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HEALTH FINANCING IN AFRICA TODAY: CHALLENGES AND OPPORTUNITIES



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Africa's Health
in 2010 

May 2008

This publication was produced for review by the United States Agency for International Development. It was prepared by Chris Atim, Consultant; Lisa K. Fleisher, Abt Associates Inc.; Laurel Hatt, Abt Associates Inc.; Stephen Musau, Abt Associates Inc.; and Aneesa Arur, Abt Associates Inc.; for the Health Systems 20/20 Project.



Recommended citation: Atim, Chris, Lisa K. Fleisher, Laurel Hatt, Stephen Musau, Aneesa Arur. May 2008. Health Financing in Africa Today: Challenges and Opportunities. Washington, DC: Africa's Health in 2010, Academy for Educational Development, and Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.

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Submitted to:

Hope Sukin, USAID/Afr/SD
Ishrat Husain, USAID/Afr/SD
Africa Bureau,
Office of Sustainable Development
United States Agency for International
Development

Karen Cavanaugh, USAID/GH/HIDN/HS, CTO
Yogesh Rajkotia, USAID/GH/HIDN/HS, co-CTO
Bureau of Global Health
Global Health/Population and Reproductive
Health/Service Delivery Improvement
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and
Research
United States Agency for International Development

Contract No.
RLA-C-00-05-00065-00

Project No.:
GHS-A-00-06-00010-00

Contact information:

Africa's Health in 2010
Academy for Educational Development
1875 Connecticut Avenue, NW
Suite 600
Washington DC 20009, USA
Tel. 202 884 8000
Fax 202 884 8447
<http://africahealth2010.aed.org/>

Health Systems 20/20
Abt Associates Inc.
4550 Montgomery Avenue
Suite 800 North
Bethesda, Maryland 20814
Tel: 301 347 5000
Fax: 301 652 3916 |
<http://www.healthsystems2020.org>
www.abtassociates.com

This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Contract No. RLA-C-00-05-00065-00 (Africa's Health in 2010) and Project No. GHS-A-00-06-00010-00 (Health Systems 20/20). The contents are the responsibility of the Africa's Health in 2010 project, managed by the Academy for Educational Development, and Health Systems 20/20, managed by Abt Associates Inc., and do not necessarily reflect the views of USAID or the United States Government.



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Medicine

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ACRONYMS

ACT	Artemisinin-based Combination Therapy/Treatment
AIDS	Acquired Immunodeficiency Syndrome
AMC	Advance Market Commitments
AMFm	Affordable Medicines Facility-Malaria
APRM	African Peer Review Mechanism
ARV	Antiretroviral
CBHI	Community-based Health Insurance
CCT	Conditional Cash Transfer
CMH	Commission on Macroeconomics and Health
DR Congo	Democratic Republic of Congo
DRSF	Debt Relief Savings Fund
EU	European Union
FBO	Faith-based Organization
G8	Group of Eight
GDP	Gross Domestic Product
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
HSS	Health System Strengthening
IDA	International Development Association
IFC	International Finance Corporation
IFFIm	International Finance Facility for Immunization
IHP+	International Health Partnership Plus
ILO	International Labour Organisation
ISS	Immunization Services Support
MDG	Millennium Challenge Goals
NGO	Nongovernmental Organization
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PBF	Performance-based Financing
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Performance Expenditure Review
PETS	Public Expenditure Tracking Survey
PMI	President's Malaria Initiative

PMTCT	Prevention of Mother-to-Child Transmission
RBM	Roll Back Malaria
SWAp	Sector-wide Approach
TB	Tuberculosis
USAID	United States Agency for International Development
VAT	Value-added Tax
WDI	World Development Indicators
WHO	World Health Organization
WHOSIS	World Health Organization Statistical Information System

Currency note: All dollar amounts are in U.S. dollars.

ACKNOWLEDGEMENTS

The general framework for this report is a paper entitled "Health Financing in Africa," which was produced with support of the U.K. Department for International Development and authored by Chris Atim on behalf of the HLSP Institute for the Special Summit of African Union on HIV/AIDS, Tuberculosis, and Malaria in May 2006 in Abuja, Nigeria.

This report was funded by the United States Agency for International Development (USAID) Africa Bureau. The authors are indebted to the guidance and feedback provided by USAID's Hope Sukin and Ishrat Husain throughout the development of the report. The authors also wish to thank Stella Goings for her thoughtful comments and suggestions on an earlier version of the paper.

