HEALTH POLICY AND PLANNING; 8(3): 267-274 

# Research report

# The Bamako Initiative: where is it going

KARA HANSON[1] AND BARBARA MCPAKE[2]

*[1]Harvard University, USA, and [2]Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, UK*

The Bamako Initiative was launched in September 1987 as a means of increasing access to essential drugs through community participation in revolving drug funds. The response of the public health community was highly critical of the Initiative. Issues raised included equity and access; problems of integration, management and logistics; the relative importance given to drugs; and sustainability and dependency.

The Initiative has evolved in part in response to these criticisms, now focusing on increased accessibility and quality of services, and the strengthening of health system management. An evaluation carried out in 1991 reviewed the main areas of criticism. In all areas, a relative approach was found to be useful. For example, while substantial problems of equity and affordability exist, in some cases, services of a given quality have been made available more cheaply than before.

The most important outstanding policy issues were considered to be: the need to strengthen community support mechanisms for those without economic access to services and to develop payment mechanisms compatible with seasonal income patterns; the feasibility of regional cross-subsidization of revenues; the development of an improved model of community participation; and the nature and extent of external support to the programme.

## Introduction

The Bamako Initiative was announced at a meeting of the WHO Regional Committee for Africa in September 1987, in response to the severe financing problems experienced in sub-Saharan Africa during the 1980's. It was based on a premise described in a speech by the Executive Director of UNICEF, Mr James Grant:

> " . . We . . . are discovering that there is a key to making PHC centres work effectively, that there is one element which, when available on a dependable and affordable basis, draws families to the centres and for which the majority of families are actually willing and able to pay. The component of PHC which may prove most capable of filling this catalytic role is the provision of essential drugs for all."

In the resolution adopted by the African Health Ministers, the main mechanism for this revitalization of PHC was to be the financing of health services through community participation in revolving drug funds. This formulation was evident in the resolution itself, in which health ministers agreed to:

> "a) encourage social mobilization initiatives to promote community participation in policies on essential drugs and maternal and child health at district level;
> b) ensure a regular supply of essential drugs of good quality and at lowest cost, to support the implementation of PHC;
> c) define and implement a PHC self-funding mechanism at district level, especially by setting up a revolving fund for essential drugs."

The response of the public health community to this new Initiative was highly critical of this approach to strengthening PHC being advocated by UNICEF. A number of articles were subse-

quently published which directed criticism at five main areas (see, for example, Kanji 1989; Lancet 1988; Chabot 1988; Garner 1989).

First, problems of equity and access were highlighted. UNICEF's assertion that people are "willing to pay" for health care was contrasted with their *ability* to pay, and the cost in terms of household welfare which may be incurred by switching expenditure from other goods and services towards paying for health care. The difficulties associated with operating exemption mechanisms for the poorest were also mentioned.

Second, the problems of integration of Bamako Initiative (BI) activities with the rest of the health system were emphasized, in particular the problems of strengthening primary level services without additional resources being injected at higher levels of the health system. The Initiative's activities risked becoming yet another vertical programme.

Third, the management and logistics difficulties associated with community-based revolving drug funds were highlighted: constraints included the weak levels of managerial skills at community level, poor supervision, and, for some countries, the inaccessibility of health facilities for large parts of the year making drug distribution systems unreliable. The difficulties of extending small "pilot" projects, which may have received exceptional amounts of technical and financial support, to national level were also raised.

Most critics raised the problem of the focus on drugs as the main locus of cost-recovery efforts. Fears have been expressed that the financial imperative imposed by cost-recovery schemes will undermine the achievements of the WHO Action Programme on Essential Drugs in improving prescribing practices.

Finally, problems of sustainability and dependency were stressed: only partial cost recovery was aimed at in some projects, raising the question of what will happen when the supply of free drugs runs out. The result could be a continuing reliance on external funds for drug provision. Associated with this were the difficulties of converting the local currency generated by the revolving drug funds into foreign exchange for the purchase of drugs.

Since the declaration in 1987 the Bamako Initiative has evolved from its initial formulation. This is due in part to a response by the Bamako Initiative Management Unit at UNICEF to the criticism which was directed at the Initiative. A second contributing factor has probably been the gathering of implementation experience. The initial focus on drug revolving funds reflected too narrow an approach to the strengthening of PHC, and was not practical in all circumstances given countries' different starting points.

