The state of health financing in the African Region

Laurent Musango, Riku Eloainio, Juliet Nabyonga and Bokar Toure
WHO, Regional Office for Africa
Corresponding author: Laurent Musango, e-mail: musangol@afro.who.int

Health is increasingly recognized as a key aspect of human and economic development in Africa and countries are increasing investment in actions and reforms to improve health outcomes and accelerate progress towards meeting the health Millennium Development Goals. The political will of national leaders to put health at the forefront of development has been reiterated at the continental level through actions such as the Abuja Declaration of 2001 on increasing government funding for health, the Addis Ababa Declaration of 2006 on community health in the African Region, the 2008 Ouagadougou Declaration on Primary Health Care and health systems in Africa and the 2012 Tunis Declaration on value for money, sustainability and accountability in the health sector. Health system financing is one of the key areas that offers important opportunities to translate these commitments and political will into results. Health financing is also the crucial element for moving countries towards the objective of universal health coverage (UHC) – a health system development goal for all countries that has been widely supported by the Member States of the WHO and of the United Nations (as endorsed by Resolution WHA64.9 at the Sixty-fourth World Health Assembly in 2011 and Resolution ResA/67/36 at the United Nations General Assembly in 2012).

The need to develop strong health financing systems is a common objective of all countries. Even the richest countries are finding it increasingly difficult to keep up with rising health care costs, and the current economic downturn is adding more pressure on health spending. In low- and middle-income countries, i.e. the vast majority of African countries, scarcity of funds for health is an even more acute problem. The average total health expenditure (THE) in African countries stood at US$ 135 per capita in 2010 – only a small fraction of the US$ 3 150 spent on health in an average high-income country. Insufficient investment in the health sector and in actions to tackle the environmental and social determinants of health is a serious obstacle to improving health outcomes in Africa, particularly considering that the continent bears the bulk of the global morbidity and mortality burden for maternal and infant mortality, HIV/AIDS and noncommunicable diseases.

In about half of African countries, 40% or more of THE is made up of out-of-pocket payments (OOPs), which is the most regressive way of funding health care. The reliance on OOPs creates financial barriers to access to health services and puts people at the risk of impoverishment. Furthermore, the current financial flows within the health systems are creating and exacerbating inefficiencies and inequities, for example through skewed allocation of funds to urban areas and specialized care. These weaknesses in the health financing systems have been identified as the main underlying reasons for the limited progress towards achieving the health MDGs in Africa.

The main objective of this paper is to provide information on the current state of health financing in the African Region in a manner that will support evidence-based policy discussions and policy-making. In this way it responds to the current challenge of measuring, observing, evaluating and analysing data on health financing.

Methodology

A data collection tool was developed and sent to countries to collect data on...
the parameters of their health financing system and the health system in general. Where gaps existed in health expenditure data, national health accounts data, which are collected annually by WHO and verified by the countries before finalization, were used.

To assess the country rankings on various indicators, categorizations were used with point estimates set mostly at 2001, 2005 and 2010. These years were chosen because of their association with key milestones in health financing targets and availability of data. The milestones were the declaration made by Africa Union Member States to invest in health in Abuja (2001) and the World Health Assembly (WHA) Resolution 58.33 of 2005 that urged WHO Member States to adopt the goal of UHC and develop health systems and health financing systems to support this goal. The year 2005 was also the base year for the calculations included in the High Level Task Force for Innovative International Financing for Health systems (HLTF). The most recent internationally comparable health expenditure data available are for 2010.

Results

Macroeconomics, government income and external funds
According to the World Bank classification, 26 of the 45 countries assessed in the Region are categorized as low-income countries (see Figure 1).

Total health expenditure
Total health expenditure is an aggregate measure that reflects the total level of funds available for health from public, private and external sources and reflects the importance of health care in the overall economy.

In 22 of the 45 countries the level of funding for health is below the minimum level of US$ 44 per capita recommended for 2009 by the HLTF. Figure 2 shows the trends in THE for the African Region over a period of ten years.

Countries have been increasing expenditure on health although at a varying pace. For example, Rwanda more than doubled its (nominal) per capita expenditure on health over a period of ten years, with a large part of this increase attributed to external funds. On the other hand, six countries have remained below the expenditure level of US$ 20 per capita. Eleven countries have persistently spent over US$ 44 per capita over the same period.

Domestic funds for health
Many African countries have shown to have limited capacity to raise public revenue mainly because the informal nature of their economies makes tax collection difficult, including payroll tax collection for social health insurance. The performance, accountability and administration of the tax system are often an additional problem for many countries. Figure 3 gives an overview of...
the public financial capacity in African Region countries

There is important variation among the countries in their capacity to mobilize public financial resources. Countries with high GDP in absolute per capita terms are able to spend more, even when their government expenditure as a share of the economy is low. This shows the macroeconomic constraints that limit the fiscal space in many countries and explains to a large extent why Gabon, for example, has a government expenditure of US$ 2 410 per capita while Malawi, with a similar share of GGE over GDP (28%), has an absolute GGE of only US$110 per capita.

