometimes in the structure's pharmacy, etc. For the moment, this system works relatively well, but it will be difficult to control these stocks at the current level or if they increase in proportion to need. The problems will be related to real assessment of need as much as the possible "outflow." Since this involves the same drugs as those sold at pharmacies, the separation could be difficult to maintain given the urgency of certain demands and the pressure of some temptations. A patient's path to finding available drugs will become more complex between the different suppliers (free pharmacy vs. paying public pharmacy vs. the private pharmacy).

Tests and reagents for laboratory exams have also been donated to several structures. Generally, these are entrusted to laboratories, but even then, keeping stocks separated is not easy for products in everyday use.[3] The logistical problems did not arise too often because, in the experimental phase, contacts were frequent but the reliability of these supply systems is cause for concern, especially in the more remote structures.

Organisational impact

The risks of poor management and waste do not originate in free access itself but in the failure to quantify these donations. These stocks are not always recorded in a common system and the structures sometimes do not even know the amount donated. Therefore, a structure can be under the impression that it will recover its costs while its operating costs are covered by donations (when stocks have not been compartmentalised precisely).

The first major drawback of this type of funding is that is removes responsibility from the director of the health structure. The problem can be blamed on the fact that the centre was not supplied or that the

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[2] - 32 million CFA francs in 2005; 38 million CFA francs in 2006.

[3] - This is the case for nearly all reagents used in the initial assessment for antiretroviral treatment.

donation was not appropriate. The indicators on which donations are based are always difficult to establish and give rise to much discussion (as was the case for delivery kits). Senegal is committed to the principle of decentralisation, founded on health structures maintaining control over their orders. Having the health structures purchase products directly (by going through a wholesale group) is the simplest system for ensuring this autonomy.

The second drawback for funding through grants comes from the fact that workload (in terms of time and quality) is not taken into account. Given the prices for ARVs, services account for a relatively low proportion of treatment costs, but this proportion will increase, as it does for all chronic diseases. In fact, payment for services plays a critical role in motivating personnel in most of the country. The difficulties encountered with free childbirth clearly illustrate these problems.[4] Non-payment for services can lead to unmotivated staff. This will have a negative impact on the quality of services if no other mechanism is proposed.

- **Funding through equipment donations**

Certain donors prefer to fund the purchase of equipment under the pretext that aid for operating costs would not be “sustainable.”

The preference for investment

Funding for increasingly large investments reveals difficulties that are particularly sensitive to sustainability when equipment maintenance and operation is left to local resources. In fact, funding donated equipment is certainly easily administered (invitation to tender) with maximum visibility (media coverage of delivered equipment that is new and labelled!). It is easier for a donor to manage this type of funding simply because the donor handles the acquisition and distribution but is not involved in controlling the equipment’s final use. In theory, an invitation to tender is easier to control than a subsidy system.

Even when theoretical needs remain high, the equipment’s use is often limited by the capabilities of those using it (level of training and frequent turnover of trained staff). In short, capacities for absorption will also be limited by the necessary expenditures for operation and maintenance of this apparatus. In many countries (including Senegal), some equipment (particularly the flow cytometers) is not operating, due to poor maintenance or lack of properly trained staff. To compensate for these drawbacks, international aid is being distributed more evenly, with the aid organisations taking more responsibility for ongoing expenses.

Compensating losses through new revenues

Many donors (particularly the World Bank) have made large donations of laboratory equipment. The external effects on the laboratories’ overall activity are significant both in obtaining new revenues from other exams and appreciably improving staff motivation. However, it is difficult to assess this impact or even to gauge the real financial gains. This so-called equivalence (additional revenues compared to lost profits from free exams) does not encourage transparent management and could often be used as an excuse for excessive fees. Many structures have already set out to create capital through a high number of exams that are often unnecessary, unused or useless. Indeed, the funding of equipment runs the risk of exacerbating the biomedical approach and the pursuit for technological sophistication that is one of the major problems facing health systems in Africa.

- **Funding through budgetary allocations**

Increasing budgetary allocations appears to be the simplest way to fund administrative expenses, all the more so since budgetary aid has become one of the preferred channels for international aid. A significant effort has been made to improve the budgetary circuit. Nevertheless, the current situation must be taken into account before advocating the use of this modality for urgent expenses in the short term.

