# Reformofhealthsystemfinancing in Senegal, 2004–2008

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## Introduction

Generally, several countries are reforming their health system in a bid to enhance the efficiency and management of health services as well as the offer of these services, especially in favour of the destitute. As health systems are expanding and becoming more complex, policy-makers need to be equipped in order to ensure the efficient management of their health resources.

In Senegal, as in most developing countries, two situations may be observed: (i) multiplicity of health actors, which accounts for redundancy in the funding of certain activities and lack of transparency in the use of resources; (ii) inefficient use of resources, which explains the differences between the increasingly important resources injected into the sector and the low benefit that the poor populations in particular are receiving.

Deriving more benefit from the funding for the populations is a challenge to be met at a time when there are increasing numbers of public funding opportunities.[1]

In Senegal, resources for the health sector are mobilized from four main sources. For the first phase of the national health development programme (PNDS) (1998–2002), these sources were: the state (49%), local authorities (3%), populations (15%), development partners (33%).[2]

## Background

The analysis of government funding of health shows that considerable financial efforts were made, in the past years, in favour of health services in general and basic health in particular. These efforts made it possible to increase basic infrastructures and improve health coverage in peri-urban and rural areas.

According to the results of the final evaluation of the first phase of the PNDS (1998-2002), coverage in pre-natal consultation increased from 44% to 69% between 1996 and 2002, while the completion rate rose from 44% to 54.2%. Assisted deliveries also increased from 31% to 55% and the number of fully immunized children from 33% to 67% during the same period. Total fertility rate for women aged between 15 and 49 years declined from 5.7% to 5.2% between 1997 and 1999.[4]

These data indicate that appreciable efforts were registered. However, inadequacies in the efficient mobilization and use of resources are still weaknesses increasingly decried, which are distorting the results that could have been obtained from the flow of funding registered in the sector.

To eliminate the above weaknesses observed during the evaluation of the first phase of the PNDS (1998-2003), the State authorities, especially those in the Finance Ministry, have decided to adopt reforms aimed at enhancing the capacity to mobilize and absorb resources, while ensuring clarity and transparency in the use of these resources.

There are, however, some weaknesses in the efficient mobilization and use of resources within the set timeframe, that are increasingly observed, and which are distorting the results that could have been obtained from the flow of funds registered in the sector.

The following reforms will be undertaken and enforced with effect from 2004, at the start of phase II of the PNDS: budget support, decentralization of expenditure authorization, medium term expenditure framework of the national health account and macro-economy and health approach.

## Budget Support

Adopted as a strategy for government funding in the health sector is the framework for the implementation of the Poverty Reduction Support Credit. Budget support is a prerequisite for mobilizing resources for attaining the results to be measured according to pertinent indicators of the sector.

With the ninth EDF, the European Union is striving to develop, in collaboration with the Government of Senegal (ministries of finance, health and education), a macro-economic support programme amounting to 53 million euros.[3]

The African Development Bank (ADB) plans to place the health sector on the agenda of its future interventions under this result-based funding scheme. The budget support will consist in transfer-

References

[1]Support and Monitoring Unit of the PNDS: Preparatory documents of Phase II of the PNDS, February 2004.
[2]DIENG K. Eléments constitutifs du Rapport de la Phase I du PNDS (1998-2002) février 2004.
[3]NDIAYE I.: Note de présentation sur l'appui budgétaire octobre 2003.
[4]NDOUR M. C: Note de présentation du Crédit de soutien à la réduction de la Pauvreté CSRP/Santé, janvier 2004.

ring to the national budget resources from development partners that subscribe to the scheme. This will consequently increase the budget allocation for services benefiting from these support initiatives and which correspond to the volume of activities funded by these partners.

As they are included in the national budget, these budgets will be financially executed in accordance with government accounting rules and procedures.

To facilitate the mobilization of resources, the revolving funds will be reopened, taking into account the conclusions of the study on the possibility of injecting more funds into the facility before the end-of-year audit, since the two operations are not related.

At the organizational level, this new funding strategy calls for strengthening the accounting and procurement procedures of the health district. To that end, it is proposed to establish a management office comprising two sections, one section in charge of accounting and the other in charge of contracts.

## Decentralization of Expenditure Authorization

The evaluations of the public finance management system underscored the need for gradual introduction of reforms in the channel for mobilizing and utilizing resources allocated to certain pilot sectors, including health. It was therefore decided to entrust the expenditure authorization functions to the ministries.

The decentralization of expenditure authorization, limited for the 2004 fiscal year to the central departments of the ministries concerned, required that measures be taken to strengthen the organization and technical capacities of the Ministry of Health to enable it to carry out the resulting new tasks.

More specifically, this will involve strengthening the capacities of the department charged with this responsibility. The measure should be taken concomitantly with the strengthening of management capacities of the central services.

