

HEALTH FINANCING

Trends in Sub-Saharan Africa

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Preface / Acknowledgements

This keynote paper was developed for use in the CABRI dialogue on 'Value for Money in the Health Sector: health financing and expenditure management for allocative and technical efficiency'. This is the 2nd CABRI dialogue on Value for Money in the Health Sector. The team to support the dialogue is led by John Kruger. Other team members are: Tomas Lievens (health expert), Luize Guimaraes (case study researcher) and Clara Picanyol (case study researcher).

Responsibility for errors in interpretation or facts remains with the author.

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Abbreviations

AU	African Union
CBHI	Community Based Health Insurance
СМН	Commission on Macroeconomics and Health
FTT	Financial Transaction Tax
GNI	Gross National Income
GNP	Gross National Product
ILO	International Labour Organization
МНО	Mutual Health Organization
NHI	National Health Insurance
NHIF	National Health Insurance Fund
ODA	Overseas Development Aid
OOPE	Out Of Pocket Expenditure
OPM	Oxford Policy Management
PHI	Private Health Insurance
SHI	Social Health Insurance
SSA	Sub Saharan Africa
UNAIDS	United Nation Aids Agency
WHA	World Health Assembly
WHO	World Health Organization
WHR	World Health Report

Introduction

As was recently pointed out at a high-level health financing dialogue (Gomes Sambo et al. 2011), the African region has the highest disease burden relative to other regions but its per capita health spending is the lowest. And, in contrast to the wealthier regions of the world, a very large proportion of health spending in Africa comes directly from the pockets of its citizens and not from general government revenue or insurance funds.

The health financing dialogue at the Fifteenth Ordinary Session of the Assembly of the African Union 2010 (Gomes Sambo et al. 2011) attributed the current unsatisfactory state of health financing in the African continent to "lack of clear vision and plan for health financing; a lack of national health accounts and other evidence to guide development and implementation of national health financing policies and strategies; low investments in sectors that address social determinants of health; predominance of out-of-pocket spending; underdeveloped prepaid health financing mechanisms; large informal sectors vis-à-vis small formal sectors; and unpredictability and non-alignment of [the] majority of donor funds with national health priorities".

There is today a consensus that in general, more resources, and less out-of-pocket expenditure, are necessary to fund the health sector if Sub-Saharan Africa wants to significantly improve its indicators and reach the Millennium Development Goals. Ministries of Finance and Ministries of Health have to work together on this: exploring complementary routes that can be used to increase the resources to the sector at a national level and to join the international partners' reflection about the design and feasibility of global and regional mechanisms to complement national commitment.

While there is a general understanding that more money is needed, more money alone is not enough to overcome Sub-Saharan Africa's health challenges. How money is spent is just as important as how much is spent, in other words, ensuring value for money in the health sector. Wastage is however difficult to eradicate in any health system and the routes to improving efficiency not straightforward (WHO 2010). Ministries of Health and Finance need to work at this together.

As pointed out by the Director-General of the WHO in launching the World Health Report 2010, entitled "financing for universal coverage", the report was commissioned in response to the need "expressed by high and low income countries for practical guidance on ways to finance health care. The objective of the report was to transform the evidence, into a menu of options for raising sufficient resources and removing financial barriers to access, especially for the poor." The report points out that on the road towards universal health coverage, "countries will take differing paths ... depending on where and how they start ...". Within the context of exploring value for money this keynote paper sets out some of the options with regard to two key components of the health system, namely: health financing and payment provider mechanisms.

Health financing has three main functions: revenue mobilization and collection, risk pooling and resources allocation. Health financing policy is key to the health system, as it determines: i) the sources of fund, and therefore how much is available to the sector; ii) how health risks are pooled; iii) who controls the funds and how they are allocated; iv) The equity of the sector funding, and hence indirectly, how many people will fall into poverty (or not) as a consequence of potential catastrophic expenditures to cover health services. Provider payment focuses on the way in which services are purchased strategically; and on the incentives implicit or explicit between providers and purchasers (through formal or informal contracts) and their implication to health service delivery.

For both areas mentioned above the keynote paper provides a theoretical framework and outline possible approaches. Examples of how countries in SSA have used some of those approaches are provided.

The final section the paper discusses two common trends in health financing across African countries: performance based financing and targeted free health care. Some evidence is reviewed which provide to consider when designing and implementing health financing policies.

1 Health Financing framework: objective and policy instruments

Health Financing is central to all health systems. The World Health Report 2010 states that "health financing is much more than a matter of raising money for health. It is also a matter of who is asked to pay, when they pay, and how the money raised is spent". It encompasses the mechanisms through which resources are mobilized, ranging from general revenue and social and private health insurance to out-of-pocket payments. It includes the way in which health risks are pooled and financial resources allocated, as well as institutional arrangements for financing.

Key Messages

- Health financing policy is a key instrument to improve the equity of health financing
- The choice of revenue sources is a key determinant of equity in financing
- Pooling and purchasing arrangements that support more efficiency create greater scope for re-distribution
- The structure of benefits affects utilization which in turns affects acceptability of financial burden

1.1 The objectives of health financing

The objectives of health financing policy are derived from the overall health system performance goals. These goals as described in the world health report of 2000 are:

- To improve the level and distribution of health of the population;
- To improve the level and distribution of responsiveness of the health system to the expectations (other than health) of the population;
- To improve the "fairness" of financial contributions to the health system made by the population; and to improve overall system efficiency, i.e. maximizing attainment of the previous goals within the limits of available resources.

Figure 1.1 Health financing framework



Source: Joseph Kutzin, 2008	
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1.2 Health financing: the sources, collection and pooling of funds

Out of which sources of funds heath care services are funded affects the equity in the health system; the efficiency of its health system, as well as the transparency and accountability towards its citizens. This will in turn influence the final outcomes of the health system: health outcomes, financial protection and client satisfaction/responsiveness, as presented above.

1.2.1 Sources of funds

Seven main sources of funds and methods of fund collection are presented below, including a note on innovative mechanisms.

1.2.1.1 General revenue

Revenue is mainly earned from:

- Direct and indirect taxes (e.g. personnel income taxes; corporate profit taxes; property taxes; wealth taxes; Indirect taxes; sales taxes; value added taxes; import and export taxes)
- Earnings from government enterprises (e.g. oil; extractive industry resources, SACU revenues)

General revenue is spent according to decisions and priorities set by the government and approved by the Parliament, reflecting the preferences of the electorate (taxpayers). Under this approach taxes are not generally levied for the funding of specific activities, nor are decisions regarding the allocation of resources to specific programmes separated from the overall public spending decisions.

Government is the main source of funding for health in Sub- Sahara Africa (SSA). The second most important source is Out Of Pocket Expenditure (OOPE), developed in section 1.2.1.5

While government funds are the main sources of fund Sub-Saharan Africa (SSA), public health expenditure is low in absolute terms (which part explains the high level of other sources of funding). On average, governments in SSA spent \$10.19 per capita on health in 2005¹ (African Union, 2009²).

To improve this situation, heads of States of the African Union (AU) member states committed in 2001, in Abuja (Nigeria), to allocate at least 15% of government expenditure to the development of the health sector³, in what became known as the "Abuja target".

¹ The figures presented excludes data from South Africa

² Fourth session of the African Union conference of ministers of health, Addis Ababa, Ethiopia, 4 – 8 may 2009

³ The declaration made 27 April 2001, in Abuja (Federal Republic of Nigeria) by the AU Heads of state also calls upon donor countries to complement these resource mobilisation efforts by fulfilling the yet to be met target of 0.7% of their GNP as Official Development Assistance (ODA) to developing countries and cancelling Africa's external debt in favour of increased investment in the social sector.





Source: World Bank WDI database 2008.

Many countries are still far from achieving their commitment made in Abuja. Furthermore, in spite of the importance of the commitment⁴, it is not necessarily enough to provide a basic package of care. In 2001 the World Health Organization's Commission on Macroeconomics and Health (CMH), estimated that basic services could be made available for about US\$ 34 per person⁵, called the "CMH target", close to what Rwanda is spending now (WHR, 2010).

The report prepared for the Fourth session of the African Union conference of ministers of health, in Addis Ababa in May 2009 shows that if current levels of public spending increased to 15% of government expenditure in all countries in SSA, and if private spending levels remained the same, 23 countries in SSA would still not reach the \$34 level of per capita spending, as illustrated in the figure below. Of these, 8 countries would not achieve even half of what the CMH estimates to be the required level of per capita spending necessary to ensure an essential package of health services for the population. To reach the health related Millennium Development Goals (MDGs), it is estimated that the proportion of government spending on health would need to increase nearly six-fold and that more than 12 percent of GDP would have to be spent on health.

⁴ Reverend Desmond Tutu declared in 2008 that the Abuja 15% pledge is one of the most important commitments African leaders have made to health development and financing

⁵ World Health Organization. 2001. <u>Macroeconomics and Health: Investing in Health for Economic Development. Report of the</u> <u>Commission on Macroeconomics and Health. WHO: Geneva.</u>



Figure 1.3 Progress toward the CMH Target: public and private per capita health expenditures

Source: World Bank WDI database 2008.

Note: Countries spending >\$90 total per capita and populations with < 1 million excluded to improve the graph's readability (Swaziland, Mauritius, Namibia, Gabon, South Africa, Botswana, Sao Tome, Cape Verde, Equatorial Guinea, Seychelles, Mauritius and Comoros).

In most developed countries, the overall tax burden as a percentage of GDP is often in the range of 40%. In SSA only 2 countries – Madagascar and Lesotho – have tax rates exceeding 40%. Almost half the countries have tax rates below 30 $\%^6$.

1.2.1.2 Social Health Insurance

Social Health Insurance (SHI) provides funds to the health sector through a mix of payroll taxes and employer contributions earmarked for health, usually paid into a social insurance fund. Based on an European model of the 19th century it is typically mandatory; it can be managed publicly or privately and funds can be monopolies or competitive. The model requires a large formal sector employment for a successful national coverage, as compliance by self-employed and informal sector workers is hard to enforce⁷. Evidence shows that SHI also tends to function better in context with relatively high wages and salaries, low poverty rates, low dependency ratios and high capacity to provide health care⁸.

