

Challenges in Financing Health Sectors in Africa

Background Paper

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Challenges and Opportunities**

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Africa is economically and epidemiologically transforming fast. This paper explores the challenges and opportunities this throws up in achieving Universal Health Coverage (UHC). It will focus on why and how the Ministries of Finance and Health can work together to achieve UHC.

Defining characteristics of African health systems

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 African¹. 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 health out of domestically generated tax revenue. Managing increasing fiscal space within an expanding framework of national and sectoral development goals, with fiscal discipline and allocative and technical efficiency, sets the agendas of most African Ministries of Finance.

Africa is also on the move epidemiologically speaking. There has been a strong improvement in health outcomes especially for common communicable, maternal and childhood diseases over the last 20 years, even if many of these conditions are still top contributors to disease burden across the continent. Especially malaria and HIV/AIDS continue to be substantial causes of morbidity and mortality in some parts of the continent. At the same time, many countries experience an increase in disease burden due to non-communicable diseases and injuries. Developing flexible, adequately resourced, health systems that can effectively address this double burden of disease is what defines Ministries' of Health current challenges².

Over time, the number of health policy priorities has increased significantly. National health policies and strategies are aligned with targets agreed at the regional, continental, and international level. There have been seven major African health initiatives between 1987³ with the most recent in 2012⁴. Most African countries are members of the World Health Assembly (WHA) and there have been several international (for example the Millennium Development Goals, the Global Strategy for MNCH) and regional initiatives (for example the SADC Sexual & Reproductive Health Strategy (2006–2015)), all of which guide national health policy agendas. However, three more recent initiatives seem to capture contemporary health policy concerns in a consensual way, and are also embedded in the Sustainable Development Goals.

- Universal Health Coverage (UHC) is increasingly recognised, both globally and nationally, as a framework that comprehensively embraces, and provides effective direction to system-wide reform. UHC has been defined by the WHO as ensuring that "all people obtain the health services they need without suffering financial hardship when paying for them."⁵ Internationally, UHC has been supported by the WHO⁶ and the United Nations General Assembly. Nationally, the World Bank states that "*Today, more than 30 middle-income countries are implementing programs that should push them down the road toward UHC, and many more low- and middle-income countries are considering launching similar programs.*" Sub-sets of the UHC policy reform agenda have accounted for the brunt of health reform in Africa over the last two decades (see paper 4 for more detail).
- The "Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector", an initiative by the African Development Bank, recognises that wider and more equitable coverage of health services can be achieved through a more effective and efficient use of both existing and additional public and private resources which economic growth is expected to generate for health. Endorsed in 2012 by African Ministers of Finance and Health, it explicitly recognises universal health coverage as a policy goal, and situates this within a value for money (VfM) agenda. Since the United Nations Financing for Development Conference in Monterrey in 2002, further supported by the fiscal constraints resulting from the global economic crises in 2009, VfM has become a mainstream paradigm in health system reform, as reflected in the Sustainable Development Goals agreements.
- 'Fast Track: Ending the AIDS epidemic by 2030' is a recent initiative by UNAIDS, the Joint United Nations Programme on HIV and AIDS, which proposes rapid and substantial acceleration of HIV prevention and treatment programmes. While 'Fast Track' is not the object of an internationally binding commitment, it reflects the significant attention given to HIV, especially by those countries with generalised epidemics. As Africa is home to 70% of people living with HIV, the 'Fast Track' initiative, as part of a wider policy framework of international, regional and national initiatives, is likely to shape national health policy agendas (see paper 3 for more detail).

The rapidly changing fiscal and epidemiological context experienced by African countries, together with an increased emphasis on UHC and value for money and a sustained urgency to tackle the HIV/AIDS epidemic, sets national health policy agendas. Ministries of Finance and Health therefore have a unique opportunity to work collaboratively to improve health outcomes while delivering value for money and fiscal responsibility.