The macroeconomic underpinnings differ between the countries. According to the International Monetary Fund (IMF), 20 of the 45 countries in sub-Saharan Africa can be viewed as significant exporters of natural resources. The situation of public finances in these countries is very different from that in the countries without or with limited revenue from natural resources and explains to a large extent the differences in fiscal space between these two categories of countries. But even in countries with large natural resource sectors the question of sufficiency and sustainability of public funds is crucial, if only because in only two of these 20 countries are revenues from natural resources projected to increase markedly during 2011 to 2016.

External funds for health

In the majority of Member States of the WHO African Region, external sources account for less than 20% of THE. But some countries face special circumstances, such as Malawi, where donor funding consistently accounted for more than 40% of THE between 2001 and 2010.
Burundi and the United Republic of Tanzania registered significant increases in the relative importance of donor funding between 2005 and 2010 – in both countries external funding rose from about one third of THE to around 50% during this period.

Several issues have been raised regarding external sources in financing health services, including possible negative effects of donor funding on predictability of funds and/or on the fragmentation of health systems. Nonetheless, external funding for health will remain crucial in cutting the negative spiral of illness and poverty in the vulnerable countries. Increase in available international resources for health should be possible if the donor countries fulfil their promise to allocate 0.7% of their gross national income to official development assistance (ODA). In 2009 only five donor countries met this requirement.

**Extent of government prioritization of health**

There is scope for governments to allocate more money for health from domestic sources. In this regard, the 2001 Abuja Declaration urging African Union states to allocate “at least 15%” of national budgets to the health sector was a landmark. This commitment was further reaffirmed in the Maputo Declaration in 2003. Unfortunately this target had been achieved by only five countries by 2010 as shown in Table 1. During the same period 13 countries had reduced their relative government allocation to health while in four others the trend had not changed. The average amount allocated to the health sector by African Region countries stands at 9.8%. It is important to note, however, that allocations to the health sector as a percentage of total government budget ranged from 2% to 20% in 2010 in the African Region.

It is logical to consider the Abuja Declaration target together with the recommendation of the HLTF of reaching US$ 44 per capita THE. Over one third of the countries in the African
Region have not managed to raise health spending to the level of US$ 44. Only Botswana, Rwanda and Zambia have managed to meet both the Abuja and the HLTF targets as shown in Table 1.

Table 1. THE against GGHE/GGE

<table>
<thead>
<tr>
<th>THE per capita</th>
<th>GGHE/GGE &gt; 15%</th>
<th>GGHE/GGE &lt; 15%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;US$ 44</td>
<td>Botswana, Rwanda, Zambia (3 countries)</td>
<td>Algeria, Angola, Cameroon, Cape Verde, Republic of Congo, Côte d’Ivoire, Equatorial Guinea, Gabon, Ghana, Guinea-Bissau, Lesotho, Mauritius, Namibia, Nigeria, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Uganda (20 countries)</td>
</tr>
<tr>
<td>&lt;US$ 44</td>
<td>Madagascar, Togo (2 countries)</td>
<td>Benin, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Guinea, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Niger, Sierra Leone, United Republic of Tanzania (20 countries)</td>
</tr>
</tbody>
</table>

Financial risks and barriers to access to health services

Countries with a low level of public investment in health have high OOPs. In the African Region, 20 had a share of OOPs of over 40% of THE. Some studies have pointed out that where OOPs is below 15–20% of THE, catastrophic health expenditure drops to negligible levels. In 23 countries out of 45 that have reached the level of THE recommended by HLTF (US$ 44 per capita), in sixteen of them reliance on OOPs is still more than 20%. Countries that have reached the US$ 44 per capita mark but have a high level of OOPs have thus progressed relatively well in resource mobilization but need to focus also on developing and strengthening pooled prepayment mechanisms.

Abolition of user fees or effective exemptions

Several countries have put in place mechanisms to protect the poor and vulnerable groups regarding OOPs. Voucher schemes for pregnant women, for example in Uganda and Kenya, and social grants for marginalized groups have been implemented, though largely on a pilot basis. Subsidies have been often extended also to private not-for-profit providers to enable them to provide free services to specific groups or for certain diseases or to provide services at highly subsidized fees to enable access by the larger population (Kenya, Lesotho, Malawi, Swaziland and Uganda). In some countries where fees exist, for example in the United Republic of Tanzania, there are exemption mechanisms for reproductive and child health services, chronic illnesses and epidemic diseases and for the poor. Experience with exemption mechanisms is varied, more especially as they relate to the poor, because of the challenges of implementing a robust system of identifying them. Some countries have abolished or reduced fees (at the point of access); some like Uganda and Malawi have implemented blanket targeting to provide services which are free to all, while others have geographical targeting such as Zambia. In all countries that have abolished or reduced fees at the point of access, maternal and child health services are provided free in public facilities.