There is some level of disagreement on the description of what is SHI. The International Labour Organization (ILO) considers the key defining feature of SHI to be a health insurance system

⁶ World Bank, World Development Indicators (2007).

⁷ Costa (2002) provides a good overview of six basic features normally associated with SHI schemes.

⁸ Ibid.

mandated by government⁹. The economics literature at the other hand, often describes social insurance financing as indistinguishable from government tax financing, but social insurance experts tend to disagree (Ball 2000, Meyers 1981). Economists view social insurance as a tax-financed program mainly because the contribution is compulsory. But this view ignores many major social and institutional differences that distinguish general-tax-revenue-financed insurance (e.g. Sweden) from social insurance (e.g. Germany, Japan, and Taiwan) were contributions (premiums) paid for social insurance programs are earmarked for those programs and are separated from general taxes.

Quite apart from these divergent views, many social health insurance approaches share the following characteristics:

- It is compulsory—everyone in the eligible group must enrol and pay the specified premium (contribution). This contribution is most often expressed as a percentage of the wage. Once someone has paid a set level of payments, the person becomes entitled to the specified benefits.
- Its premiums represent a social compact. By law the contribution rate and the benefits are not easily adjustable by mere administrative action. Instead, they are specified in law or in a difficult-to-change regulation. Social insurance is thus based on an implicit social contract: citizens agree to pay a certain amount with the expectation that the funds will be used fairly and effectively to finance care for those entitled to benefit from the system.
- They often rely, at least partly, on earmarked taxes.
- It is not a right of all citizens but only covers those who are eligible and have met the
 minimum contribution requirements; therefore many countries have multiple systems. Most
 SHI schemes only cover workers in the formal sector; to increase coverage beyond those
 entitled to SHI benefits the government typically applies general tax revenue, or other
 sources of funds, to provide benefits to populations groups such as pensioners, the
 unemployed, the poor, workers in the informal sector, etc.
- By pooling risks and covering a large part of a population SHI circumvents many of the economic concerns associated with voluntary health insurance such as risk selection (cream skimming), moral hazard, and so on. More detail can be found in section 1.2.1.3
- In many contemporary SHI systems governments pay the premium on behalf of the poor, who become then entitled to the SHI coverage (Hsiao, 2006).

Box 1.1 Risk and the insurance jargon

Risk Pooling

Illnesses, and the health-care costs associated with them, are not evenly distributed in the population. To manage this uncertainty health risks and financial resources can be pooled, and made available to those who become sick. A complicating factor is when there are identifiable high- and low-risk groups within one risk pool. Low-risk groups, such as young people, often do not want to be pooled with high-risk groups, as this increases the average individual contribution.

The ability to pool health risks varies widely among the various health funding sources. General revenues pool risks if they are used for health services accessible to all. Mandatory social insurance can provide substantial risk pooling, provided coverage is more or less universal. Private group insurance only pools health risks within a selected group, such as for the workers of a particular company or the members of an occupational group. Patients' out-of-pocket payment, offers no risk pooling (Hsiao, 2008)

⁹ Normand C. and Weber C. (1994), Social Health Insurance. A Guidebook for Planning (Geneva: WHO and ILO)

Risk Selection

Risk selection indicates that people with a higher than average risk of using health care are identified and excluded from, most often private, health insurance. People who need health care most, the elderly, the chronically ill, women in reproductive age, for example, face problems accessing care. Government have often tried to develop regulation to avoid risk selection, or cream skimming, but private health insurers have shown to be creative both in the selection, and exclusion, of bad risks. The graph below, from South Africa, shows the relationship between age (one identifiable risk factor) and expected cost of health care use. The blue horizontal line shows the average individual contribution in this particular pool. It is clear that if bad risks were to be excluded, i.e. the elderly, or maternity care, both easily identifiable risks, the average contribution in the pool would go down.

Figure 1.4 Relationship between age (one identifiable risk factor) and expected cost of health care use



Although SHI remains a popular policy option, very few countries in SSA have been able to successfully implement a SHI scheme. The few examples of National Health Insurance schemes in sub-Saharan Africa have evolved from two distinct approaches to insurance: SHI and community-based health insurance schemes, described in the section 1.2.1.4 below.

Box 1.2 SHI development the case of Ghana

Ghana is one of few African countries which has recently implemented a National Health Insurance (NHI) scheme. Previously other African countries have attempted to implement NHI but they have been rather unsuccessful (Atim et al., 2009). As the model depends largely on the ability of governments to enforce compulsory membership through the deduction of payroll taxes, they are more suited to contexts in which there are high levels of well-paid, well regulated formal employment (Cichon et al., 2003; Coheur et al., 2007).

The Ghanaian National Health Insurance Scheme (NHIS) has adapted the SHI model to include informal workers into the scheme, by using elements both of SHI and Community Based Health Insurance (CBHI). By combining a network of CBHI schemes with a centralised authority and source of funds (the SHI component) to ensure nationwide coverage and to guarantee the financial sustainability of the schemes, the NHIS integrated both models.

Before the NHIS was created the health financing policy in Ghana included reliance on user fee contributions, also known as 'cash and carry,' which aimed at recovering 15% of the government's total recurrent expenditure on health (Asenso-Okyere et al., 1997). The cash and carry system was neither a social nor financial success. The Ministry of Health recouped on average, about 10% of its annual costs through user fees (Asenso-Okyere et al., 1997). Additionally, user fees resulted in a decline in the number of people utilizing health services (Waddington and Enyimayew, 1989).

The NHIS was created through the Act 650 in August 2003 with the purpose of assuring equitable universal access to a quality basic package of health services for all residents in Ghana (Asante and Aikins, 2008).

National Health Insurance Fund (NHIF) was established to pay for the NHIS through: i) subsidies to scheme; ii) reinsurance for schemes; iii) cost of enrolling the indigent; iv) supporting access to health care. And the fund for it come from the following sources :

- National Health Insurance Levy (NHIL) 2.5% of V.A.T.
- Payroll deductions (2.5% of income) for formal sector
- Employees
- Other funds voted by Parliament, income from investments, any donations, or loans
- In addition, DHMIS will raise funds from premia for informal sector members, to be set by agreement with the National Health Insurance Authority (NHIA). (Witter S. et al, 2008)

A recent study found that the financing of the NHIS was progressive (richer people pay a higher share of their income to health, compared with poorer people). The equity of the scheme is however somehow diminished by: i) the contribution from the informal sector, which was although small (around 5%), is highly regressive; and ii) the OOPE that are still a financial burden to certain populations, as the waivers and exemptions elaborated have not been effectively implemented (Akazili et al, 2011).

The NHIS was launched in 2005, but is expected to further evolve as some level of trade-off will be necessary between the current specification of benefit package (with no co-payments) and the objective of universal coverage (Witter S., et al, 2009).

1.2.1.3 Private Insurance

In private voluntary insurance buyers are willing to pay a premium to insurance companies which in turn:

- i) pool health risks and covers members for health expenses;
- ii) contract and pay providers who provide treatment for members.

Insurance purchases can be made on either an individual or a group basis, and, contrary to SHI, the premiums reflect the buyer's risks rather than their ability to pay.

Private voluntary health insurance coverage in Sub-Sahara Africa is generally very low. Notable exceptions are South Africa, Namibia and Zimbabwe where the market is better developed.

1.2.1.4 Community Financing

Community-based health insurance (CBHI) schemes, also called mutual health organizations (MHOs) or health micro insurance, are non-profit schemes based on voluntary membership and low premiums (Coheur et al., 2007). CBHI aims to extend the benefits of insurance to populations that have been excluded from traditional social protection schemes, such as rural populations and those working in the urban informal sector. These groups account for the majority of the population in most SSA countries.

CBHI are most often financed as any other insurance through periodic contributions from adherents or contributors, although they are sometimes complemented by income generating activities organized by the community. Most CBHI are defined contribution / defined benefit and being up-to-date with contributions is a necessary condition for coverage. This distinguishes them from traditional self-help schemes which determine benefits in function of the size of the member's need and the available resources. They also tend to be multi-risk in nature, and not only cover health events but also life-cycle risks such as birth, marriage and death. Traditional schemes have only a limited capacity to protect its members against catastrophic expenditure following ill health (Lievens, 2011).

CBHI schemes tend to develop where social networks are strong and a tradition of self-help and social action exists and where the health services are of acceptable quality with relatively high user fees. Differently from SHI, the schemes operate mostly, but not uniquely, in the informal sector.

They mobilize additional resources for the health system¹⁰, as they allow to capture resources from traditionally excluded group. As such they represent an attractive complementary source of funding, although the actual amounts these schemes have been able to raise are limited as they have historically found challenging to scale up beyond the community level (Atim et al., 2009).

Additionally, CBHI schemes often encounter problems of financial sustainability: they present in general low cost-recovery ratios¹¹, high drop-out rates, small risk pools, and low premiums all contribute to this problem (Coheur et al., 2007).

The rapid growth of CBHI schemes in many SSA countries is a relatively recent phenomenon, although the history of such schemes in Africa goes further back¹² and in spite of considerable long term support in some cases, especially from international donor funded programmes, population coverage by CBHI schemes remains low. The last complete inventory of CBHI schemes in 11 countries of Francophone west and central Africa in 2003 identified 622 MHO, of which 366 were considered "active" and the remainder under development, planned, failing, or otherwise inactive¹³. The estimated population covered by all MHO in the sub-region¹⁴ was just over 1,900,000 beneficiaries. In terms of total population coverage, research found that the effective population coverage is rather small, on average around 10% of target populations¹⁵. Financial sustainability is therefore a challenge for many CBHI.

¹⁰ Björn Ekman (2004), "Community-based health insurance in low-income countries: a systematic review of the evidence," *Health Policy And Planning* 19(5): 249–270. The schemes reviewed by Ekman covered both Africa and Asia; however the majority of schemes were African.

¹¹The systematic literature review of Ekman et al, found that the average cost-recovery ratio was around 25%.

¹² Some CBHI schemes were started in Belgian-ruled Congo and Burundi in the 1950s.

¹³ La Concertation. 2004. « Inventaire des mutuelles de santé en Afrique: Synthèse des travaux de recherche dans 11 pays », Octobre 2004. An attempt to update this inventory in 2007 was not equally successful; this exercise should be repeated in order to have a better picture of the most recent situation with regards to the development of these schemes.

