



Toward Solving Health Financing Challenges In Africa – A Way Forward

In recent years, African countries have recorded economic growth rates of around five to six percent¹— on par with the rest of the world — and policy improvements have brought greater stability to many countries in the region. These trends have been good news for efforts to reduce poverty and improve health in Africa. However, sub-Saharan Africa still faces a grim scenario with respect to the health of its people. The region, home to 12 percent of the world's population, accounts for 22 percent of the total global disease burden and more than 68 percent of the people living with HIV/AIDS.² Efforts to address poor health status are hampered by limited health financing and scarce human resources for health. Large gaps remain between available and needed resources. Low per capita income, limited ability to collect taxes, and health systems bottlenecks complicate governments' ability to effectively and efficiently ensure access to health care services. These challenges persist despite unprecedented volumes of donor assistance in recent years, especially for HIV/AIDS, tuberculosis, and malaria programs.

To explore ways to address Africa's health financing challenges, USAID's Health Systems 20/20 project and the Results for Development Institute's Health Financing Task Force hosted a roundtable discussion in November 2008 on innovations in health care financing in Africa. Experts recommended approaches that hold promise for helping sub-Saharan African countries attain more equitable, efficient, and sustainable health financing.

These options address the three core functions of health financing: revenue generation (tapping into additional resources for health), risk pooling (increasing access and financial protection through insurance mechanisms), and purchasing (strategic spending to ensure efficient, effective service provision).³

This paper provides a summary of the financing situation in sub-Saharan Africa, presents an analysis of prospects for financing, and suggests paths to a better future. We begin by summarizing current data on health financing gaps in sub-Saharan Africa. Using analytic

modeling, we project a possible trajectory for Africa's health financing into the future and identify where the greatest attention needs to be paid. We then describe some of the suggested health financing options that emerged from the expert consultations, and conclude by offering policy recommendations for stakeholders — governments, the private sector, and donor partners.

Roundtable discussants included Amie Batson, World Bank; Charlie Griffin, Brookings Institution; Benjamin Loevinsohn, World Bank; Marty Makinen, Results for Development Institute; William McGreevey, Georgetown University; Agnes Soucat, World Bank; Shamsuddin Tareq, International Monetary Fund; and Netsanet Walelign, UNICEF.

WHERE IS SUB-SAHARAN AFRICA NOW?

Health spending in sub-Saharan Africa,⁴ at \$27 per capita, is lower than in any other region of the world. Governments in the region contribute a smaller portion of total health resources (46 percent⁵) than in any other region except South Asia.⁶ The private sector accounts for 54 percent of total health spending, and most private spending (82 percent) comes from out-of-pocket spending by households – the most regressive form of financing and the most likely to impede access to healthcare by the poor.⁷ Donor assistance – which WHO includes as part of its estimates of both public and private sector spending, rather than tracking as a mutually exclusive third category – accounts for 17 percent of total health expenditures, a larger share than any other world region.⁸

These averages mask important country-level variations in health financing. Table I shows health financing patterns by sub-region and income group for sub-Saharan Africa in 2006, the latest year for which data are available. In Western Africa, for instance, out-of-pocket spending on health accounts for 59 percent of total health expenditures, more than six times the proportion in Southern Africa. In Eastern Africa, external assistance as a share of total health expenditures accounts for nearly three times the levels in all other sub-regions. The highest-income countries spend nearly six times more per capita on health (\$45) than the poorest countries (\$8), where donor financing for health accounts for nearly 40 percent of total health expenditures. The great diversity across the region in the sources and levels of resources for health implies that a wide menu of financing options should be considered.

TABLE I. HEALTH FINANCING IN AFRICA, BY SUB-REGION AND INCOME GROUP, 2006

Sub-region	Total population (000s)	Average GDP per capita	Total health expenditures per capita	Government health exp. as % of total govt exp.	Government health exp. as % of total health exp.	Private health exp. as % of total health exp.	Private out-of-pocket exp. as % of total health exp.	External resources for health as % of total health exp.
Western	278,804	\$779	\$29	5%	34%	66%	59%	11%
Central	115,109	\$843	\$28	6%	57%	43%	42%	10%
Eastern	289,138	\$364	\$19	10%	52%	48%	32%	31%
Southern	7,034	\$3,150	\$185	13%	71%	29%	9%	12%
GDP per capita								
Less than \$250	168,634	\$172	\$8	10%	55%	45%	37%	38%
\$250 to \$499	204,198	\$344	\$20	12%	49%	51%	36%	31%
\$500 to \$999	144,685	\$733	\$36	7%	38%	62%	53%	16%
\$1000 or more	172,568	\$1,369	\$45	5%	48%	52%	44%	7%
Total	690,085	\$640	\$27	7%	46%	54%	44%	17%

Notes: Excludes South Africa, Sudan, and countries with populations <1 million (Cape Verde, Comoros, Equatorial Guinea, Seychelles, and Sao Tome and Principe). All estimates are weighted by population size.

Source: WHO SIS, <http://www.who.int/whosis/en> and IMF World Economic Outlook Database October 2008, <http://www.imf.org/external/pubs/ft/weo/2008/02/weodata/index.aspx>