1 Stephen Jennings, *Africa: the world's most exciting investment story*, lecture for the Global Economics Governance Programme, Department of Politics and International Affairs, University of Oxford

2 Institute for Health Metrics and Evaluation, Human Development Network, The World Bank. *The Global Burden of Disease: Generating Evidence, Guiding Policy – Sub-Saharan Africa Regional Edition*. Seattle, WA: IHME, 2013

3 OAU *Declaration on Health as a Foundation for Socio-Economic Development*, Addis Ababa, Ethiopia, 1987

4 African Union "*Roadmap on shared responsibility and global solidarity for AIDS, TB and malaria in Africa*", 2012

5 World Health Assembly Resolution 58.33, 2005

6 World Health Assembly Resolution 58.33, 2005

Health spending benchmarks

Universal Health Coverage and Ending AIDS 2030, alongside other important health goals, require an increased investment of financial resources. One of the important challenges African countries face are therefore fiscal in nature.

Public spending capability grows with the economy. Ministries of Finance are stewards of fiscal policy and public finance management. Within the boundaries of the legislative and regulatory framework they allocate fiscal space to the various ministerial departments and public agencies in a pursuit of national development goals. While health sectors are increasingly committed to UHC and/or Ending AIDS 2030, other departments embark on equally ambitious policy agendas. This then throws up the question of the amount of public spending that should be allocated to particular issues.

There are essentially four common forms of guidance on 'targets' for health spending. First, there are political commitments. One of the most prominent in health in Africa has been the Abuja Declaration. In April 2001, African Union countries meeting in Abuja pledged to increase government funding for health to at least 15% of their annual budget, and urged donor countries to scale up support. Although both total health expenditure, and public health expenditure as a share of general government expenditure (GGE) have increased since 2001, to date, only a handful of countries have achieved the Abuja target. While internationally binding targets provide important means to advocate for more resources, Ministries of Finance are asked to honour commitments, often made by Heads of State, which taken together may exceed the budgetary room they dispose of⁷. Another drawback is that since the Abuja target is defined as a proportion of GGE, and therefore a variable number, there is no guarantee that it will be enough to provide an adequate health service. In 2012, the Sierra Leonean government spent approximately \$11.5 per capita in total (GoSL, 2014). Even if it had allocated 15% of government expenditure to the health sector, it would still have only spent \$17.50 per person, which is not enough to fund an adequate health sector.

A second approach to informing national health spending is based on international comparison of key health financing variables such as health spending per capita, GHE/GGE, THE/GDP⁸, and so on. Comparator countries can be chosen using a number of criteria such as similarity in level of economic development, epidemiological profile, and health policy objectives, or include countries that serve as a role model. While comparisons of this kind are inherently imperfect, they often provide useful benchmarks to both Ministries of Finance and Health in budget negotiations.

The third, and most common, source of guidance to determine

an adequate level of health spending comes from the costing of health plans, possibly within a multi-year structure such as a Medium Term Budgeting and Expenditure Framework. The advantage is that, if costing is done properly, it provides a solid basis for expenditure planning and implementation towards public health goals. The drawback may be a form of path-dependency: Ministries of health do not always have the capacity to carry out robust costing, resulting in health budgets being developed on historic budgeting patterns, rather than prospective planning.

A last form of guidance comes from international costing exercises. In part based on the criticisms of the Abuja health financing target, McIntyre and Meheus have recently proposed a lower limit benchmark for public expenditure on the provision of UHC that aims to recommend a minimum-but-adequate expenditure on health given the size of an economy and the absolute cost of basic health care⁹. They refer to three large costing studies that have estimated the absolute cost of provision of UHC in low-income countries, one carried out by the Commission on Macroeconomics and Health in 2001, and the other two done by the High Level Taskforce on Innovative International Financing for Health Systems in 2005. They recommend that the minimum acceptable cost of achieving UHC for a basic package of services is public spending (including mandatory social health insurance contributions) of 5% of GDP or \$86 per capita (expressed in 2012\$)¹⁰

Similarly, UNAIDS has carried out costing of the 'Fast Track' initiative, focussing on 28 countries that account for 89% of all new HIV infections. Unlike health, the cost will vary in function of (mainly) the share of HIV in the total disease burden. Zambia, Zimbabwe and the Solomon Islands have amongst the highest fiscal need per capita ranging between \$25 and \$35. In most of the countries, however, recommended minimum expenditure is much lower, and in over half of a subset of 45 countries, it is below \$5 in 2015.

