WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL DE L'AFRIQUE

ORGANIZAÇÃO MUNDIAL DA SAÚDE
ESCRITÓRIO REGIONAL AFRICANO

REGIONAL COMMITTEE FOR AFRICA

AFR/RC52/RT/3
12 February 2002

ORIGINAL: ENGLISH

Fifty- second session
Brazzaville, Congo, 19-23 August 2002

Provisional agenda item 9.3

HEALTH FINANCING

Round Table 3

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BACKGROUND

1. With the increasing burden of disease and amidst scarce resources and low economic growth, high levels of poverty, inequitable distribution of income,[1] and weak public sector management, countries in the African Region are facing the challenge of ensuring access to essential and quality health services that are financed equitably.

2. For almost two decades most countries in the Region have been undertaking health care financing reforms chiefly aimed at raising additional revenue. Such reforms have included: introduction of user fees for public health services which, for many countries, were free after independence; introduction of social and private health insurance; earmarked taxes; medical savings accounts; and community prepaid schemes.

3. However, available evidence shows that the levels of spending on health in the Region are low compared to other regions. In 1998, total health expenditure as a percentage of the GDP in the Region averaged 4% per annum. Twenty-six countries spent less than US $20 per capita, 13 between US $20 and US $60 per capita and seven above US $60 per capita. The health systems of most countries depend largely on households as sources of revenue through direct out-of-pocket payment mechanisms (user fees averaging 36% of total health spending) which complement health financing through general tax revenue.[2]

4. Much as there is absolute inadequacy of financial resources in most health systems in the Region, it is also evident that the few resources available are often inequitably distributed and inefficiently managed. Geographic inequities persist in the distribution of resources, with urban areas having more resources than rural areas and tertiary health facilities consuming more resources than primary level facilities.[3]

5. In order to achieve the vision of the Health-for-all policy for the 21st Century in the African Region by 2020, which is to overcome diseases related to poverty, exclusion and ignorance through good governance and autonomous development of a proactive health system for a decent and acceptable living standard by the year 2020, there is an urgent need to find financing strategies for the Region that would mobilize adequate and sustainable resources and reduce inequities and inefficiencies.

FRAMEWORK

6. The development of viable and fair financing strategies require knowledge of total spending on health, sources, amount of contribution by each source and uses of funds. Without this information there is little basis for evaluating alternative financing options, allocating resources, and developing efficient

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[1]Sub-Saharan Africa has experienced very low economic growth in the last twenty years, with per capita growth averaging 1.3%. In addition, poverty has worsened during the same period, with incidence rising from 31% to 46%. Income distribution is still very uneven and the Gini index of most African countries ranges from 45 to 60.

[2]WHO, World Health Report 2001. Mental Health: New Understanding, New Hope. Geneva, 2001.

[3]Eastern and Southern African NHA Network. National Health Accounts in Eastern and Southern Africa: A Comparative Analysis. Unpublished Report. Cape Town, South Africa, 2001.

and effective ways of providing services. The framework for health financing in this Region will be in terms of collection and pooling of financial resources, and purchasing of health services.

Collection of financial resources

7. The African Region has used mainly eight alternative ways of collecting revenue to fund health services. These are general tax revenue, social health insurance, private health insurance, community-financing schemes, user fees (known as cost-sharing or cost-recovery by different countries), external resources (donors), earmarked taxes and medical savings accounts.

8. General tax revenue has been the commonest way of financing health services in the Region. Government collects taxes from individuals and firms and uses part of the amounts collected to finance health services. This form of funding is generally considered to be more efficient and equitable. However, it depends largely on national macroeconomic performance, the size of the tax base and the human and institutional capacity of the government to collect taxes.

9. Social health insurance is a system that involves mandatory contributions by individuals and employers. It can be an effective way of generating resources for health and can be inexpensive to administer.

10. Equity in the provision of health care services can be affected negatively in a situation where social health insurance is not universal, in the sense that a two-tier system is often created: one for the insured and the other for the uninsured. Thus, high-tech health services are provided for the insured, which results in high per capita costs. Only a few countries in the Region have introduced this system of health care financing, and in these countries, the system does not cover the entire population.