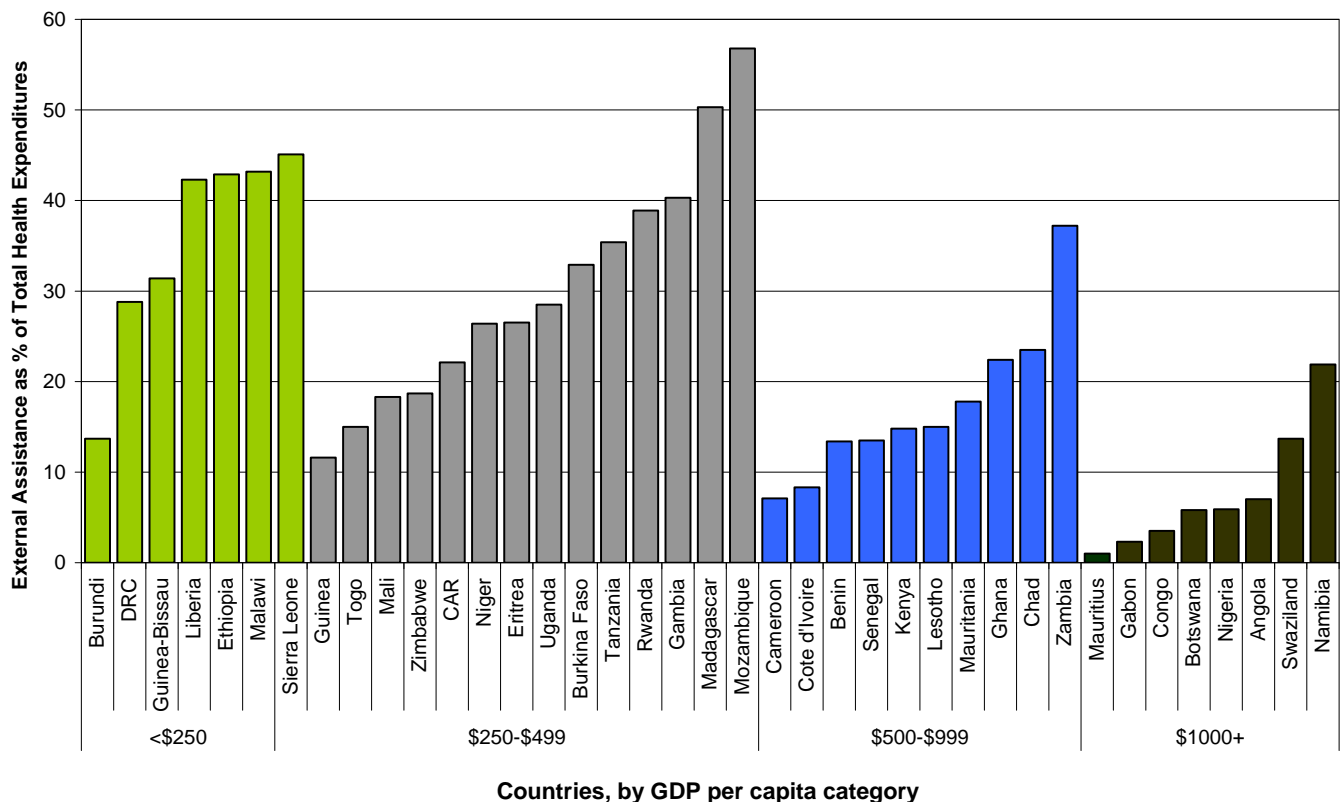
CHALLENGES OF CURRENT GOVERNMENT, PRIVATE, AND DONOR HEALTH FINANCING

Governments in most African countries are constrained in their capacity to finance health, primarily because of low per capita incomes, a small taxable formal sector, and low budget execution rates. While growth rates have increased in recent years, the global economic crisis will likely further strain the health financing capacity of the public sector because governments will have fewer tax revenues at their disposal. Tax administration systems are weak and inefficient, the informal sector is large and difficult to reach, and higher taxes are politically unacceptable. Many governments rely on user fees at health facilities to raise additional revenue, fees which – although sometimes providing the only means for facilities to purchase needed inputs – can create a financial barrier to accessing services.⁹

Heavy reliance on private out-of-pocket spending for health is not equitable, and tends to be inefficient (for example, concentrating on curative rather than preventive services). It leaves households vulnerable to impoverishment from catastrophic health expenditures, and slows progress towards health improvements such as the Millennium Development Goals by limiting access to essential health services among the poor. Channeling household expenditures through risk pooling mechanisms would help, but today mechanisms to pool spending are limited; private pooled spending accounts for less than four percent of total health expenditures across Africa.

Donors are major funders for health in Africa. Figure I below displays the percentage of total health expenditures contributed by donors, according to countries' GDP per capita. Countries at all income levels are heavily dependent on donor support.. Over the past two decades, donor aid for health has soared – in 2006 it reached an unprecedented high of \$3.7 billion, about \$5 per person.¹⁰ However, this amount still falls far short of the levels of aid estimated to be needed to finance basic health priorities; for instance, the WHO Commission on Macroeconomics and Health (CMH) in 2001 estimated that Africa would need \$19 billion annually in donor assistance for health to scale up essential interventions.¹¹ Until recently, donor assistance was primarily provided for disease- and intervention-specific programs, rather than for the strengthening of health systems more broadly. As donors today begin to invest in wider health systems interventions, they face challenges in helping countries effectively and efficiently utilize the resources provided because of limited absorptive capacity at the country level; governments have difficulty spending what they already receive. Countries are also challenged by the multitude of international initiatives and global actors. Addressing donor coordination is an increasingly high priority for donors and countries alike.¹²

FIGURE I: EXTERNAL ASSISTANCE FOR HEALTH AS A PERCENTAGE OF TOTAL HEALTH EXPENDITURES, BY INCOME CATEGORY, 2006



Sources: WHOSIS database and IMF World Economic Outlook database

Note: Countries with populations <1 million excluded (Cape Verde, Comoros, Equatorial Guinea, Sao Tome & Principe, and Seychelles).

CAN SUB-SAHARAN AFRICA GET TO WHERE IT NEEDS TO BE?

Given this health financing landscape, what are the specific gaps in resources that Africa faces, and how soon can these gaps be closed? For answers, we look at Africa's health financing patterns measured against two indicators that highlight the adequacy of resources for health.

In April 2001, African leaders meeting in Abuja pledged to devote 15 percent of their governments' budgets to health. Setting the "Abuja target" was intended to demonstrate countries' commitment to addressing the resource shortfalls for health in the region. But government expenditures on health as a proportion of total government budgets have declined in 19 out of 39 countries since 2001 and remained stagnant in two countries. As of 2006, about seven percent of government resources in Africa – some of which were originally contributed by donors – are going to health overall. Only Botswana, Burkina Faso, Liberia, Malawi, and Rwanda have crossed the 15 percent threshold. And even though this is a notable achievement, it is unclear that meeting the Abuja target leads to good health outcomes or sustainable health financing; for instance, under-five mortality rates in all five countries are all greater than 100 per 1,000, and all but Botswana rely on donors for more than 30 percent of health financing.¹³