The Ministry of Health is expected to take the following measures: (i) creating a division within the Department in charge of expenditure authorization; (ii) adopting a decree on delegation of the signature of the Ministry of Health to the official with power to authorize expenditure; (iii) allocating offices to the financial operations controller attached to the Ministry of Health.

The other levels of the health system (regions and districts), concerned by the reform with effect from 2005, will be prepared now to assume these new responsibilities.

Entrusting more responsibility to the ministry at the different levels (central, regional and district) should be accompanied by the establishment of budget monitoring mechanisms in order to ensure transparency, security, promptness and efficiency in the execution of the operations. To that end, the Ministry of Health should be strengthened in terms of human resources, training and equipment in order to facilitate the necessary monitoring of the attainment of the aforementioned objectives.

Other actions to be taken include the amendment of the legal framework, training, technical and logistical support, which fall within the scope of the Ministry of Economy and Finance and have an impact on the implementation of the above-mentioned activities.

## Medium-term Expenditure Framework

The programme approach is maintained for the second phase of the PNDS. Consequently, it has been decided to systematize the development of a medium-term expenditure framework (MTEF) as a tool for programming and at rationalizing the interventions in order to ensure efficient use of the resources allocated by the different actors.

Based on the data collected from the four sources, (state, local authorities, populations and development partners) as of 11 March, the medium-term expenditure framework of the health sector covering the period 2004-2008 was developed *(see Table 1)*.

Of the 22 that partners intervened during the first phase of the PNDS, only 11 have indicated their intention to fund activities under the new programme. It should be recalled that the contribution of development partners to the funding of the first phase programme, which has just ended, represented 30% of the total cost. There is every reason to expect the same level of commitment in the coming months.

*Table 1:* **Medium-term Expenditure Framework (million CFA francs)**

| | 2004 | 2005 | 2006 | 2007 | 2008 | TOTAL | % |
|---|---|---|---|---|---|---|---|
| State | 56 183 | 60 519 | 65 314 | 70 618 | 76 486 | 329 120 | 62% |
| Local Authorities | 4 316 | 4 316 | 4 316 | 4 316 | 4 316 | 21 580 | 4% |
| Populations | 27 229 | 27 229 | 27 229 | 27 229 | 27 229 | 136 145 | 26% |
| Partners | 21 284 | 9 661 | 6 783 | 4 721 | 1 705 | 44 154 | 8% |
| TOTAL | 109 012 | 101 725 | 103 642 | 106 884 | 109 736 | 530 999 | 100% |

The planning and budgeting per objectives will be based on the MTEF and the intervention orientations defined in PNDS II. The objectives will be taken into consideration during the allocation of resources.

This MTEF programming tool should enable the Ministry of Health to efficiently monitor the expected funding opportunities in the sector, to better exploit them and especially to avoid losing funds for failing to consume them (lack of control of the funding procedures, lack of information). In fact, the Ministry of Health is quite often criticized for its weak capacity to mobilize both domestic and foreign resources.

## National Health Accounts

The need for transparency and control of the different flow of funds is today shared by both the authorities of the Ministry of Health and those of the Ministry of Economy and Finance. The multitude and diversity of producers, sources and funding agents are further complicating funding efforts, thereby making it difficult to attain the objective of ensuring the efficient use of resources to effectively meet health demand by taking care of populations in poor areas.

To that end, the production of national health accounts constitutes one of the most important actions that should equip actors of the sector in their declared desire to ensure greater efficiency in the use of resources.

This basic exercise will be carried out by the team set up at the end of the training workshop on national health accounts organized and conducted by the Regional Office in Dakar from 29 September to 3 October 2003.

It aims at attaining the following specific objectives:

- To identify the different sources of funding and their trend, using the concept and principles of national health accounts;
- To analyse the trend of expenditure of funds devoted to health through the implementation, monitoring and evaluation of national health accounts;
- To analyse the distribution of health expenditures at the various levels of the health pyramid (primary, secondary, tertiary and administration);
- To analyse health expenditures per type of expenditure (investment expenditures and operational expenditures) and per expenditure item (staff expenditures, recurrent expenditures and expenditure on drugs).

The processing of data on the different flows of funds will enable the Ministry of Health to play its regulatory role in order to bring about a more equitable distribution of health within the country and among zones and their populations. With the support of the WHO, Senegal should produce these national health, accounts, at the latest, in the course of the 2006-2007 biennium.

## Macroeconomy and Health Approach

During phase II of the *PNDS,* Senegal, with the support of WHO HQ, will embark on the development of an investment support programme as part of the extension of "pro-poor" services, as recommended by the conclusions of the Macroeconomics and Health Committee.

This phase will, in fact, enable the country to acquire capacities to advocate for major additional investments,[5] which are expected to contribute not only to an improvement of the health status of the population but also to poverty reduction.