The authors are very grateful for the valuable written comments received from the panel of expert reviewers: Catherine Connor, Ed Elmendorf, Eytayo Lambo, Marty Makinen, Doyin Oluwole, Oscar Picazo, and Nancy Pielemeier. Additional comments and feedback were received from Rena Eichler. Sara Bennett and Oscar Picazo provided comments on early versions of the outline of this report.

The team also thanks Jenna Wright and Ananya Price for valuable research assistance, Paul Gubbins for indispensable help with the Creditor Reporting System (CRS) database of the Organisation for Economic Co-operation and Development's Development Assistance Committee, and Linda Moll and Maria Claudia De Valdenebro for final editing and design.

EXECUTIVE SUMMARY

For the first time in 30 years, African countries are recording economic growth rates of around 5 to 6 percent per annum¹ – on par with the rest of the world – and policy improvements have brought greater stability to many countries.² These positive trends in economic growth and stability are 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.³ The region's poor health status is mirrored by crises in health financing and human resources for health. With only 2 percent of the global health workforce and only 1 percent of the world's health expenditures,⁴ sub-Saharan African countries are ill-equipped to adequately address their health problems. Low per capita income, limited capacity for domestic revenue mobilization, and pervasive health systems bottlenecks complicate governments' ability to respond effectively to the health challenges in their countries. Even with substantial external assistance, large gaps remain between available and needed resources.

The purpose of this paper is to evaluate the capacity of sub-Saharan African governments to finance sustainable and functional health systems, and to present realistic health financing approaches that could complement government financing. We review current patterns of health expenditures in sub-Saharan Africa, including the contributions of the public sector as well as those of households, other private sector stakeholders, and the donor community. We discuss estimates of the financing gaps that exist, and offer a review of complementary financing approaches, including innovative strategies.

Progress toward financing targets is slow

Governments in Africa are constrained in their capacity to finance health, as evidenced by the low levels of public sector health spending in most African countries. On average, total health expenditures in sub-Saharan Africa (excluding South Africa) were \$23 per capita in 2005, the most recent year for which data are available. Governments spent \$10.19 per capita on health in 2005, or 44 percent of the total. Private households were the largest financiers of health care, spending \$10.47 per capita or 45 percent of the total. The remaining 11 percent came from other private sources (primarily employers and private insurance arrangements). External resources for health, which flow through both the public and private sectors, accounted for approximately 17 percent of the total.

¹ OECD (Organisation for Economic Co-operation and Development) Development Centre and the African Development Bank. African Economic Outlook 2005/2006 (May 16, 2006). Published by the OECD Development Centre and the African Development Bank, with financial support from the European Commission.

² World Bank. African Development Indicators 2007. (Washington, DC: World Bank Group, October 2007).

³ 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). http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf. Accessed January 4, 2008.

⁴ Pablo Gottret and George Schieber. Health Financing Revisited: A Practitioner's Guide. (Washington, DC: World Bank, 2006).

Targets for health and poverty reduction, established both by African leaders themselves as well as by the international community, have re-focused attention on the commitment of country governments to financing health, as well as on the urgent need to provide a package of essential health services. However, progress to meet these goals is slow, and large resource gaps remain.

- At a 2001 meeting in Abuja, African leaders committed to allocating 15 percent of total government spending to the health sector (the “Abuja target”).⁵ However, only five sub-Saharan African countries had reached this target as of 2005 (Burkina Faso, Lesotho, Liberia, Malawi, and Rwanda).⁶ However, these countries receive significant external assistance, much of which is funneled through the public sector for use on social programs such as health.
- The World Health Organization’s Commission on Macroeconomics and Health (CMH) estimated that in low-income countries, a basic package of health services could be provided for \$34 per capita⁷ (the so-called “CMH target”). However, current per capita spending on health is lower in sub-Saharan Africa than in any other region, and would need to increase by 68 percent to provide the CMH package. In 2005, only 15 countries had total per capita health spending of \$34 or more.
- To reach the Millennium Development Goals (MDGs), it is estimated that the proportion of government spending on health would need to increase nearly six-fold and that more than 12 percent of gross domestic product would have to be spent on health, which is unrealistic.⁸

Furthermore, even if all countries were able to meet the Abuja target today and allocated 15 percent of government financing to health, 23 countries still would not reach the \$34 spending level. A projection analysis shows that even under optimistic assumptions about economic growth, population growth, and tax revenue collection, and assuming that all countries meet the Abuja target, the majority of governments in sub-Saharan Africa will not meet the CMH target even by 2020. Without question, more resources for health are needed in sub-Saharan Africa.

