Oxford Policy Management

CABRI
Collaborative Africa Budget Reform Initiative

Health financing

Trends in Sub-Sahara Africa

Nairobi, July 9-10, 2012

Overview

- **Health financing**
  - Context
  - Objectives
  - Health financing framework
  - Sources of funding and collection of resources
  - Purchasing of health services
- **Two trends in health financing in Africa**
  - Performance based financing
  - Targeted free health services
- **Conclusions**

Health financing - Context

- **Health financing in Africa today**
  - Highest disease burden
  - Lowest per capita spending
  - Large share of total health expenditure is from household out-of-pocket spending

    => Poor health outcomes

- **Health MDG 4, 5 and 6: MMR, CMR, HIV/AIDS, TB and malaria**
  - More money is needed
  - Less out-of-pocket expenditure
  - Better spending of resources: efficiency, effectiveness, equity

- **Health financing is key to achieving progress**

Health financing - Objectives

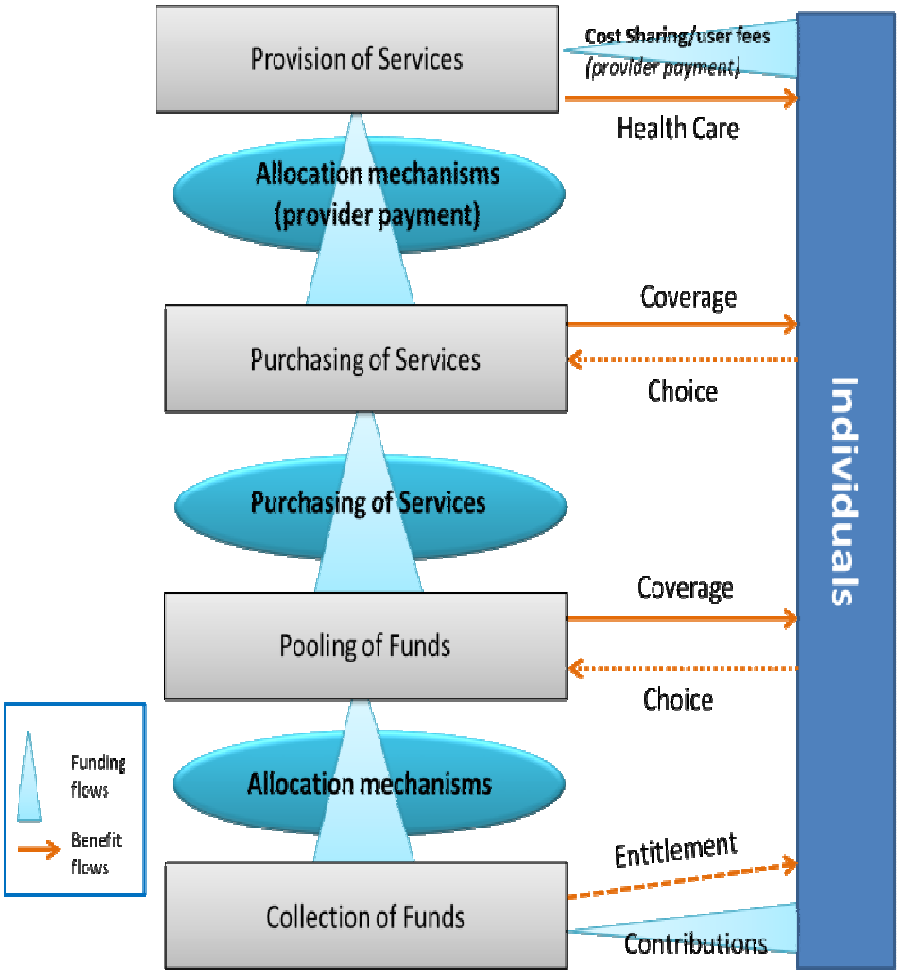
- **Health financing is "much more than a matter of raising money for health systems"**

- **Health financing is key to achieving health system objectives (WDR 2010)**
  - Improve level and distribution of health in the population
    - E.g. targeted free care (maternal health)
  - Improve level and distribution of the responsiveness of the health system to the expectations of the population
    - E.g. allocation of resources (basic benefit package), freedom of choice (vouchers), voluntary private insurance (services outside BBP)
  - Improve 'fairness' of financing contributions
    - E.g. SHI, targeted free care (poor populations)
  - Improve overall system efficiency, maximum attainment of goals with minimum resources
    - E.g. purchasing of health services

Health financing - Framework

- **Health financing functions (Kutzin, 2000)**
  - Collection
  - Pooling
  - Purchasing
  - Providing

- **Modalities of each of the functions, and interplay directly impacts health system objectives**
  - Tax revenue main source of funding => equity?
  - Fragmentation of risk and resources pools => efficiency? => equity?
  - Block grant based financing => efficiency?
  - Weak compliance to treatment protocols => effectiveness?