¹⁴ calculated by applying a country-specific average mutuelle size to the total number of respondent mutuelles in each country ¹⁵ Ekman (2004)

Box 1.3 CBHI in western Africa: challenge of scale and potential solutions

Available data indicate that there may be 1,000 or more CBHI schemes in West Africa, most of them have relatively few members, with 95% of the schemes having less than 1,000 members (Ndiaye et al., 2007; Waelkens & Criel, 2004).

Lessons can be learnt on how to integrate the poor into health insurance programs in Africa, from different experience. The following measures are most commonly used.

Figure 1.5	Measures	to	promote	health	insurances	amongst	the	poor,	learning	from
	Africa									

Measure	Examples	Does it increase member- ship among the poor ?	To remember			
a. Premium subsidised 100%	Rwanda, Ghana, Tanzania	Yes, when the subsidy is really applied.	Sufficient funds must be available to compensate for premiums not paid by the poor. The population must be informed of the subsidy.			
b. Premium partially subsidised	Burkina Faso, Ghana	Yes, for some of them.	Even "minimum" premiums that households must still pay are obstacles for the poorest.			
c. Premium varies based on income	Bangladesh	Yes, if the level of premium is well established	Premium levels must accurately reflect the levels of wealth in the population.			
d. Premium paid in kind or by work	Ethiopia, India	Indications that this is acceptable for the poor	The "amount" of the payment in kind or in work must be clearly defined to avoid exploitation.			
e. Loans to help pay the premium	Rwanda	Yes, for the moderately poor	Institutional support is important to facilitate access to loans for moderately poor households.			
f. Dividing the premium into smaller payments	Uganda, Mali, Senegal, Tanzania	Yes, for the moderately poor				
g. Payment of the premium at harvest time	Burkina Faso, Guinea- Conakry	Indications that it can work for the moderately poor	It is important to know the annual periods of resource availability.			

Source: Morestin & Ridde (2009)

Box 1.4 Building on CBHI towards universal Coverage: the Rwanda model

Rwanda, in its efforts to improve access to health services after the genocide on the expansion of health insurance to the informal sector through the expansion of community based mechanisms. Building on the experience of earlier pilots, the government supported start-up initiatives and over 100 mutuelles schemes were created between 2000 and 2003. Population coverage increased continuously during this period and was estimated to have reached 27% in 2004. Coverage was further scaled up in 2005 with the support of external funding. The aim of this expansion was to rapidly increase membership of vulnerable groups through premium subsidies and strengthen administrative capacities and pooling mechanisms.

The schemes were hence funded my membership (premiums) collected by community health workers and transferred to a district level mutuelles fund, which is also subsidized by other sources including the government. For non-subsidized members, premiums are paid annually and were US\$ 1.8 per person per year in 2006.

By 2007, around 74% of the population had some form of health insurance cover. In 2008, a formal legal framework for MHI was created with the adoption of a law on mutual health insurance. The

law makes Health Insurance membership mandatory.

The law also introduced formal cross-subsidization between health insurance schemes leading the way forward for a possible national pool.

In 2010 CBHI coverage in the whole population was 36.6%. (Saksena P. et al, 2010). A survey conducted for the 2010 WHO health report found that CBHI membership in Rwanda was associated with higher utilization, as well as better financial risk protection for households. They found however that there is evidence of limited nature of the protection currently offered by the CBHI.

Rwanda is one of the most successful examples in terms of using CBHI as a complementary source of fund to their health system.

Source of data: Saksena P. et al, Impact of mutual health insurance on access to health care and financial risk protection in Rwanda World Health Report (2010), Background Paper, 6

1.2.1.5 Out-of- Pocket Expenditures

Out-of-Pocket Expenditure¹⁶ (OOPE) on health refers to the direct outlays of households, including gratuities and in-kind payments made to health practitioners and to suppliers of pharmaceuticals, therapeutic appliances and other goods and services. This includes household direct payments to public and private providers of health care services, non-profit institutions, and non-reimbursable cost sharing, such as deductibles, co-payments and fees for services. It excludes indirect costs households face to access care such as transport to the health facility, and the cost of time lost when seeking care.

As shown in the figure below, most private spending in Sub-Saharan African countries (80%) is out-of-pocket spending paid directly by households at the time of service.

¹⁶ OOPE is different from Private Health Expenditure: the sum of expenditures on health by prepaid plans and risk-pooling arrangements, firms' expenditure on health, non-profit institutions serving mainly households, and household out-of-pocket spending



Figure 1.6 Total health spending by source, 2005

Source: WHOSIS database and World Bank WDI database 2008

Although access to health care and financial protection against the cost of unforeseen ill health are squarely at the centre of most if not all national and international health policies such as for example expressed in the 2005 World Health Assembly (WHA)¹⁷, private expenditure on health in the African Region hasn't changed significantly between 2000 and 2008. They remain more than half of the sector funding, from which the majority is OOPE, indicating a high potential for catastrophic health spending (more on this in box below).

Box 1.5 Catastrophic health expenditures

Catastrophic spending occurs when households spend more than 40% of their disposable income (after deduction of subsistence expenses) on health (WHO, 2005)¹⁸.

A household is said to be vulnerable to health shock if the net value of its consumption budget falls below the national poverty line due to the occurrence of a health shock. It is not just the occurrence of a health shock or the payment of OOPE health expenditure, but the probability that when a health shock occurs the household's total consumption expenditure (net of health expenditure) falls below a predetermined poverty line.

¹⁷ WHA 58/ 33

¹⁸ WHO, Designing health financing systems to reduce catastrophic health expenditure, Geneva, WHO, technical, 2005

Figure 1.7 Out of pocket expenditures in the African region compared to private and government expenditures



* General government expenditure on health as % of total expenditure on health

** Private expenditure on health excluding out-of-pocket expenditure, as % of total expenditure on health

*** Out-of-pocket expenditure as % of private expenditure on health Source of data: World Health Statistics, 2011

Box 1.6 Medical Savings Account

One particular method of direct payment, medical savings accounts, has received special attention in health-reform discussions internationally. The prototypical example is found in Singapore (Hsiao 1995) where households build up a financial reserve dedicated to their own health care expenditures. The scheme is mandatory and put in place in anticipation of an aging population and the increasing use of health care. The policy introduced compulsory savings (based on a percentage of wages) deposited into dedicated individual savings accounts, which can then be used to pay for inpatient services. The system is a savings scheme designed to compel workers to save now in anticipation of large medical expenses in later years. There is no pooling of health risks or financial resources, and households save to cover their own future health care costs. The scheme does provide some level financial protection. In 1990, when it became clear that many households struggled to pay for inpatient services despite the medical savings accounts, Singapore revised the savings scheme by adding a catastrophic insurance plan in which workers pay the premiums by withdrawals from their medical savings account (Lim 1998).

A well-developed regulatory environment and tax system needs to be in place to enable the implementation of such scheme.

1.2.1.6 Aid funding, Donors

Aid dependence can be defined as a situation in which a country cannot perform many of the core functions of government, such as operations and maintenance, or the delivery of basic public services, without foreign aid funding and expertise. As a proxy for this, measures of "intensity" of aid are used: countries receiving aid at levels of 10 percent of GNP or above can be considered aid-dependent (Bräutigam D., 2000).

Many of the low-income countries targeted for substantial increases in aid already receive historically unprecedented flows. For instance, ODA to sub-Saharan Africa was the equivalent of 11.7 percent of the continent's GNI in 2003 (excluding Nigeria and South Africa¹⁹). Exactly half of

¹⁹ Including South Africa and Nigeria, two large economies that receive very little aid, brings this proportion down to 5.7 percent of GNI (WDI, 2005)

the region's 46 countries with data for 2003 received in excess of 10 percent of GNI in ODA, and 11 received more than 20 percent. Globally, there is a core set of roughly three dozen countries that have received a tenth of GNI or more in aid for at least the last two decades (Moss et al, 2006).

The health sector is in SSA often largely aid dependant; external assistance plays therefore a significant role in health sector financing in all the African sub-regions, and particularly in Eastern Africa.20

External assistance plays a significant role in health sector financing in all the African subregions, and particularly Eastern Africa.21 in External resources account for 17% of total health expenditures overall and for more than one-third of health expenditures in the Low Income Countries (LDCs). Over the past two decades, donor aid for health has soared in 2006 it reached an unprecedented high of \$3.7 billion, ¹⁰. SSA has major been the beneficiary of this aid, as illustrated in figure 1.8



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Figure 1.8 Donor Financing for Health by WHO Region (2000, 2006)

As the figure above shows, the large majority of SSA countries are heavily dependent on donor support for the health sector.

However, this amount still falls far short of the levels of aid estimated to be needed to finance basic health priorities; WHO²² estimated in 2001 that Africa would need \$19 billion annually in donor assistance for health to scale up essential interventions.

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Source: WHO, 2009

1.2.1.7 Innovative sources of fund

Sambo et al. (2011) recently pointed out that "[e]ven though Africa has the highest disease burden compared with other regions, it has the lowest per capita spending on health. In 2007, 27 (51%) out the 53 countries spent less than US\$50 per person on health. Almost 30% of the total health expenditure came from national government budgets, 50% from private sources (of which 71% was from out-of-pocket payments by households) and 20% from donors." More resources, and less

²⁰ If South Africa is included in the analysis, external assistance as a share of total health spending decreases to 2 percent in the Southern Africa sub-region, total health expenditures per capita increase to \$365, and average GDP per capita increases to \$4,284. ²¹ If South Africa is included in the analysis, external assistance as a share of total health spending decreases to 2 percent in the

Southern Africa sub-region, total health expenditures per capita increase to \$365, and average GDP per capita increases to \$4,284. 22 Commission on Macroeconomics and Health (CM H)

out-of-pocket expenditure, are necessary to fund the health sector if SSA wants to significantly improve its indicators and also reach the MDGS.

After a decade of increase, ODA started to slow down, mainly as a result of continuing fiscal constraint following the 2008 financial crisis. Future aid flows are uncertain. Simultaneously, Africa is economically transforming and fast becoming one of the most attractive investment destinations globally. Economic growth has averaged 6% a year over the last decade; and 40% of the fastest 20 growing countries in the world are African. Although important differences between countries remain, the implication is that many African countries are increasingly able, and expected to be more so over time, to generate resources for public services. Yet at this stage, many African governments turn to alternative sources.