Challenges of public sector and donor financing cannot be ignored

In addition to indicating commitment to a population’s health, public sector financing for health can improve equity through subsidizing health services for the poor and providing financial protection, and public financing is often the most efficient way to finance health services that qualify as public goods. However, there are significant challenges to public sector health financing in Africa, including low domestic resource mobilization capacity and other factors limiting fiscal space. These challenges constrain African governments from significantly increasing the level of resources allocated to health.

Over the past two decades, donor funding for health has been steadily increasing, with substantial new influxes since the late 1990s in response to the HIV/AIDS pandemic as well as the MDGs. While the volume of donor resources for the health sector has reached unprecedented levels (\$3.7 billion in 2006), donor aid can be volatile and is still largely tied to disease-specific priorities. External aid may displace domestic resources and fail to reach its intended recipients, and fulfilling multiple donor reporting requirements can put strains on understaffed local institutions. There is room for improved

⁵ The Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases. African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases. Abuja, Nigeria. April 24-27, 2001. http://www.un.org/ga/aids/pdf/abuja_declaration.pdf. Accessed December 21, 2007.

⁶ World Bank. World Development Indicators 2008. Data are from 2005.

⁷ World Health Organization. Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health. (Geneva: 2001).

⁸ Disease Control Priorities Project. Achieving the Millennium Development Goals for Health: So far, progress is mixed – Can we reach our targets? (February 2007). <http://www.dcp2.org/file/67/DCPP%20-%20MDGs.pdf>. Accessed December 16, 2007.

coordination among donors and increased attention to the effectiveness and efficiency of donor spending.

Complementary sources and approaches offer promise for improving efficiency and equity

Other financing sources and approaches have emerged both in Africa and internationally which could complement traditional public sector service delivery and financing. These include additional sources of revenue for health as well as mechanisms to make existing health spending go further.

For instance, private sector sources play a major role in health financing in the region, accounting for the majority of health expenditures. The bulk of private expenditures in Africa originate as out-of-pocket expenditures from households. These could be more effectively channeled through various insurance mechanisms and lead to greater financial protection for the poor. Experience to date with revenue raising and risk pooling through insurance in sub-Saharan Africa suggests these mechanisms have potential. The role of private investors, employers, and faith-based organizations as financiers of health care could also be further expanded.

Second, as donors will continue to play a major role in health financing in Africa for the foreseeable future, greater emphasis is needed to ensure that external assistance helps to build the overall health system. New, innovative international financing mechanisms, which are designed to address some of the problems with the global health aid architecture, have the potential to bring more flexible resources for health.

Third, strengthening health systems in sub-Saharan Africa through improving leadership and government effectiveness, increasing absorptive capacity, and building the capacity of the health workforce can help existing and additional resources go further. Performance-based financing offers possibilities for improving the efficiency of public and private health spending. Experience to date in Rwanda show promise for increasing the technical efficiency of service provision, improving the quality of care delivered, and stimulating demand for priority services.

Health financing does not lend itself to cookie-cutter solutions. Complementary approaches must take into account the unique epidemiologic, demographic, structural, cultural, and macroeconomic characteristics of each country, as well as the overarching political economy influencing the adoption, implementation, and scaling up of policies and programs. Many of the approaches are not yet backed by an extensive evidence base and require further implementation, monitoring, and evaluation.

An expanded approach to financing health in Africa

The mechanisms and approaches examined in the report provide avenues to raise additional revenue for health, but also can increase the efficiency of spending, improve equity and sustainability of financing, and better align country and donor priorities. Attention to *how* money is spent in addition to *how much* is a central tenet that we and others⁹ argue should drive the approach to health financing in low-income countries, including those in Africa.

⁹ Refer to: William Hsaio. "Why is a Systemic View of Health Financing Necessary?" Health Affairs Vol. 26, No. 4: (Bethesda, MD: Project Hope, 2007); Anne Mills. "Improving the Efficiency of Public Sector Health Services in Developing Countries". In: Colclough C. (ed). *Marketizing Education and Health in Developing Countries—Miracle or Mirage?* Chapter 10, pages 245-274, (Oxford: Clarendon Press, 1997); Gottret and Schieber, 2006; The World Bank. *World Development Report 1993: Investing in Health*. (Washington, DC: The World Bank, 1993); World Health Organization (WHO). *World Health Report 2000: Health Systems – Improving Performance*. (Geneva: WHO, 2000).

