Health financing in the WHO African Region

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Introduction

Mills and Ranson define health financing as the raising or collection of revenue to pay for the operation of the health system[1]. It has three sub-functions: revenue collection, pooling of resources, and purchasing of interventions.[2]

WHO[3] describes revenue collection as the process through which the health system receives money primarily from households and organizations or companies (firms), as well as donors. There are two broad sources of health financing: public sources and private sources.

Public sources include: general tax revenues (from personal income tax, taxes on domestic business transactions and profits, taxes on imports and exports, and property taxes); indirect taxes incorporated into the selling price of a good or service (e.g. sales and value added taxes and excise duties on tobacco products and alcoholic drinks); taxes on lotteries and betting; domestic and international deficit financing (issuance of debt certificates or bonds and loans from bilateral and multilateral agencies); external grants (includes charitable donations by foreign governments or organizations); and social insurance (mandatory insurance payments by employers and employees).[4]

Private sources include: households (direct out-of-pocket payments by a health services consumer to the provider); employers (firms paying for or directly providing health services for their employees); private insurance (voluntary payments to private insurance companies in return for coverage of pre-specified health service costs); donations (charitable contributions made in cash or kind); and voluntary organizations or non-governmental organizations.[5]

WHO defines pooling as "the accumulation and management of revenues in such a way as to ensure that the risk of having to pay for health care is borne by all the members of the pool (i.e. the financial risk is shared) and not by each contributor individually (as is the case with out of pocket payments)".[6]

Purchasing is "the process by which pooled funds are paid to providers in order to deliver a specified or unspecified set of health interventions".[7] Provider payment mechanisms include: line item budget; global budget; capitation; diagnostic related payment; fee-for-services.

The performance of a health financing system depends on the level of prepayment; the degree of spreading of risk; the extent to which the poor are subsidized; and strategic purchasing (active leveraging of provider payments mechanisms to optimise overall health system performance).[8]

We present below an analysis of the patterns of health financing in the WHO African Region.

Methods

The national health accounts data on the 46 WHO Member States in the African Region were obtained from The world health report 2004.[9] It consisted of information on: levels of per capita expenditure on health; total expenditure on health as a percentage of gross domestic product (GDP); general government expenditure on health as a percentage of total expenditure on health; private expenditure on health as a percentage of total expenditure on health; general government expenditure on health as a percentage of total government expenditure; external expenditure as a percentage of total expenditure on health; social security expenditure on health as a percentage of general government expenditure on health; out-of-pocket expenditure as a percentage of private expenditure on health; and private prepaid plans as a percentage of private expenditure on health. The analysis was done using EXCEL spreadsheet.

Results

Percentage of GDP spent on health: Four countries spent less than 5% of GDP on their health; 25 countries spent between 5% and 10% of their budget; and 13 countries spent between 11% and 14 % of their budget on health *(Figure 1).*

Per capita total expenditure on health: Total expenditure on health per person per year is less than US$ 10 in 12 coun-

References

[1]Mills AJ, Ranson MK, The design of health systems. In: Merson MH, Black RE and Mills AJ (editors). International public health: Diseases, programmes, systems, and policies. Gaithersburg, Aspen Publishers, Inc, 2001.
[2]WHO, The world health report 2000. Health systems: improving performance, Geneva, WHO, 2000.
[3]Ibid.
[4]Mills AJ, Ranson MK, The design of health systems. In: Merson MH, Black RE and Mills AJ (editors). International public health: Diseases, programmes, systems, and policies. Gaithersburg, Aspen Publishers, Inc, 2001. WHO, The world health report 2000. Health systems: improving performance, Geneva, WHO, 2000.
[5]Ibid
[6]WHO, The world health report 2000. Health systems: improving performance, Geneva, WHO, 2000.
[7]Ibid.
[8]Ibid.
[9]WHO, The world health report 2004, Geneva, World Health Organization, 2004.