A few popular alternative sources of funds are introduced below²³. Many of these are direct or indirect taxes, and therefore recommendations about their use should take into account possible adverse economic effects.

- Airline levy. An aviation solidarity levy has been originally used to help mitigate what are seen as negative impacts of globalization and also provide funds to finance HIV/AIDS treatment. UNITAID is an international organisation that derives most of its revenue from airline levies collected by its member countries. However, an airline levy can also be implemented by individual countries outside the UNITAID framework and for purposes other than AIDS programmes.
- Alcohol and/or tobacco levy. There is an established link between alcohol consumption and/or smoking and deterioration of health condition, and hence there is a plausible argument that funds raised from such levies should be devoted to the health sector (maybe even to specific areas of the sector).
- Mobile phone levy. The telecommunication sector in low and middle-income countries has seen unprecedented growth. Proposals have been made that a small non-distortionary levy could be imposed on mobile phone calls, which would nevertheless generate large returns.
- Taxes on remittances. Imposing a levy on international remittances has been identified as a potential revenue source by adding a small fee onto all money transfers from abroad. Whilst there is a significant amount of remittances in most low and middle-income countries, these have not been subject to a levy so far. Remittances can be made through formal and informal channels but the policy option to impose a levy would only impact on the formal sector transactions. This additional cost to transferring money through formal channels may lead to an increased use of informal channels or a decrease in total remittance flows, as the price elasticity is largely unknown. As remittances represent at least 2.5 times the volume of official development assistance and provide an important safety-net function for poor families, caution is needed with the implementation of any tax on remittances.
- Tourism tax. Tourism is relatively easy to tax and is also a popular target for taxation owing to its high revenue potential. Also, taxing tourism is relatively less politically conflicting since tourists are not voters. Tourism-specific levies may be justified and advisable when they are easy to administer by governments, easy to comply with, and effectively generate revenues. There are two widely used tourism taxes; entry/exit taxes and accommodation/hotel room taxes.

²³ Much of this section is borrowed from OPM's work on behalf on UNAIDS.

Dormant funds or unclaimed assets are property that has gone unclaimed for a defined time period. The policy idea is to invest the funds whilst tracking down the owners. The interest accrued could be collected by the government to pay for social services. The current international best practice for managing unclaimed financial assets suggests the establishment of a specific legal and regulatory framework. This typically entails the identification of unclaimed financial assets according to prescribed definitions as well as the segregation, reporting and remittance of such assets into a central reclaim fund or trust. The portion of remitted funds in excess of those required to meet claims of asset owners is invested for social, community, and economic benefit.

The study carried out by OPM on behalf of UNAIDS "Potential of Innovative Financing Mechanism for HIV, health and development" further shows that the revenue potential varies dramatically from source to source. Perhaps more surprisingly, we also find that the same mechanism doesn't always yield the same level of revenue across countries, as revenue potential also depends on the size of the sector in which the mechanism is applied and, in the case of taxes, on the room to add additional taxes.

A qualitative assessment of each alternative source of funding moreover shows that some are more desirable than others. Generally each mechanism attracts different scores on dimensions such as sustainability (or the longevity), stability (whether revenue is stable over time), progressivity (or equity in financing), administrative efficiency and side effects (both negative as



positive).

The figure sets the different mechanisms out on two dimensions: their qualitative score and the revenue they generate as a % of GDP. The upper quadrant contains right options that score high both on the qualitative assessment as on their financial potential contribution. This provides further guidance to countries in assessing

possible alternative funding sources.

1.2.2 Source of funds, Equity and Financial Protection

Health financing is the main tool governments have to achieve equity gains as it allows governments to target resources to intended beneficiaries through various means. It can target subsidies by income group, by health and socioeconomic status of a community, by class of hospital ward, and by types of services.

The different sources of fund can be place on an equity scale, function partly of their characteristics regarding risk pooling and risk selection (defined in section 1.2.1.2), as illustrated in the figure below. We will look at those aspects for each one of the sources mentioned above.

Figure 1.9 Main methods of Financing Health care scale in terms of equity, risk pooling, risk selection and efficiency



Adapted from William Hsiao's lecture. Health Care Financing: An Overview, November 12, 2009 *Efficiency includes technical efficiency and administrative costs.

General revenue sources are funded by national wealth and could be used to redistribute the resources between high and low risk population, as well as across all income groups. It is therefore considered the most equitable source of fund. In decentralized countries this method can potentially create incentives for some regions to lower their participation to the tax revenue collection and free-riding on the collective efforts of the richer parts of the country. In this context, decentralizing taxing decisions also runs the risk of creating a race to the bottom, especially as regions compete in attracting business by lowering taxes, and regions (usually the more powerful ones) can object to the creation of an interregional system of redistribution, precisely because it threatens to eliminate their own advantages.

General revenue is the most efficient way to collect resources for health as the administrative cost to collect resources is lowest compared to the other sources of funding. As the second session and key note illustrate the challenges associated with this funding source are generally weak government capacity in budgeting and expenditure management systems, and equally inadequate health care purchasing mechanisms.

Social Health Insurance is generally progressive (Azakili et al, 2011), which places the source high on the equity scale, as it allows for a cross-subsidization and risk pooling between healthy/wealthier people and less healthy/poorer. Health risks are highly skewed: it is estimated that 10% of population usually consume 60% of the total health expenditure, while 30% has no expenditure in the sector. In this context health insurance presents appealing features as the mechanism is based on predictable regular payments by all members to cover unpredictable costs when sick and/or injured, providing a financial protection to all the members of the scheme.

Private Health Insurance (PHI) is based on a free market approach, where the consumer is supposed to make informed and rational choices and the market to satisfy the individual preferences while optimising efficiency. As economic theory goes, it means that each household

would shop for the best-quality goods at the lowest price, which in turn would force the providers to compete in producing the best quality goods in the most efficient way. PHI are therefore voluntary schemes, motivated by the prospect of earning a profit; they compete for clients on the basis of "price" and quality.

An extensive economic literature shows that a market approach is not the best approach for producing and allocating resources for public and merit goods, and that governments have to intervene to correct market failures and to fill voids in which the private market cannot be established. (Hsiao, 1995). Therefore, regarding health economics Hsiao talks about: "abnormal economics".

Regarding PHI as a source of health care funding, from a public health and equity perspective private insurance present many challenges, the main ones being:

- Adverse selection: any voluntary insurance will attract more of the relatively sick. This process drives up the average cost of the insured, which in turn drives out the healthiest subscribers to the insurance, which drives up the cost of the insurance, and so on. This process leads to a breakdown of the insurance, and can only be circumvented by insuring larger groups at the same time. Company based insurance, in which all employees are covered simultaneously, and where there is no choice to opt in or out, are an illustration of how private insurance combat adverse selection.
- Moral hazard: when the cost of a service to the user is less than the real cost of the service, the user will have a tendency to use more of the service than what she/he really needs. This causes inefficiency in the system. In any insurance system the link between cost of service to the user (which is the premium plus any co-payments) is by definition delinked from the cost of the health care services covered by the insurance. Private insurance develops all possible schemes to avoid moral hazard as it has a direct negative impact on their resources and benefits.
- *Risk selection or "Cream Skimming":* private insurers have an incentive to identify and prevent from enrolling those people that represent a 'bad risk', i.e. have a probably to use high levels of health care. As such those that need care most are often excluded from private health insurance.

Regulation can attempt to control these effects but empirical evidence shows it is very difficult to do so. Private Insurance is by definition not about equity but cost efficiency – to achieve the objective of the insurance company, which do not always match public health objectives.

Additionally, PHI often face high administrative costs²⁴ and market competition, if possible (as it demands an excess of supply) engenders high transaction and admin cost (Hsiao, 1995).

Community Based Health Insurance has shown to have a protective effect against the potentially catastrophic expenditures related to hospitalization in some regions in Africa²⁵. CBHI members tend not to be the poorest of the poor, as a premium still need to be afforded to join the scheme (unless subsidization pays for the ones who can't); their impact on equity is therefore mixed. Evidence shows that they have been successful among the rural "middle class," often leaving the poorest of the poor behind in terms of enrolment and positive impacts (Bennett et al., 2004).

Regarding OOPE for outpatient care the evidence is contradictory. Ekman (2004), in a systematic review of the literature, finds some evidence that CBHI schemes "do provide effective protection to

²⁴ U.S. insurance companies often spend 25% to 30% of total revenue on expenses other than patient care (sales, administration, and profit), Hsiao, 2008

²⁵ Diop, F., S. Sulzbach, S. Chankova. 2006. The Impact of Mutual Health Organizations on Social Inclusion, Access to Health Care, and Household Income Protection: Evidence from Ghana, Senegal, and Mali. Abt Associates/PHRplus, September 2006.

the members of the schemes by significantly reducing the level of OOPE payment for care", while studies from Western Africa and Rwanda show that CBHI have little effect on OOPE expenditures for curative outpatient care^{26,27}.

Although CBHI allows capturing funds from traditionally excluded population, as mentioned above, it does not target the poorest, usually excluded by the incapacity of paying the membership premium. Many accounts suggest that the better-off in rural populations are more likely to join CBHI schemes than the poorest households²⁸. Although an important health system and health sector objective, CBHI schemes do not generally claim to foster equity as a key objective.²⁹ In some cases, the premiums of the poor are subsidized by the government, or through external assistance, enabling as such the poorest to benefit from risk pooling.

Out Of Pocket Expenditure is the most inequitable source of fund. As the poor have fewest resources to protect themselves against these health risks, they spend a higher proportion of their income on health than do non-poor groups. This can divert scarce household resources from other basic needs, including food, and from investment in income-generating activities such as farming and micro-enterprises.³⁰ The 2010 WHR states that it is only when direct payments fall to 15–20% of total health expenditures that the incidence of financial catastrophe and impoverishment falls to negligible levels.