Funding at the district level

First of all, it is necessary to carefully consider the role played by budgetary allocations in funding

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[4] - The midwives received compensation linked to payments for deliveries.

health structures. At the district level, less than half of revenues come from the State. The share is greater if public sector salaries are counted, but the revenues themselves play a role that is proportionally greater because they are much more easily mobilised. With decentralisation, public funding is carried out by the local authorities, which use the Decentralisation Allocation Fund (*Fonds de Dotation de la Décentralisation* — FDD). The local authorities make a very modest contribution from their own resources.

However, the structures are normally informed about the availability of these funds in the month of August during the current year. In October, the structure administrators send their orders to the mayors, who generally sanction expenditures only in November or December. The payments are then made by accountants in the Treasury (during our investigation, in December no payment had been made and a large proportion of the assigned funds had not been disbursed). These obstacles are caused either by gridlock at city hall or long delays at the Treasury. Meanwhile, in order to ensure that structures survive, assigned funds are disbursed from the central level biannually (for fuel, maintenance, office supplies). In the study sample, these funds only amount up to 5.6% of the public allowance. These constraints must be taken into consideration if funding through the channel of the State budget is to be ensured.

The increasing of budget allocations (assigned funds or the Decentralisation Allocation Fund) is inevitably constrained by annual budgeting and by the current rigidity of the funding process. A quick analysis of the timing of this public spending — while modest — confirms this problem. The accounting system (particularly with its requirement to pass through the Treasury's local services) was designed by the Napoleonic administration for tasks that are mainly derived from sovereign power. It appears difficult to adapt these volumes to the scale of activity produced.

To indirectly fund structures that have no legal autonomy, it is also possible to envision funding the management committees that have association status. Regional mechanisms used to collect invoices have also been proposed within the framework of the Sesame Plan, though this had not yet been implemented at the time of this study. Nevertheless, it appears difficult to entrust these payments to a private structure on the basis of rules for public contracts.

Funding public institutions

Increasing the allocation to public institutions seems to be a less rigid channel. This system already operates within the regional hospitals, and it is a matter of granting administrative autonomy to the district hospitals, thus greatly facilitating funding modalities. This reform is a large-scale task because it would eliminate administrative associations. The district hospital would then be under the direction of an administrative council, and the chief doctor would have greater administrative power. This more "entrepreneurial" reasoning is fully compatible with funding an activity. However, if the funds are used directly by the institution, payment of the subsidy will follow the public funding circuit (going through the Treasury services annually or biannually). It will be difficult to adapt to changes in the activity. It is important to find an automatic and adaptive mechanism extending to the most peripheral levels.

- **Expanding the care system for the poor**

Confronted with budget constraints, funding modalities targeting specific individuals have often been sought, particularly in extending systems to care for the poor. Analysis of these modalities proves worthwhile because it already involves a large number of PLWHA. In each structure, in both health centres and regional hospitals, a social worker is in charge of identifying and monitoring poor patients. In general, the social worker also plays a central role in the care of PLWHA and is responsible for the preliminary social survey prior to initiating ARV treatment.

Although the preliminary social surveys of patients prior to initiating ART and the surveys determining payment exemption status for the poor are treated in two different files, they are usually carried out by the same person. Exemption procedures are also renewed for each medical act for both the poor and PLWHA, creating redundancy in the files.

Those in charge of health structures often complain about the workload caused by free care for the poor, but the share of the budget devoted to exemption of payments remains quite modest. At the district level, only five people classified as destitute received services each month, and it was estimated that only 1.6% of expenditure was not recovered because of these exemptions. This is a very low amount in the poor provinces, especially when compared to the 10% that is often cited in

implementing the Bamako Initiative. At the regional-hospital level, administrators emphasise the high number of exemptions (approximately 500 services without payment per year) but the percentage of revenues lost is still relatively low (less than 1%).[56]

Given budgetary constraints, funding medical care for PLWHA with funds for the poor seems inadequate. In a structure that is highly involved in this care (such as the "Silence" Hospital in Ziguinchor), 75% of the poor are PLWHA. And yet, the percentage of people who are exempted as poor is still low. Therefore, the situation risks becoming untenable as patients face impoverishment as a result of their deteriorating physical status. Even if the number of poor patients increases considerably, the system could only cover some of the PLWHA, and no other cases, which would inevitably cause tensions.