International costing benchmarks such as those for UHC and the 'Fast Track' initiative can provide important, often forward, guidance to budget planning. However, ideally they should be complemented, or replaced by national level costing that is both accurate and sufficiently reflective of the stated health policy goals and actual service utilisation patterns.

Promises and commitments: the fiscal challenge

Going by international benchmarks for UHC (such as defined by McIntyre and Meheus) current health funding strategies will not deliver an adequate level of financial resources to achieve UHC. Current sources of funding relevant for UHC comprise essentially of public spending, donor funding, and mandatory social health insurance contributions. Out-of-pocket expenditure, often an important share of THE, is

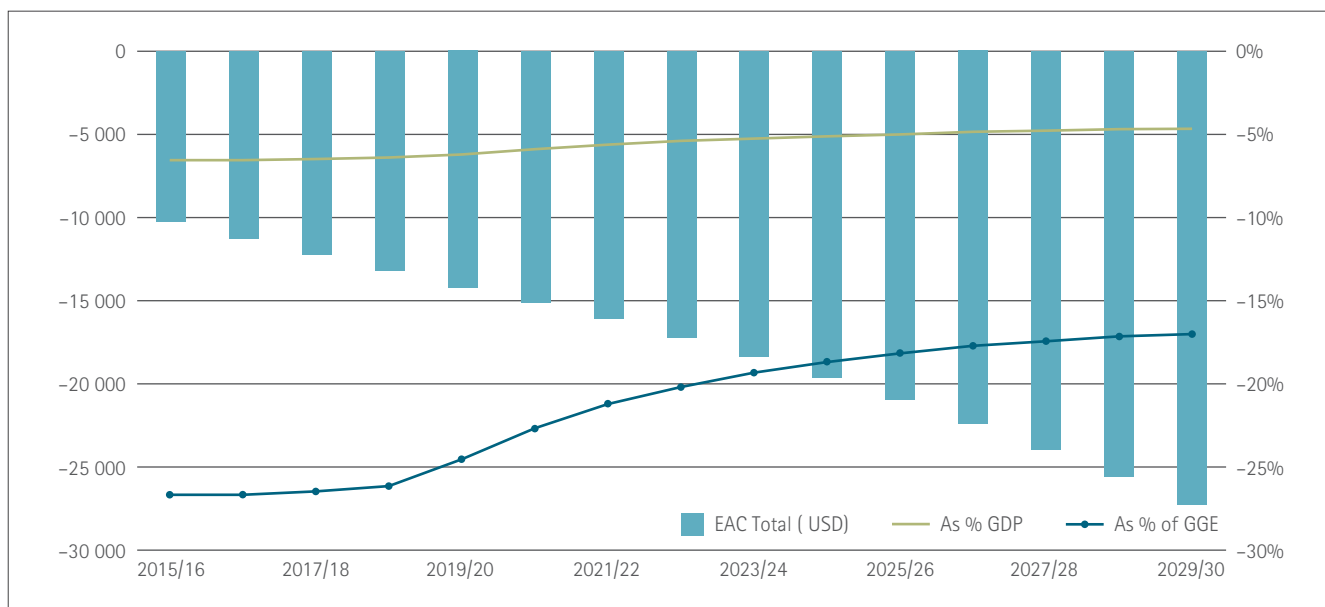
7 Alongside the Abuja Declaration, most African countries have also signed up to the Maputo Declaration saying that 10% should be for agricultural development or the Education for All Initiative saying that 20% should be for education. There are also agreements on spending targets relative to GDP for social protection (4.5%), water and sanitation (1.5%) and infrastructure (9.6%).