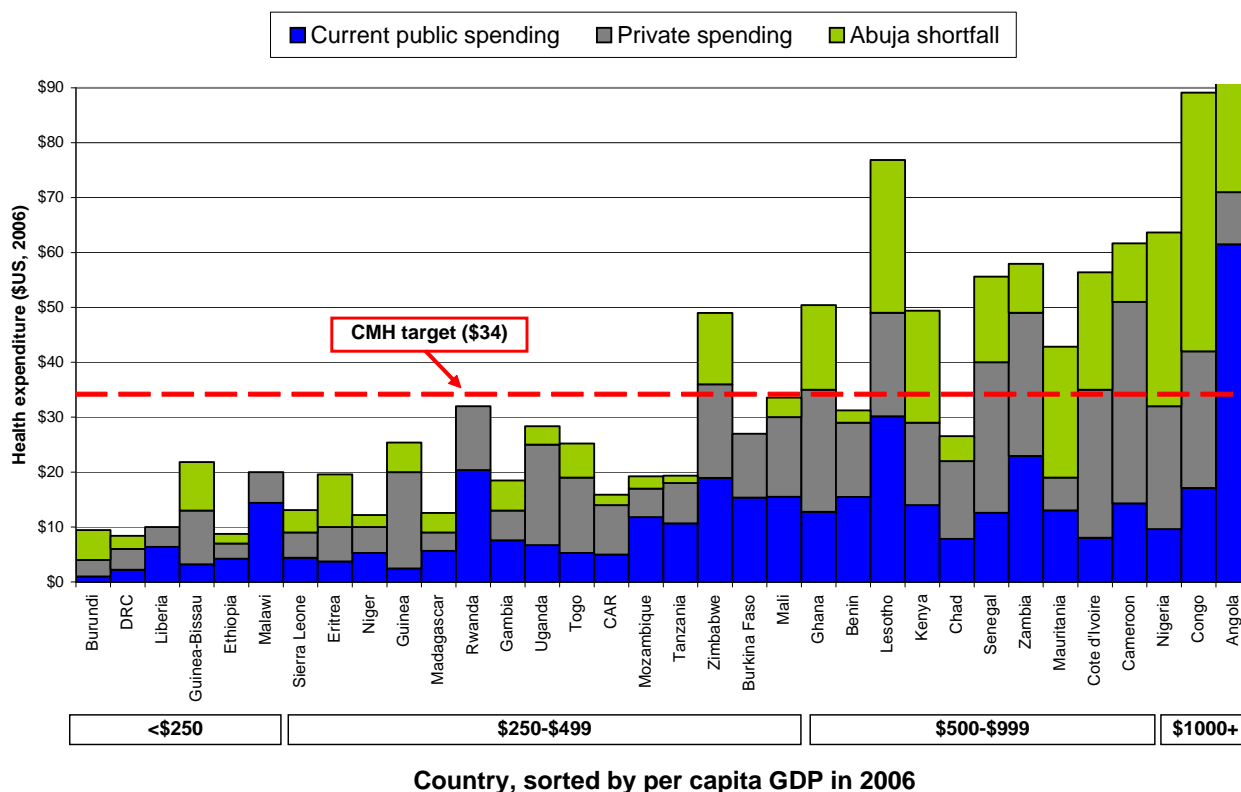
Another commonly referenced financing indicator is the CMH estimate of the cost of a basic package of essential health interventions. In 2001 the CMH estimated this package would cost \$34 per person in developing countries.¹⁴ Though no specific breakdown between public and private spending was suggested, the Commission argued that most of the cost would need to be paid by governments because some essential interventions are public goods (like infectious disease control) and because \$34 is more than many poor households can afford. The report also acknowledged that the \$34 "average" figure might not be enough in some contexts – especially in countries with high HIV prevalence – and that this can fund only a "minimal health system."¹⁵ Furthermore, there has been price inflation since 2001, meaning that \$34 now buys less than it did then. Today, only six out of 39 governments in sub-Saharan Africa are spending \$34 per capita or more on health. Adding in private health spending, 14 countries are spending enough to provide the estimated CMH basic package. But this spending goes only partially to the interventions identified as essential by the CMH. Ten of these countries still have under-five mortality rates greater than 100, and half rely on donors for more than 10 percent of health financing.

Moreover, meeting the Abuja target is no guarantee that a country will spend \$34 per capita on priority health services. Figure 2 demonstrates this point.¹⁶ Current government spending (in blue at bottom) is less than \$34 in all but one of these countries, even those that meet the Abuja target. Adding current private spending (in gray) brings eight more countries past the \$34 threshold. If all these countries met the Abuja target today (indicated by the green bars on top), another three countries would pass this threshold. But 22 countries would still not be able to afford the CMH package, and of these eight would not achieve even half of what the CMH estimates as the level of per capita spending necessary to ensure an essential package of health services for the population.

How soon might countries be able to close these financing gaps, in the best-case scenario? We conducted several simple projection analyses to explore this question. We started with actual government health spending in 2006 (using WHO data), and then applied three very optimistic assumptions:¹⁷

- Governments' budget envelopes increase by five percent per year – as a result of economic growth, better tax collection, and continued high levels of donor assistance
- Population growth slows to a flat two percent per year (we modeled actual growth rates in the 11 countries where they are currently less than two percent)
- Governments steadily work to reach the Abuja target, increasing the percent of their expenditures allocated to health by one percentage point per year, until they reach the Abuja target (15 percent). At that point, we assume that government allocations remain constant at 15 percent.

FIGURE 2. WHAT ABUJA MEANS FOR CMH: EXPENDITURE ON HEALTH (2006) COMPARED TO THE \$34 CMH TARGET



Sources: WHOSIS database, IMF World Economic Outlook 2008, and author's calculations
 Not shown: countries with populations <1 million (Cape Verde, Comoros, Equatorial Guinea, Seychelles, Sao Tome & Principe) or total health spending >\$100 per capita in 2006 (Swaziland, Namibia, Mauritius, Gabon, Botswana, & South Africa)