The situation is less serious in the regional hospitals where the proportion of PLWHA in the total number of patients is relatively lower. As an example, we gathered statistics for exemptions over a five-month period at the Ziguinchor Hospital for 2006

Regional hospital	Number of persons exempt					
Ziguinchor	Laboratory tests			Drugs		
2006	**Total: non-paying**	PLWHA	>60 years	**Total: non-paying**	PLWHA	>60 years
January	**13**	1	2	**22**	4	2
February	**12**	2	0	**43**	3	3
March	**18**	2	1	**36**	2	0
April	**14**	3	2	**31**	1	3
May	**10**	2	1	**41**	2	2
June	**5**	0	0	**21**	1	1

Table 1: The number of PLWHA among those exempt from payment at the regional hospital in Ziguinchor, 2006.

In this example, which can be considered fairly representative, the burden of PLWHA appears relatively low and comparable to that of exemptions for seniors. Moreover, the number of unpaid services appears very low in our view for a structure that treats approximately 120 PLWHA, and it is highly probable that the situation is going to rapidly deteriorate. In fact, the information system does not make it easy to determine whether these are the same people who are exempt from payment for laboratory tests and drugs (as well as other services).

This example demonstrates the difficulty in using mechanisms to treat the poor; especially with scaling up, the number of PLWHA will grow considerably.

- **Reimbursement for free services by a third party**

Rather than target people, it is often more useful to target invoices and specific care. Various experiences in reimbursing invoices were implemented in Senegal by different partners (NGOs, community financing schemes and the State).

The need to strengthen administration of one's own resources

These mechanisms aim to strengthen a health structure's system for managing its own resources. Despite all its adverse effects, one of the Bamako Initiative's chief positive impacts was to increase the involvement of health structures in managing their own resources. Revenues earned in health centres cover the greatest share of costs for drugs and a significant share of staff wages. These revenues are generated by administrative associations (health committees), which collect revenue and decide how it will be spent in mutual agreement with the chief doctor (and with a double signature). The chief doctor is usually quite involved in the management of these funds, and relationships are not always easy in this *de facto* co-administration. Equilibrium is established with the necessary checks and balances, and the partners manage to limit the risks of blocking expenditure.

However, even if the amounts generated sometimes reach a high total, they are low relative to the needs of a health structure (on average less than two euros per habitant in the sample, 0.8 euros per habitant for drugs). Even if reference to "health committees' wealth" is becoming commonplace,

[5] - The identification and provision of care for "paupers" in health care systems in French-speaking Africa present insurmountable problems. See Ridde, V. (2007).

counting on their own resources to fund free access is not reasonable, and certainly dangerous in principle, as this may discourage administrators. On the other hand, the principle of free access can strengthen this management if the funding mechanisms allow for increased revenues by making demand from a third-party payer solvent.

In several health structures, care for PLWHA was reimbursed by a donor through the intermediary of an NGO (FHI in Ziguinchor, Enda in Mbour and Médecins du Monde-Spain in Saint Louis, for example). The care system did not require additional documents and was easily managed by a local office. The payments quickly adapted to demand. However, these practices corresponded to a project rationale that was temporary and variable. Meanwhile, the population's payment habits change slowly. With the termination of FHI projects in 2006, for example, the amount of unpaid invoices suddenly increased. The NGOs did not have a proper control system to verify the accuracy of invoices both in terms of what kind of service was performed and the identity of the beneficiaries.

Potential for community financing schemes and health insurance

In some countries (for example, Rwanda), some donors (World Bank, Caritas) have given funds to community financing schemes for PLWHA, thus ensuring coverage that is identical to that received by paying members and without having to generate reimbursements for individual invoices. We could not identify similar cases in Senegal, either because the community financing schemes were too few,[6] or because no donor wanted to take on this responsibility. Mutual aid projects are being studied by the coordination organ of the community financing schemes in Thiès. The principle would be that the community financing scheme would contribute its own funds for the care of PLWHA. Some community financing schemes will have already developed this system to cover one or two poor people. However, these schemes have very limited funding, which could raise questions about the status of these "free" members in the scheme's administration if they become numerous.