8 GHE: Government Health Expenditure, GGE: General Government Expenditure, THE: Total Health Expenditure

9 McIntyre, D. & Meheus, F., 2014. *Fiscal space for domestic funding of health and other social services*, London: Chatham House

10 Updated to 2015, OPM finds that this is USD 100 per capita (in 2015\$) (OPM, 2015)

Figure 1: East Africa Community regional combined HIV in UHC resource gap M USD and as percentage of GDP and Budget (2015/16 to 2029/30)



discounted as a source of funding because contradicts equity goals (inherent to UHC) or is not spent on cost-effective basic care. Private sector contributions, such as direct investments in health or voluntary private health insurance are also not taken into account. Going by these, arguably broad-brush rules, most African countries that wish to achieve UHC will face an important funding gap, for health, for HIV, and for health and HIV combined (see paper 3 for more details on the HIV funding gap). Figure 1 gives an example of the health funding gap across the East African Community¹¹ countries (Burundi, Kenya, Rwanda, Tanzania, Uganda). The funding gap is obtained by setting out the required resources for UHC (public spending = 5% GDP or USD 86, whichever is highest) against the available resources. The resources available are obtained by projecting forward the current sources of funding relevant for UHC (public spending, mandatory health insurance and donor funding). This produces a funding gap, which, across the five countries, amounts to USD 10 billion in 2015, and raises to more than USD 25 billion in 2030. To avoid this scenario, additional funding sources have to be identified.

Governments have only a finite number of options to expand fiscal space to plug funding gaps associated with UHC. The options available are often demonstrated by the fiscal space diamond, shown in Figure 2 below. The four corners correspond with the possible sources of fiscal space (for additional information see Paper 4).

One of the single most important ways to increase fiscal space is to re-prioritise funding within the public budget, i.e. increase the GHE/GGE¹² ratio. To set a target, countries can

inspire themselves from any of the 'benchmarks' discussed above. Increasing the allocation to health from the public budget remains a very attractive option, because of its potential to significantly contribute to health funding, and because it allows pooling and re-distribution of funding between population groups, providing a corrective mechanism on income-distribution, i.e. cross-subsidisation. From a conceptual point of view, this logic is similar to mandatory social health insurance. However, public budgets rely on the size of the tax-base, while social health insurance on the size of the formal labour market. Both can be small in low-income countries, and social health insurance systems are mostly complemented by tax funding.

Additional resources for health can also be obtained by expanding fiscal space as a whole, and then allocating (part) to health. While general tax reform often aims to do just that, i.e. increasing the tax-to-GDP ratio, innovative mechanisms can also provide a short-term workaround. Innovative mechanisms are discussed in more detail in Paper 6. They can mobilise up to an additional 0.5% of GDP for health.

Increasing donor funding up and above their current contribution is unlikely to be an important source of funding, as the growth rate of Development Assistance to Health is decreasing, and tending towards zero (see Figure 3 below). However, while this is true at the aggregate level, increased levels of international funding for health may be an option for countries individually, particularly fragile States.

Improving the technical efficiency of the health system is another important source of funding. The essence of the fiscal policy question facing Ministries of Health and Finance is how health services can be delivered more cheaply while achieving their high-level policy objectives, thus creating fiscal space for health, and reducing the funding gap. Since 2000, several studies have been conducted to estimate efficiency of national

11 Lievens, T, A Murray, P Booth (2015) Sustainable financing analysis of universal HIV and health coverage in the East African Community. EAC. UNAIDS

12 Government Health Expenditure/General Government Expenditure, or the share of the total public budget allocated to health