An expanded approach to health financing should be multi-pronged, involving governments leading the effort to explore complementary financing mechanisms; using private sector resources more equitably and efficiently; and increasing collaboration with donor partners to ensure external and domestic resources help build the health system. Recent efforts to set health financing targets have certainly galvanized a tremendous response by donors and countries alike. However, with a plethora of new financing initiatives directed toward disease-specific priorities in Africa, space still remains for a more comprehensive shift in the approach to health financing.

This shift will not be an easy task. It will involve changes in the actions and behaviors of both donors and countries alike. Without these changes, however, current and additional resources for health in Africa will continue to have limited impact on health outcomes.

I. INTRODUCTION

After decades of stagnation, the economies of many sub-Saharan African countries are beginning to grow once again. For the first time in 30 years, African countries are recording gross domestic product (GDP) growth rates at around 5 to 6 percent per annum¹⁰ – on par with the rest of the world – and policy improvements have brought greater stability to many countries.¹¹ These positive trends in economic growth and stability are good news for efforts to reduce poverty and improve health outcomes in Africa.

However, sub-Saharan Africa, perhaps to a greater extent than any other region in the world, still faces a grim scenario with respect to the health of its people. The region – which is home to 12 percent of the world's population – accounts for 22 percent of the total global disease burden. Poor population health status is mirrored by crises in health financing and human resources for health. With only 2 percent of the global health workforce and only 1 percent of the world's health expenditures,¹² health systems in sub-Saharan African countries are ill-equipped to adequately address their health problems. Low per capita income and limited capacity for domestic revenue mobilization complicate governments' ability to respond effectively to the health challenges in their countries.

Purpose and objectives

The purpose of this paper is to evaluate the capacity of African governments to finance sustainable and functional health systems, and to explore realistic health financing approaches that could complement government financing. The objectives are to:

1. Review current patterns of health expenditures in sub-Saharan Africa including the financing contributions of the public sector, the donor community, households, and other private sector stakeholders;
2. Estimate the financing gaps that exist, relative to key health financing targets;
3. Review the potential of governments and donors to fill these gaps;
4. Review the potential of complementary financing sources and approaches, including innovative strategies, to provide additional revenue for health as well as make existing health spending go further.

Organization of the paper

Section 2, Current Patterns of Health Financing in Sub-Saharan Africa Challenge Progress toward Targets and Outcomes, sets the context for the health financing situation in the region, and analyzes how low spending levels are leaving significant gaps in what is needed to adequately finance and sustain functional health systems. Targets for health and poverty reduction have re-focused attention on the commitment of country governments to financing health, as well as the urgent need to design and

¹⁰ OECD (Organisation for Economic Co-operation and Development) Development Centre and the African Development Bank. African Economic Outlook 2005/2006 (May 16, 2006). Published by the OECD Development Centre and the African Development Bank, with financial support from the European Commission.

¹¹ World Bank. African Development Indicators 2007. (Washington, DC: World Bank Group, October 2007).

¹² Pablo Gottret and George Schieber. Health Financing Revisited: A Practitioner's Guide. (Washington, DC: World Bank, 2006).

provide a package of essential health services. However, progress on increasing public sector spending on health – as embodied by the Abuja target – and providing a basic package of health services – as embodied by the World Health Organization (WHO) Commission on Macroeconomics and Health’s (CMH) estimate of \$34 to provide a basic package – remains slow.

Section 3, *Capacity of Governments in Sub-Saharan Africa to Finance Sustainable and Functional Health Systems*, reviews the opportunities and challenges facing the public sector in health financing. In addition to indicating commitment to a population’s health and well-being, public sector financing for health can improve equity through subsidizing health services for the poor and providing financial protection, and is often the most efficient way to finance health services that qualify as public goods. However, there are significant challenges to public sector health financing in Africa, including limited fiscal space and domestic resource mobilization capacity.

Section 4, *Challenges with External Assistance for Health in Sub-Saharan Africa*, explores the dynamics of donor financing in Africa, which has reached unprecedented levels offering solutions to some problems but also creating others. The volume of donor resources for the health sector in Africa has reached unprecedented levels and continues to rise. However, the volatility and unpredictability of aid flows for health complicate long-term planning efforts and compromise sustainability. Also, while disease-specific funding flows can achieve short-term successes for specific health outcomes, they may not strengthen underlying health systems.