A recent external evaluation of the Bamako Initiative reviewed the available community financing literature and studied the implementation experience of five African countries (Burundi, Guinea, Kenya, Nigeria and Uganda), one of which has not formally adopted the Bamako Initiative framework (McPake et al. 1992). Drawing on case study material from these five countries we shall attempt to determine whether or not the initial concerns about the Initiative have proved to be founded, and to define some of the outstanding policy issues.

The concept of a *relative improvement* has been a very useful concept in considering the issues associated with the Bamako Initiative: it is difficult to measure changes in absolute terms, and the interactions between health seeking behaviour and cost sharing systems are complex. Looking at improvements in relation to the available alternatives and at changes at the margin may provide more useful insights. Given the high level of controversy which has surrounded the annnouncement and subsequent implementation of BI activities, we believe it is essential to consider the successes and failures of the Initiative in relation to other programmes which aim at improving the access to and quality of peripheral health services.

The criticisms of the Initiative mentioned above are clearly not only relevant to the Bamako Initiative. They reflect more general concerns about how the health sector should be financed and the impact of financing changes, as well as widespread problems of health system management where existing structures are weak. Where possible we will use the criteria of relative improvement in assessing the available evidence about the successes and failures of the Initiative

in addressing these issues. Before doing this, however, we must define what we mean by the Bamako Initiative.

## The Bamako Initiative: what is it?

It is difficult to define precisely what type of activities constitute the Bamako Initiative. This is due partly to a deliberate "flexibility" in the conceptual framework, through which countries are free to define their own programmes in the context of the needs of their health care systems, and on the other hand, to changes in the orientation of the programme over time.

A review of official Bamako Initiative documentation reveals that policy evolution can be discerned in a number of areas. One of these is the timeframe over which it is expected that self-reliance can be achieved (initially anticipated to be 5 years, but more recently acknowledged to depend on the individual economic circumstances of each country, and in some cases requiring a long term donor commitment to support recurrent costs). As UNICEF (1990) has stated: ". . . For countries hard-hit by economic recession and the AIDS epidemic a major financial burden will have to be assumed by donors to respond to needs beyond the normal levels of support, both in type (including recurrent costs) and quantity, given the low financial capacity of governments and the large proportion of low-income and even destitute families."

The common perception of the Bamako Initiative as requiring a fee-for-service system of payment for drugs is similarly not borne out by a review of recent literature. It is clear that a variety of payment mechanisms including payment for drugs, payment per episode, prepayment schemes and even rather more unconventional methods such as registration fees and earmarked local taxes are acceptable cost-recovery mechanisms (UNICEF, draft, 1990). Although country experience suggests that revolving drug funds, through fee-for-service payment mechanisms, constitute the most common form of BI (Bamako Initiative) programmes, others are adopting programmes which are more broadly aimed at strengthening PHC, and at reorienting health care systems. The paucity of prepayment forms of financing mechanism more likely reflects their relative scarcity in Africa than a fee-for-service bias within the Initiative.

Given these provisos about the flexibility and evolution over time of the Initiative, and using what we know about the four BI programmes studied in-depth, we can begin to define the Bamako Initiative on the basis of a number of "common elements". First, all have some element of "community financing", defined as revenue raised and retained at local level. Second, community health development committees exist in all four BI countries in some form. Finally, all the activities were initiated with the intention of eventually achieving national coverage and of coordinating and integrating activities.

A more concrete working definition of what constitutes the Bamako Initiative can be conceived of as including *features*, *objectives*, and *strategic elements*. The features of BI programmes are community financing, community participation and the intention to eventually reach national coverage. These features must be part of a programme which includes in its objectives an improvement in the quality of and access to health services. In all countries, programme objectives emphasize issues of management and accountability, essential strategic elements in the process of implementation of the Initiative if its objectives are to be achieved.

This view of health system development is considerably broader than was originally described in James Grant's speech in 1987. The focus on increased accessibility and quality of services, coupled with efforts to strengthen health system management, can be seen as a policy evolution, both in response to external criticism of its initial formulation and of the practical experience of implementing BI projects in-country.