Figure 1: **Total expenditure on health as a % of GDP (in 2001)**

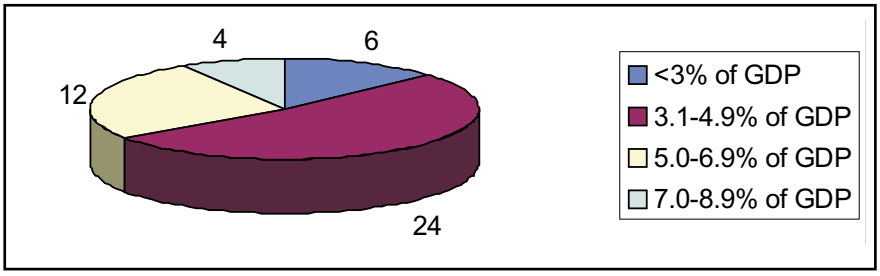


Figure 2: **Levels of per capita total expenditure on health (in 2001)**

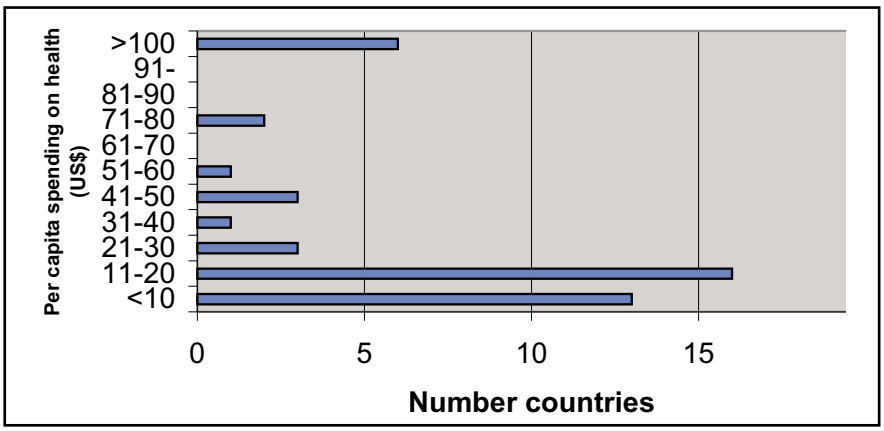


Figure 3: **General government expenditure on health as a percentage of total expenditure on health, 2001**

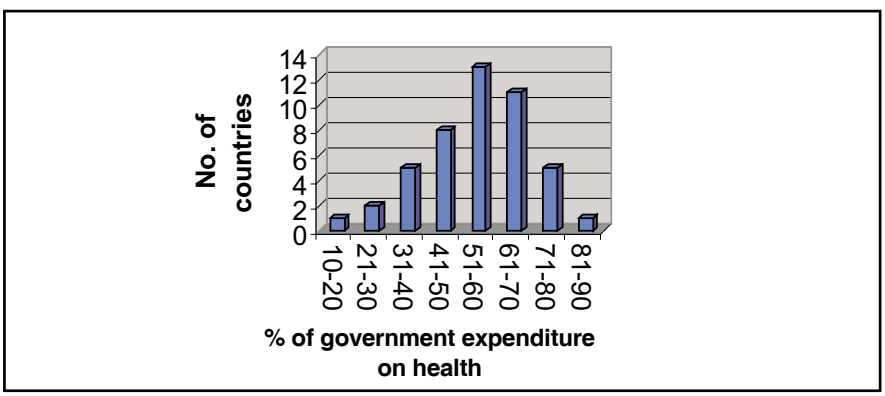
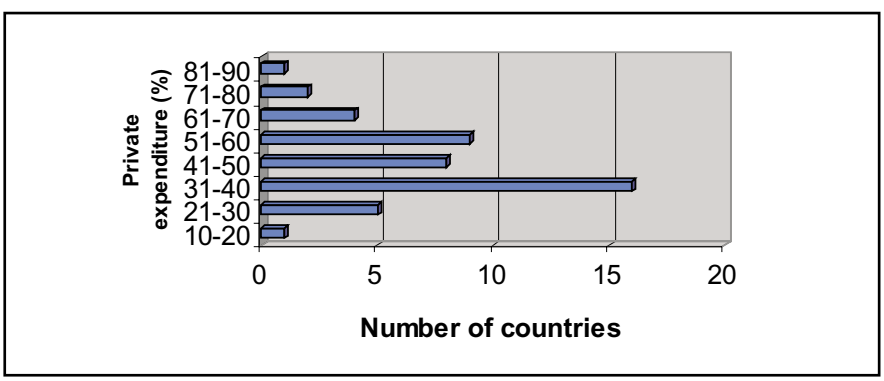