Figure 2: How to Increase Fiscal Space

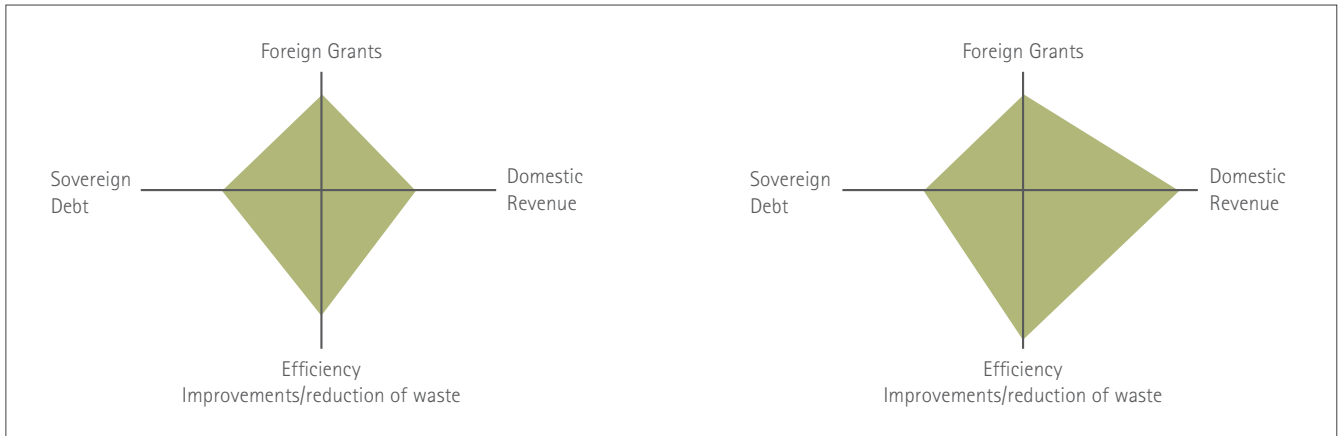
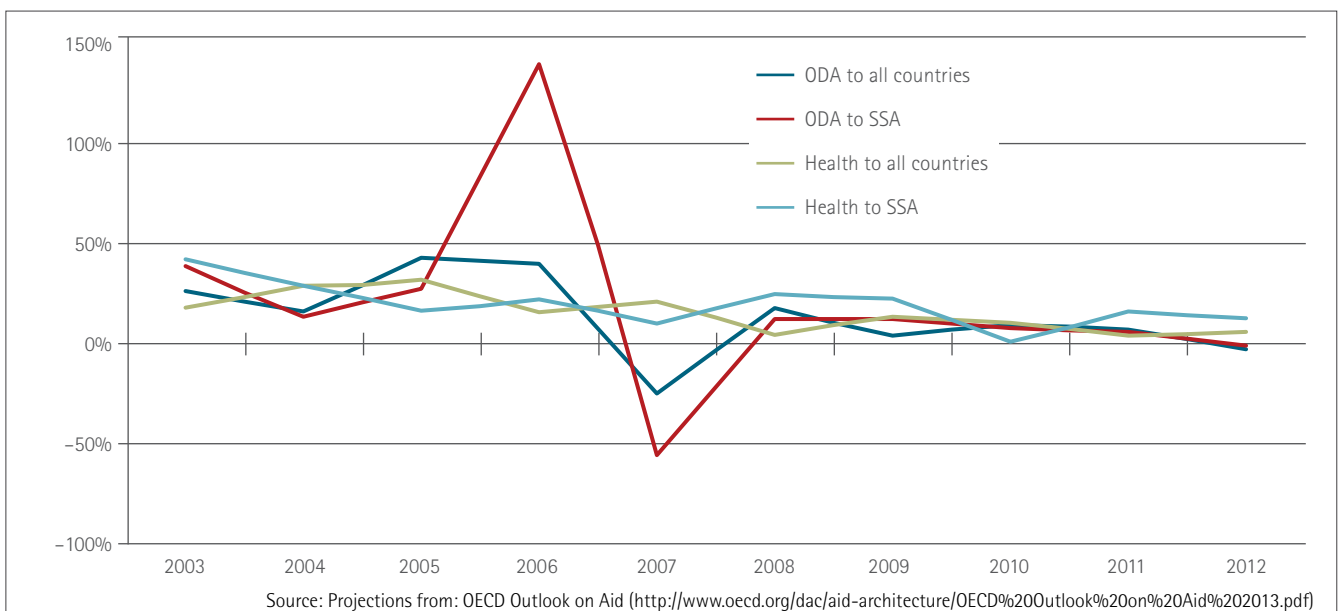


Figure 3: Comparison of ODA Disbursements (annual change)



health systems, and found a wide variation of the performance among countries. The World Health Report 2010 suggests that between 20 and 40% of health expenditure is 'wasted'. Recent evidence from a cross-country study covering 173 countries globally, finds that on average over the period 2004-2011 efficiency of health systems was 79%¹³.