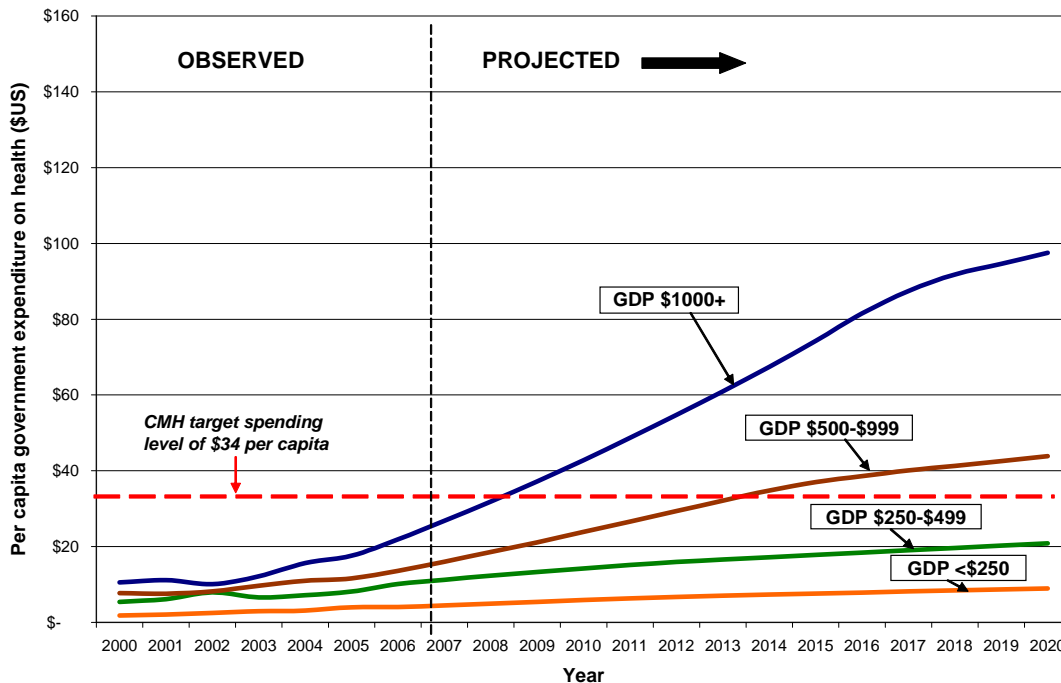
Under these assumptions, we found that all 39 countries in sub-Saharan Africa would meet the Abuja target by the year 2020 (Table 2):

TABLE 2. PROJECTION: WHEN WOULD COUNTRIES MEET THE ABUJA TARGET?

2006	Botswana, Burkina Faso, Liberia, Malawi, Rwanda	2013	Cameroon, Gambia, Zimbabwe
2007		2014	DR Congo, Lesotho, Sierra Leone
2008	Benin, Gabon, Tanzania	2015	Ghana, Kenya, Senegal, Togo
2009	Mali, Mozambique	2016	Angola, Mauritania
2010		2017	Congo, Côte d'Ivoire, Eritrea, Guinea, Guinea-Bissau
2011	Central African Republic, Ethiopia, Namibia, Niger, Uganda, Zambia	2018	Nigeria
2012	Chad, Madagascar, Mauritius, Swaziland	2019	Burundi

What does this mean for reaching the CMH target? We found that six out of eight governments in countries with current GDPs greater than \$1,000 per capita are already spending more than \$34 on health. Eight out of ten governments in countries with GDPs between \$500 and \$999 would cross this threshold by 2020 (Figure 3). But governments in 22 countries – 20 of which have GDPs per capita less than \$500 – would still be spending less than \$34 per capita in 2020. Two governments (Democratic Republic of Congo and Ethiopia) would still be spending less than \$10 per capita.

FIGURE 3. PROJECTED AVERAGE PER CAPITA GOVERNMENT SPENDING ON HEALTH (US\$), GROUPED BY GDP PER CAPITA IN 2006



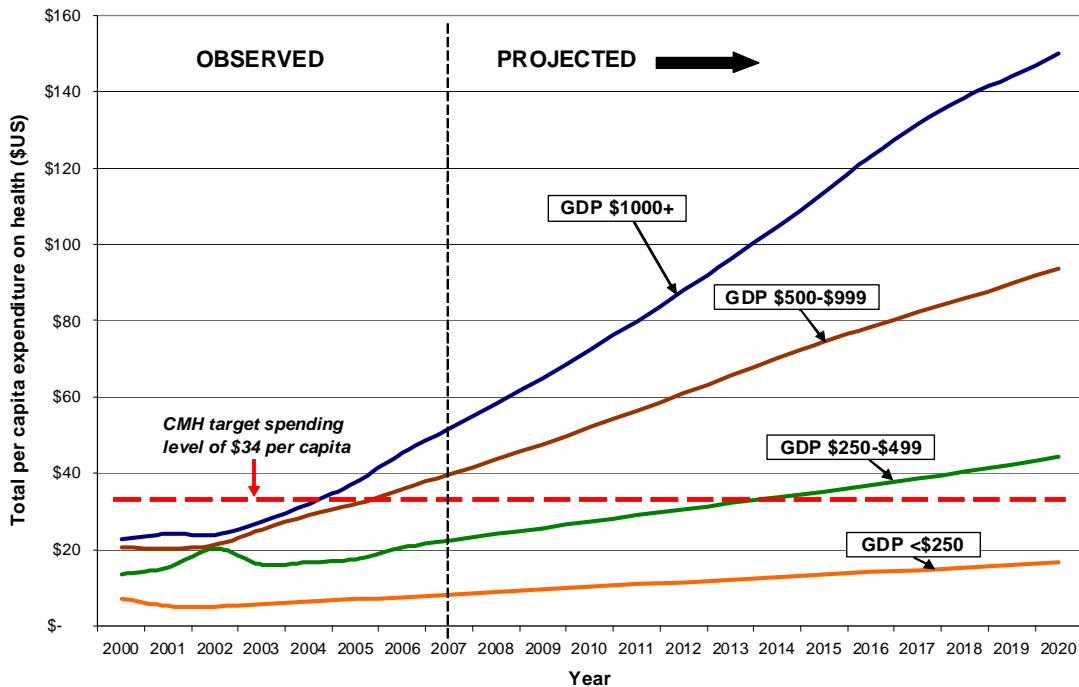
Sources: WHOSIS, IMF World Economic Outlook database, and authors' calculations. Excludes S. Africa and countries with pop. < 1 million.

The analysis was then modified to model private spending. Adding in private spending helps to narrow these financing gaps (Figure 4). Assuming that private health expenditures continue to grow at 5.9 percent per year (their observed trajectory from 2000-2006) and maintaining the previous assumptions about government spending, total public and private health spending in 29 out of 39 countries would surpass the \$34 level by 2020.