11. Most countries in the Region have some form of private health insurance scheme that covers the formal sector alone or is operated on a voluntary basis. Large amounts of revenues can be raised through private insurance. It works well in a situation where there is a large formal sector. It is however inequitable due to its capacity for 'adverse selection'[4] and 'moral hazard' behaviour.[5] Government can reduce adverse selection by subsidizing those who cannot afford the premiums while 'moral hazard' can be reduced through co-payments.

12. A number of countries in the Region have been implementing community financing schemes. The Bamako Initiative is a good example. It can be an efficient way of collecting revenue for non-salary costs, especially at primary care level, and can reduce catastrophic expenditures by the very poor. However, it

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[4]Adverse selection is a particular type of imperfect information where the patient knows more about his/her potential for illness and may be able to hide this information from the insurer. Those patients with great risk will demand more coverage, while those with lower risk may opt not to be insured. This has the effect of increasing the average risk of those remaining insured; as a result, premiums rise.

[5]Moral hazard is where the attitudes of consumers and providers of health care change because the full cost of health care is being reimbursed. The incentive to adopt healthier styles is diminished and over-utilization of health care services may occur.

entails problems of coverage, membership across different ethnic groupings, management capacity and inadequacy of resources for service provision, because the premiums are too low.

13. Direct out-of-pocket payment is the major product of health financing reform widely implemented in the African Region. The direct out-of-pocket mechanism links both payment for and utilization of health services. However, evidence shows that its potential for generating revenue is very low (on average about 5% of recurrent costs).

14. Furthermore, direct out-of-pocket payment has serious implications for equity in access to health care services as it discourages the very poor from utilizing health care services. It forces households into catastrophic expenditures, borrowing and selling of household assets. Exemption mechanisms so far designed to help the poor meet these expenditures have not been effectively implemented due to several problems, including the criterion for identifying the 'poor'.

15. External resources include grants and loans made to the government by international and local organizations. These offset government revenue shortfalls and play a significant role in financing capital expenditures, essential drugs and supplies, human resource and institutional building and some health programmes in the Region.

16. However, this form of financing is unsustainable and can increase inequities as donor preferences might be at variance with those of governments. In addition, the provision of the resources is contingent on many factors which often lead to delays in the implementation of activities, giving a false impression of inadequate absorptive capacity of the countries. Over-dependence on external funding can thwart the implementation of national health plans.

17. Some countries are experimenting with earmarked taxes, usually "sin" taxes like those on alcohol or tobacco. On the public health front, earmarked taxes are effective in reducing the demand for harmful substances by raising the price closer to its true social costs, thus increasing the price for the consumers.

18. However, earmarked taxes can generate conflict of interest for public firms and reduce flexibility over time in allocating public funds. They can also reduce the accountability of agencies to which the funds are allocated. They are inequitable (imposition of an additional tax) as the poor are the largest consumers of these products.

19. Some countries are implementing medical savings accounts. These are separate personal bank accounts where individuals save money with a view to using it to finance health care when the need arises. Medical savings accounts can guarantee access to medical care services when the need arises. However, this system can only be viable where there is a vibrant economy and the propensity to save is high.

Pooling of financial resources

20. Pooling of funds means that financial resources are no longer tied to a particular contributor. Healthy people will pay more to the pool than they receive in terms of health services, while the unhealthy will receive more services.

21. Health insurance is an example of pooling. This type of arrangement has many advantages. Unlike the direct-out-of pocket payment mechanism, it does not force individuals into catastrophic health expenditures, such as using up all their resources, borrowing or drawing upon households and extended family networks.

22. However, there are problems in deciding the 'right' kind of pooling. This is because pooling touches on fundamental ethical questions such as the distribution of the tax burden and of benefits between the rich and the poor. There are also questions as to whether there should be one pool or many pools, each pooling variant having its advantages and disadvantages. In general, there are only a few countries in this Region that practice pooling.

Purchasing of health services

23. Purchasing is the process through which revenues that have been collected and pooled are allocated to providers to deliver a set of interventions to groups of individuals. This covers budgeting and contracts between purchasers and independent providers; it even covers individual transactions between clients and providers.

24. The efficiency of the health financing system is heavily influenced by the way health services are purchased. Purchasing arrangements generate strong incentives that can alter access, quality, utilization, coverage, productivity of health providers, and allocation across interventions.