Community financing schemes, in fact, may play a social role more than a financial one: many only survive because they are subsidised not only by an international donor but through preferential pricing from the hospital. For example, the Saint Jean de Dieu Hospital in Thiès uses part of the community financing scheme network to help parishioners (with prices that are twice as low). It is uncertain whether these schemes make it possible to reach those who are the poorest and the least socially integrated. In any case, though useful in other aspects, these experiments remain too fragile to take on an additional load.

Senegalese law requires businesses to organise medical coverage for their salaried employees. Some are grouped under IPMs (*Institut de Prévoyance Médicale* – Employer Health Insurance Schemes) which cover their care and could therefore be led to cover PLWHA (Laborde-Balen and Taverne, 2004). However, this care is primarily delivered in the private sector (pharmacies or medical practices). In all cases, the percentage of PLWHA in the formal sector still remains relatively low. Nevertheless, useful lessons can be drawn from these funding mechanisms. One of the fundamental principles of these reimbursement systems is the principle of a starting-provision of funds, which is gradually audited based on justified expenditures. This provision, which was included in the Sesame Plan, is essential for ensuring trust from the service provider.

Reimbursement of costs by the State

Most regional hospitals are reimbursed for invoices for caesareans that theoretically should be free. The invoices are transmitted to the Division of Reproductive Health and then paid in addition to the subsidy from the institution. Proof of expenses is verified by a withdrawal, and even if the amount of this withdrawal (which does not always cover the costs of the necessary service package) may be under discussion, the justification system is relatively simple.

A similar system has been set up for seniors. The hospital sends invoices to the Seniors Bureau of the Ministry of Health. Analysis of these invoices and calculating the reimbursed service package is much more complex than with deliveries. It is still too early to assess this recently implemented system. Nevertheless, one can already speculate about the advisability of adding a similar system for PLWHA with control for invoices assigned to an AIDS Division.

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[6] - There are only three communities financing schemes in Ziguinchor, covering less than 1000 persons in total. The situation is similar in Mbour. There is none in Bignona. Thiés (with approximately 40 community financing schemes) is an exceptional situation, linked to the region's history and sociology.

The various divisions under the Ministry of Health have not been trained in these invoice analyses, nor are they responsible for regulating the multiple reimbursements demanded by the various health structures. In short, considerable gains in efficiency could be obtained by implementing joint management and by avoiding compartmentalisation of different reimbursements. The services are different but are often justified, based on similar principles (pricing techniques), and concern the same partners (contractualisation and accreditation of structures). Hence, the notion of a joint purchasing fund appears to be an alternative worth analysing.

The feasibility of a purchasing fund for PLWHA

The practice of "funds" has extended into developing countries for various reasons (targeting, visibility and absorption of funding, management control). This may appear contradictory to the 2005 Paris Accord recommendations (integration of aid, use of unique and local procedures), but the principle of a fund can also be a tool for putting them to better use (pooling resources, improved governance).

Thus, it is important to clearly identify the characteristics of the fund that is to be implemented and to analyse how it can cover PLWHA. With the existence of several types of funds, we will begin be discussing these various types, then we will investigate the status and organisation of a fund for PLWHA care, the modalities for accreditation and contractualisation, and fund-raising to study the feasibility of this kind of fund in the specific case of Senegal.

- **The different types of funds**

Generally speaking, there are four types of funds. These can be categorised by: the funding recipient, the way beneficiaries are selected, the extent of coverage they provide, and the different funding mechanisms.

Type of fund	Subsidizing funds	Equity funds	Performance aid funds	Purchasing funds
Recipient	Inputs	People	Activities, ratios	Service package
Selection	Need for services	Poverty criteria	Public-health priority	Demand for certain services
Coverage	Supplementary	All for those selected	Supplementary	All for the chosen package (except co-payment)
Mechanism	Strengthening supply	Making demand solvent	Strengthening supply	Making demand solvent

Table 2: Summary of the main characteristics of the four main types of funds.