## Country experience contributions to the original concerns about the Initiative

### *Equity and access*

The original criticism of the Bamako Initiative raised the problems of equity and access caused by charging for health services. The "demand-based" approach adopted by UNICEF, based on evidence of willingness-to-pay for health services

was contrasted with a "need-based" view of health service provision. This suggests, however, an absolute perspective on ability to pay, whereas comparing programmes with the alternatives available, and their achievements in terms of improved accessibility and coverage, may be a more useful criteria for assessment.

The evaluation objectives included addressing the issue of affordability of health services. This was evaluated using a number of techniques, including a household survey and focus-group interviews. Precise conclusions were not possible given the limitations of time and study techniques, and a very mixed picture of affordability emerged. There seemed to be fairly widespread evidence of financial inaccessibility, particularly but not exclusively related to non-BI services.

A much clearer picture emerged of the "relative affordability" (i.e. relative to both the cost and the quality of alternative sources of care) of BI activities. In Kenya, the sale of essential drugs through community pharmacies clearly reduces both financial and geographical barriers to access. In Guinea, prices in government health centres compare favourably with the mix of private sources which was available in the virtual absence of services being offered in the public sector prior to the introduction of the Initiative. The greater public sector supply of drugs resulting from BI activities suggests that the same is true in Nigeria. In Burundi, BI activities have not resulted in changes in prices or payment mechanisms: existing prices are not set at cost-recovery level, but do not seem to pose major problems of affordability. In Uganda, it appears that even the small official charges increase financial barriers to access and it is not clear that the quality improvements to date enable the services to become comparable to more expensive alternatives.

It is also clear that there are marginalized groups who remain without access to health services, for a variety of reasons. There was no reason to suggest that the implementation of BI activities has worsened the situation for these groups, but neither do they seem to have resulted in any improvement.

What is clear is that affordability questions should be addressed within the context of the cost and perceived quality of alternatives. The problem of improving access to the poorest has yet to be resolved.

*Issues of focus: problems of strengthening the peripheral level without commensurate efforts to improve the quality of care at higher levels of the referral system*

The issues of focus referred to in the original criticism of the Bamako Initiative can be seen as related to the level of integration of the Initiative's programmes with the rest of the health system. Most countries have experienced some problems in integrating the Initiative with existing health sector activities. In Guinea, for example, little attention has been paid to the district hospital and higher levels of the referral system. This is recognized by the Ministry of Health, but it has been accepted as a necessary price to pay given that a complete re-building of the health system was needed. Now that significant progress has been made in improving the quality and management of peripheral level health services, the need for a national policy on hospital financing is recognized, and will be implemented using some of the lessons learned from experience at the peripheral level.

In Kenya a key problem has been that BI activities are marginalized from the rest of the sector. The choice of the community as the level for improving access to drugs through the creation of community-based pharmacies, managed by the Community Health Committee and Community Health Workers, has resulted in a number of contradictions. The most obvious of these is that in order to reduce supervision costs, community pharmacies are often located very near to dispensaries at which drugs (when available) are free of charge. As a consequence, the community pharmacies rely on the failure of the government-run facilities for their own financial success. Improvements in the central drug distribution system during the year preceding the evaluation meant that the financial performance of the community pharmacies was deteriorating. The extent of marginalization is clear from the complete absence of the Bamako Initiative in the prominent health care financing debate.

In Uganda, BI activities were perceived to necessitate a "pilot district" approach. This was deemed to be politically and socially impossible

in Uganda, and was a major impediment to the formal adoption of the Initiative.

Does a peripheral focus mean that no efforts can be made to strengthen the higher levels of the health care delivery system? The Burundian example suggests otherwise. Although one province has initially been chosen as the main focus for BI activities, there have been a number of country-wide initiatives designed to strengthen district health service management, such as training in information systems and drug management. At the same time, the evaluation team did note that BI activities appeared to be operating in isolation from the planning and management of the "vertical" programmes and other donor-funded projects, and that efforts were needed to integrate BI activities with the other health sector activities.

