Health Financing in Africa: More Money for Health or Better Health For the Money?

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Harmonization For Health in Africa
OUTLINE

MORE AND BETTER MONEY: WHERE ARE WE?

A TALE OF ONE COUNTRY: RWANDA’S INNOVATIONS IN HEALTH FINANCING

FROM HERE TO THERE

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Harmonization For Health in Africa
Maternal Mortality Remains Very High in SSA

Source: World Development Indicators

Harmonization For Health in Africa
Most countries in SSA are off track to reach MDG5
Most SSA countries spend less than US$50 per capita on health.
Some Countries Have Problems Accommodating even a Basic Package of Services
More than half of health expenditures in SSA are private.
Out of Pocket Spending dominates private financing in most countries.
External aid is an important source of health spending in Sub-Saharan Africa
Six years to the MDGs

- The MDGs horizon is six years away: what are the low hanging fruits? What is most effective? What can be quickly scaled up?

- The health sector does not produce results. Why is it? It does not need to be so: some countries are doing much better than others..

- Some countries give very little priority to health..why? What needs to be addressed?
Critical issues to be addressed

- Fragmentation and donors’ processes disconnected from country processes
- Planning and Budgeting not based on evidence and analysis of country specific constraints to delivering high impact interventions
- Public money benefits richer groups
- Public Financial Management frontline providers do not have resources (PETS)
- Post colonial civil service models reach their limits. Dramatic lack of linkage between performance and incentives.
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Harmonization For Health in Africa
Rwanda

- A small country in Central Africa
- Genocide in 1994
- In 2005, 4/10 births attended by a health professional.
- Infant Mortality: 86 per 1,000
- HIV: 3.1%

Rwanda

- Shortage of human resources for health services
- No cash resources in health facilities
- Low levels of productivity and motivation among medical personnel
- Low user satisfaction & poor quality of service leading to low use.
Rwanda has undertook major reforms to strengthen accountability of all institutional and individual actors for MDGs related results...
..through a shift of paradigm..

- **Fiscal Decentralisation** with strong governance structures and community participation.

- **IMIHIGO**: Performance contracts between President of the Republic and mayor of Districts;

- **PBF**: Performance Based Financing;

- **CBHI**: Community Health Insurance;

- **Autonomy** of health facilities, including hiring and firing of health personnel;
Strengthening accountability in the health sector in Rwanda

- **NATIONAL GOVERNMENT**
  - Local Government
  - Performance Based, Cash and In Kind Investment Input Subsidies Transfers

- **LOCAL GOVERNMENT**
  - Performance Contracts

- **CLIENT POWER**
  - Clients / Citizens
  - Community Governance
  - Community Health Insurances Mutuelles

- **VOICE**
  - Umushyikirano, Citizen Report Cards, Ombudsman

- **AUTONOMOUS FACILITIES PROVIDERS**
  - Community Health Workers Providers
Results show Rwanda is now back on track towards the health MDGs...
All income groups benefit although inequities still persist ...

Under five mortality trends by income quintile (2005-2007)

Rwanda: Coverage with MDGs High Impact Interventions increases

![Bar chart showing coverage improvements over time in various health outcomes:]

- % delivered in a health facility TOTAL
- DPT3 (%)
- Currently Using any modern FP method (%)
- % U5 who slept under an ITN the past night

**Harmonization For Health in Africa**
Increase in utilization of assisted deliveries

Decentralization

- Administrative, fiscal and financial decentralization has provided large sums of money to local levels of government and given them much flexibility by providing them with block grants.
Total health personnel in publicly funded facilities has almost doubled in 3 years ...

Source: Public Expenditures Review Rwanda; 2005
Financing has more than tripled in four years (going from USD 7.5 to 30.3 millions, of which the PBF has grown more than tenfold from USD 0.8 to 8.9 millions)

Source: Public Expenditures Review Rwanda; 2005
Health Insurance in Rwanda

- Micro-Insurance model with two levels of re-insurance funds
- Tax subsidy and cross-subsidy from formal sector insurance
- Rapid increase in enrollment from 7% in 2003 to 91% in 2008
- Mutuelle enrollment significantly improves access to health care at all income levels, including the poorest – and reduces inequality in access, particularly among the top four quintiles.
- Mutuelle enrollment significantly reduces the risk of catastrophic health expenditures.
Rwanda: Scaling up of community health insurance