But the ten remaining countries present some of the most difficult health financing challenges, and these are where the greatest attention needs to be paid. Per capita income in all these countries is about \$375 or less, meaning that the average citizen gets by on \$1 per day or less. Even doubling the trajectory of private spending (assuming 12 percent growth in private spending per year) leaves seven of the poorest countries (Burundi, Democratic Republic of Congo, Ethiopia, Liberia, Madagascar, Niger, and Sierra Leone) unable to finance the basic package by 2020.

Meeting the Abuja target alone will not solve Africa's health financing challenges, particularly for the poorest countries. It may not be realistic to expect that governments will meet the Abuja target in the short term anyway. Only 18 out of 39 governments – most of them with per capita incomes less than \$500 – are closer to that target in 2006 than they were in 2001. Donor support, which is included in both the government and private spending projections above, may help keep government budget growth on a five percent trajectory, but this is by no means guaranteed given the current global economic downturn. The economic crisis is likely to hit private spending for health even harder – given limited access to credit and the lack of social safety nets in Africa – making six percent annual growth an optimistic figure for the next several years.

FIGURE 4. PROJECTED AVERAGE PER CAPITA GOVERNMENT AND PRIVATE SPENDING ON HEALTH (US\$), GROUPED BY GDP PER CAPITA IN 2006



Sources: WHOSIS, IMF World Economic Outlook database, and authors' calculations. Excludes S. Africa and countries with pop. < 1 million.

WHAT INNOVATIVE OPTIONS CAN HELP FILL THESE HEALTH FINANCING GAPS – AND MAKE BETTER USE OF AVAILABLE RESOURCES?

Current global awareness of the funding crisis in Africa is unprecedented, and there is a historic opportunity to make a sustainable difference in Africa's health financing. Various existing and innovative approaches to health financing could add significant additional resources for health in Africa, and encourage more efficient use of current resources.¹⁸ In this section, we detail nine approaches that have potential, including those that directly address health financing challenges (three to increase revenue generation, one to improve risk pooling, and two to increase efficiency through strategic purchasing) and three options which are complementary. The approaches described here are largely informed by the expert recommendations from the November roundtable discussion.¹⁹

TO MOBILIZE GREATER RESOURCES FOR HEALTH:

- Leverage the organized private sector.** A recent report by the International Finance Corporation²⁰ estimates that \$11-\$20 billion of new investments (about \$1.50 to \$3 per person per year) could be raised from private investors in the next ten years, largely in physical infrastructure for health. Other potentially profitable opportunities include investments in distribution and retail systems, as well as pharmaceutical and medical supply production facilities. In order to encourage this type of investment, and to ensure that private spending achieves desired outcomes for the health sector, it will be important to strengthen the capacity of public and private regulatory bodies, enhance the ability of public entities to procure services and manage contracts with private organizations, and increase access to local and international capital for private investors in health.

Corporate social responsibility initiatives can also generate significant resources for health. Product RED, which encourages private sector investment to fight HIV/AIDS in Africa, has galvanized \$100 million in financial support for the Global Fund from some of the world's largest companies.²¹ A number of Africa's

biggest employers are also becoming increasingly involved in financing health care in Africa, primarily through the provision of health services and HIV/AIDS prevention, care, and treatment programs for employees and their dependents.

- **Explore new global taxes to finance global health priorities.** These could include airline ticket taxation, a "Tobin tax" on the trade of currency across borders,²² and taxes on global "bads" like environmental pollution to raise revenue for global priority health interventions. UNITAID is one example of an innovative tax initiative; participating countries impose a "solidarity tax" on airline tickets to help finance access to affordable drugs for HIV/AIDS, malaria and tuberculosis. To date, nine countries have imposed the tax and another 15 countries are in the process of doing so.
- **Support innovative financing mechanisms for new health technologies.** Various new health technologies that have the potential to transform health outcomes in Africa are in the product pipeline. However, they are likely to be costly. Innovative financing mechanisms, such as Advance Market Commitments (AMC) for vaccines and the Affordable Medicines Facility for Malaria (AMFm), provide revenue to stimulate the development and manufacture of vaccines for developing countries and to facilitate widespread financial access to malaria treatments, respectively. The International Finance Facility for Immunizations (IFFIm) also provides long-term, predictable financing to support immunization programs in poor countries.

To STRENGTHEN RISK POOLING:

- **Develop and strengthen health insurance systems.** More extensive and sustainable risk pooling systems are needed to harness household spending in an equitable, predictable way, and, potentially, improve the efficiency of purchasing. In addition to providing financial protection from catastrophic health expenditures and increasing access to priority services, insurance can improve the effectiveness of health spending by driving improvements in the quality and appropriateness of service provision and increasing the predictability of resource flows from users to providers. Insurance reaps economic efficiency gains, relative to individual out-of-pocket spending, and may help mobilize additional revenues for the health sector. Insurance approaches established in Africa that have had some success, though they are limited in scope of application, range from community-based health insurance to national health insurance schemes. A potential "Health Insurance Challenge Fund" was described during the roundtable discussion.²³ This multi-donor fund, similar to the Global Fund, would support countries that wanted to shift their health financing budgets into insurance and would provide a mechanism for donors to support scaling up insurance models.

To SPEND HEALTH RESOURCES MORE EFFICIENTLY:

- **Improve the efficiency of donor spending by increasing donor coordination, putting donor spending on-budget, and engaging in longer-term commitments.** The involvement of a multitude of donors in a country's health sector often has high overhead and transaction costs. Improving coordination among donors so that agendas and priorities are aligned with those of recipient countries increases the efficiency of resource utilization and reduces the country's reporting burden. Donor health financing that is "on-budget" (included within the country's national budget) can help to foster sustainability, accountability, and transparency. On-budget assistance facilitates resource tracking and can also improve coordination among donors and governments. Lengthening the duration of donor commitments could expand a country's ability to invest in health systems strengthening activities that are accompanied by long-term recurrent costs (e.g., salary expenditures associated with hiring additional health workers). Other mechanisms which can improve the efficiency of donor spending are Sector Wide Approaches (SWAs), basket funding, and budget support.²⁴
- **Implement performance-based financing systems.** By aligning financial incentives with the achievement of desired results, performance-based financing (PBF)²⁵ seeks to change behaviors of health system actors and reward actions that lead to results. Part of the appeal of PBF is that it provides incentives to households, providers, and local governments to find on-the-ground, practical, and effective solutions to health systems challenges. Demand-side financing, where payments follow or go directly to health care