One of the challenges for the Initiative's implementation has been to avoid the trap of becoming yet another vertical programme, with parallel management and planning structures. This has not proven to be easy in countries where peripheral health services initially developed out of donor-funded EPI programmes. The forces working against such an integration may include donors as well as vertical programme managers themselves, who fear that the advantages accorded to them by managing such programmes may be lost. Of the countries studied the goal of creating a "PHC umbrella" through the integrating forces of the Bamako Initiative has only succeeded in any significant way in Guinea. Thus, the difficulties experienced in integrating BI activities can also be seen as symptomatic of the more general problems of health sector integration, and not necessarily associated with the Initiative. Some tactical errors have been made, however, which could be avoided by other countries.

*Implementation problems: logistics, management and achieving national coverage*

Most countries have experienced some difficulties in managing the expansion of their programmes, and there have been some problems which could have been avoided through more careful programme design. In Kenya, for example, the setting up of community pharmacies next to government facilities need not have happened, and the resulting problems of competition could have been avoided. Similarly, with the exception of Guinea, where monitoring and supervision systems are strong, most countries have experienced difficulty in this area where more careful programme design could have helped. In both Kenya and Guinea the profits on drug sales, which are retained by communities, have not been spent. Balances accumulate in bank accounts and lose value through inflation and negative real interest rates. By the time of the evaluation, problems of logistics and supervision were beginning to arise in Guinea due to the high level of centralization of programme management in the early stages of activities.

These problems illustrate some of the conflicts of development itself. How much central control can there be over community generated funds (for example, setting out the uses communities can make of their funds) without eroding completely the principle of community management? How far into the periphery can services be extended in the absence of logistic and management systems? Should all progress wait until the systems are developed, or is it better to go ahead and iron out the problems as they arise?

Although some avoidable problems have been experienced in the countries studied, it is difficult to say that they are intrinsic to the Bamako Initiative: they are rather the outcome of weak management systems and poor supervision processes. Using the experience of other countries and "learning by doing" are very much a part of the natural process of health system development.

*The problems of using drugs as the locus of cost recovery*

The potential for the incentives inherent in a drug-based cost-recovery programme to contribute towards inappropriate drug use were highlighted from the beginning. In Kenya, Uganda, Nigeria and Guinea, essential drugs programmes have been adopted, and the Initiative falls within these activities. In Burundi, because there is not as yet an explicit focus on financing of health services, no conflicts have arisen. A key issue is whether the problem is the Initiative itself, or the choice of payment mechanism and the incentives created.

The choice of payment mechanism should be made in full knowledge of the incentives (both to

providers and to users) which it creates. There is evidence that a fee-for-drugs will encourage over-consumption (as in Nigeria), while the fee-for-diagnosis system in Guinea seems to encourage some multiple prescription by health workers. "Simple" pricing systems, such as a flat rate per episode or its variations, which allow for some cross-subsidization between those requiring expensive and inexpensive treatments, may result in a fall in utilization by those who are less ill and perceive that they are receiving less value (in terms of drugs) for their money. Although pre-payment systems carry the least incentives for over-prescription by health workers, they may encourage over-use by those who are covered ("moral hazard") or the participation only of those who are more likely to require health services ("adverse selection").

In Kenya particular conflicts were found concerning the payment of community health workers. Although there are potential dangers of over-consumption of drugs if community health workers are paid on the basis of a fixed percentage of sales, this was the mechanism which was felt to be "fair" by the CHWs themselves. The dangers of drug misuse must be balanced with the incentives to work fewer hours which are created by a flat-rate reimbursement system.

This is an example of the more general trade-off which may exist between tolerating some level of drug overuse resulting from the payment mechanism or not having drugs available at all. The key to avoiding irrational drug use may lie in stronger management and supervision of health worker practices. This in turn, can form part of a stronger programme of quality improvement, a necessary component of any successful cost-sharing initiative.

*Sustainability and dependence on UNICEF for drug supply and foreign exchange*

It is true that fairly large sums of money (and in the case of Guinea, technical assistance) have been invested into BI projects, creating important questions regarding replicability elsewhere.