Section 5, *Complementary Approaches for Health Financing: Possibilities in the Sub-Saharan African Context*, discusses various mechanisms that can increase the total revenue available for financing health as well as make current financing more efficient and effective. It is undeniable that financing levels are low and more money is needed. Substantial new resources are not likely be readily available from the public sector, however, and more money alone is not enough. Increased attention to the efficiency and effectiveness of public, private, and external health financing, as well as overall health systems strengthening, is essential to closing health financing gaps and improving health outcomes in the region. This section presents a review of experience to date and future potential of private sector health financing, innovative international financing approaches, revenue raising and risk pooling through insurance, and health systems strengthening activities.

The paper concludes in Section 6 by offering recommendations for policymakers in sub-Saharan African countries as well as bilateral and multilateral development organizations involved in health financing in sub-Saharan Africa.

2. CURRENT PATTERNS OF HEALTH FINANCING IN SUB-SAHARAN AFRICA CHALLENGE PROGRESS TOWARD TARGETS AND OUTCOMES

The health financing crisis facing sub-Saharan Africa is particularly acute because of the magnitude of the epidemiologic, demographic, and macroeconomic challenges within the region. This section provides an overview of the epidemiological and financing context in sub-Saharan Africa to set the stage for an analysis of the evidence on countries' progress in reaching the Abuja and CMH targets. More broadly, these underlying patterns indicate that there is a need to explore complementary approaches to traditional public and private (i.e., out-of-pocket expenditures by households) expenditures for health in the region.

2.1 OVERVIEW OF HEALTH OUTCOMES AND HEALTH FINANCING IN SUB-SAHARAN AFRICA

Table 1¹³ shows key epidemiological and demographic information for sub-Saharan Africa (excluding South Africa), divided by sub-region and income group. The wide variation in the size of populations and the HIV prevalence rate across the sub-regions and income groups has implications for the costs of government efforts to provide a basic package of health services. For example, Southern Africa is hardest hit by the HIV/AIDS epidemic, with a prevalence rate of 23 percent. It also has the highest prevalence of tuberculosis (TB), which may reflect HIV/TB co-infection.

Within the generally low-income context of sub-Saharan Africa, higher GDP per capita does not always correlate with better health outcomes. For instance, Angola, with a GDP per capita of \$1,903, has an estimated maternal mortality ratio of 1,700 per 100,000 and an infant mortality ratio of 154 per 1,000 – among the highest in the region. Similarly, Madagascar, with a GDP per capita of only \$270, has an estimated maternal mortality of 550 and an infant mortality rate of 76 – among the lowest in the region. While there is generally a correlation between wealth and health, health outcomes are affected by many additional factors. Maternal mortality ratios, for example, are particularly affected by the performance of the health system.¹⁴ Post-conflict countries such as Angola often suffer from weak health systems as a result of decades of strife. While the East Africa sub-region spends the least on average (\$16 per capita), these four countries have the highest life expectancies (male and female), though other health outcomes, such as maternal and infant mortality are similar or worse compared to other regions. The

¹³ These data exclude South Africa, which, if included in the analysis, decreases the prevalence rate of both HIV/AIDS and tuberculosis in the Southern Africa sub-region to 17 percent and 532 per 100,000 population, respectively. See Annex 3 for tables with data including South Africa.

¹⁴ T. Sundari. "The untold story: How the Health Systems in Developing Countries Contribute to Maternal Mortality". *International Journal of Health Services* 22(3,1992); E. Urassa et al. "Operational Factors Affecting Maternal Mortality in Tanzania". *Journal of Health Policy and Planning*. 12(1,1997). AK Mbonye et al. "Declining Maternal Mortality Ratio in Uganda: Priority Interventions to Achieve the Millennium Development Goal". *International Journal of Gynecology and Obstetrics*. 98(3, 2007); A. Kampikaho and LM Irwig. "Incidence and Causes of Maternal Mortality in Five Kampala Hospitals, 1980-1986". *East Africa Medical Journal*. 68(8,1991).

broader implication for health financing policy is that it is possible for countries to achieve much better health outcomes without increasing the levels of health financing.