Figure 4: **Private expenditure on health as a % of total expenditure on health**



tries; between US$ 10 and US$ 29 in 20 countries; over US$30 in 13 countries *(Figure 2)*.

Per capita government expenditure on health: Government expenditure per person per year is between US$ 1 and US$ 9 in 30 countries; US$ 10 and US$ 28 in seven countries; and US$ 46 and US$ 307 in nine countries.

Sources of funding

Governmentfinancing: Generalgovernment expenditure on health includes health expenditure at all levels (and ministries) of government, including the expenditure of public corporations. Over 51% of the total expenditure on health in 30 countries is from government sources *(Figure 3)*. Government is an important source of health financing, seldom paying less than 20% of the total health expenditure, and sometimes over 80%.

Private financing: Private financing for health comes from personal out-of-pocket payments made directly to various providers (e.g. private practitioners, private pharmacists, traditional healers), prepayments to community financing schemes (e.g. Bamako initiative), private insurance and indirect payments for health services by employers (firms) and local charitable groups. *Figure 4* depicts private spending on health as a percentage of the total expenditure on health. In 40 countries (i.e. 87%) private spending constituted over 30% of the total expenditure on health. In 16 countries, over 50% of the total expenditure on health was made up of private spending.

Out-of-pocket payments: The contribution of out-of-pocket expenditures into the private health expenditure is quite significant in most countries of the Region. In 19 countries, out-of-pocket expenditures constitute 100% of the private health expenditure *(Figure 5)*. In the remaining countries, out-of-pocket contribution varies from 18.7% to 99.9%.

Health insurance: In principle, health insurance consists of social insurance

(which is compulsory), private insurance (which is voluntary), and employer-based insurance (eligibility dependent on employment status). Out of 39 countries whose data were available, 23 of them had no health insurance. However, in the remaining 16 countries there were health insurance plans that made varied contributions to the private health expenditure (*Figure 6).* It was only in two countries (Namibia and South Africa) where health insurance contributed over 72% of the private health expenditure.

External financing: This consists mainly of loans and grants from multilateral and bilateral aid donors and non-governmental organizations. As shown in *Figure 7,* all countries in the Region receive some external funding for health. However, the magnitude of external funding on health as a percentage of total expenditure on health varies a lot from country to country. A total of 23 countries obtained over 20% of their total expenditure on health from external sources; 12 of these financed over 30% of their total expenditure on health using external financing.

Figure 5: **Out-of-pocket spending as a % of private health expenditure (in 2001)**