Evidence points to the need for careful attention to the design and implementation details of health service delivery prior to abolishing fees. In a majority of cases, the effects have been generally positive with respect to utilization of health services though sustainability in the medium to the long term has been varied. Implementation processes are poorly understood and require system wide investments. Significant investments need to be made to improve service delivery if the poor are to have financial risk protection.

Actions proposed

The following actions, in appropriate combination according to local context, may enable countries to improve health financing sector. The proposed actions are consistent with those contained in the framework for the implementation of the Ouagadougou Declaration on PHC and the Tunis Declaration on value for money, sustainability and accountability in the health sector.

- In the future, with Africa still on a projected path of economic growth, the focus should turn to how the economic expansion will affect availability of funds for health. Will health expenditure grow faster, slower or at the same pace as per capita income? The answer to this question will necessarily vary from country to country, but as there are most probably going to be “push” factors, such as the rise in noncommunicable diseases or in the ageing population, and “pull” factors, such as investment growth in high technology that will be similar to high income countries elsewhere, it is probable that many African countries will follow the same pattern of “excess growth” (health spending outpacing economic growth) that has been observed in high income countries. Looking at the very low levels of per capita spending and of total health expenditure as a share of GDP in most African countries this would be a welcome outcome in most countries, but it should not turn away focus on inefficiencies in utilization of resources.

- Countries need to find ways to increase health funds from prepaid sources which are subsequently pooled. The potential to identify new sources of tax or other government revenue such as sales taxes and currency transaction fees exists. While these funds are not usually earmarked for health, an increase in government revenue will indirectly impact the capacity of governments to finance health services. Innovative tax and levy mechanisms that have already been implemented in some countries include those associated with tobacco, alcohol, environmental pollution, petroleum products, community support, currency transactions and risky behaviour such as drunken driving. Many of these taxes and levies target behaviour and products that negatively affect health thus promoting public health objectives, even if they do not mobilize additional revenues. Moreover, if these levies are successful in reducing unhealthy behaviours, some of the cost pressure on health care, especially related to many of the noncommunicable diseases, could be alleviated in the medium to long term.
• External sources play a significant role and the focus should be on addressing challenges to their effective use. Improving predictability of donor funding and harmonization of donor funds with national priorities and mechanisms are among the issues that need to be addressed. A sector wide approach for better coordination and harmonization among the development partners themselves and between development partners and the countries is key. In this regard there exist useful tools such as the IHP+ Global Compact (International Health Partnership), signed by all parties. The health sector needs to develop a clear policy and a strategic plan as an investment framework for all available funding. In addition, the capacity of the ministries of health needs to be strengthened and collaboration between the ministries of health and finance should be improved to monitor donor aid for health.

• Strengthening budget execution and demonstrating results from funding already provided to show return on investment. This calls for strengthening of monitoring mechanisms, and signals a need to institutionalize national health accounts (NHAs) and improve efficiency in health systems, including equitable access to skilled health workers and the introduction of measures such as results-based financing and incentives to enhance transparency and performance and reduce wastage.

• Collaboration between the ministries of health and finance has to be improved and the misconception that health is an unproductive sector demystified. This includes setting up inter-ministerial committees and strategic alliances for continued dialogue and information sharing; health sector participation in bilateral and multilateral engagements between government and partners; and finance ministry support for capacity building in financial management in the health sector. In addition, there is a need for finance ministries to participate fully in health financing processes right from agenda setting through to implementation and monitoring of interventions.

• Every country will need to lay out a path towards universal health coverage, in particular countries need to develop strategies for reinforcing their health financing mechanisms so that they collect more and sustainable revenue, pool effectively financial risks among the population and ensure equitable and efficient use of resources.

Several African countries have recently implemented successful health financing reforms. Countries in which health system financing has been improving and countries with more acute need for reforms and action, all need to constantly track progress in health financing in order to adapt to changing situations. This monitoring effort and the analysis derived from it will need to be translated to policy readjustments and/or into new actions and reforms so that countries stay on track to achieve the health financing goals that will support the objective of UHC.

The ministries of health cannot do this alone. The policy dialogue around the health financing strategy will need to engage all the key stakeholders. Particular focus should be given to the interaction between the ministries of health and finance in increasing health funding. Developing a health financing system that supports the objective of UHC will to a large extent depend on the overall government financial and fiscal position.

Conclusion

This paper gives an overview of the health financing situation in the Member States of the WHO African Region. It shows that despite progress, many countries are still on average far from achieving their health financing goals such as the Abuja target of allocating 15% of government budgets to health or the goal of reducing the share of out-of-pocket expenditure in total health expenditure. For example, in 20 out of 45 countries out-of-pocket expenditures are still higher than 40% of the total health expenditure and in 22 countries the level of total health expenditure does not reach even the very minimal target of US$ 44. This cross-country analysis demonstrates that in general the health financing systems in Africa are weak and do not ensure sustainable progression and equity in the way funds are collected and pooled.

References