1.3 Health services purchasing

Key Messages

Provider Payment is a key instrument to increase efficiency by:

- Limiting public spending on ineffective interventions
- Emphasizing cost-reducing preventive actions
- Balancing spending on infrastructure with spending on medicine and supplies
- Influencing appropriate use of different levels of health system
- Reinforcing treatment protocols in service delivery

1.3.1 Understanding the purchasing function

While there is a general understanding that more money is needed, more money alone is not enough to overcome Sub-Saharan Africa's health challenges. How money is spent is just as important as how much is spent. This is what technical efficiency is about.

Box 1.7 Technical efficiency

[http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/ Resources/281627-1095698140167/Jakab-SocialInclusion-whole.pdf]; Jakab et al. found that community financing reduced financial barriers to health care as demonstrated by

higher utilization and lower out-of-pocket expenditure among scheme members, controlling for a range of socioeconomic variables ²⁷ Pia Schneider and François Diop. 2001. "Impact of Prepayment Pilot on Health Care Utilization and Financing in Rwanda: Findings from Final Household Survey". Abt Associates/PHRplus, Technical Report 002, (October 2001).; A similar comparison from a household survey in Rwanda found that mutuelle members in three pilot districts enjoyed considerably better access to curative health care

²⁸ See for instance A. S. Preker et al. (2002)

²⁶ Melitta Jakab, Alexander S. Preker, Chitra Krishnan, Pia Schneider, Francois Diop, Johannes Jutting, Anil Gumber, Kent Ranson, and Siripen Supakankunti (2001), "Social inclusion and financial protection through community financing: initial results from five household surveys," World Bank Health Nutrition and Population Discussion Paper

²⁹ See for instance Jakab and Krishnan, 2001.

³⁰ Sinha, S., M. Lipton and S. Yaqub. 2002. 'Poverty and "damaging fluctuations": How do they relate?' J. Asian and African Studies 37: 186–243. Skinner, J. 1991.

Technical efficiency refers to the delivery of a given output using the minimum number of inputs.

Regarding this, provider payment systems can be powerful tools to promote the development of health systems and achieve health policy objectives. Different payment methods produce different incentives. There is not one right way to reach the optimum situation; understanding payments implies achieving the right combination of incentives which is possible through a mix of methods.

Box 1.8 Provider payment & purchasing

A provider payment system is defined as the health service payment method together with all the supporting systems, such as contracting, accountability mechanisms that accompany the payment method, and management information systems. In the context of health systems, therefore, provider payment systems accomplish far more than simply the transfer of funds to cover the costs of services. However, sometimes a provider payment method is defined more narrowly as the mechanism used to transfer funds from the purchaser of health care services to the providers (Gottret P, Schieber G, 2006).

Purchasing refers to the process by which pooled funds are paid to providers in return for delivering services (Gottret P, et al, 2008). The two main issues to consider in the purchasing function of health financing systems are firstly, the choice of the provider payment mechanism (covered in section 1.3) and the choice of the benefit package (covered in section 1.4)

The figure below summarizes the different methods presented above and their implications both for the provider of service and the purchaser. Each method and their implication, including in term of efficiency will then be presented in detail.

Figure 1.10 Understanding the payment function: different payment methods and their implications

		Risk borne by:		Provider incen			
Payment Mechanism	Basket of services paid for	Payer	Provider	Increase number of patients	Decrease number of services per payment unit(s)	Increase reported illness severity	Select healthier patients
Fee for service	each item of service and consultation	all risk borne by payer	no risk borne by provider	Yes	No	Yes	No
Case-mix adjusted per admission (e.g., DRG, PBF)	payment rates vary by case	risk of number of cases and case severity classification	risk of cost of treatment for a given case	Yes	Yes	Yes	Yes
Per admission	each admission	risk of number of admission	risk of number of services per admission	Yes	Yes	No	Yes
Per-Diem	each patient day	risk of number of days to stay	risk of cost of services within a given day	Yes	Yes	No	No
Capitation	all covered services for one person in a given period	amount above "stop-loss" ceiling	all risk borne by provider up to a given ceiling (stop-loss)	Yes	Yes	N/A	Yes
Global Budget	all services provided by a provider institution in a given period	no risk borne by payer	all risk borne by provider	No	N/A	N/A	Yes

Sources: Prepared by William C. Hsiao, 1997, modifying data from WHO 1993, Bodenheimer and Grumbach 1994

The methods of purchasing create powerful incentives that influence the actions of all organizations and individuals in the health care system. In essence, payment systems establish the incentive structures to influence providers' behaviour through financial rewards and risk sharing. Incentives also exist at the patient level (e.g. the price paid for services rendered) and supplier level for providers including practitioners, hospitals, and pharmaceuticals; it is the combination of these incentives that affects efficiency and quality of health care.

To explain the purchasing function we will first present the different common methods of payment; the note will then present the other key decisions that define the payment function, which will lead to a review about efficiency in health services.

Fee for service

In Fee for Service (FFS) the provider is reimbursed for each individual service provided. FFS determines a fee per service provided, which means that the higher the volume of service given, the higher the revenue of the provider. Fees may be either input-based or output-based. They are input-based if there is no fixed-fee schedule and if services are not bundled (that is, where health care services are not grouped into a higher aggregated unit). In this case, providers are permitted to bill purchasers for all costs incurred to provide each service.

FFS leads to an inflation of health services, including an unnecessary supply (also referred to as 'provider induced supply'). It leads to a fragmentation of services into smaller units, as each unit will prefer to produce its own service to receive payment, even if the patient has to be referred. This negative impact of fee for services are documented throughout the world, and although in many countries in SSA this method is still used, most richer economies have abandoned it (Hsiao, 2008). Therefore FFS is not considered a very efficient method of payment.

Capitation

Under a capitation approach the provider is paid, in advance, a predetermined fixed rate to provide a defined set of services for each individual enrolled with the provider for a determined period. Per capita payment systems are output-based, and the unit of output is the coverage of all predefined services for an individual for a fixed period, usually one month or one year. A lump sum (capitation) rate is determined prospectively to cover all the services to be provided to an individual or a group of individual (often for a household for example). The capitation rate can vary by age, sex and disability status of the individuals.

Under this system the patient has to designate a provider (family doctors or hospitals) that in turn gets for each insured person a lump sum. The key principle is that the payment to a provider is not linked to the inputs that the provider uses or the volume of services provided. Therefore, some risk is shifted from the purchaser to the provider that will have to manage potential losses (when a patient's care is more expensive than the capitation) as well as savings. There is also potentially in the capitation a built-in incentive to create a longer term relationship with the patient, as the provider will only be designed and/or keep its patients if they are satisfied with the services. In reality this is not always the case as there is often not enough competition amongst the providers for the patients to be able to choose or change if unhappy (this is if they are allowed to).

The methods is ranked high on the efficiency scale, although there is a risk, similarly than with the payment per admission to have a large group of young and healthy enrolees and exclude the complicated and expensive cases, or alternatively not provide the treatment they would ideally require and multiply the volume of referrals (especially when the method is only used at primary health care level).

Global Budget

A global budget is a payment fixed in advance to cover the aggregate expenditures of that provider over a given period to provide a set of services that have been broadly agreed upon. Differently from classic line-item budgets, global budget may be based on either inputs or outputs, or a combination of the two, including case mix adjustment³¹; additionally they also allow for more flexibility for the provider as he does not have to keep each volume of expenditure by line of activities pre-agreed.

Because payment to providers is both set and made prospectively, the incentives are similar to those in line-item budgets. However, a global budget generally offers flexibility to move funds across expenditure categories, so that there is a mechanism to improve the efficiency of the input mix.

Per admission

Payment per admission implies that a contract (formal or not) exist between the provider of health service and the purchaser fixing a cost of admission (at the hospital usually for inpatient care) and what does this cost comprise of. The provider is then, in principle committed to provide the agreed package of activity at the agreed cost.

This methods, contrary to the fee for services creates strong incentives to make economies and savings, to a point that it could hinder the quality of services provided; additionally it also open the doors for risk selection. Under this system providers have incentives to get in a maximum number of patients, and do a minimum number of services and/or not complex and expensive ones.

Per Diem

Per diem systems (payment per day) imply that the provider will get paid a fixed price, agreed previously, per day of inpatient care, regardless of the care provided.

In a per diem system, the dominant incentive is to increase the number of hospital days, increasing bed occupancy, and possibly increasing bed capacity and generally shifting outpatient and community-based rehabilitation services to the hospital setting. At the same time, there is an incentive to reduce the intensity of service provided during each bed-day.

1.3.2 Compensating health personnel

While the methods above generally apply to health facilities, they tend to have repercussions for health staff incentives as well, in as much as there is a link between the way in which a facility and staff are paid. Some methods specifically focus on compensating staff and aim to generate additional incentives to influence staff behaviour.

An extensive literature exists on staff incentive, both financial and other. Evidence from some countries shows that the latter has significant impact on personal motivation and retention; and that the impacts above mentioned are stronger when both types of incentives are in place. We will however focus on the financial incentives.

³¹ Ireland introduced a case-mix adjustment to global budgets for acute hospital services in 1993, and since then nearly all EU countries with global budgets have followed with some case-mix adjustment

Empirical evidence consistently shows that financial incentives are among the most important influences over organizational and individual behaviour in the health sector (Cutler et al., 1997). Unlike regulation, which relies on the power of the state to coerce individuals to comply through the 'stick' of threatened punishment, financial incentives rely on the 'carrot' of monetary reward to induce changes in behaviour. Different mechanisms exist to provide financial incentive to the health personnel, attractive salaries, salaries with some kind of performance indicators translated in a financial bonus (based on number of services provided, quality of care, number of patients attended, etc), bonuses defined by other criteria's (number of years of service, geographical postage, speciality, ect). Each of the indicators creates a different incentive, with their own implication for the system. In the second part of this note we will look in detail into one of those methods: performance based financing (PBF) for health.

Each type of payment method has variations that may create a different set of incentives, and the methods may be used in combination to enhance or mitigate the incentives that are created by each method individually. The examples cited above illustrate how difficult it is to get the mix right; constant monitoring, follow up and adaptation is necessary to maintain the system in the tracks and towards the direction sought.