– Subsidising funds are the most widespread; most projects include them in some form. They finance inputs (allowances, operations, materials) that are often complementary to State budgets or to their own receipts, and contingent on the needs for services (identified by donors in negotiation with authorities);

– Health equity funds were initiated by NGOs (in Cambodia, for example [Noirhomme and Thomé, 2006) and are now being used to fight poverty. They make some of the demand from certain target populations solvent, on the basis of poverty criteria (but could also be based on sociological or medical attributes);

– Performance aid funds strengthen supply, complementing State budgets on the basis of performance indicators. Given the complexity of these indicators, they were set up, temporarily, on an experimental and small-scale basis. Some countries, however, (for example, Rwanda) would like to use them as part of a national strategy (Soeters *et al*., 2006);

– Purchasing funds draw on certain aspects of each type of fund, and therefore they often share points in common. They follow a different logic, however. Purchasing funds finance demand, like health equity funds, but are essentially based not on people but on a services package. Health equity funds may also focus on certain services, but only for particular populations. Purchasing funds have universal coverage, even if the chosen services package could be focused more particularly on one part of the population. For example, the wealthiest will choose other services. In this case, the selection criterion depends on patients' choice rather than revenue.

Purchasing funds differ from performance aid funds in that they finance the demand and not the supply. The package that is financed by purchasing funds could also be pegged to public health principles, but the patient remains a primary decision-maker. Purchasing funds could be linked to accreditations that ensure minimal quality of service, but the financing will depend primarily on the quantity produced — in other words, the patients' choices.

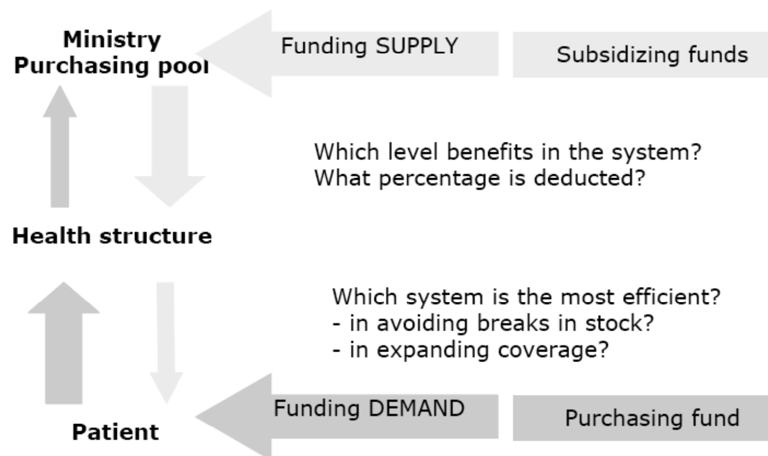

Figure 1: Funding supply and demand through a Purchasing Fund.

These different funds could be complementary. Subsidising funds could improve the quality of services (training or equipment, for example) offered by a structure, so that it can better respond to the demand that is made solvent by purchasing funds. The type of fund used depends on the services package offered, the power given (or left) to patients, the capacity of the information system to measure services rendered, and the nature of services that cannot easily be quantified. Political interest in purchasing funds comes from the willingness to give more power to patients, who are increasingly well-informed, but whose financial means do not allow them to bear the costs of care.

- **The status and organisation of a fund for PLWHA care**

This type of fund is unique insofar as it addresses a specific population (as in a health equity fund) and is for a particular service (as in a purchasing fund). Nevertheless, in its logic, it is closer to the purchasing fund because it does not entail the difficulties in selecting patients on the basis of income criteria involved in the health equity fund.

The main problem with these funds is ensuring their proper management. Dividing up the State should not be an opportunity to reduce controls. But the control system must correspond to a rationale of fiduciary funds (based on rules set by officials) and not necessarily the sovereign functions of the State (with its slow pace linked to centralisation from the Treasury accountants). Regular audits could be conducted and funding sustainability correctly linked to good management.

Different statuses are possible by bringing in participation from civil society, the beneficiaries themselves (PLWHA), the health professionals, the private sector (outside of the health domain), and particularly the financial sector (banks and micro-credit[7]). We believe it would be useful for international donors also to be included on the administrative council. State representation is an issue that must be carefully studied. In any case, the Ministry of Health would retain supervisory authority.