There are several approaches to assessing efficiency, or more broadly, value for money, and there's no standard framework applicable to health that stands out. However, a common approach to VfM is structured around the transformation chain¹⁴.

This framework is often enriched with a focus on equity (commonly referred to as the fourth 'E'). Any of the VfM analyses – economy, efficiency (and cost-efficiency), effectiveness, cost-effectiveness would provide valuable insights in how services can be delivered more cheaply while achieving similar levels

of outcomes; or with great impact on health outcomes, with similar levels of resources.

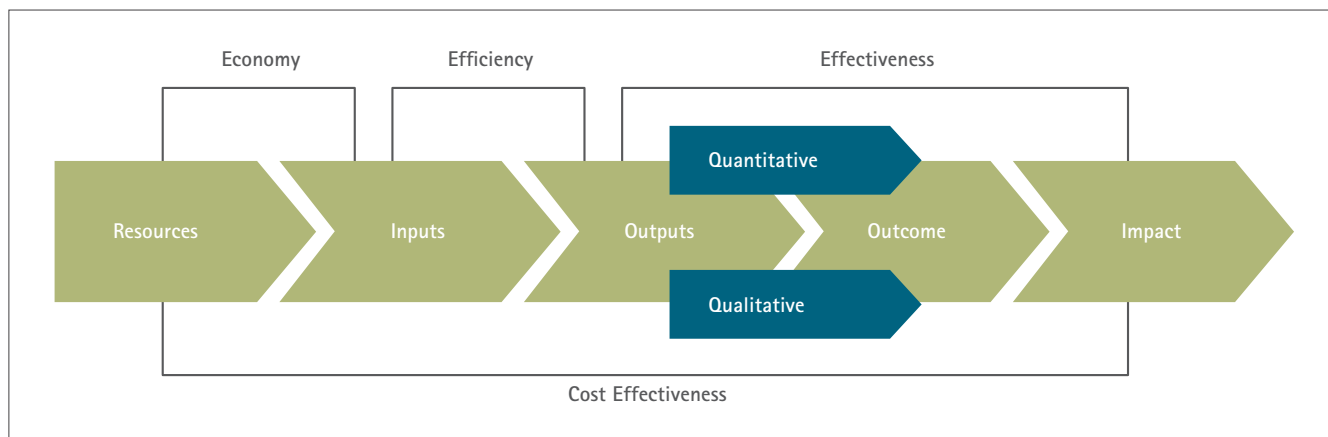
Borrowing is a last resort financing mechanism available to governments. The purpose of government borrowing is to adjust the timing of government expenditure. Instead of spending a sum each year on a particular expenditure, a government bond brings all the expenditure to the current year in return for a future stream of repayments. As such, government borrowing is simply an inter-temporal reallocation of expenditure. However, in addition to the future stream of repayments, government must also pay interest. For this reason, it is generally accepted that government borrowing should only be used for capital expenditure, where the future returns from an investment are expected to outweigh the cost of borrowing.¹⁵ Under this thinking, government borrowing should not be used to finance a permanent increase in current expenditure. However,

13 Zeng, Wu (2014), Evaluation of the performance of national health systems in 2004-2011: An analysis of 173 countries, Oxford Policy Management (unpublished)

14 Smith, P. C. (2009). *Measuring value for Money in Healthcare: concepts and tools*. QQUIP

15 An exception to this rule is the use of borrowing for temporary counter-cyclical fiscal policy during periods of recession. However, good fiscal policy dictates that any such borrowing must be repaid during the subsequent years of higher growth.

