Health Financing in Sub-Saharan Africa 2007

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February 28, 2007

Organization of presentation

- Context information
- Social health insurance
- Community-based health financing
- Other approaches
- Future prospects
- Conclusions

Situation in sub-Saharan Africa

- Lowest income region of the world
- Positive per capita income growth in last 5-10 years in non-war countries
- Health indicators poor, but improving in non-HIV, non-war countries

Health financing

- Low health spending by governments:
  - Low tax revenue
  - Low shares of total spending to health
  - Result: about $12-15 per capita per year
- Donor support adds $4-5 more
- Private spending about equivalent of government and donors together

Service delivery

- Governments own and operate hospitals and health centers
  - Wide geographic coverage with primary care; hospitals in larger urban centers
  - Sometimes charge user fees (Bamako Initiative), sometimes not
- Private service delivery growing rapidly
  - Concentrated in urban areas
  - Charge user fees

Broader context

- Bamako Initiative
- Sector Wide Approach
- Global initiatives: GFATM, GAVI, Roll Back Malaria, Stop TB, etc.
- Millennium Development Goals
- Poverty Reduction Strategy Papers
- Medium-Term Expenditure Framework
- New technologies: new vaccines, HAART

Financial risk sharing

- Limited, with some notable exceptions
  - Civil servants get government services at no charge or covered by government schemes
  - Formal sector employees subject to obligatory social insurance or offered private insurance by employers
  - Above usually represent no more than 15% of population
  - Growing voluntary, informal-sector schemes

Ministries of health want universal social health insurance (SHI)

- Proposals for SHI in countries like:
  - Kenya, Uganda, Nigeria, and Senegal
- Conditions not favorable for success:
  - Low share of population in formal sector
  - Already difficult to collect taxes
  - Wagstaff argues SHI no better than general revenue financing

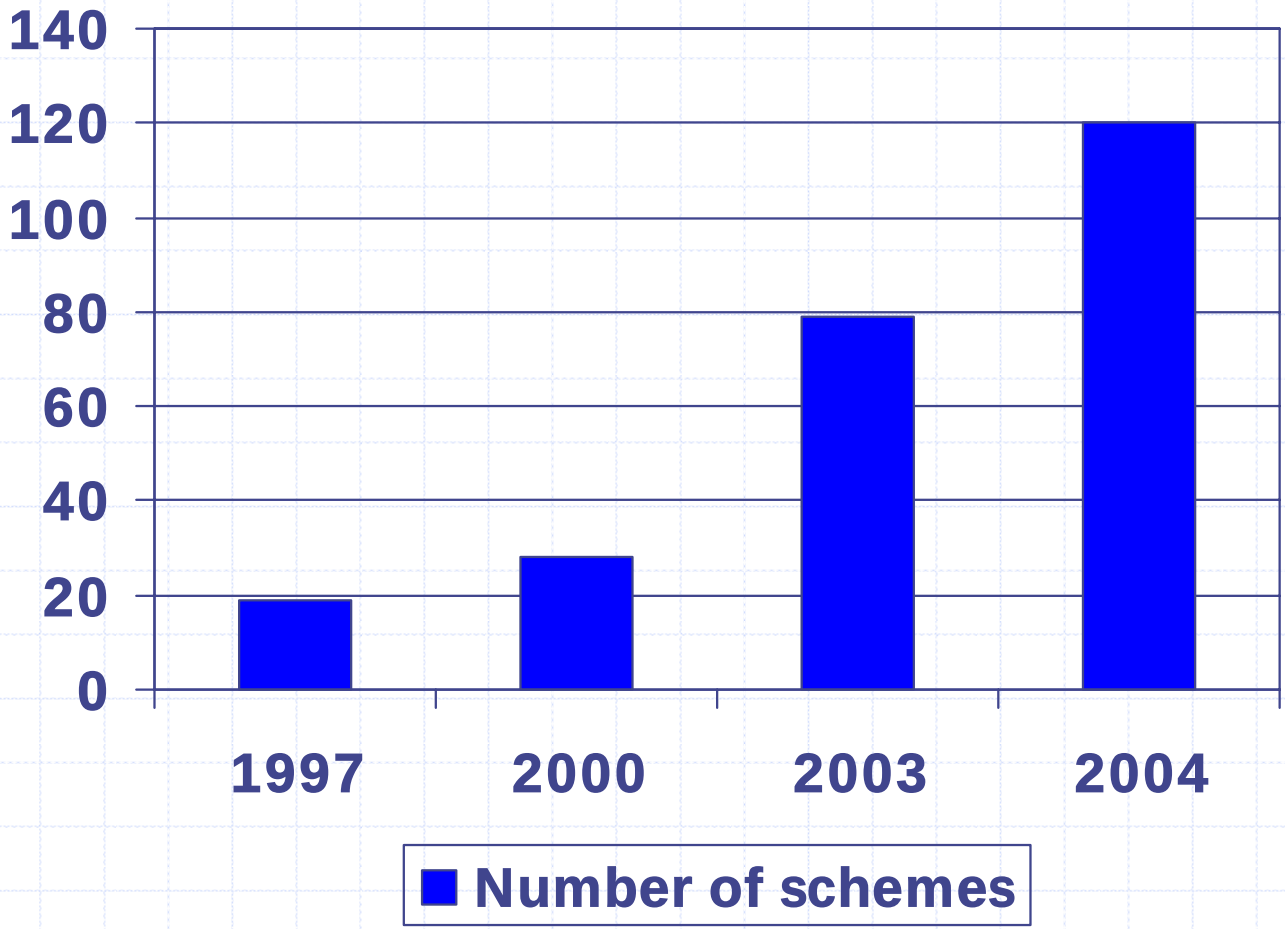
Growing community based health financing (CBHF) movement