consumers (through vouchers or conditional cash transfers) rather than directly subsidizing service providers, can be used to target the poor and encourage desired behaviors, like seeking prenatal care or complying with tuberculosis treatment.²⁶ Subsidies and vouchers can empower consumers to seek higher quality care, encouraging competition among providers and thereby increasing the efficiency of health spending. Supply-side PBF seeks to change behavior among public and private sector organizations, managers, and health workers by linking their payment to health outcomes and other measurable indicators of performance.²⁷ In Africa, the Democratic Republic of Congo, Rwanda, and Zambia have pilot-tested or implemented supply-side PBF, as have countries like Afghanistan and Haiti in other regions. Settings that seem conducive to success for PBF include countries with strong community engagement in the health sector; countries with large NGO and private sectors, or a large public payer such as a social health insurance organization; and countries which have large amounts of funding from donors that use PBF as a funding criterion.²⁸

Donors can also employ results-based aid provision. The GAVI Alliance, the Global Fund, and the World Bank are just a few of the donors that have used performance criteria as a determinant of disbursing more funds. The new Debt2Health initiative, for which donors agree to forgive certain debts if beneficiary countries commit to invest in Global Fund-approved local programs,²⁹ also contains a performance-based aid component. As a means of encouraging better domestic resource mobilization and allocation, donor support to countries could also be linked to a country's ability to generate resources and use the resources effectively.

CROSS-CUTTING AND COMPLEMENTARY APPROACHES:

- **Strengthen governance of the health sector.** Government leadership and effectiveness are widely recognized as key complementary factors to financing that determine whether health sector goals are achieved even when adequate resources are available. Strengthening governance would stretch tight health budgets. Some approaches to support better governance include:
 - **Improve public financial management.** Without monitoring how money has been spent, it is impossible to evaluate program effectiveness and to hold leaders accountable. Improved public financial management (PFM) would reduce corruption and have spillover effects to other sectors. PFM can be improved by developing more robust central budget controls, preparing multi-year budgets linked to fiscal policy and revenue targets, using performance information in monitoring against targets, and establishing computerized information systems.³⁰ Tools such as Public Expenditure Tracking Surveys and Public Expenditure Reviews³¹ can also help to identify public sector bottlenecks that inhibit the effectiveness and efficiency of health financing.
 - **Increase civil society oversight of health financing.** Civil society actors should be encouraged to play a greater role in demanding equity, efficiency, and propriety in government spending; in monitoring budgets; and in advocating for transparency and accountability. Accountability mechanisms which engage civil society organizations, the media, and local research institutions around the analysis of budget allocations and results should be developed. Sample approaches include citizen report cards and participatory planning and budgeting processes.
- **Build the health financing evidence base, including household and facility-based data.** Donors should enhance the quality and availability of empirical data on health financing through support for household and facility surveys, and strengthen country-owned routine health information systems. Tools such as National Health Accounts describe the sources, uses, and flow of resources within the health system and help document and validate successful interventions; they are a basic requirement for optimal management of health sector resources.
- **Leverage successful disease-based programs to strengthen the wider health system.** Significant financial resources flow into countries for specific disease programs. These resources can have positive health system spillover effects if they are not only used to "work around" system constraints, but are channeled into activities that fundamentally address the constraints to the benefit of all programs, such as human resources development, information system strengthening, or improvement of supply chain management.

At least three major global health initiatives – PEPFAR, the GAVI Alliance, and the Global Fund – have recognized the importance of health system strengthening in their policy language and funding, and these efforts should be continued.

NEXT STEPS: WHAT SHOULD GOVERNMENTS, THE PRIVATE SECTOR, AND DONORS DO?

Thus far this paper has shown that there are critical financing gaps in sub-Saharan Africa. Our analysis indicated that some countries will succeed in closing these gaps over the coming decade, but half are not making progress towards the Abuja target. We demonstrated that even with concerted efforts the poorest countries will not be able to pay for a minimum package through at least 2020 and will therefore continue to need substantial external assistance. We then described a range of options for the international community to consider to address health financing challenges in Africa. Below we outline key policy recommendations for African governments, private sector actors, and donors that emerge from these analyses. The bottom line is that in addition to generating additional revenue for health, it is necessary to use whatever domestic and external financing is available more effectively, efficiently, and equitably.

AFRICAN GOVERNMENTS

TO MOBILIZE GREATER RESOURCES FOR HEALTH:

- Increase budget allocations to the health sector as a share of total government spending, and accelerate progress towards the Abuja target with the ultimate goal of providing a basic package of health services
- Improve the collection of tax revenues by upgrading tax administration systems and staff capacity, and upholding accountability and anti-corruption measures
- Promote tax policies that are friendly to private sector investment in the health system, including corporate social responsibility initiatives and employer-financed health care; work to increase access to local and international capital for private investors in health

TO STRENGTHEN RISK POOLING:

- Promote risk-pooling initiatives, either at the community level or above, aiming for high levels of population coverage, increased access to health care among the poor, and reduced reliance on out-of-pocket expenditures to finance the health system.³²
 - Pursue national or social health insurance schemes where appropriate institutional structures exist or can be developed
 - Encourage sound design, development, and capacity building of community-based health insurance in areas with less formal institutional organization or capacity, and with high community solidarity
 - In collaboration with donors, explore setting up equity funds or similar mechanisms to subsidize health care costs for poor and vulnerable groups

TO SPEND HEALTH RESOURCES MORE EFFICIENTLY:

- Implement pilot tests of performance-based financing systems, engaging technical assistance to ensure careful design and effective monitoring systems, then scale up successes
 - Use demand-side financing to subsidize the poor directly and encourage desired consumer behaviors
 - Use performance-based payments to providers and local governments to create incentives for efficient, effective service provision

- Engage in public-private partnerships; contract with private sector service providers to expand access to high-quality services
- Enhance the quality assurance capacity of regulatory agencies for both public and private sectors

CROSS-CUTTING AND COMPLEMENTARY APPROACHES:

- Improve public financial management by developing more robust central budget controls, using performance information in monitoring against targets, and establishing computerized information systems
- Track health expenditures regularly to monitor the sources and uses of funds and to understand whether resources are reaching their intended recipients