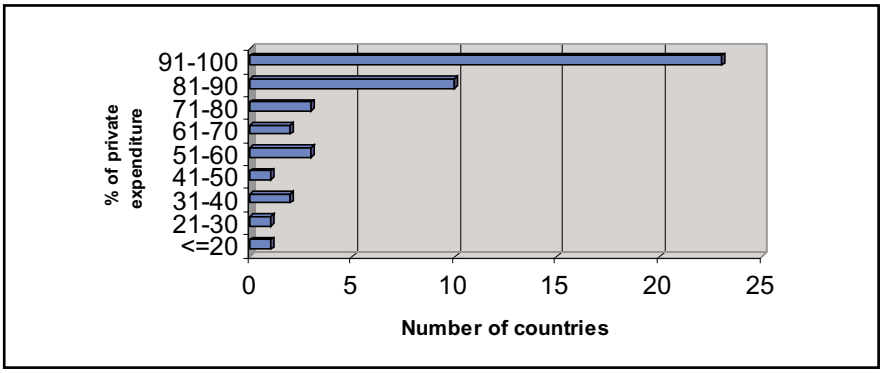


Figure 6: **Prepaid plans as a % of private health expenditure**

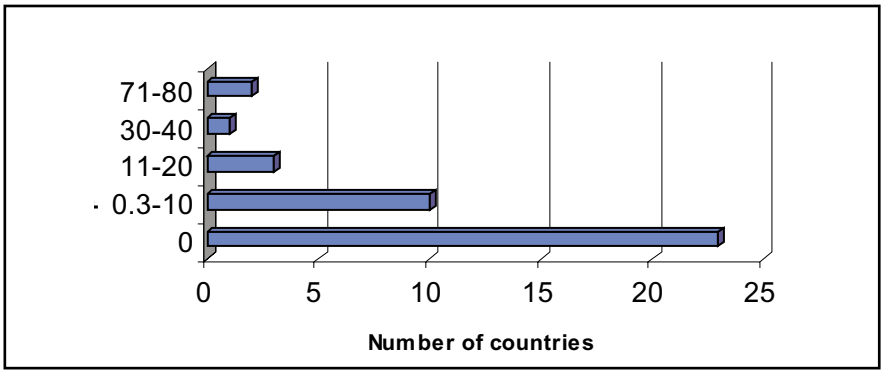
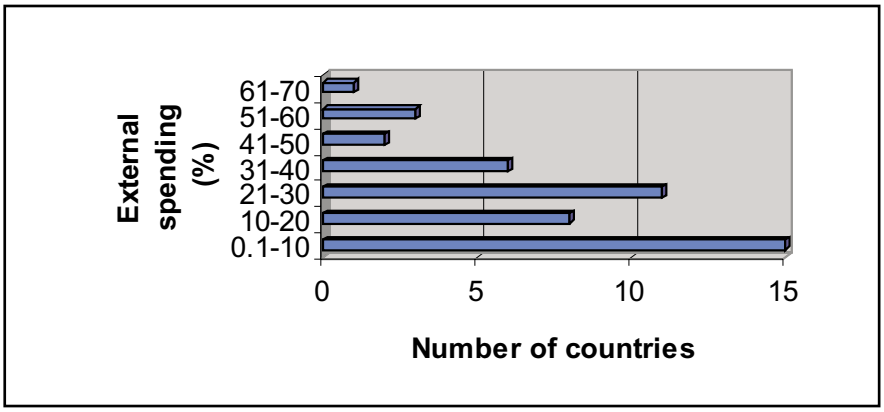


Figure 7: **External funding on health as a % of total expenditure on health**



Discussion

Percentage of GDP spent on health: In the Region, 65% of the countries allocated less than 5% of their gross domestic product (GDP) to health. Given the importance of health in human capital development, and hence, in economic growth and development, one would have expected countries to invest a greater share of GDP to health development. The size of GDP allocated to health sector depends mainly on the priority attached to health development and on the rate of economic growth. If these two factors are low, the likelihood is that the percentage of GDP allocated to health would also be low, and vice versa.

National budget allocated to health: Heads of State of African countries made a commitment in Abuja to allocate at least 15% of their annual budgets to the health sector.[10] By end of 2001, only four countries spent 15% and above of their budgets on health. This means that 42 countries spent less than 15% of their national budgets on health and will need to take appropriate steps to honour the commitment given by their respective Heads of State.

Per capita government expenditure on health: Thirty seven percent of the governments in the Region spend less than US$30 per person per year on health. The WHO Commission for Macroeconomics and Health report estimates that a

[10]AU, Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases. Addis Ababa, Organization of African Unity, 2000.

minimum government expenditure of US$ 34 per person per year will be required to provide an essential package of public health interventions in order to achieve both the relevant MDGs and NEPAD targets.[11] Thus, those governments currently spending less than US$ 34 on health per capita per year will need to increase their budgetary allocations to reach the recommended minimum health spending.