1.3.3 Technical efficiency: snapshot of SSA countries

There are three broad types of efficiency concerns:

- Efficiency of revenue collection, covered in section 1.2 looking at the funding sources;
- Technical efficiency, when services are produced at the lowest possible cost, as mentioned above
- Allocative efficiency, allocation of resources to maximize the welfare of the community by producing the desired health outcome. As this falls outside of the health financing framework presented initially (figure 1.1) it will be briefly covered in the last section (refer to section 1.4)

The figures below illustrate that there is generally a big variation between countries in health outcome achieved per dollar invested. (Note: all the figures come from Gapminder <u>http://www.gapminder.org/</u>. The data used by Gapminder comes from World Bank and UN data available.)



Figure 1.11 Child mortality rates compared to Government health spending per person (in USD)

The figure shows levels of Child Mortality Rate (CMR) set out against Government health spending per person, for different countries. Madagascar and South Africa achieve similar levels of CMR in 2006 around 75. Similarly, Ivory Coast, Zambia and Equatorial Guinea have CMRs in the interval 133 and 134. Yet, while the outcomes are the same in the two groups, the spending in the groups varies widely, as shown in the table below.

Country	Government health spending per person (USD)
Madagascar	6
South Africalvory	191
Coast	8
Zambia	23
Equatorial Guinea	215



The figure illustrates the difference between CMR in countries with similar absolute levels of government health spending (around 4USD per person) in Eritrea, Ethiopia and Sierra Leone governments; and between 105 and 115 USD per person per year in Mauritius, Cape Verde and Namibia. However, despite similar levels of spending, the outcomes vary dramatically in the two groups:

Country	Child Mortality Rate (under 5 dying per 1 000 birth))
Eritrea	72
Ethiopia	118
Sierra Leone	196
Mauritius	16
Cape Verde	39
Namibia	54



Figure 1.13 Life expectancy compared to total health spending per person (USD)

The figure shows the difference between countries with similar life expectancy for different health spending per person (USD). All the countries highlighted in the figure have a life expectancy of 45 years, and the following health spending per person:

Country	Total health spending per
	person (000) per year
Sierra Leone	9
Central African Republic	14
Zimbabwe	36
Zambia	49

Figure 1.14 Total health spending per person (USD) compared to life expectancy

The figure shows the differences in life expectancy between countries with a similar health spending per person per year (in USD). Sierra Leone and Madagascar both spend 9 USD on health per year; their life expectancies are respectively of 45 and 65 years old. Zimbabwe and Ghana spend respectively 36 and 35 USD in health per year for life expectancies of 45 and 62 years old. Equatorial Guinea spend 274 USD per year and can expect to life 50 years old, while Gabon spend a bit less (267 USD) and can expect to live 10 years longer (life expectancy of 60).



All the differences highlighted above cannot be explained by one single cause. However evidence across the world demonstrates that there is usually always room to improve the technical efficiency of health service. This is not only the case in SSA, OECD countries as well look for efficiency savings. In other words there is scope for increasing provision of health services using the current levels of resources allocated to hospitals and health centres. This could entail for instance:

- Reducing misallocation of resources by regions (e.g. choice of health facility sites based on political criteria rather than need) and levels of care (investment of the majority of resources in tertiary and secondary hospitals instead of in cost-effective primary health care)
- Leveraging of health promotion strategies to create demand of underutilized primary health care or transferring specific inputs from over resourced to under resourced health facilities. (Kirigia. M, et al, 2008)
- Reducing unproductive expenditure (e.g. the militaries)
- Reviewing capital investment decisions and choice of public health interventions to follow cost-effectiveness and cost-benefit analysis criteria.

Box 1.9 Main sources of inefficiency

The World Health report of 2010 identified the following leading sources of inefficiency :

- Under-use of generics and higher than necessary prices for purchased drugs
- Inappropriate and ineffective use of medicine, including use of sub-standard and counterfeit medicine
- Medical errors and suboptimal quality of care
- Inappropriate hospital size (e.g. low use of infrastructure)
- Oversupply and overuse of equipment, investigations and procedures
- Inappropriate or costly staff mix, unmotivated workers
- Inefficient mix/inappropriate level of strategies
- Leakages, waste, corruption, fraud

Source: World Health Report, 2010

1.4 Beyond the health financing framework: what to fund?

The health financing framework developed by Kutzin, presented in figure 1.1 covers the health financing functions from the collection of funds (or sources of funds), to the allocation of funds to providers (through provider payment). Closely linked but outside the framework is the question of what to fund, and set rules for the allocation of resources over different health services. This is a crucial question to policy makers from Ministries of Health and Ministries of Finance.

1.4.1 Universal coverage, an attainable goal?

The world health report (WHR) in 2010 states that "Financing systems need to be specifically designed to: provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective and ensure that the use of these services does not expose the user to financial hardship".

However, with very low levels of funding, countries cannot ensure universal access to even a very limited set of health services. Additionally, higher levels of funding might not translate into better service coverage or improved health outcomes if the resources are not used efficiently or equitably. Universal coverage can therefore be considered as "a direction, not a destination" (J.

Kutzin, 2011): if no country can fully achieve all the coverage objectives, all countries can move towards them.

In order to move towards universal coverage (UC), in addition to the health financing framework presented above, policy makers need to consider the allocative efficiency of resources, as explained below.

1.4.2 Allocative efficiency

If technical efficiency looks at how to fund, allocative efficiency focuses on what to fund. Allocative efficiency compares the impact of different services, or packages of services, and prioritises the ones with highest outcome. For example, it will examine whether the relative weight of investment (expenditure) in prevention and treatment programmes delivers the highest outcomes (for example in terms of (quality-adjusted) life-years saved).

The need to allocate resource arises from a dismal fact: human wants far exceed the resources available. Governments, private firms, and individual households all have to make painful choices about allocating scarce resources. We have to choose how much to spend for health care versus other desirable goods; and decisions must be made on how to spend to achieve the best possible results. Governments make these choices at two levels. First, there is the tradeoff between spending in one sector over spending in another. Second, within a given sector, there is the tradeoff between spending on one program over others. For example, more money for primary care means less for inpatient hospital services (Bitran y Asociados 2000).

The complexities of the health resource allocation and its necessary trade-offs are often undermined and easily misunderstood, as it cannot be based solely on cost-effectiveness, which focuses on efficiency but ignores equity.





Source : World Health Report, WHO, 2010

As the path towards universal coverage is unique to each country, WHO developed the following steps to guide such reforms. As illustrated in the figure 1.15 the yellow box represents the services currently delivered and covered (if not affordable) by a health system. The large empty box represents the vision, the goal a health system might want to achieve; and the arrows represent the paths that need to be taken to get there.

The WHR of 2010 explains that the following steps need to be taken to engage in the path towards UC:

- 1. First the country needs to define its vision, goal;
- 1. Then it needs to conduct a situation analysis,
- 2. Do a financial assessment, and
- 3. A constraints assessment, in order to elaborate a
- 4. strategy for change and on this basis pass to
- 5. the implementation phase
- 6. Finally monitoring and evaluation need to be conducted to form a learning loop, for the next step of improvement

2 Two common trends in health financing in SSA

Performance based financing and targeted free health care are two common trends in health financing across African countries. These will be reviewed in turn.

2.1 Performance Based Financing for Health

2.1.1.1 The new health financing fashion for low income countries

PBF definition and objectives

The different names for performance base

Programs that incorporate financial and in-kind incentives are known by many names, including Performance Base Incentive (PBI), Pay for Performance (P4P), Results-based Financing (RBF), Performance-based Financing (PBF), Output-based Aid (OBA), Conditional Cash Transfers (CCT), Performance-based Contracting (PBC), Cash on Delivery Aid (COD), and Performance-based Aid (PBA). While these types of schemes all have in common that they link incentives to results, there are differences between them.

PBI, P4P, and RBF are often used as umbrella terms for all these programs. We will not here focus on the semantics of the different terms, but rather look at the concept they all try to integrate into a service delivery system.

Improving the performance of health care delivery systems is an important objective, both in highincome settings but even more critically in low- and middle-income settings, where resources for health are much more constrained.

Pay for performance is currently receiving increased attention as a strategy for improving the performance of healthcare providers, organisations and governments. It is also promoted as an important tool for achieving the health Millennium Development Goals, and for improving the effectiveness of development aid. However, there is currently a lack of rigorous evidence on the effectiveness of these strategies in improving health care and health, particularly in lower income countries (Witter et al, 2010; Eldrigde C et al, 2009).

PBI is defined as the "transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target." (Eichler and Levine 2009). Incentives can be given to patients when they take health-related actions (such as having their children immunized), to health care providers when they achieve performance targets (such as immunizing a certain percentage of children in a given area), or to health managers at the district, provincial, and national levels, conditional on such things as timely and accurate reporting, or the performance of the facilities they are responsible for.

Therefore, while paying for performance is a relatively simple concept, it includes a wide range of interventions that vary with respect to the level at which the incentives are targeted: recipients of healthcare, individual providers of healthcare, health care facilities, private sector organizations, public sector organizations, and national or sub-national levels. The types of outputs or outcomes targeted can also vary widely, as can the type of accompanying measures (such as investments in training, equipment and overall resources).

In OECD countries, paying for performance is generally described as a tool for improving quality (Christianson J, et al, 2007), cost containment and the rationalization of the provision of care, such

as the case of prescription of unneeded, expensive drugs and services (Morgan L, et al, 2010). In low and middle income countries, the issue to address is that health services are under-produced, and PBF generally has wider objectives (Witter et al, 2010), including: i) to increase the allocative efficiency of health services (by encouraging the provision of high priority and cost effective services); ii) to increase the technical efficiency (by making better use of existing resources such as health staff); iii) to improve equity of outcomes (for example, by encouraging expansion of services to hard-to-reach groups).

This difference in the reasons for implementing P4P affects naturally the design and in some cases the effectiveness of the scheme; those initial objectives also need to be clearly stated to allow for an evaluation to measure the impacts achieved (defined against the initial objectives).

Rwanda: the creation of a model?