PRIVATE SECTOR (COMMERCIAL AND NONPROFIT)

TO MOBILIZE GREATER RESOURCES FOR HEALTH:

- Pursue investment opportunities in health infrastructure, human resources pre-service training, distribution and retail systems, and pharmaceutical and medical supply production
- Pursue corporate social responsibility activities for the health sector
- Provide health care benefits to employees

TO STRENGTHEN RISK POOLING:

- Where feasible, invest in voluntary private insurance programs (including community-based health insurance), in coordination with public sector initiatives

CROSS-CUTTING AND COMPLEMENTARY APPROACHES:

- Build the capacity of civil society to critically analyze information and constructively demand government accountability in health financing – to advocate for increased resources for health, monitor the health budgeting and allocation process, and track how health resources are spent

DONORS

TO MOBILIZE GREATER RESOURCES FOR HEALTH:

- Participate in innovative financing mechanisms to fund new technologies, especially where market failures make it difficult for products to get to market
- Support innovative international health taxes, such as the UNITAID airline tax

TO STRENGTHEN RISK POOLING:

- Provide technical assistance to countries on design and implementation of national, social, or community-based insurance schemes (including establishing legal frameworks for insurance, strengthening health information systems, designing benefits packages and payment systems, setting premiums, and building the capacity of institutions needed to operate and manage the schemes)
- Consider investing in a "Health Insurance Challenge Fund," which would create a mechanism for donors to support the expansion of insurance systems in developing countries
- Provide financial backing for equity funds or similar mechanisms that subsidize poor and vulnerable groups
- Support reinsurance for catastrophic expenditures to increase the stability and sustainability of government-backed insurance pools

TO SPEND HEALTH RESOURCES MORE EFFICIENTLY:

- Allocate foreign aid in a coordinated and predictable fashion, in ways that strengthen health systems and provide incentives for local performance
 - Put donor spending "on budget"; move away from a project funding approach towards broader support that is integrated into the budgetary process of the country
 - Coordinate with other donors in accordance with the 2005 Paris Declaration on Aid Effectiveness
 - Commit to providing more predictable, longer-term funding
 - Build the capacity of government staff to effectively manage donor funding
 - Work to instill local ownership of programs to improve performance and sustainability
 - Explore disbursing aid based on the achievement of performance indicators
- Provide technical assistance to countries on the design and implementation of performance-based financing systems (including developing clear performance indicators and targets, designing contracts, monitoring compliance, and processing payment)

CROSS-CUTTING AND COMPLEMENTARY APPROACHES:

- Ensure that spending on priority diseases simultaneously works to strengthen the larger health system, by for example, strengthening health information systems, logistics and procurement processes, and human resources development and retention
- Invest in developing a better evidence base on health financing; enhance the quality and availability of empirical data on household health spending, consumer and provider behavior, sources and uses of health funds, etc.
- Support activities that strengthen governance in the health sector by funding efforts to strengthen civil society oversight of health financing, improve accountability, and strengthen public financial management within the health sector

CALL TO ACTION

Health financing gaps in sub-Saharan Africa present an urgent challenge – and a call to action. Continuing along on the current spending trajectory will not be enough, and there is no time to lose. In this paper, we have presented a range of health financing solutions that hold potential but have not been fully exploited. They should be, and soon. There is a groundswell of interest in solving health financing problems in Africa,³³ and the international community must take advantage of this window of opportunity – to mobilize additional revenues for health, improve equity and financial protection, and create incentives for spending health resources more efficiently and effectively.

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ANNEX: LIST OF SUB-SAHARAN AFRICAN COUNTRIES INCLUDED IN THE ANALYSES

Distribution of countries by sub-region of Africa

Western		Central	Eastern		Southern
Benin	Mali	Angola	Burundi	Mauritius	Botswana
Burkina Faso	Mauritania	Cameroon	Eritrea	Rwanda	Lesotho
Cote d'Ivoire	Niger	CAR	Ethiopia	Tanzania	Namibia
Gambia	Nigeria	Chad	Kenya	Uganda	Swaziland
Ghana	Senegal	Congo	Madagascar	Zambia	
Guinea	Sierra Leone	DR Congo	Malawi	Zimbabwe	
Guinea-Bissau	Togo	Gabon	Mozambique		
Liberia					

Distribution of countries by GDP per capita (2006)

<\$250	\$250-499		\$500-999		\$1,000+
Burundi	Burkina Faso	Niger	Benin	Kenya	Angola
DR Congo	CAR	Rwanda	Cameroon	Lesotho	Botswana
Ethiopia	Eritrea	Sierra Leone	Chad	Mauritania	Congo
Guinea-Bissau	Gambia		Côte d'Ivoire	Senegal	Gabon
Liberia	Guinea		Ghana	Zambia	Mauritius
Malawi	Madagascar				Namibia
	Mali				Nigeria
	Mozambique				Swaziland