Health financing – Sources and collection of funds

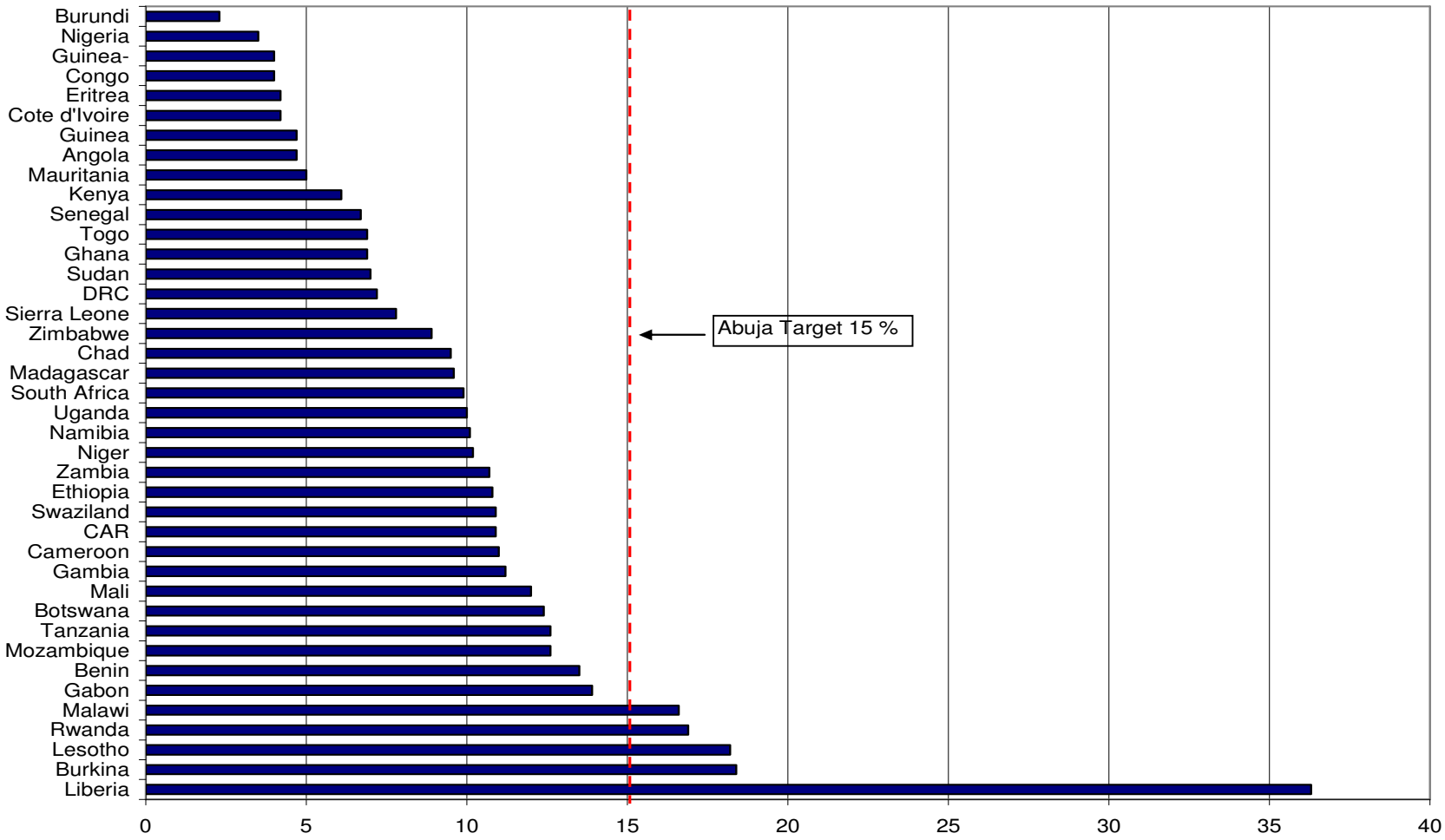
- **Common sources of funding for health**
  - General revenue
  - Social Health Insurance
  - Private Health Insurance
  - Community financing
  - Out-of-pocket expenditure (OOPE)
  - Donor funding
  - Alternative sources of funding

Health financing – Sources and collection of funds

- **General revenue**
  - **Generated from**
    - Direct and indirect taxes (personal and corporate)
    - Earnings from government enterprises (extractive industries)
  - **General revenue is main source of funding for health in Africa**
    - Government in Africa spend US$ 10.19 per capita on health (2005)
  - **Commission on Macroeconomics and Health**
    - US$ 34 per capita total health expenditure is required to supply a basic package of services (2001)
    - Abuja Declaration: “at least 15% of government expenditure to the development of the health sector”

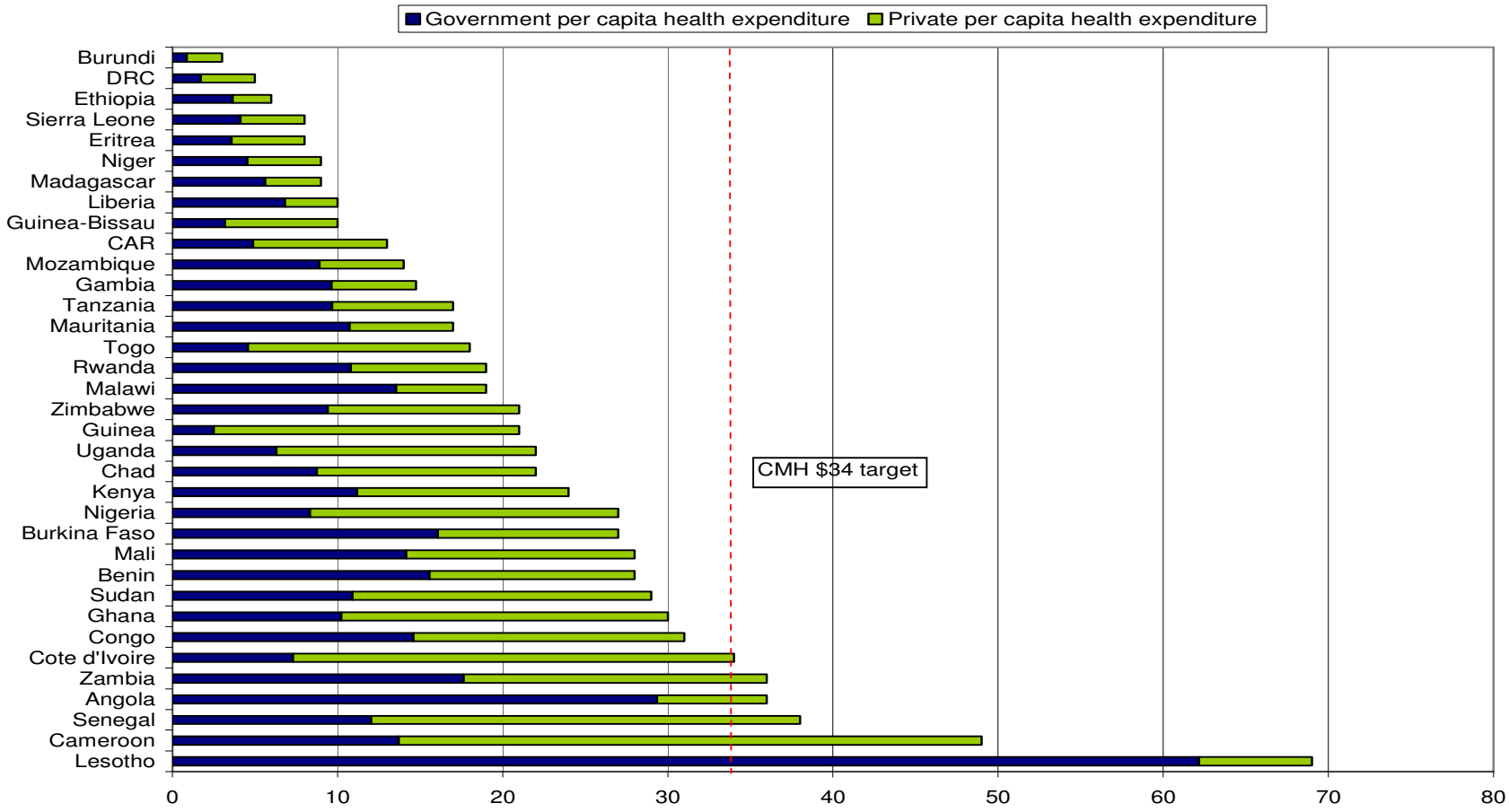
Health financing - Sources and collection of funds