TABLE I. KEY POPULATION HEALTH CHARACTERISTICS IN SUB-SAHARAN AFRICA, BY SUB-REGION AND INCOME GROUP

Sub-region	Number of countries	Total population (000s)	Adult HIV prevalence (2005)	TB prevalence per 100,000 population (2004)	Maternal Mortality Ratio (2000 estimates)	Infant Mortality Rate (2004)	Life expectancy at birth (male) (2004)	Life expectancy at birth (female) (2004)	Population growth rate (2005)
Western	15	271,992	3.0%	505	860	104	46.5	48.3	2.6%
Central	7	111,868	3.7%	456	1044	122	43.4	47.2	2.5%
Eastern	13	278,059	7.9%	581	1019	93	47.5	49.1	2.5%
Southern	4	6,967	23.2%	654	325	64	42.8	45.5	1.2%
GDP per capita (2005)									
Less than \$250	9	179,384	4.1%	554	1032	118	45.2	48.3	2.7
\$250 to \$499	13	202,113	5.7%	494	1016	90	47.7	49.6	2.6
\$500 to \$999	10	260,163	4.7%	557	821	98	46.4	47.6	2.4
\$1000 or more	7	27,226	7.2%	398	1138	117	43.3	46.7	2.4
Total	39	668,886	5.0%	531	949	102	46.3	48.4	2.5

Sources: WHO Statistical Information System (WHOSIS) database and World Bank World Development Indicators (WDI) database 2008

Notes: (i) Excludes South Africa, countries with populations <1 million¹⁵, Sudan, and Somalia. Estimates are weighted by population size. (ii) See Annex 2 for list of countries in each sub-region and income group. See Annex 3 for the same table including South Africa.

A review of health financing indicators reveals that overall health spending in sub-Saharan Africa is low, especially in comparison with other regions (Table 2). On average, countries in sub-Saharan Africa, excluding South Africa, spent \$23 per capita on health in 2005.¹⁶ This is the lowest level of per capita health expenditures in the world. However, government health spending as a percentage of total government expenditure (7 percent) is comparable to countries in the Eastern Mediterranean region and Western Pacific, and is greater than that in South-east Asia and North and South America.

¹⁵ Countries with populations <1 million include: Cape Verde, Comoros, Equatorial Guinea, São Tomé, and Seychelles.

¹⁶ If South Africa is included, total health expenditures per capita rise to \$50. See Annex 3 for tables including South Africa.

TABLE 2. HEALTH FINANCING INDICATORS, BY WHO REGION (2005)

WHO region	Total population (000s)	Average GDP per capita (average exchange rate, \$US)	Total health expenditures per capita (average exchange rate, \$US)	Government health exp. as % of total government exp.	Government health exp. as % of total health exp.	Private health exp. as % of total health exp.	External resources for health as % of total health exp.
South-east Asia	1,651,677	\$825	\$33	5	28	72	1.5
Africa	750,460	\$934	\$53	9	46	54	6.8
<i>Sub-Saharan Africa (excluding South Africa & nations with populations <1 mn.)²</i>	668,886	\$519	\$23	7	44	56	16.7
Eastern Mediterranean	531,568	\$2,353	\$104	7	57	43	1.2
Western Pacific	1,733,518	\$5,116	\$358	7	70	30	0.1
Region of the Americas	879,955	\$18,270	\$2,575	1	47	51	0.02
Europe	872,682	\$18,258	\$1,665	15	76	24	0.0

Sources: WHOSIS database and World Bank WDI database 2008

Notes: (i) Total health expenditures are broken down into government and private expenditures. External resources for health include all grants and loans for health goods and services, in cash or in kind. These pass through governments or private entities and are not mutually exclusive categories. As a result, government health expenditures are likely overstated as a percentage of total health expenditures. (ii) Excludes Algeria, South Africa, and nations with populations less than 1 million, for comparison with other analyses in this paper. (iii) All estimates are weighted by population size. (iv) For a listing of countries in each WHO region, refer to WHO SIS.

Global aggregates of health spending levels can mask important intra-regional geographic and income-level variations in health financing patterns. Table 3 portrays these patterns by sub-region and income group for sub-Saharan Africa.¹⁷ The poorest countries (with GDP per capita under \$250) spent on average \$7 per capita on health, while countries with per capita GDP greater than \$1,000 spent \$91 per capita.

¹⁷ The income group stratification was developed by the authors to show the variation across sub-Saharan Africa within the typical low-income category classification (i.e., as used by the World Bank).