Once more, a relative perspective is useful: what are realistic goals for sustainability? It needs to be seen within the context of the long term ability of national governments to meet the recurrent costs of health care provision, and, to the extent that community financing mechanisms are aimed at increasing the availability of funds to the health system, they are moving in a "sustainable direction". For very poor countries, it may be unrealistic to expect the recurrent financing needs to be met in their entirety by local resources in the short to medium term: donor agencies may have to consider longer term recurrent funding commitments.

The question of dependence on UNICEF for drugs may be one of time-frame. In Guinea and Kenya communities are already beginning to recycle their receipts into drug purchases. It is more important, however, to look at BI activities in relation to other donor-funded health programmes: are there better alternatives which differ substantially in their approach to user-financing of recurrent costs?

Issue of foreign exchange involves the capacity to exchange local currency receipts into hard currency for re-purchase of drugs. There has been considerable market liberalization in Burundi, Guinea and Uganda, such that access to foreign exchange is not a problem. A greater constraint is of course the purchasing power of that currency with downwards pressure on exchange rates. For those countries with relatively convertible currencies, the problem thus becomes one of affordability, resulting from increased local currency prices for a given amount of drugs. The possibility of local production of drugs (in Kenya, Nigeria, Guinea and Burundi) may go some way towards reducing the foreign exchange requirements, but there will still be a need to import certain raw materials, and the quality of locally produced drugs may be a problem. Clearly, foreign exchange requirements remain a problem, but not one necessarily unique to the Bamako Initiative.

## The outstanding policy issues

*Equity and affordability*: The conclusion of the evaluation was that the experience of BI implementation in the countries studied showed that it is possible, in most contexts, to raise amounts of revenue capable of covering significant components of recurrent costs, through community financing. Improvements in relative affordability, which requires the retention of funds generated at local level, and use of these funds to improve the quality of services offered,

have been achieved in three of the four BI programmes.

At the same time, problems of absolute affordability remain. There was no evidence that marginalized groups were made worse off by BI activities, but it is certainly too early to reach any firm conclusion. Exemption mechanisms aimed at increasing the access of marginalized groups to health services do not seem to be working, and further work is needed to determine how best these groups can be assisted. It may be necessary to go beyond simple exemption mechanisms and to strengthen community-based support mechanisms. This also requires the collaboration of the international community in supporting the creation of operational mechanisms to ensure that services are provided for the poor and the marginalized.

There is a need for additional attention to be paid to alternative payment mechanisms which can help to overcome constraints imposed by seasonal income patterns. This should involve a specific focus on making pre-payment mechanisms operational, building on the experience of countries who have adopted community-based insurance systems in the past.

An explicit effort needs to be made to ensure that geographical inequalities in the ability to finance the recurrent costs of health services do not erode provision for these groups. This may involve a specific re-allocation of central government expenditure to assist poorer communities, or cross-subsidization mechanisms between communities (a "solidarity tax").

Above all, it is essential that there be a continued dialogue to keep issues of affordability and equity in the debate.

*Community participation*: This is often seen as the most important element of the Bamako Initiative. At the same time, it remains problematic, and needs to be more clearly defined. Guidelines are needed at individual country level on what community committees are expected to do, and the training and supervisory support they require to perform this role. Health workers at the different levels of the system need to be trained in working with the community, and there should be clear links between the community health committee and other development committees at different levels. There needs to be a particular commitment to including women and traditional healers in the health decision-making process.

*Replicability*: The level of external assistance (both financial and technical) received by some of the more clearly successful BI countries poses questions about the extent to which these programmes can be replicated elsewhere. The amount of investment should be seen in relative terms: in Guinea, the cost per person covered in 1992 was roughly calculated to be around $2.50 (based on assumptions of population coverage made in project proposals). In the light of the programme's achievements, as well as the pioneering nature of the work, the cost does not appear to be excessive.

*The role of other donors*: Up to the present time, the Bamako Initiative has been seen to be primarily UNICEF-driven (not least because of the high level of suspicion on the part of the other multi- and bi-laterial donors), and as such has in most cases been geographically limited in implementation. Only in Guinea have other donors joined wholeheartedly into the process and are implementing their programmes along lines determined by the Government within a BI framework. The need for substantial investment in the process of reinforcing health care systems should be recognized, and this burden shared by other donors.