- **Progress to Abuja declaration, 2008**



Health financing - Sources and collection of funds

- **Progress to Commission on Marcoeconomics and Health, 2008**
  - If governments honour Abuja target => 23 countries would not achieve CMH target



Health financing – Sources and collection of funds

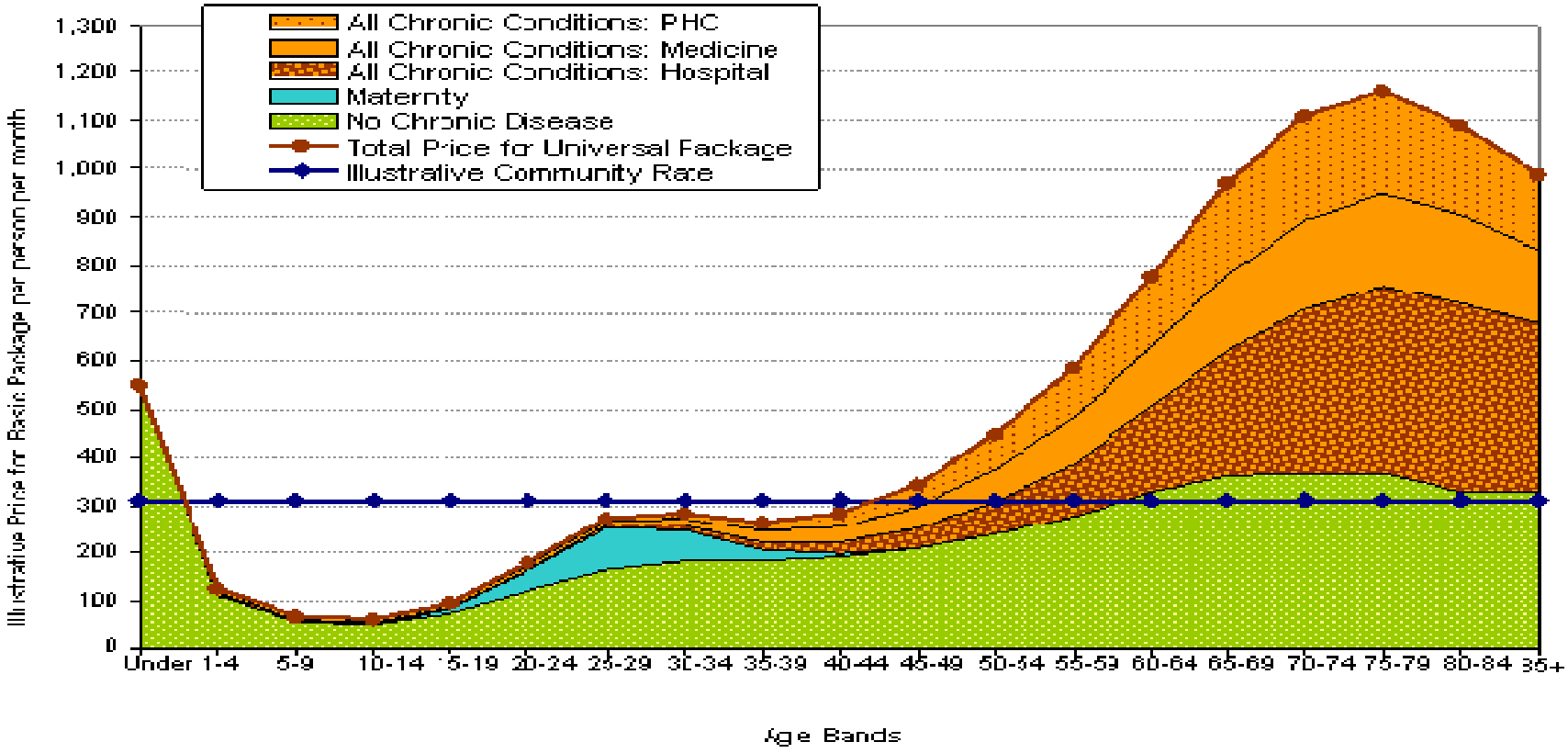
- **Social Health Insurance**
  - **Generated from a payroll taxes and employer contributions**
  - **Mandatory**
    - Circumvents economic problems with health insurance
  - **Earmarked taxes**
  - **Restricted coverage**
    - Government pay for poor
  - **Operational**
    - Require large formal employment sectors
    - High wages, low poverty, low dependency, high capacity to provide health care
    - Public or private management
    - Monopolistic, quasi-monopolistic or competitive fundholders
- **SHI in Sub-Sahara Africa**
  - SHI in all countries but limited population (and service) coverage
  - WHO / GIZ supported feasibility studies in a large number of contries => limited follow-up
  - Ghana, South-Africa