The creation of these funds should provide an opportunity for reflection on new modes of governance. It is uncertain whether models emerging from a kind of "health democracy" would be the most efficient. This type of orientation in managing health structures often leads to blockages (the revenues accumulate and end up being spent on heavy equipment, such as an ambulance). Purchasing funds are founded on a logic that is technical and administrative, converging toward a new "entrepreneurial"

[7] - Micro-financing cannot fund care for HIV/AIDS patients, but these institutions can act as channels to ensure improved management and allocation of resources (for example, community banks in rural settings).

logic for autonomous institutions (and no longer for administrative associations). Policy choices concerning the care services packet and accreditation conditions are made upstream.

The level of decentralisation of funds depends on the number of patients receiving care. A certain threshold is needed to develop sufficient expertise to negotiate accreditations and analyse invoices. During implementation, a central agency would be sufficient but with the development of the decentralisation of ISAARV (Senegalese Initiative for Access to ARV), the regional level appear to be more suitable. A service covering between 300 and 600 PLWHA in 10 structures could continue with light administration. In the long term, if the fund covers many other risks and people, a structure at the level of each district could be envisaged later. Additionally, with this decentralisation, participation from local authorities could be envisaged, to encourage them to also increase their funding to the health sector. Experiences such as the DISC Project (USAID) have shown that the difficulties in local funding result from administrative rigidity as much as meagre local resources. The mayors may be incited to contribute to these purchasing funds through their participation in the management committees.

- **Accreditation and contractualisation**

The process of accreditation has already been conducted by the Division for the Fight Against AIDS and STIs (DLSI), which carefully monitored conditions when each service provider started offering triple-therapy treatment. Financing through a fund could also be an important tool in verifying and ensuring that service quality is maintained.

Conditions for purchasing services can draw on the efforts developed by many projects that have worked on community financing schemes (pricing, withdrawals). In the rationale for funds, the information system becomes a determining factor for funding. Health structures are therefore more motivated to carry out this demanding task; nevertheless, web-based data-processing tools can greatly simplify this administration. On the other hand, this calls for monitoring of the quality of the data, which could be biased for financial reasons. Thus, the contractual policy must include monitoring, supervision and dialogue that will truly allow the system gradually to evolve.

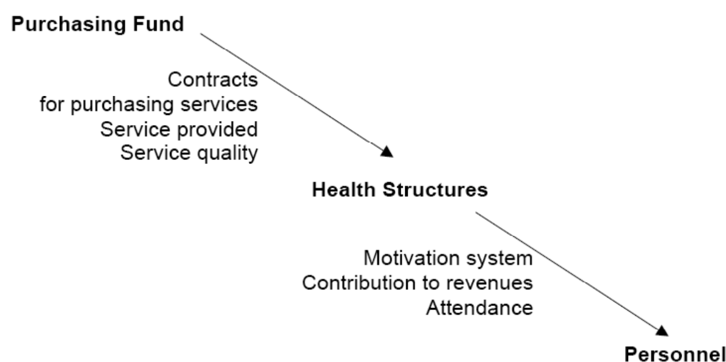

Figure 2: Purchasing funds at the source of a two-level contractual policy.

The contractual policy extends out to two levels, between the health structure and the purchasing fund and between the health structure and staff. This second aspect is essential for ensuring that personnel are sufficiently motivated to improve service. In the beginning, it could take on simple forms linked to attendance, since absenteeism is one of the main problems. Financing staff through the intermediary of a purchasing fund offers a much more flexible performance-related system than global measures to raise public sector salaries.

- **Fundraising**

The rationale for purchasing funds prioritises expenditure analysis by recognising from the start the necessity for public or international funding. It is better to recognise this situation in a number of health domains for a poor population than to create mechanisms that have considerable transaction costs and that collect ridiculously low amounts. This requires the creation of a system to manage the funds efficiently. In the end, institutional sustainability will ensure financial sustainability.

In this way, the State would be further encouraged to commit to health care funding, whereas the recovery of costs often poses an opportunity for the State to disengage. On the other hand, autonomous management of these funds ensures a clear separation between the State's sovereign functions—especially in defining standards and strategies—and the function of public health funding. The Department of Health carefully maintains its prescribed role. The funds can be fully autonomous by being under the coordination of the Division for the Fight Against AIDS and STIs.