TABLE 3. HEALTH FINANCING INDICATORS IN SUB-SAHARAN AFRICA, BY SUB-REGION AND INCOME GROUP (2005)

Sub-region	Number of countries	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.	External resources for health as % of total health exp.
Western	15	271,992	\$598	\$26	5%	34%	66%	11%
Central	7	111,868	\$684	\$22	7%	50%	50%	9%
Eastern	13	278,059	\$314	\$16	10%	51%	49%	33%
Southern	4	6,967	\$2,973	\$187	12%	67%	33%	8%
GDP per capita								
Less than \$250	9	179,384	\$152	\$7	11%	55%	45%	41%
\$250 to \$499	13	202,113	\$340	\$19	11%	44%	56%	29%
\$500 to \$999	10	260,163	\$693	\$30	5%	35%	65%	10%
\$1000 or more	7	27,226	\$2,602	\$91	8%	67%	33%	6%
Total	39	668,886	\$519	\$23	7%	44%	56%	17%

Sources: WHOSIS database and World Bank WDI database 2008

Notes: (i) Excludes South Africa, countries with populations <1 million, Sudan, and Somalia. (ii) Total health expenditures are broken down into government and private expenditures. External resources for health include all grants and loans for health goods and services, in cash or in kind. These pass through governments or private entities and are not mutually exclusive categories. As a result, government health expenditures are likely overstated as a percentage of total health expenditures. (iii) All estimates are weighted by population size. (iv) See Annex 2 for list of countries by sub-region and income group. See Annex 3 for estimates including South Africa.

Table 3 also highlights the fact that governments are not the primary financiers of health care in sub-Saharan African countries. Private spending on health (56 percent of total health spending) exceeds public spending (44 percent of total health spending) at the regional level and in Western Africa. However, most of the private spending in the region is out-of-pocket spending, paid directly by households at the time of service – not pooled by any insurance mechanism. In addition, external assistance plays a significant role in health sector financing in all the sub-regions, and particularly in Eastern Africa.¹⁸ External resources account for 17 percent of total health expenditures overall, and for more than one-third of health expenditures in the poorest countries.

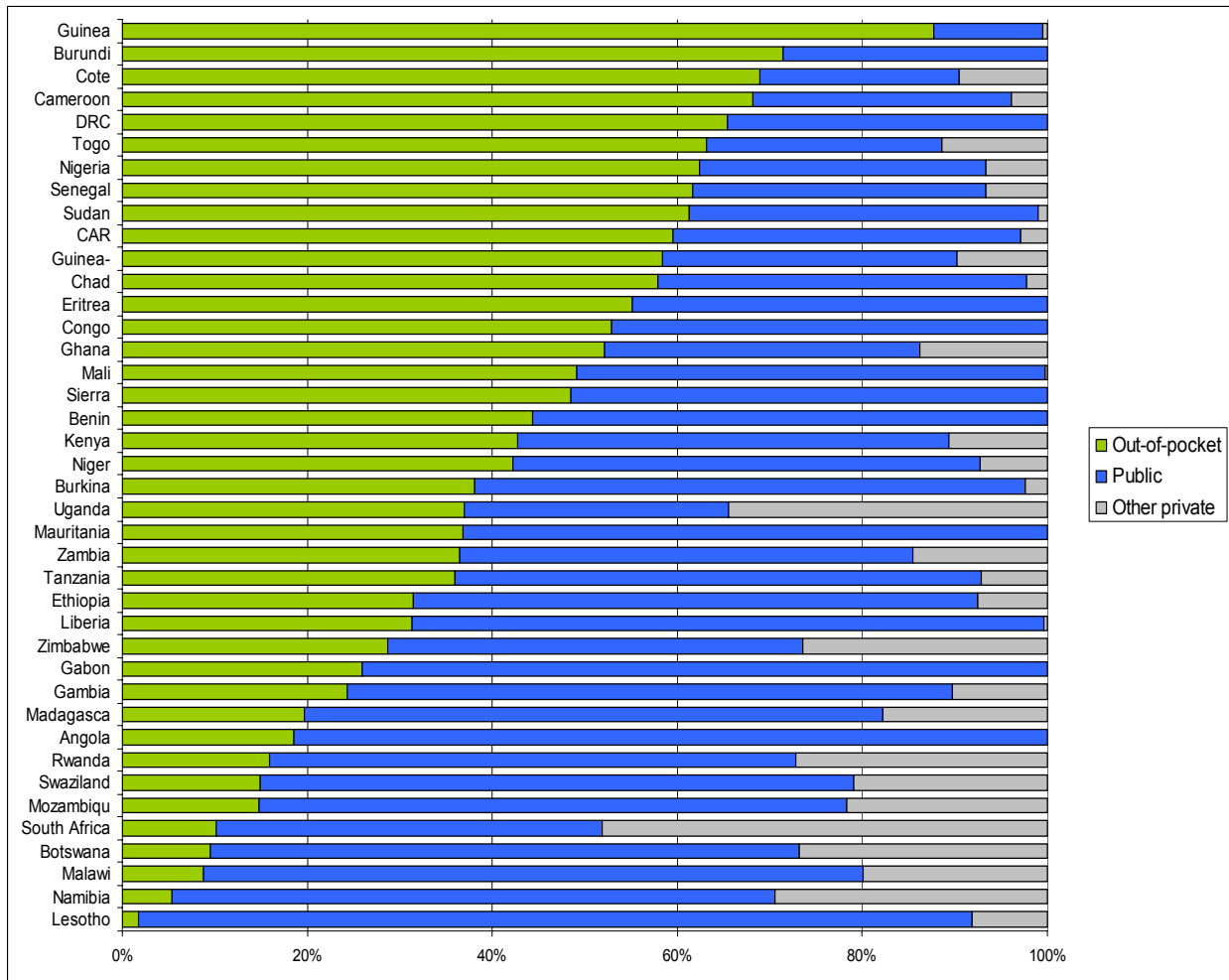
Figure 1 graphically depicts the relative magnitude of private sector expenditure on health, including the role of out-of-pocket payments. Several countries, particularly in West Africa, finance more than half of all health expenditures through out-of-pocket payments. The burden on households of paying out-of-pocket for health care – especially for higher-priced services – often results in impoverishment and can prevent individuals from seeking care when needed.¹⁹ Figure 1 also shows that the private sector contributes to health financing through pre-paid plans and risk pooling arrangements in some countries