NOTES

- ¹ OECD (Organisation for Economic Co-operation and Development) Development Centre and the African Development Bank (2006), *African Economic Outlook 2005/2006*. Published by the OECD Development Centre and the African Development Bank, with financial support from the European Commission.
- ² World Bank, *World Development Indicators 2008* (Washington, DC: World Bank, 2008) <http://ddp-ext.worldbank.org>, accessed May 8, 2008. Alan Lopez et al., *Global Burden of Disease and Risk Factors* (Washington, DC: World Bank, 2006). UNAIDS (Joint United Nations Program on HIV/AIDS), *AIDS Epidemic Update* (Geneva: 2007).
- ³ World Health Organization (2000), *The World Health Report 2000: Health systems: Improving performance* (Geneva: WHO).
- ⁴ Throughout this paper, our discussions of “sub-Saharan Africa” refer to 39 countries; please see Annex A for the full list. We exclude Sudan (for lack of data), South Africa (for purposes of comparability), and countries with populations of less than one million (Cape Verde, Comoros, Equatorial Guinea, Sao Tome and Principe, and Seychelles).
- ⁵ Health financing statistics throughout this section (unless otherwise indicated) are taken from the WHO Statistical Information System (SIS) and the authors’ calculations. Figures are for 2006. WHOSIS is online at <http://www.who.int/whosis/en/>.
- ⁶ By way of comparison, average per capita health expenditures in the WHO Europe region were \$1,750 in 2006 and government health expenditures constituted 77 percent of total health expenditures.
- ⁷ Gottret, Pablo and George Schieber (2006), *Health Financing Revisited: A Practitioner’s Guide* (Washington, DC: The World Bank).
- ⁸ External resources for health pass through governments and private entities and therefore overlap government and private spending. The WHO does not track donor support as a mutually exclusive third category.
- ⁹ Lagarde, Mylene and Natasha Palmer (2008), “The impact of user fees on health service utilization in low- and middle-income countries: How strong is the evidence?” *Bulletin of the World Health Organization* 86(11): 839-846.
- ¹⁰ OECD DAC Creditor Reporting System database, <http://stats.oecd.org/WBOS/Index.aspx?DatasetCode=CRSNEW>.
- ¹¹ Commission on Macroeconomics and Health (2001), *Macroeconomics and Health: Investing in Health for Economic Development* (Geneva: WHO); Shantayanan Devarajan, Margaret J. Miller, and Eric V. Swanson (April 2002), “Goals for Development: History, Prospects, and Costs,” World Bank Policy Research Working Paper No. 2819 (available at SSRN: <http://ssrn.com/abstract=636102>).
- ¹² World Health Organization, “Report on the expert consultation on positive synergies between health systems and Global Health Initiatives, WHO, Geneva, 29-30 May 2008.” Available online at http://www.who.int/healthsystems/hs_&_ghi.pdf.
- ¹³ WHOSIS data, <http://www.who.int/whosis/en/>.
- ¹⁴ Commission on Macroeconomics and Health (2001), op. cit. Adjusted for inflation, this is equivalent to approximately \$40 per capita today.
- ¹⁵ Ibid., p.56.
- ¹⁶ Figure 1 displays the 33 countries in sub-Saharan Africa that spent less than \$100 per capita on health in 2006. A version of this chart was originally created in 2006 by Chris Atim in a paper written for the African Union, entitled “Health Financing in Africa” (http://www.africa-union.org/root/au/conferences/past/2006/may/summit/doc/en/SP_PRC_ATM5_Financial_factors.pdf).
- ¹⁷ These assumptions can be considered optimistic for the following reasons: 28 out of 39 countries have current population growth rates that exceed two percent; progress towards the Abuja target is currently occurring at a rate of 0.17 percentage points per year; given the current global economic downturn, government budgets may not increase at five percent per year in the future.
- ¹⁸ Lane, Christopher and Amanda Glassman (2007), “Bigger and Better? Scaling Up and Innovation in Aid for Health,” *Health Affairs* 26(4): 935-948.
- ¹⁹ Other key sources for this section include a presentation entitled “Innovative Financing for Global Health – Overview” given by Charles Griffin of the Brookings Institution at the OECD Global Forum on Development’s Workshop on Lessons for Development Finance from Innovative Financing in Health in Paris, France, on October 7, 2008; and a review paper titled “Health Financing in Africa Today: Challenges and Opportunities” drafted by Chris Atim, in collaboration with the Health Systems 20/20 and Africa’s Health in 2010 projects.

- ²⁰ International Finance Corporation (2007), *The Business of Health in Africa* (Washington, DC: World Bank Group). Available at www.ifc.org/HealthinAfrica.
- ²¹ www.joinred.com
- ²² Spratt, Stephen (2006), "The Tobin tax in the 21st century: Financing development and promoting international financial stability." Paper prepared for the Tax, Poverty and Finance for Development Conference, Essex University, July 6-7, 2006.
- ²³ The concept was described by Charlie Griffin of the Brookings Institution during the November 5, 2008 roundtable discussion on "Innovations for Health Financing in Sub-Saharan Africa."
- ²⁴ Sector Wide Approaches (SWAps) involve governments and donors collaborating to advance sectoral policies and strategies. Basket funding involves donors pooling non-earmarked funds for a government's use to implement a health sector strategy or poverty reduction strategy. Budget support refers to donors providing assistance directly to a recipient country's budget on a regular basis.
- ²⁵ Performance-based financing is also known as results-based financing and pay for performance (P4P).
- ²⁶ The most well-known example of conditional cash transfers is the *Oportunidades* program in Mexico; see Levy, Santiago (2006), *Progress against Poverty: Sustaining Mexico's Progres-a-Oportunidades Program* (Brookings Institution Press). Kenya has implemented a pilot voucher program for safe motherhood services and family planning, which is currently being evaluated; see Bellows, Ben et al., "Using Vouchers for Paying for Performance and Reaching the Poor: the Kenyan Safe Motherhood Initiative," available at <http://uaps2007.princeton.edu/download.aspx?submissionId=70556>.
- ²⁷ Eichler, Rena (2006), "Can 'Pay for Performance' Increase Utilization by the Poor and Improve the Quality of Health Services?" Discussion paper for the first meeting of the working group on performance-based incentives, Center for Global Development.
- ²⁸ Ibid.
- ²⁹ This is currently being piloted in Kenya.
- ³⁰ Wescott, Clay (2008), "World Bank Support for Public Financial Management and Procurement: Conceptual Roots and Evidence of Impact." Presented at the CAPE (Centre for Aid and Public Expenditure) Public Finance Conference, 12-13 November 2008. <http://www.odi.org.uk/events/2008/11/12/295-presentations-session-4.pdf>.
- ³¹ Public Expenditure Reviews (PER) can be used to assess sectoral allocations and Public Expenditure Tracking Surveys (PETS) identify whether budgets reach the appropriate operational levels and end users.
- ³² Guy Carrin and colleagues have proposed a useful framework for countries interested in moving towards universal health insurance coverage. See Carrin, G. et al. (2008), "Universal coverage of health services: tailoring its implementation," *Bulletin of the World Health Organization* 86(11): 857-861.
- ³³ As indicators of this current attention, the entire November issue of the Bulletin of the World Health Organization was devoted to health financing challenges, in Africa and around the world, with several articles echoing the conclusions and recommendations found here. Various entities and initiatives have emerged that focus on health financing – such as the Health Financing Task Force (http://resultsfordevelopment.org/hftf_home.php), the GTZ-ILO-WHO Consortium on Social Health Protection (<http://www.socialhealthprotection.org>), the African Health Economics and Policy Association (<http://afhea.org>), and Innovative Results Based Financing (http://www.norad.no/default.asp?V_ITEM_ID=11711), to name a few.

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