Health financing – Sources and collection of funds

- **Private health insurance**
  - **Market transaction**
    - Buyers pay a premium to insurance company which in return covers health expenditure for selected health risks and manages health care providers
  - **Individual or group based**
  - **Premium reflect health risk (and not ability to pay)**
  - **Challenges based on information asymmetry**
    - Adverse selection: bad risks drive out good risks
    - Moral hazard: insurance premium doesn't reflect the price of services and leads to overconsumption
    - Cream skimming: insurance companies focus on good risks
      - OECD: gave up on idea of strategic regulation of voluntary private health insurance
  - **Private health insurance in Africa**
    - Believed to be limited
    - South-Africa and Namibia

Health financing – Sources and collection of funds

- **Private health insurance**
  - South Africa, Heather McLeod, 2006

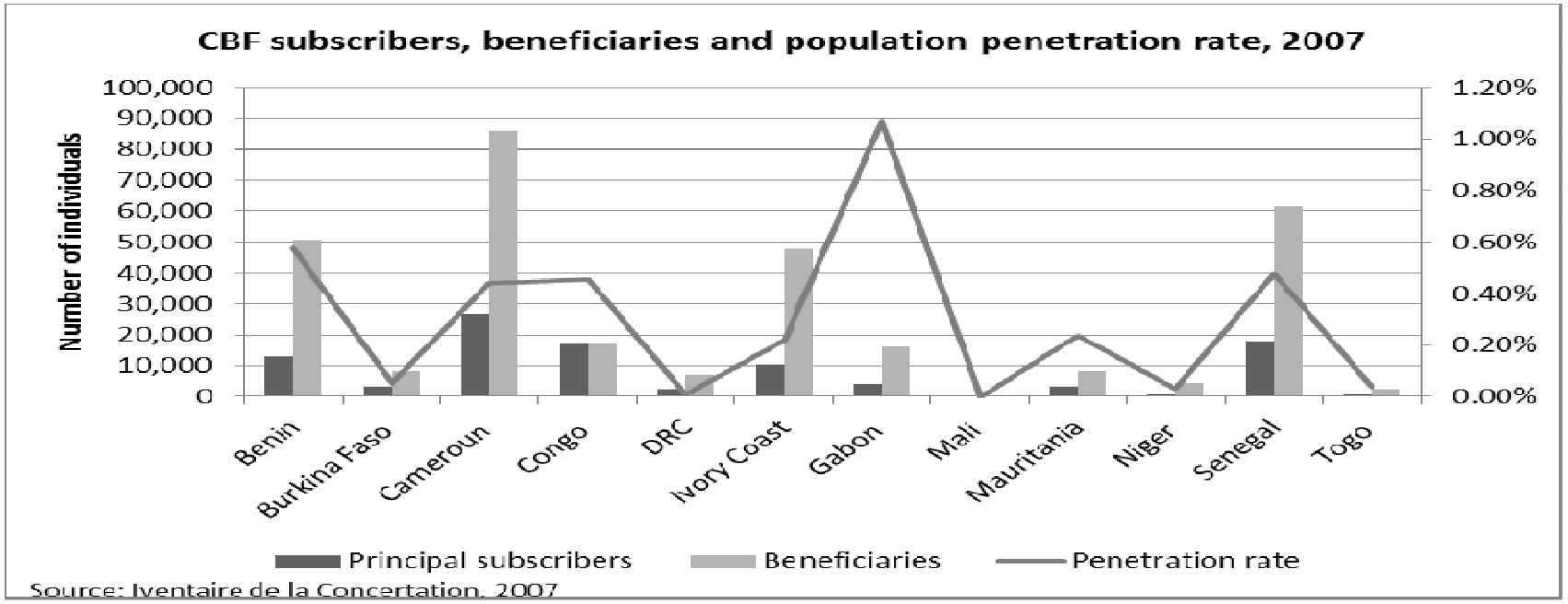


Health financing – Sources and collection of funds

- **Community financing**
  - **Mutual health organisations, health micro insurance**
  - **Voluntary**
  - **Low premiums**
  - **Diverse realities**
    - Initiated by: community, providers, service groups (e.g. micro finance)
    - Large – small membership pools
  - **Defined contribution / defined benefit**
    - Contrast with traditional schemes
  - **Conditions for success**
    - Strong social networks
    - Acceptable quality and quantity of care
    - Some ability to pay

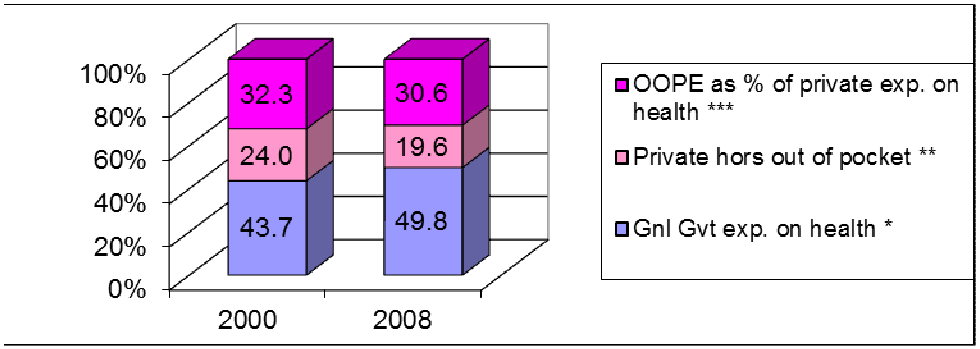
Health financing – Sources and collection of funds

- **Community financing**
  - **Sub-Sahara Africa**
    - Limited scale up
    - Financial sustainability: high drop-out rates, small risk pools, low premiums
    - Generally low cost-recovery, but: role in local health systems?
    - Generally not a cornerstone of health financing? However: Ghana, Rwanda