The experience in Rwanda and more recently Burundi have provided the most positive examples in Africa so far and from which most lessons have been derived. Rwanda, for example, piloted RBF in 2002-2005 and decided then to be scaled up in the entire country, paying for performance at the health facility level in 2006. The results have been encouraging seeing an increase in the volume and quality of services, and increase of staff productivity and enthusiasm and motivation of health providers. Some of the challenges met were around building consensus on results indicators, the resistance of some existing players with their own models and the coordination of partners and activities on the ground. Among the lessons learnt from Rwanda are the need for strong implementation oriented coordination structures and the need for strong leadership and political will from authorities³². Morgan³³ emphasises the importance of Rwandan government's commitment, its willingness to try new things and being firm to lead donors to align behind its national plan. In Burundi, the pilot started in 2006 and the scale-up began in 2010. The results so far have also been positive and some of the lessons emerging include the need for a clear institutional framework to guide the process and the important role of community engagement and participation.³⁴

Results from the pilots must be interpreted carefully because analysis was limited to comparison with non-contracting provinces, in addition to other limitations³⁵, which made it difficult to untangle the effects of the performance-based schemes.

However, results from the three schemes showed improvements in coverage and quality of health services. There were large increases in the number of curative consultations and institutional deliveries and smaller increases in immunization against measles and in new family planning acceptors. PBI provinces also scored higher on quality measures such as effective management of deliveries and referral systems. Furthermore, views with respect to the frequency/adequacy of supervision were relatively positive and consumers paid less out of pocket in PBI regions36 (Morgan L, et al, 2011). This success of the pilots prompted the MOH to scale up PBI nationwide; it

³² MoH (2008) How did Rwanda Operationalise Performance-based Financing?, Ministere de la Sante, Presentation at the Results Based Financing Workshop, Gisenyi, Rwanda, October 2008

³³ Morgan L. (2010) Signed, Sealed, Delivered? Evidence from Rwanda on the Impact of Results-based Financing for Health, The World Bank, 2010

³⁴ Busogoro, J.F. and A. Beith (2010) Pay for Performance for improved health in Burundi, United States Agency for International Development, 2010

³⁵ Data were sometimes drawn from a relatively small sample of facilities and, thus, providers were not representative or statistically significant, and information for all indicators was not available long enough to surmise trends. There were also several other interventions happening simultaneously (e.g., community-based health insurance schemes (*mutuelles*) were scaled up).

³⁶ Quality was examined by randomly selecting eight health centers in Cordaid and HealthNet regions and comparing quality in eight randomly selected health centers from two non-PBI regions. A team verified data and assessed quality by examining a small sample of patient files in each health center to determine appropriateness of care. Each health center could score one point for each of 13 indicators of quality, and each province could score a maximum of 52 points (4 health centers x 13 points)

was adopted as a national policy as part of the 2005–2009 Health Strategic Plan and subsequently incorporated into the National Finance Law (Morgan L, et al, 2011).

The Performance Based Financing Community of Practice reports that PBF programs exist at various stages of design and implementation in at least 23 African countries.³⁷ While this approach can represent an opportunity there is still limited evidence of PBF impact.

2.1.1.2 Evidence of the impact of results based financing

The evidence base for RBF in health in Africa is however still limited. Very few robust impact evaluations have yet been completed, though some early ones do suggest improvements in some of the targeted indicators (Basinga et al. 2010). Moreover, although RBF has been reported to be capable of having an impact on quality of care (Peabody 2010), the current consensus is that early impact is more likely to be on volume of care (Basinga, 2010).

One recent overall assessment (Toonen, 2009) is that: "PBF is not the magic bullet to boost health worker performance, nor is it a ready-made solution to resolve a fragmented health system. However, having considered the contextual factors, the confounding factors, and the reliability of the available information, we conclude that in general PBF indeed can be instrumental in achieving better results in the health sector if compared to the traditional input financing approach."

It is important to draw a conceptual distinction between RBF and the payment of performance bonuses (as a particular form of RBF). While the payment of performance bonuses has been reported to have a positive impact on health worker behaviour and the adoption of more entrepreneurial approaches, rigorous evidence impact is still limited (Witter et al, 2011). Performance bonuses are usually a central component of RBF initiatives, particularly in contexts where there are enduring problems of inadequate public sector pay, but it is possible to have RBF where the use of the finance provided is restricted to an approved list of types of spending which could not include performance bonuses. In principle, the impact on system performance may differ for different types of spending allowed on the PBF payment regime.

2.1.1.3 PBF assessment framework: pre-conditions for PBF to be able to work

While the evidence base for RBF and its variants is still emerging, the general conclusion of the experience so far is that such approaches can improve results if well designed and implemented. Derived from experience and theoretical considerations, OPM has developed an assessment framework identifying 10 pre-conditions that need to be in place – or can be developed, for RBF to be implemented effectively and 3 additional conditions for it to achieve an impact on system performance (more details on the following requirements can be found in annex A):

Implementation requirements:

- 1. Split of responsibilities between purchasers and providers of health services
- 2. Autonomy of health providers
- 3. Predictable flow of resources
- 4. Capacity to manage (explicit or implicit) contracts between actors at different levels
- 5. The presence of a competent fund holder
- 6. Community involvement
- 7. Functioning monitoring system

³⁷ Countries known to have (i.e., programs are currently being implemented or being designed) or that once had PBI programs include Benin, Burundi, Cameroon, DRC, Eritrea, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, Somalia (Somaliland), South Sudan, Tanzania, Uganda, Zambia, and Zimbabwe

- 8. Independent verification mechanism
- 9. System for assessing staff performance
- 10. Adequate management arrangements

Impact and sustainability requirements:

- 11. Facilities can provide a service for which there is a demand (so resources can be productively used)
- 12. Political leadership and commitment
- 13. Capacity and level of finance can be sustained beyond the project.

2.2 User fees for health services

2.2.1 Cost of accessing health care in Africa

Following the Bamako Initiative adopted by African ministers of health in 1987, user fees for health services were introduced in most of SSA countries. In the context of the structural adjustment policies, the initiative was in general a condition of lending by the WB and IMF. The Bamako Initiative was also sponsored by UNICEF and WHO, as a mechanism to increase resources for the primary health care sector, in line with the Almaty commitment for increased focus on primary health care: with a very small and considerably reduced budget available for the sector, the initiative was supposed to capture a part of the households expenditure for health within the public system. In theory the Bamako Initiative has the provision of a safety net for the poorest; however this was seldom put into practice (Ridde 2011).

In a global context of fight against poverty, the economic consequences of illness in developing countries have been the focus of increasing attention (Foster A, 1994; Gertler P, et al, 2002). A recent study shows that about 150 million people annually suffer catastrophic financial shocks due to uninsured health care expenditures (Ke Xu DB et al, 2007). Health shocks, defined as unpredictable illnesses that diminish health status, are among the most important factors associated with poverty in LDCs. . Households facing health shocks are often affected by both the payments for medical treatment and the income loss from an inability to work (Wagstaff A, et al, 2003; Xu K, et al, 2003). Formal health insurance in developing countries is rare and health care is expensive (proportionally to the income) many households also lack access to formal credit and savings arrangements (Banerjee A, et al, 2007), correspondingly, much of the borrowing and saving by households is informal in nature and reliant on the social capital of communities.



Figure 2.1 Out-of-Pocket Expenditure (as Percent of Private Expenditure on Health)

Source: WHO, World Health Statistics 2012, available³⁸ at: <u>http://www.who.int/gho/publications/world health statistics/2012/en/index.html</u>. See also, WHO, Global Health Observatory, available at: <u>http://www.who.int/gho/database/en/</u>.

In a context of poverty, very poor health and commitment to achieving the Millennium Development Goals, health care access became a major issue (Gilson et al. 2007). One solution to increase access was to lower the financial barrier to access by exempting those who cannot afford to pay (Leighton and Diop 1995; Ridde 2008).

In 2009, Oxfam and 62 other NGOs published a report, "Your money or your life" to draw attention to the issue of user fees. The report states: "half a million pregnant women die each year because they do not have access to healthcare, over nice million children die each year before their fifth birthday and people are facing abuses such as being imprisoned in clinics, because they cannot pay doctors' fees" (Oxfam, 2009). Support for the abolition of user fees gained strong momentum: there is now an increasing understanding that charging fees for health care is one of the most significant barriers to progress in scaling up access to health care in poor countries.

International experience suggests that the case for reducing or removing official user fees for primary health services is strong. This is based on evidence that fees raise little money and tend to be an inequitable and an inefficient means of funding health care; besides associated with reduced use of services, especially by the poor and vulnerable; failure to complete treatment; and delays in seeking treatment (Pearson M, 2004). The WHO General Director, Margareth Chan declared in 2009 that "user fees for health care were put forward as a way to recover costs and discourage the excessive use of health services... This did not happen. Instead user fees punished the poor...

³⁸ The estimate for Iraq does not include expenditures of northern Iraq. The estimate for Serbia does not include expenditures incurred in Kosovo and the province of Metohia. ; Some country estimates are derived from scarce data

This is a bitter irony at a time when the international community is committed to poverty reduction." $^{\!\!\!\!^{39}}$

However, as mentioned in section 1.2.1, the fiscal environment of most SSA countries remains a constraint to fund the health services adequately; additionally it's not only about volume of funds, the questions how to abolish user fees demands careful preparation, thorough design and implementation of the policy and comprehensive accompanying measures⁴⁰. Evidence demonstrates that an abolition of fees calls for a comprehensive set of accompanying measures to be applied before abolition in order to avoid negative effects on the health system (Gilson et al, 2005).

The literature demonstrates that the abolition of user fees has had generally positive effects on utilization of services, and on reduction of catastrophic health expenditures (Ridde, 2011). However, in some cases the abolition of user fees does not have this expected impact, unexpected consequences are observed; additionally the implementation difficulties sometimes cancel the impact expected.

In some cases, such as Ghana, the application of the abolition of MCH was intermittent, depending on funding availability. Hence, some health facilities temporarily reinstated user fees (Penfold et al. 2007; Witter and Adjei 2007). In South Africa, research has shown that while there was a short term significant impact after the user fees abolition, it did not last. The number of visits among children and pregnant women grew rapidly after the first abolition measure, but when the abolition of the fees was extended to the whole population in 1996 it had little effect on the pre-existing trends (Wilkinson et al. 2001). In other cases, health workers started or continued to charge unofficial fees (Kajula et al. 2004; Witter et al. 2007), which cancelled the effect of the user fees abolition. When resources (e.g. drugs) are unavailable in the public sector, those who can, turn to paid services in the private sector (Kajula et al. 2004). In Uganda, although utilisation of health services by the poor significantly increased after the abolition of user fees, the incidence of catastrophic health expenditure among the poor did not fall. This appeared to be the result of the unavailability of drugs at government facilities (Nabyonga-Orem et al. 2008). The examples mentioned below of Ivory Coast and Niger abolition policy implications call once more for caution when designing and implementation such policy.