- West and Central Africa:
  - Rural and urban communities and professional groups creating voluntary self-managed schemes
- East Africa:
  - Facility-based schemes
  - Slower growth

Some country cases

Country	Design features	Weaknesses	Percent of pop covered
Tanzania	Central design and co-financing	Low user charges, low uptake	<5%
Ghana	Obligatory district schemes built on CBHF; explicit tax subsidy	Many covered exempt from premiums, not sustainable	About 20%
Senegal	Spontaneous CBHF, Govt promo	Many schemes financially fragile	5-10%
Rwanda	Facility-community partnership, local govt active promo	None	About 70%

Growth in number of CBHF schemes in Senegal



Other approaches and challenges

- Subsidies/exemptions:
  - Targeting the poor in alignment with central poverty reduction strategies
  - Making effective “public health” subsidies: preventive services, target groups (children < 5), services (deliveries), chronic care (e.g., DOTS)
- Performance based financing/contracts with districts or NGOs

Other approaches and challenges (2)

- National Health Accounts/Subaccounts show mis-allocations
  - Is there the will and ability to address them?
- Sustainability of support for HAART
  - Will external support continue as financing needs grow?
- New vaccines, drugs, and technologies
  - How to decide which ones to pay for?

Future prospects

- “Light-touch” approach to promoting CBHF—involve local governments, other initiatives – integrate with PBF approaches
- Improve social insurance for formal sector – precondition for expansion

Future prospects (2)

- Recognize and involve private providers
- Make subsidy regimes effective and efficient
- Institutionalize NHA and use of data
- Join fully in poverty reduction efforts

Conclusions

- No single magic bullet for health financing in sub-Saharan Africa
- Good possibilities to do more and better with current financing—CBHF, improved subsidy policy, NHA, PBF, private sector
- More resources for health can be had from government budgets and poverty reduction initiatives

Thank you

Additional slides

Targets and objectives of Senegal subsidy initiatives (1)

- Poor
- Children under five (vaccinations)
- Mothers (deliveries, cesariens)
- Elderly (Sésame initiative)
- Prevention (vaccinations, ITNs)

Targets and objectives of Senegal subsidy initiatives (2)

- Infectious diseases (TB, polio, measles; blood supply)
- Chronic diseases (diabetes, TB, HIV)
- Economically important diseases (malaria)
- Reducing risk of impoverishing spending on health related costs (medical evacuations)

Criteria for evaluating subsidy initiatives in Senegal

- Concept
- Compensating losses
- Adequat financing
- Sustainable financing
- Efficacy
- Incentives
- Accountabilty mechanisms
- M&E
- Potential sources of financing
- Links with other mechanisms and initiatives (CBHF, decentralization, Ministry of Social Action)
- Targeting of the disadvantaged
- Efficiency

Tanzania—centrally designed

- Voluntary membership provides no-charge services at health centres and district hospitals
- Contribution rate set by districts

Tanzania (2)

- Contributions go to the budget of the health centre where the member lives
- User charges are low, low uptake
- National coverage less than 5%

Ghana—national program built on community schemes

- CBHF schemes grew rapidly in number in early ’00s (168 in ’03)
- National Health Insurance Act (2003) required district schemes, standard benefits and premiums

Ghana (2)

- Those <18 or >70 pay no contribution
- Subsidized by 2.5% of sales tax and pension contribution
- Reached > 20% of population by 2006, but majority of beneficiaries <18 years and premiums inadequate to cover costs

Senegal–rapid growth of CBHF schemes

- Since late ’90s, number of schemes growing —rural communities/professional groups
- Members set premiums, benefits, waiting periods
- Fragility: premium collection, small pools

Senegal (2)

- Benefits now emphasize more primary care
- Federations forming to share information—might be the beginnings of reinsurance
- Government role: share info, provide TA
- CBHF covers about 5-10% of population

Rwanda—promotion of CBHF schemes reaches high coverage

- CBHF piloted carefully in late 1990s, then rolled out
- Schemes co-managed by facilities and communities
- Local governments actively promote joining
- Links with micro-credit schemes
- Total population coverage reaching nearly 70% in ‘07