The objective of the Macroeconomics and Health approach is to enhance the sustainability of the programme and reduce dependency on external support. During the second phase of the PNDS, the approach will focus on three main themes: (i) improvement of the health status of the poor; (ii) mobilization of additional resources for health; (iii) elimination of non-financial constraints in order to strengthen the absorption capacity for provision of health services through a series of reforms, where necessary.

In order to achieve these results, Senegal started receiving support from KIT Amsterdam in February 2004, at the request of WHO HQ.

During that year (2004), Senegal expected the following forms of support from KIT:

- Assessment of the specific situation of the country from macroeconomics and health point of view, taking into account current programmes such as PSRP, MDGs and NEPAD;
- Analysis of the process including the institutional framework of a Senegalese Select Committee for the development and implementation of a macroeconomics and Health plan;
- Assistance needed for the second phase;
- Development of an action plan for the second phase, including a logical framework for macroeconomics and health activities;
- Identification of the problems encountered (including actions for resolving them).

The establishment of the macroeconomics and Health Committee and commitment of the highest government authorities to ensure its functioning will mobilize more actors in a funding environment made clearer and more transparent through the production of national health accounts and a medium-term expenditure framework.

[5]TOONEN J.: Appui technique à Macroéconomie et santé au Sénégal - Etat des lieux, KIT/OMS, mars 2004.

On the whole, the various government reforms are aimed at mobilizing more resources for the sector, ensuring greater transparency and promptness in their increased use through improved absorption capacity in order to effectively meet the health needs of the population in general and the poor in particular.

## Local authorities

Since 1 January 1997, the local authorities (regions, districts, urban districts and rural communities) are fully exercising their management responsibility. The health sector is part of the areas of competence transferred to local authorities, which are now receiving funds to cover the operational expenses of health structures under their responsibility.

The endowment funds were not received during the first semester of the budget year concerned. This imposed a serious strain on resources expected for community participation and, consequently, a dramatic strain on the prices set for users, particularly the poorest population groups.

To remedy the situation, which is affecting the functioning of health structures and opportunities for meeting the health needs of the poor, the ministries involved in the process of determining and allocating endowment funds must take the necessary measures before the end of the first semester of the budget year. This would help avoid, or at least limit delays in mobilizing resources intended for the health sector from the local authorities, which have been made aware of their responsibilities in the framework of the decentralization process.

The time saved in resource mobilization will be all the more beneficial to the sector since, from the year 2003, all the local authorities in the country started receiving funds from the health sector as from 2003, the year this measure was extended to the rural communities.

## Population

The promotion of financial access to care is the most significant contribution made by the Ministry of Health under the National Poverty Alleviation Programme, as it facilitated access of poor populations to basic social services.

Indeed, the government has clearly indicated its intention to reduce the cost of health for the population in general and the poor in particular. This option consists of mobilizing funds to offer, as from 2004, free care and treatment of certain priority health problems identified in the context of the PNDS (maternal mortality: PNC, deliveries and caesarean operations) for populations of the four poorest regions of Senegal. This coverage will be extended geographically and to other health problems in the coming years. This will reduce the pressure on the prices set for users and part of the funding borne by the populations, representing about 25%.

At the same time, the government will continue to support mutual benefit initiatives and provide necessary access facilities by obtaining from its care structures, procedures enlightened through contracting with mutual insurance companies, and a control of costs of services it will continue to subsidize.

## Partners

The major innovation in the funding by development partners intervening in the health sector is the adoption, by some of them, of the budget support scheme.

Initiated by the government as a means of funding and adopted by the World Bank, ADB and the European Union, budget support constitutes a major step in the process of harmonizing the procedures of partners participating in the funding of the sector. The positive results obtained with this new approach could encourage other partners, which for the moment are submitting to concerted planning with the ministry at the different levels of the health system, to adopt it.

An exhaustive and regularly updated identification of funding actors in the different areas and intervention structures is envisaged to meet this need for synergy, complementarity and harmonization in order to ensure greater efficiency in the use of resources earmarked for the same objectives.

Finally, it should be pointed out that the support of partners for the medium-term expenditure framework and their concern was to see the Ministry of Health improve its organization in order to better benefit from the multiple support opportunities for the health sector and, consequently, for the populations whose health needs are yet to be met.

## Conclusion

The challenge facing the Ministry of Health for the next five years of the PNDS is to produce results commensurate with the resources programmed for the sector.

Sector performance will be appreciated when the population has access to quality care, observes an improvement in their health status and experiences a reduction of health costs in general and for the most destitute in particular. The effective execution of these reforms will ensure efficient use of resources.

The monitoring of the implementation of the reforms should occupy a central place in the agenda of the Ministry of Health in the coming years.

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