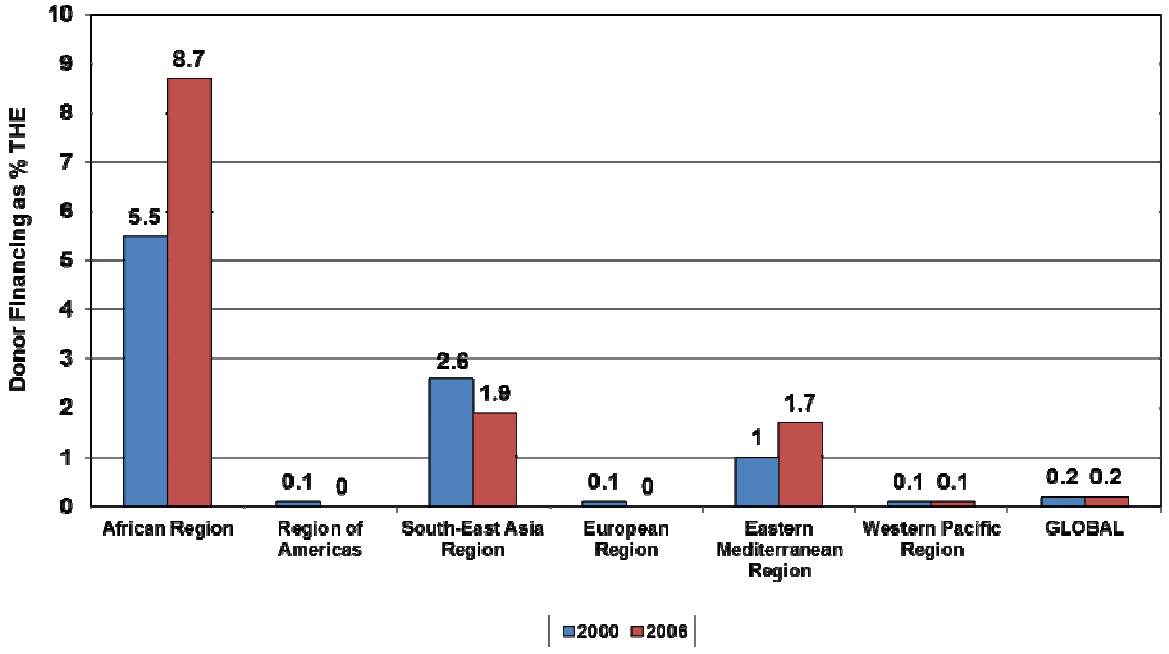
Health financing – Sources and collection of funds

- **Out-of-pocket expenditure**
  - **Direct household outlays to health providers for services, drugs and medical supplies**
    - Excludes indirect payments
  - **Catastrophic health expenditure**
    - Health expenditure is more than 40% of household disposable income
    - Households fall below poverty line following catastrophic health expenditure
  - **OOPE in Sub-Sahara Africa**



Health financing – Sources and collection of funds

- **Donor funding**
  - **ODA unprecedented high levels**
    - ODA as a share of African GNI 11.7% (2003, excl. Nigeria, South-Africa)
    - Donor financing for health by WHO region



Health financing – Sources and collection of funds

- **Donor funding**
  - **ODA for health in SSA unprecedented high in 2006 US$3.7 billion**
    - CMH estimates (2001) US$ 19 billion donor funding annually was required to offer basic package of services
  - **Donor funding raises issues of aid-dependency and accountability**
  - **ODA for health slowing down post 2008 financial crisis and global economic downturn**

Health financing – Sources and collection of funds

- **Innovative sources of funding**

  - **ODA for health slows down because of global fiscal constraint**
    - African countries go through economic transition
      - Economic growth 6% annual average last decade
      - 40% of 20 fastest growing countries worldwide are African

  - **Opportunity of increased future domestic revenue but current threat of diminishing donor resources**

    ⇒ Governments explore alternative sources of funding

  - **Limited number of popular choices amidst a wide range of possibilities**
    - Important to assess revenue potential alongside qualitative attributes

Health financing – Sources and collection of funds

- **Innovative sources of funding**
  - **Revenue potential**
    - Share of GDP
  - **Qualitative assessment**
    - Sustainability
    - Stability
    - Progressivity
    - Administrative efficiency
    - Side effects

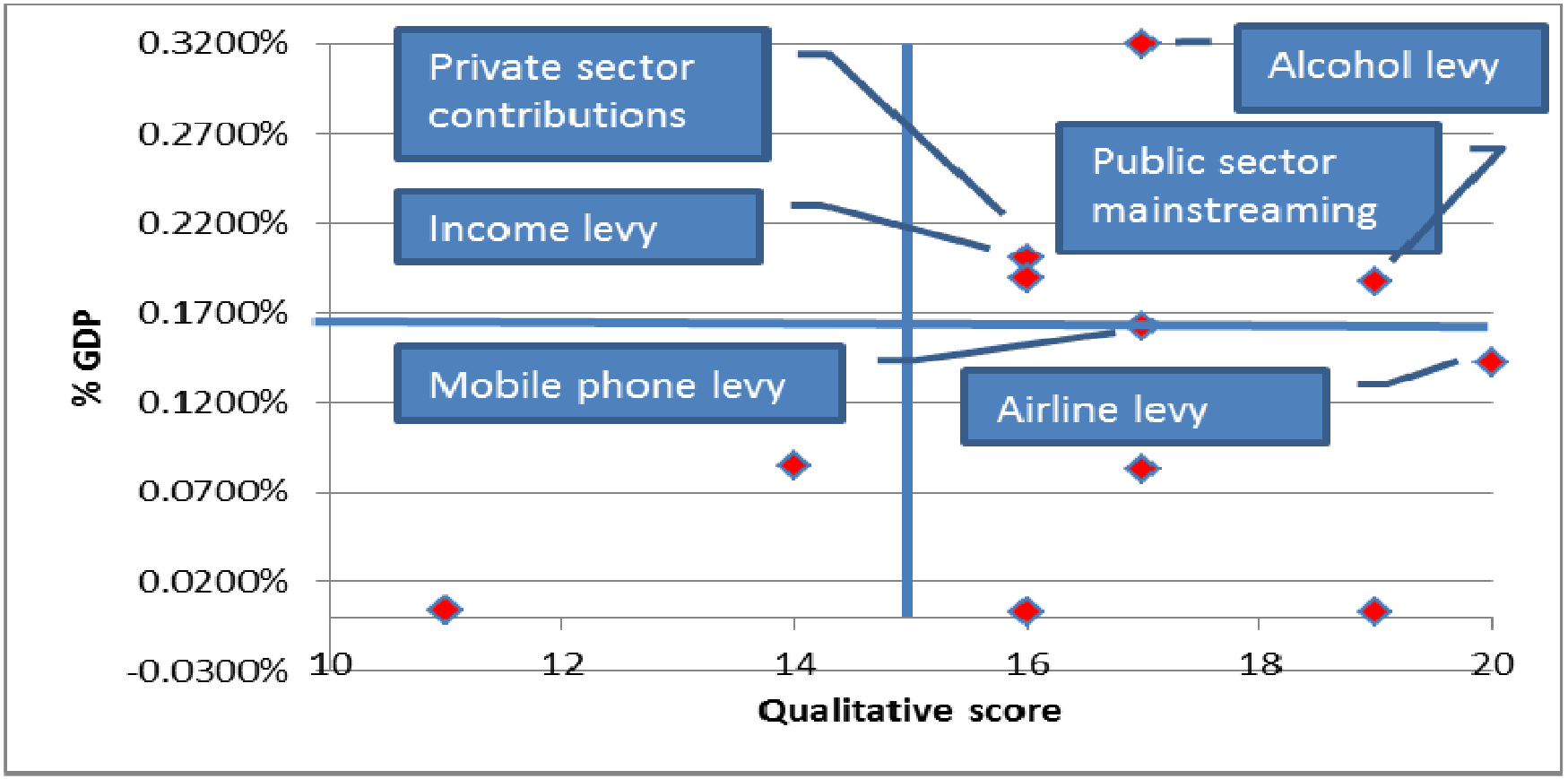
Health financing – Sources and collection of funds