25. There are different ways of purchasing health care services among which are budgeting, fee-for-service and capitation:

(a) Budgeting is where the purchaser contracts with providers on a salary basis and builds and equips facilities. This is the most common purchasing arrangement found in the public health sector in the African Region. Though administratively simple, it requires administrative capacity to ensure that funds are used efficiently, distributed equitably and managed well. It also gives little incentive for improving and monitoring quality of care.

(b) Fee-for-service requires paying for health services or goods that were actually provided. Quality of care is generally high; however, it encourages overprovision of care, leading to cost escalation.

(c) Capitation requires that the purchaser contracts with providers for maintaining the health of each affiliated person in return for payment per person. This has the advantage of extending services to the underserved population groups or of delivering specific services. However, this requires setting in advance the prices of inputs, outputs and outcomes, which are not always easy to determine. This purchasing arrangement is not common in the African Region.

CHALLENGES

26. Some of the formidable challenges that a large number of countries in this Region will have to overcome in developing viable and fair financing strategies include:

(a) limited technical capacity to manage the complex health financing issues; the high turnover of policymakers and planners both due mainly to poor financial incentives;

(b) limited institutional capacity to facilitate the development and implementation of viable and fair financing strategies;

(c) lack of continuity with health financing reforms, given the wider context of institutional instability of the public sector; and

(d) weak analytical capacity, leading to evidence not being used for formulating health policy and taking decisions.

27. In addition, the constraining factors in developing fair and viable health financing strategies are the same as those impeding development in the Region. These are, for example: low economic growth (narrow tax base) and high unemployment; high levels of poverty; a huge informal sector and low wages in the formal sector; a high disease burden, especially from HIV/AIDS.

28. To overcome the above-mentioned constraints, countries need to collect empirical evidence on economic, social, political, epidemiological and health financing systems before embarking on health financing reforms.

29. With regard to health financing systems, National Health Accounts (NHA) is an internationally established method that can be used for policy development, implementation, monitoring and evaluation. NHA provides a clear overview of the financial functioning of the health system, identifying its financial sources, financing agents, providers and consumers and also showing the sources and uses of money. It is therefore necessary to enhance the implementation and institutionalization of the NHA in the Region.

DISCUSSION POINTS

30. Choice and implementation of health financing reforms should be guided by relevant evidence on current levels of health spending; sources and uses of those funds; the economic viability analyses of various financing options; health policy analysis; legal analysis; socio-political environment analysis; etc. How best can such evidence be generated in the Region?

31. Different funding levels in health systems are associated with different health outcomes in different countries. Is there a "right or minimum amount" per capita that should be spent on health per annum?

32. Countries are in desperate need of additional revenue and, at the same time, there is great need to achieve fairness in financing. How should countries raise additional revenue while ensuring fairness in financing? Exemption mechanisms that allow the very poor to access health services freely during health financing reforms have to date proved to be ineffective. How can these be improved?

33. Most countries have poor economic prospects and large informal sectors; they suffer from unemployment and high HIV/AIDS prevalence. How can these countries minimize out-of-pocket payments and maximize the use of prepayment schemes?[6]

34. Donors provide a significant share of health funds in the Region. Currently, these funds mainly support capital expenditures and some health programmes, and are subject to conditionalities. How can countries improve effectiveness, efficiency and equity in the use of donor funds for health?

35. Given the limited potential of various financing mechanisms to raise substantial revenue for health in the face of an increased disease burden, how can countries undertake institutional changes, improve equity and efficiency in the allocation and utilization of existing health funds?

EXPECTED OUTCOMES

36. Mechanisms agreed upon for generating evidence to inform the development and implementation of the health financing policy.

37. Consensus reached on whether or not there is a "right or minimum amount" per capita that should be spent on health in the Region.

38. Mechanisms for a fair generation of additional revenue and for improving services offered to the very poor identified.

39. Mechanisms on how to improve the effectiveness of donor resources identified.

40. Mechanisms for minimizing out-of-pocket contributions and maximizing prepayment schemes identified.

41. Ways of improving equity and efficiency in the allocation and use of existing resources identified.

42. Orientations for strengthening health financing in the Region given.

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[6]General taxation, social health insurance, community-prepaid schemes, etc. other than direct out-of-pocket payments.