The study case on Burkina Faso will look specifically at this question, and look carefully into the introduction of targeted subsidize health care as introduced briefly below.

2.2.2 Targeted free health care

In some cases, when the decision of abolishing fees is not followed by at least an effective replacement of the revenue that used to be generated by the fees, such policy can even be harmful to the system. The Burkina Faso study case is an example of a gradual introduction of subsidies, allowing for certain services to be accessed free of charge gradually. The case explains the advantages and the challenges of the Burkina measured approach. Other countries in Western Africa have been much more radical in their reform which often caused great difficulties to the health systems.

³⁹ Dr. Margareth Chan (2009) 'Address at the 23rd Forum on Global Issues –The impact of global crises on health: money, weather and microbes' http://www.who.int/dg/

⁴⁰ Pre-requisites for successful abolition of user fees include careful preparation and appropriate accompanying measures in the fields of complementary funding sources, aid budget allocation, political leadership, providers' involvement, salary boosting, communication to the population, data collection and consideration of non-financial barriers on access to health care (K. Xu DB et al, 2006)

Box 2.1 The case of Niger and of Cote d Ivoire

Côte d'Ivoire introduced free health care in the spring of 2011. The policy was however not well thought through. Indeed, in January 2012, Ivory Coast health minister Yoman N'dri declared that the government was abandoning free healthcare for all. According to the news service, "As of February, the free service will only be available to mothers and their children," meaning "free care for deliveries and free treatment for diseases affecting children under six years old." The news service notes that the Minister recognized the implementation of the service had been poorly planned, including for drugs. The Public Health Pharmacy, the state's central body for distribution of medical supplies throughout the country, had just 30 percent of the stock required to implement across the board free health care.41

In 2006, Niger set up an ambitious programme for free Caesarean-section and healthcare for under-five children. A declaration entitled "Free health care in Niger is seriously ill, let's save it" was presented at a national conference around the fee exemption policy in Niger. This presentation was made to raise the alarm regarding the level of government debt, which is the third-party payer for the fee exemption system, towards health facilities and has been unable to reimburse the facilities. The first bottleneck identified is financing. Beyond the public budget, which does not cover all costs, there is no other source of funding for this programme. Other management issues such as over-billing or the method used to reimburse health facilities are also causing policy failure. Eventually the provider suffered from a lack of payment, but the patient is the first victim. Ridde et al, found in a study in 2008 that service utilization had then remained very low. (Ridde et al. 2008)

The lesson from both experiences is that a sound technical preparation both from the MOH (on the prevision of the demand and the estimation of the provider capacity and its necessary preparation) and MEF side (on budget allocation) has to be conducted before political commitment is declared, and that trade-offs will be necessary between the existing capacity of the systems and the commendable desire to reach universal coverage. To avoid the risk of making the entire system collapse or dry out, such reforms have to be designed and implemented gradually.

While looking at abolishing user fees trade-offs have to be made between the system capacity and the aspiration to increase coverage, as those policies respond to an equity concern but on their own do not consider all health system prerequisites.

Taking action on user fees alone also addresses mainly the symptoms and not the causes of poor performance at primary care level (Pearson M., 2005). Abolition of user fees can be a tactical 'quick win' and can leverage political attention for other wider reforms. It is also important to not be solely focused on user fees abolition as this can divert the attention away from the more difficult, less visible and potentially more important policy, institutional and governance challenges which prevent progress in the sector.

Governments and development partners should, therefore, focus their attention on how to allocate and manage the 95% of resources which are not raised through user fees. Equally important is meeting the target of allocating 15% of the government budget to health, committed to by African governments in the Abuja Declaration of 2000. (Pearson M., 2005)

⁴¹ Article reprinted from kaiserhealthnews.org with permission from the Henry J. Kaiser Family Foundation. Kaiser Health News

3 Conclusion

Health financing policy is a major instrument to further health system objectives of equity, efficiency and effectiveness as each of the health financing functions – collection, pooling and purchasing – impacts on the health system objectives. Each country has a unique path in progressing towards universal coverage and one of the complexities in determining health financing policy change, within limited financial resources, is the paradox that progress towards one objective often seems to come at the cost of regression for another.

However, whatever reform path is chosen, the details of implementation matter. Indeed, money itself does not produce health care. Funds have to be transformed into health care through a complex series of processes and functions. How that occurs is influenced by the system's incentive structures, organizational capacity, and regulatory framework. An increase in resources does not automatically translate into improved health outcomes.

Currently some African countries have started to focus on performance based financing and targeted free care to achieve progress on health system goals. The expectation is that similar policy reform across countries will not produce equivalent outcomes. It will therefore be important to firstly assess whether PBF, targeted free care, or any other health financing reform option is indeed the right 'next step' in a path towards universal access. Once a country has carefully weighed up the options, the complex task of crafting the chosen policy intervention to fit the contextual characteristics will provide the best guarantee for maximum impact on health outcomes.

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Annex A Preconditions for PBF

Split of responsibilities.

The Purchaser requires the capacity to design and cost a service package, including defining appropriate quality and other adjustments, (usually for PHC) as well as to manage contracts with health service providers, and independent verification agents for quality monitoring. This role also involves negotiation of business plans and prices of services with each service provider. The separation of purchaser and provider has the potential to improve incentives for efficiency and performance by clarifying responsibilities and making more transparent the roles of different agents and making it easier to assess their effectiveness in carrying out these roles as well as potentially increasing competition between service providers.

Autonomy

Facilities providing the performance based contracted services should have sufficient control over their staffing and other resources so that they can be held genuinely accountable for the results that they achieve and against which performance based payments are to be made. Autonomy also requires that sufficient management expertise and management processes and systems exist at the facility level. Autonomy may be constrained either by formal or informal exercise of authority from other actors in the system. Autonomy requires both a formal structure to guarantee it, and a credible commitment of non-interference in defined areas of responsibility (either formally or informally) as well as a credible commitment to supply the resources necessary for the functioning of the facility.

Predictable availability of resources

The weakness of the budget process as a mechanism for the management of resources is a significant obstacle to RBF implementation. A major problem under the current system of fund releases (similar to a cash budgeting system) is that it undermines the link between policy and the budget, by making it almost impossible for effective planning

Capacity to manage implicit or explicit contracts

Management of the contracts requires capacity for contract design (including developing a system of indicators that provides appropriate incentives for performance and that do not create biases in priorities or are subject to strategic or gaming behaviour by parties), negotiation and performance monitoring. It also requires that contractual arrangements are credible to each party.

Presence of a competent fund holder

Project funds will be managed by the Project Financial Management Unit (PFMU) which has an established track record at the existing financial management entity at the state level for World Bank operations. The PFMU will transfer funds to health facilities, in response to authorisation from the purchaser

Community involvement

Community involvement is an important requirement for strengthening accountability to service users. The NSHPIC envisages that contracts should be entered into between the Purchaser and the Ward Development Committee (or equivalent community body) who would also have a key role in determining how payments received for services provided by the facilities would be used and

allocated. These committees would therefore need to be representative of, and accountable to, PHC service users (particularly pregnant women and mothers); capable of managing and accounting (and being held accountable) for financial resources provided; able to exercise independent oversight of the performance of the facility; and to decide (together with facility management and within an agreed framework of rules) on priorities for the use of resources provided.

Functioning monitoring and supervision system independent verification mechanism

An independent verification process is necessary to validate information on the services provided by facilities (through checking that a sample of patients exist and have received the services reported) and to prevent possible manipulation of data or collusion between facility management and other agents.

It is envisaged that an organisation will be contracted to carry out independent verification of information supplied from facilities on the numbers of patients treated and other variables. This function is already performed by contracted NGOs for some national programmes (e.g. Roll Back Malaria) so it is anticipated that a similar arrangement could be established for the NSHPIC.

System for assessing and rewarding staff performance

The NSHPIC envisages that up to 60% of the PBF payment to facilities may be used for bonuses to enhance staff pay. For this to bring about an improvement in the facility's performance (and to be the optimal use of resources to achieve this effect) it will need to be the case that performance in principally constrained by staff incentives (rather than other factors such as weakness of management, inappropriate staffing, or lack of complementary non-staff resources), and that a system of performance bonuses can in fact be designed and implemented that will improve incentives, without having significant negative side-effects (such as prompting demotivation or industrial action by some workers because of perceived unfairness). This is likely to require strong management skills or a highly transparent system of allocation of bonuses that is introduced through a process of negotiation with key stakeholders.

Effective management arrangements

The list of management requirements set out in the NSHPIC PAD (para 87) and listed in Annex section C.1 above appears to be very demanding and unlikely to be achieved quickly, particularly in Adamawa and Nasarawa. The current budgeting and finance system at LGA level is extremely weak, while rationalising facilities and their resources on technical and productivity grounds is likely to prove difficult to implement given the continuing political pressures to expand the PHC network and to build new clinics. As discussed above, the process for strengthening autonomy at LGA and facility level will need to carefully phased and managed

Facilities can provide a service for which there is a demand

The capacity of RBF to bring about an improvement in health outcomes depends on the ability of facilities to provide a service (of sufficient relevance and quality) for which there is an effective demand from clients. This may depend on the level and quality of staffing available at a facility, as well as the existence, cost, and ease of access to alternative service providers. Cultural and gender issues may also constrain demand for some services. The ability of facilities to use resources provided to overcome constraints on demand will depend on both the level of autonomy that they possess (e.g. to change their staffing) and on the level of initiative and skills available at the facility

Political leadership and commitment

Strength of political leadership and commitment to RBF appears to be a critical determinant of the success of RBF initiatives (see Annex B). It is important though to distinguish two different levels of commitment and political support

Institutional capacity and level of finance can be sustain beyond the project

(extracted from a 2011OPM study: PBF in Nigeria – A political economy and institutional assessment)