Figure 4: Value for Money: transformation chain



a study carried out to assess the applicability of an HIV/AIDS bond found that HIV/AIDS expenditures, although classified as current expenditure, were actually 'time-limited'.¹⁶ The authors suggest that the cost-benefit analysis of these expenditures is positive, with the cost per life year saved lower than many economic valuations of a life year would suggest. Therefore, while far from a typical 'capital' investment, a HIV/AIDS bond – and potentially a health bond – represents a cost-effective time-limited expenditure and so has characteristics that could warrant financing through borrowing. Thus, for countries that do not already have high levels of debt, and particularly those with high levels of growth, there is considerable potential to raise funds from borrowing. However, unlike the other mechanisms this source of innovative financing must be repaid.

Additional resources from a combination of re-prioritised public spending, innovative earmarked funding and technical efficiency savings, possibly topped with borrowing, will make significant progress towards closing the funding gap in any African country. Figure 5 below shows how the funding gap for UHC and Ending AIDS 2030 in the five East African Community countries can be closed by 2027/28 using a combination of these fiscal policy initiatives.

There are, however, at least three qualifying comments to this general pattern:

- Some, especially low-income countries do not have enough resources within their economy to achieve the UHC and Ending AIDS 2030 funding targets within the coming 15 years, even considering all possible options. These countries should receive additional financial assistance from the donor community (for example DRC, Malawi).
- Some, especially upper-middle income countries, do already spend enough resources to, from a fiscal perspective, achieve UHC and Ending AIDS in 2030. However, they do not currently achieve other UHC aspects. Often this is because of an inequitable distribution of that spending, leaving some population groups with poor access to care, or spending on cost-ineffective care, leaving cost-effective services underfunded.
- Global benchmarks of the cost of UHC (such as the USD 86 pc or 5% GDP public spending) will not adequately reflect

specific funding challenges associated with particular population health needs, such as nutrition, HIV and malaria, as they differ from country to country. Diseases that are particularly prevalent in some countries will require specific attention, both in terms of financing, and delivery (for more details see Paper 3).

Choice under fiscal constraint: how to spend to maximum effect?

In confronting the decision regarding 'what interventions to fund as a priority' governments want to ensure that the chosen resource allocation leads to the best possible results. While the ideal scenario would be for a government to have sufficient resources to implement its desired full package of health interventions and services, the likely reality is that resources available are not adequate to do so. Agreeing an affordable basic benefit package for health confronts the prioritisation challenge with a framework that will help countries to prioritise interventions based on some objective – usually of achieving specific technical and/or social outcomes – and thereby overcoming entrenched interests and/or historical inertia.

Evidence shows that a few health conditions matter most in terms of impact on health outcomes. The Commission on Macroeconomics and Health found that just a small number of conditions accounted for 90% of the difference in the death rate at younger ages between LMICs and high-income countries¹⁷ (2001). The earlier World Health Report 1999 found that almost one-third of all deaths in LMICs were due to communicable diseases, maternal and perinatal conditions, and nutritional deficiencies.