Source: MOH Rwanda; 2005 EICV 2005
At all income levels, those enrolled in “mutuelles” are much more likely to use health services.
Performance-based Financing (PBF)

- Developed after extensive piloting from 2001-2005
- Objectives
  - Focus on maternal and child health as well as communicable diseases (MDGs 4 & 5)
  - Increase quantity and quality of health services provided
  - Increase health worker motivation
- Financial incentives to providers to see more patients and provide higher quality of care
- Operates through contracts between
  - Government
  - Health facilities providing services
<table>
<thead>
<tr>
<th>OUTPUT INDICATORS</th>
<th>Amount paid per unit (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visit Indicators: Number of ...</strong></td>
<td></td>
</tr>
<tr>
<td>1. curative care visits</td>
<td>0.18</td>
</tr>
<tr>
<td>2. first prenatal care visits</td>
<td>0.09</td>
</tr>
<tr>
<td>3. women who completed 4 prenatal care visits</td>
<td>0.37</td>
</tr>
<tr>
<td>4. first time family planning visits (new contraceptive users)</td>
<td>1.83</td>
</tr>
<tr>
<td>5. contraceptive resupply visits</td>
<td>0.18</td>
</tr>
<tr>
<td>6. deliveries in the facility</td>
<td>4.59</td>
</tr>
<tr>
<td>7. child (0 - 59 months) preventive care visits</td>
<td>0.18</td>
</tr>
<tr>
<td><strong>Content of care indicators: Number of ...</strong></td>
<td></td>
</tr>
<tr>
<td>8. women who received tetanus vaccine during prenatal care</td>
<td>0.46</td>
</tr>
<tr>
<td>9. women who received malaria prophylaxis during prenatal care</td>
<td>0.46</td>
</tr>
<tr>
<td>10. at risk pregnancies referred to hospital for delivery</td>
<td>1.83</td>
</tr>
<tr>
<td>11. emergency transfers to hospital for obstetric care</td>
<td>4.59</td>
</tr>
<tr>
<td>12. children who completed vaccinations (child preventive care)</td>
<td>0.92</td>
</tr>
<tr>
<td>13. malnourished children referred for treatment</td>
<td>1.83</td>
</tr>
<tr>
<td>14. other emergency referrals</td>
<td>1.83</td>
</tr>
</tbody>
</table>
Delivery at the health facility increased overall in Rwanda, but 7% more in PBF facilities between 2006-2008....
In the last years, PBF has increased prenatal care quality significantly...
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MDGs are ambitious: scaling up will be challenging to implement

- SSA Countries require increased and better allocated domestic and external funding for strengthening their national health systems in order to achieve the MDGs.
- Most resources are to come from countries’ contributions:
  - need for domestic advocacy to raise attention to national budgeting processes
  - Need to channel private spending into risk pool
- Importance for external aid to be catalytic: need to focus on results and efficiency gains
Evolution of Health Financing Systems

Low Income Countries
- Patient Out-of-Pocket
- Social Insur
- Gov’t Budget
- Community Financing

Middle Income Countries
- Priv. insur
- Patient Out-of-Pocket
- Social Insur
- Gov’t Budget

High Income Countries
- Government Budget/MOH
- Patient Out-of-Pocket
- National Health Service
- Social Health Insurance
- Private Insurance

Source: Modified from A. Maeda
Making private money more efficient: Health Insurance

- As out of pocket spending has been growing recently, the need for pooling emerges as a main policy priority in SSA.

- Two African countries (Ghana and Rwanda) are achieving groundbreaking success on health insurance pushing the limits of the innovation “frontier”.

- These countries demonstrate that it is possible to achieve rapid scale up of health insurance with actual effect on health utilization and income protection.
Making public money more efficient: Results Based Financing

- Purchasing of results and outputs replacing input based financing
- Promising results in Afghanistan, Burundi, DRC, India, Haiti, Nepal, Zambia
- Adopted and initiated in Benin, Ghana, Eritrea, Ethiopia,
- Scaled up in Rwanda and positive results from rigorous Impact Evaluation
Conclusion

- With the MDGs finish line in view, a strong dialogue between MOH and MOF is more needed than ever
- Dialogue can be centered around the production of results: the health sector can do it
- Both supply and demand side financing need to be tapped
- Some hard issues need to be tackled: budget reform, a new vision for public workers, PFM reform around decentralization, autonomy and results focus
THANK YOU!