Government Budget Financing: Over 51% of the total expenditure on health in 30 countries of the Region came from government sources. Akin et al has criticized this source of funding as inefficient and inequitable.[12] However, given that about 50% of the people in the Region live below the poverty line of US$1 per day, there is obviously a role for government financing as a force for equity in sharing health care costs and for government provision of services to improve equity in access for the poor. Of course, there is need to monitor the efficiency in use of funds from government and the efficiency in production of services.

Private financing: In forty countries, private spending constituted over 30% of the total expenditure on health, while in 16 others, it was over 50%. Out-of-pocket payments constitute the main component of private health expenditure in most countries of the Region.

Published evidence indicates that user fees: (i) may not necessarily have the theoretically expected efficiency effects on cost containment (mainly due to information asymmetry in the patient-clinician relationship); (ii) may not generate substantial net revenue for the health sector; (iii) may not be acceptable to consumers due to poor perceptions of the quality of services (especially in public facilities) and inability to pay; (iv) have adverse effects on demand and utilization of health services for the poor. Thus, although private spending is currently a significant source of health financing it is inequitable, and may have adverse effects on health status of the most vulnerable groups in society.

Health insurance: Generally, the role of private and compulsory health insurance in the Region has been quite limited due to wide spread poverty, and a high proportion of the population working in the informal sector. However, due to inequities related to out-of-pocket payments and the need for sustainable funding for the health sector, there is growing interest among countries on the feasibility of introducing social health insurance.[13] Efforts to introduce social health insurance may face a number of challenges: (i) lukewarm support from Bretton Woods institutions; (ii) vulnerability to changes in levels of unemployment, e.g. if unemployment increases and real wages decrease the real level of resources for health insurance decreases; (iii) administrative costs of setting and running social health insurance may be very high; (iv) weak administrative capacity and financial control systems; and (v) moral hazard (abuse of insurance benefits without bearing financial consequences of one's behaviour).[14]

External funding: A total of 23 countries obtained over 20% of their total expenditure on health from external sources; 12 of these financed over 30% of their total expenditure on health using external financing. So far, external aid is unpredictable, unstable and uncoordinated.[15] In order to increase aid effectiveness: (i) it should be 100% untied aid; (ii) 90% should be allocated to the poorest countries; (iii) partners should shift from project to poverty reduction budget support; (iv) partners should align themselves behind national health development policies and plans to ensure country ownership of health development process; (v) partners should aim for 100% debt relief for low income countries; (vi) partners should review their lending policies and practise on aid conditionality to reduce inefficient bureaucracy and attendant administrative costs; (vii) adopt an international health worker recruitment code to stem the tide of brain-drain of human resources for health to developed countries.

The CMH calls upon rich countries to allocate at least 0.7% of their gross national product to developing countries. However, none of the rich countries has met that target; and they need to implement that recommendation to enable low income countries realize the MDGs.

Conclusion

The countries that do not have health financing policies need to develop them to protect populations (especially the vulnerable groups) from catastrophic expenditures. For quite sometime to come, countries will continue having a mix of sources of funding for the health sector. However, the important thing would be to ensure that there are functional safety nets for the poor. As the countries contemplate reforming their health financing systems, it will be important to prospectively evaluate them against a number of criterion: level and reliability of expected revenue; incentives to consumers and providers of care; technical, allocative and administrative efficiency (including effects on clinical quality of care); equity in distribution of benefits and costs; expected health impact; and acceptability by consumers, politicians, medical and nursing associations, employer associations and trade unions.[16]

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[11]WHO, Macroeconomics and health: Investing in health for economic development, Geneva, World Health Organization, 2001.
[12]Akin JS, Birdsall N, de Ferranti D., Financing health services in developing countries: an agenda for reform, Washington, DC: World Bank, 1987.
[13]WHO. Sustainable health financing, universal coverage and social health insurance, EB115.R13, Geneva, World Health Organization, 2005.
[14]Kirigia JM et al, Determinants of health insurance ownership among S. African women, BMC Health Services Research, 2005, 5:17.
[15]UK Government, The UK's contribution to achievement of the MDGs, London: UK Government, 2005.
[16]WHO, Evaluation of recent changes in the financing of health services, Geneva, World Health Organization, 1993.