- **Innovative sources of funding**

Mechanism	Sustainability	Stability	Progressivity	Administrative Efficiency	Side Effects	Total
Airline levy	4	4	5	4	4	21
Dormant funds	4	4	5	3	4	20
Tax on tourism	4	4	5	3	3	19
Income levy	4	4	4	5	1	18
Alcohol levy	4	4	2	4	3	17
Tax on remittances	4	3	2	4	3	16
Private sector mainstreaming	3	3	3	3	4	16
Mobile phone levy	4	4	2	4	1	15

Health financing – Sources and collection of funds

- **Innovative sources of funding**



Health financing – Sources and collection of funds

- **Relationship between sources of funding and health sector objectives**

Funding source	Health sector objectives
General revenue	Opportunity for redistribution, efficient, choice
SHI	Progressive source of funding, administratively complex, historical path
CBHI	Efficiency, equity
PHI	Cost-effectiveness, equity in outcome, choice
OOPE	Equity in financing, efficiency, choice

Health financing – Purchasing

- **African health systems require more resources**
  - Resources alone are not enough to achieve health sector objectives: how resources are spent is also important

- **Purchasing refers** to "the process by which pooled funds are paid to providers in return for delivering services"
  - Choice of benefit package
  - Choice of provider

- **Provider payment system** is the health service payment method together with supporting systems such as contracting, accountability mechanisms, management information systems, and so on

- **Different payment systems different incentives in the health system**
  - One payment system is not better than the other
  - Achieve right combination of incentives through a mix of methods

Health financing – Purchasing

- **Global budget**
  - Fixed block grant
  - Advance payment (agreement) for defined period and set of services
  - More sophisticated: case-mix adjustment, between line item virement
  - Cost-control, input-mix efficiencies, level of provision

- **Capitation**
  - Predetermined fixed rate to provide defined set of services to patients enrolled with the facility for a defined period of time
  - Patient choice and provider competition
  - Efficiency, underprovision

- **Fee for service**
  - Fixed rate (input or output) reimbursement for each individual service
  - Inefficiency through overprovision

Health financing – Purchasing

- **Case-based systems**
  - Per admission
    - Predetermined fixed rate reimbursement per patient admitted
    - Cost-savings for care facilitiy, cream-skimming
    - More sophisticated: case-load groupings such as DRG
      - Gaming around classification
  - Per diem
    - Predetermined fixed rate reimbursement per patient day
    - Increase ALOS, bed-occupancy, bed-capacity, shift from outpatient to inpatient care, limit care provider during stay at hospital