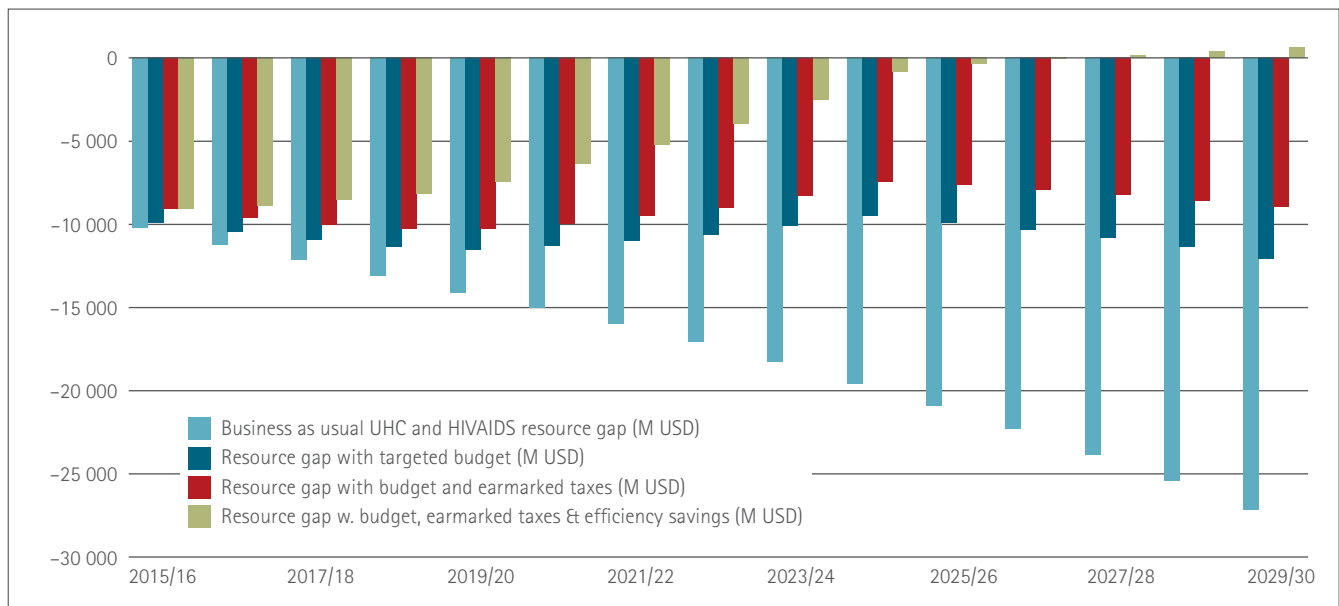
Any basic benefit package must begin by addressing the leading causes of morbidity and mortality in the country. Evidence from cost effectiveness analysis provides a good but insufficient basis for selecting priority interventions under fiscally constrained conditions. The choice process is further informed by political, policy and historical considerations.

To define a basic package of cost-effective services, offered to the entire population with financial protection (no

16 UNAIDS (2011).

17 WHO - Report of the Commission on Macroeconomics and Health, 2001

Figure 5: Closing the UHC inclusive of HIV Resource Gap for the EAC Region (M USD)



impoverishment due to accessing care), is precisely the essence of Universal Health Coverage, as discussed in detail in Paper 4. The scope of the benefit package (or the 'size of the cube') will often be determined in function of the resources available. As countries become richer, the benefit package can be expanded. However, this shouldn't undermine that the evidence suggests that USD 86 or public health spending 5% GDP is the minimum UHC threshold.

More financial resources for the health sector does not automatically lead to better population health outcomes. Indeed, fiscal space is just one aspect of achieving UHC, and for most countries, deep reform at all levels of the health system will have to go hand in hand with increased spending on health. This is the object of Paper 2 on Health financing and systems reforms.

Then a last, but far from least, dimension of health financing and system reform is equity in access and in financing. This implies that people with equal health needs have equal access to health care (horizontal equity in access), and also implies that richer households contribute proportionally more to funding health care (vertical equity in financing or progressivity). Ensuring equity in access and progressivity in financing is central to UHC and requires a sophisticated and persistent policy focus.

Let's roll up our sleeves: a collaborative agenda for Ministries of Finance and Health

Achieving high-level policy targets such as Universal Health Coverage, defining cost-effective benefit packages that address priority population health needs, and delivering value for money in the health system, within a changing fiscal and epidemiological context, is the task. One way of tackling this challenge more practically is to structure it in phases. These could, schematically, comprise the following steps, which are revisited in an iterative way:

- Defining a package of cost-effective services, with appropriate delivery strategies
- Costing a package of cost-effective services
- Developing a financing strategy for a package of cost-effective services with financial protection
- Delivering a package of cost-effective services with optimal efficiency
- Measuring outcomes including equity

This is a defining and continuing challenge, and when achieved, generates significant population welfare and economic returns. This then sets the collaborative agenda for Ministries of Finance and Ministries of Health in Africa.



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