## Conclusions

The Bamako Initiative has evolved considerably since its inception in 1987. Policy experience in a number of countries shows that it is a strategy for the reinforcement of primary health care within an integrated framework, and not the narrowly-defined revolving drug fund that was originally described. It focuses on some of the main problems of health care delivery: recurrent financing, health system management, supervision, monitoring and integration of health services. Although it will certainly not resolve all of the problems of peripheral health service management, we believe that the initial criticism of the Initiative better reflects the general constraints in terms of management capacity and vertical health structures in sub-Saharan Africa

than problems intrinsic to the Initiative itself. Its successes and failures should be seen relative to other experiences of health system development, and in relation to the trade-offs and conflicts inherent in this process. There is much that looks promising, and with increased attention paid to the above issues it is a reasonable strategy for strengthening primary health care in developing countries.

## References

Chabot J. 1988. The Bamako Initiative, letter. *The Lancet*, December 10.

Garner P. 1989. The Bamako Initiative, Financing health in Africa by selling drugs. *British Medical Journal* **299**: 277–8.

Kanji N. 1989. Charging for drugs in Africa: UNICEF's 'Bamako Initiative'. *Health Policy and Planning* **4**(2): 110–20.

*Lancet*. 1988. The Bamako Initiative, editorial. November 19:1177–8.

McPake B, Hanson K and Mills A. 1992. *Experience to Date of Implementing the Bamako Initiative: A Review and Five Country Case Studies*. Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine. March, mimeo.

UNICEF. 1990. *The Bamako Initiative: Reaching Health Goals through Strengthened Service Delivery*. Bamako Initiative Management Unit.

UNICEF. 1990. *The Bamako Initiative Planning Guide*. Bamako Initiative Management Unit. (draft).

## Acknowledgements

*This report arises from an extensive study which has involved* a large number of people in each of the five case study countries, ministries of health and country UNICEF offices provided essential support. The study was supported by ODA, DANIDA, Ministry of Foreign Affairs, Norway, SIDA, and the Drug Action Programme, WHO. Case studies were conducted by teams, the members of which all contributed invaluable insights into the study. The following team members were involved: A Baza, F Kwizera, S van der Geest (Burundi); L Deville, H Diallo, TS Diallo, Y Sacinet, I Soldholm (Guinea); NH Achime, JD Adeniye, EO Ekunwe, J Hiscock (Nigeria); F Ajuong, B Forsberg, W Liambilla, J Olenja (Kenya); AR Katohoire, ITE Olsen, CK Semwangu and RE van Dijk (Uganda).

Additional comments were received from: D Arhin, O Ashodeinde, O Bangourrra, LC Barka, AK Bill, R Christensen, D Curran, N Dabelstein, A Eidhammer, S Etyono, S Fabricant, BC Forsberg, L Gilson, N Godfrey, R Grandcourt, J Hiscock, G Holmes, S Jarrett, P Kantabaze, BL Makotsi, VFN Lukyamuzi-Mbidde, S Mogedal, M Murru, J Mwanzia, D Nshimirimana, Nyi Nyi, KS Oyegbite, A Paganini, P Brudon-Jakobowicz, SR Ramaroson and A Tembon.

An invaluable contribution was also made by Anne Mills from the Health Policy Unit at the London School of Hygiene and Tropical Medicine, UK.

## Biographies

Barbara McPake is a lecturer in the Health Economics and Financing Programme in the Health Policy Unit of the Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, UK. In recent years she has conducted teaching, research and consultancy applying health economics to developing country health services including work in Kenya, Lesotho, Uganda and Papua New Guinea. Her current interests include analysis of alternative health sector financing mechanisms and health sector reform.

Kara Hanson was a research fellow in the Health Economics and Financing Programme at the time of this study. She is now furthering her postgraduate studies at Harvard University. After graduating from McGill University she attained a M.Phil in the Economics and Politics of Development at the University of Cambridge. She was then appointed as an Overseas Development Institute Fellow in Swaziland where she was Senior Assistant Planning Officer.

*Correspondence*: Barbara McPake, Health Policy Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, Keppel Street, London, WC1E 7HT, UK.