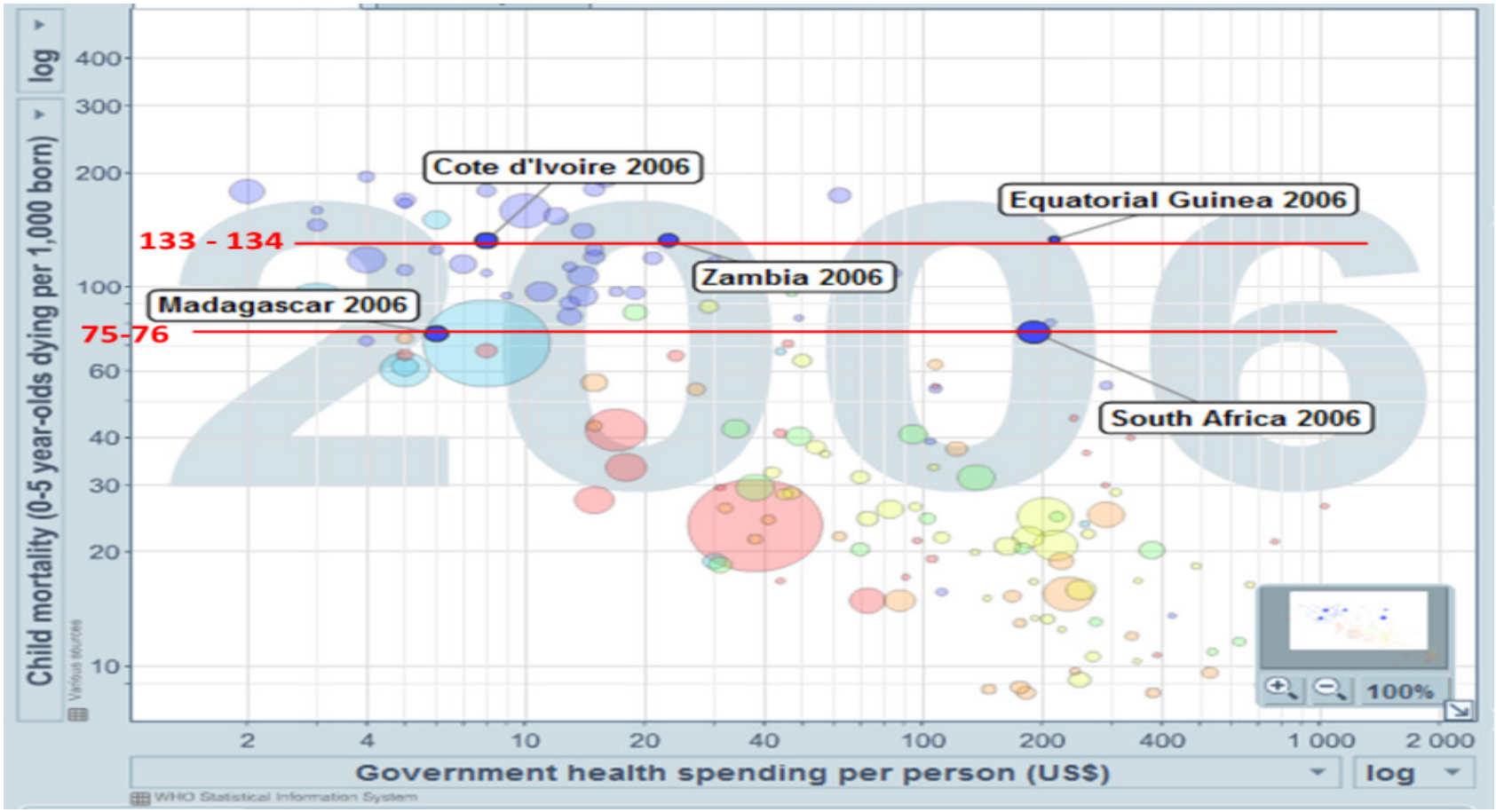
Health financing – Purchasing

- **Incentives created by purchasing regimes**

Payment mechanism	Basket of services paid for	Risk borne by: Payer	Provider	Provides incentives to: 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. Diagnostic Related Groups (DRG), performance-based financing (PBF), ect.)	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 admissions	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

Health financing – Purchasing

- **Different purchasing regimes, differences in 'health outcome / health expenditure'**



Health financing – Purchasing

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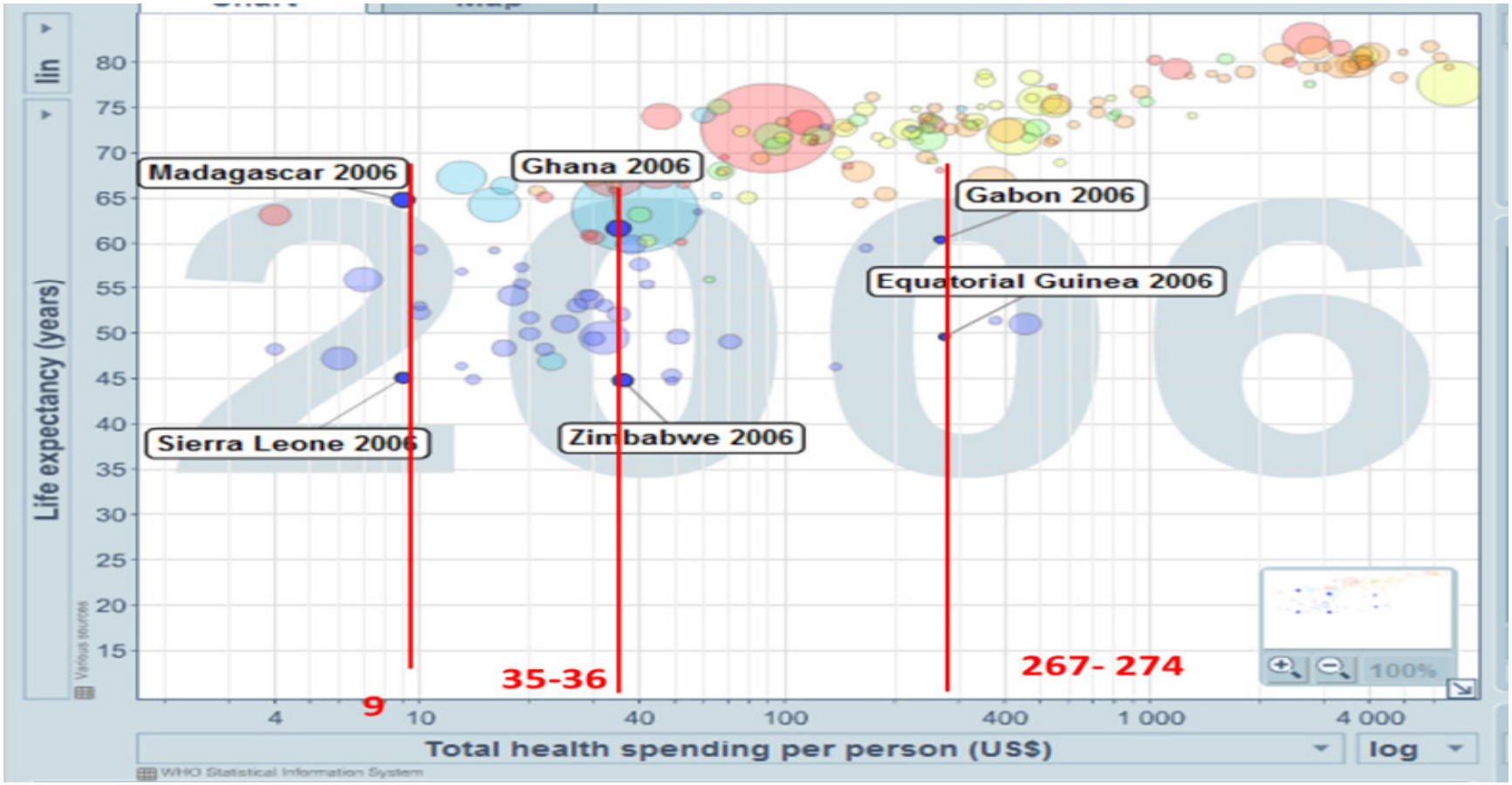