Several bodies (Global Fund, ESTHER, etc.) aim to cover a precise number of PLWHA. The purchasing fund offers them a simple mechanism for achieving this objective. Other resources (from the diaspora and private sector) can be better channelled, rather than distributed to numerous projects that are difficult to control, maintain or even complete. Purchasing funds are organised quite similarly to therapeutic trials. The Regional Centre for Research and Care at the Fann Hospital (CRCF) is well accustomed to reimbursing care for certain patients; a purchasing fund ensures treatment continuity for patients who have completed trials.

Managing purchasing funds can enter into the logic of these "common funds" from donors, which are often a transition towards a sectoral approach. Donors are increasingly devoting their resources to this type of approach and, due to the problems in the budgetary circuit, are seeking alternative funding mechanisms. These funds could constitute an interesting structure, while remaining open to other services if the domain of free access expands. This is not a case of creating temporary structures by "pooling aid"; rather, it involves creating national institutions that are responsible for an essential role in funding health care.

Conclusion

This exploratory study reveals that a diverse range of systems contributes to funding care for PLWHA in Senegal. These various systems all help to limit patient payments, though with little coordination, and to achieve free access at the treatment sites. Pursuant to this study, and taking into consideration the administrative organisation of the health system, it appears that implementing a treatment fund based on the purchasing fund model would be the most suitable system for implementing universal free access to care for PLWHA.

The principle behind purchasing funds may seem like a restructuring on the scale of the funding system. In fact, it only extends and synthesises past experiences. Purchasing funds follow the logic of insurance in several ways: the buying of a predetermined service package (contractualisation and accreditation); the use of the sectoral approach (by "pooling" public, private and international resources); results-based funding (a payment for services rendered); and management that is independent of public budgetary bottlenecks (with the participation of civil society). While other funding mechanisms for free access risk harming the management system for health structures, the purchasing fund preserves the autonomy of health structures in managing themselves, one of the principles gained from past reforms. Moreover, a purchasing fund can be implemented in a way that complements other systems already in operation. Thus, it enables a gradual transition that will not clash with the current situation.

The rationale behind a purchasing fund could be applied to different situations. However, it would be unfortunate if a multitude of funds were set up for each pathology and each type of patient. Considerable economies of scale could be obtained through a common service. In the long term, an entire basic package for the whole population could be financed through a common purchasing fund. Systems for different regimens could be organised, but a number of services could be pooled (billing, contractualisation, accreditation). As with many countries that have a social protection system, the most essential health care funding occurs outside the actual Ministry of Health budget. Nevertheless, the Ministry plays an important role as the supervisory authority for these funds and must even provide a general grant.

Senegal's low HIV prevalence, limiting the economic burden generated, the quick reaction of the health system, the quality of organisation of the care system for PLWHA and finally, the guaranteed financial commitment from the State in the fight against this disease combine to create a favourable context for applying the WHO recommendation for complete free access.

The search for the most efficient modalities for funding free access is also a critical issue for countries that have a higher HIV prevalence. If a country's need is considerably higher, international and national funding is also increased. The concept of a purchasing fund may represent a viable avenue

for funding in these countries. Interestingly, this can be evaluated first in a country like Senegal with low prevalence before envisaging its feasibility in countries where the epidemic's economic impact would be far heavier.

Complete free access to care for PLWHA answers a public health imperative endorsed by the WHO, which — since 2005 — has recommended its implementation as soon as possible. This recent recommendation caused an upheaval in reflections on health care funding and the development of social protection systems, seconded by various international organisations (World Bank, International Labour Organisation). A highly critical evaluation of the last two decades of promoting financial participation from patients in poor countries has revived the idea of free health services to promote access to care. Nonetheless, without a bold policy for health care funding, there is a high risk that this principle of free access for certain services will be called into question, even though these services are critical from a public health standpoint (Gilson and McIntyre, 2005). In some countries, overhasty decisions by policy-makers to provide free access without a real funding strategy has weakened health structures and discredited the notion of free access.

Providing complete medical care for PLWHA provides an opportunity to initiate this process of free access. The fight against HIV/AIDS provokes further reflection on the reform of health care systems.

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