Health financing – Purchasing

- **WHR 2010 Main sources of inefficiencies**
  - Under-use of generic drugs
  - Inappropriate and ineffective use of medicine
  - Medial errors and sub-optimal quality of care
  - Inappropriate hospital size
  - Over-supply and over-use of equipment, investigations and procedures
  - Inappropriate or costly staff mix, unmotivated health workers
  - Inefficient mix / inappropriate level of strategies
  - Leakage, wastage, corruption, fraud

Health financing – Two common trends

- **Performance based financing**
  - **Increased attention** to improve performance of individuals, organisations and governments
  - **Variety of designations / mechanisms**
    - Performance based incentives, Pay for performance, Results-based financing, Output-based aid, Conditional-cash transfers
    - **"Transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target"**
      - Patients: health-related actions
      - Providers: achieve targets
      - Managers: timely and accurate submission of HMIS or set performance targets for the providers they are responsible for

Health financing – Two common trends

- **Performance based financing**
  - **OECD**
    - Quality, cost-containment, rationalisation of care
  - **Low and middle income countries**
    - Under-provision of care, allocative efficiency, technical efficiency, equity
  - **Rwanda**
    - P4P scheme supplements an input-based facility budget
    - Bonus payments for quantity and quality of key-schemes
    - Indicators based on health sector priorities, ministry budget and previous experience
    - Quantity bonus: amount paid per unit (e.g. US$ 4.59 per facility delivery)
    - Quality index [0,1] multiplied with output score
    - Bonus is paid to facilities and used at facility's discretion
      - 77% used for staff bonuses (equivalent to 38% salary increase)

Health financing – Two common trends

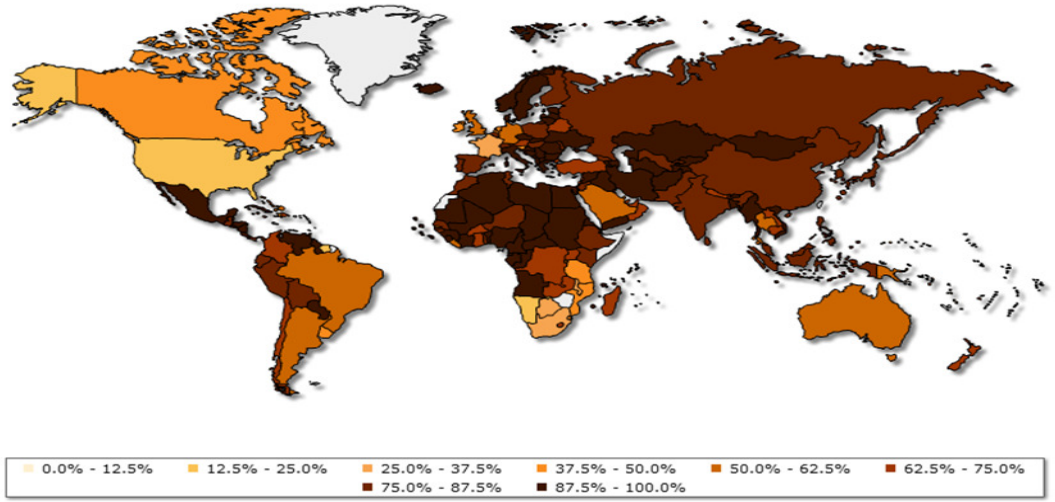
- **Performance based financing**
  - **Rwanda (cont'd)**
    - Results are broadly positive
      - Large increases in curative consultations, institutional deliveries
      - Better immunisation coverage
      - Improved quality such as management of deliveries and referral patterns
  - **PBF at various stages of design and implementation in 23 African countries**
  - **Discussion**
    - Very limited robust evidence although descriptive often qualitative reviews are available
    - Limited information on cost-effectiveness

Health financing – Two common trends

- **Performance based financing**
  - Pre-conditions for PBF?
    - Provider-purchaser split
    - Health provider autonomy including ability to retain financial resources
    - Predictable flow of resources
    - Capacity to manage and enforce contracts at different levels
    - Competent fund holder
    - Community involvement
    - Effective monitoring system
    - Independent verification mechanism
    - System to assess staff performance
  - Impact and sustainability requirements?
    - Demand for facility supplied services
    - Political leadership and commitment
    - Sustainable implementation and financing capacity

Health financing – Two common trends

- **Targeted free care**
  - **Context**
    - Lack of effective risk pooling / health insurance
    - High occurrence of OOPE basis of pervasive catastrophic health expenditure: 150 million people annually
      - Severe health shocks which go untreated lead to poverty
    - OOPE as a % of private health expenditure



Health financing – Two common trends

- **Targeted free care**
  - **Context** (cont'd)
    - OOPE for primary care
      - Generates little resources
      - Inequitable
      - Reduced use of service, delayed treatment, failure to complete treatment
  - **Increasing consensus that OOPE is significant barrier to progress in access to care**
  - **Fiscal constraints => targeted free care** especially priority highly cost-effective packages of care such as primary health care, child and maternal health care

Health financing – Two common trends

- **Targeted free care**
  - **Discussion**
    - Positive effects on utilisation and catastrophic health expenditure
    - Implementation challenges
      - Increased utilisation challenges provider capacity
        - Improved drug supply
          - Ivory Coast just 30% drugs available to support across the board free care
        - Adequate human resources for health
      - Cash at facility from OOPE must be replaced
        - Adequately determine unit-cost or adequate reimbursement level
        - May require PFM reform
        - Unofficial charging may continue
    - Careful assessment of system capacity and careful preparation of implementation are necessary conditions for successful implementation

Health financing – Conclusions

- **Health financing major instrument to achieve health system objectives**
  - Each health financing function impacts on health system objectives
- **Modalities in each of the health financing functions create a complex system of incentives**
- **Each health system and health financing strategy is unique and the focus is on understanding how incentives are structured throughout system**
- **Pay-for-performance and targeted free care offer opportunities to make progress on health system objectives**
- **A careful review of how these mechanisms alter the incentive structure, as well as a careful preparation of implementation are necessary conditions for success**

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Thank you