¹⁸ If South Africa is included in the analysis, external assistance as a share of total health spending decreases to 1 percent in the Southern Africa sub-region, total health expenditures per capita increase to \$405, and average GDP per capita increases to \$4,879. See Annex 3.

¹⁹ Ke Xu et al. "Household catastrophic health expenditures: a multicountry analysis." *The Lancet* 362 (July 12, 2003); and Alex Preker et al. "Rich-Poor Differences in Health Care Financing." In *Social Reinsurance—A New Approach to Sustainable Community Health Care Financing*, ed. D. Dror and A. Preker (Washington: World Bank, 2002), 21–26.

(“other private” spending in the figure). “Other private spending” is defined by the WHO as including firms’ expenditure on health, and non-profit institutions serving mainly households.²⁰

FIGURE I. TOTAL HEALTH SPENDING BY SOURCE, 2005



Source: WHOSIS database and World Bank WDI database 2008

²⁰ Firms’ expenditure on health is defined by WHO as “outlays by private enterprises for medical care and health-enhancing benefits other than payment to social security or other pre-paid schemes.” Non-profit institutions serving mainly households are “the resources used to purchase health goods and services by entities whose status does not permit them to be a source of income, profit, or financial gain for the units that establish, control, or finance them. This includes funding from internal and external sources.” The fact that external sources of financing may be included in “other private spending” suggests that there may be some over-representation of this type of financing.

**Box 1. User fees for health care in Africa:
A contentious debate without an easy solution**

User fees are a controversial issue in health financing, particularly in low-income country settings. User fees are charges levied at public sector health facilities at the time a patient seeks care, and they constitute one component of out-of-pocket expenditures. (Other out-of-pocket expenditures may be incurred when individuals seek care from private facilities, as well as for indirect costs such as transportation to and from the health care provider, and food and lodging while seeking care.) User fees have been shown to be a barrier to access for low-income populations, but also to contribute to improved quality of care in some facilities.

The debate on user fees has been re-invigorated in recent times by the difficulty some countries are experiencing in achieving the Millennium Development Goals (MDGs). Opponents of user fees are calling for their abolition, citing demand-side constraints as one of the possible impediments to achieving the MDGs. Opponents also cite equity concerns, as user fees are regressive and hit the poor the hardest. In addition, Uganda's experience with abolishing user fees since 2001 has contributed to the debate.

However, abolishing user fees, if not done carefully, may exacerbate some of the problems facing health systems in Africa. The revenue generated by user fees must be replaced, especially if it is normally used at the facility level to finance quality improvements. Evidence from Niger and Cameroon suggests that increased demand and improved welfare for poor and non-poor patients can result when user fee revenue is kept locally and spent on improvements in the quality of care. When user fees are abolished, additional funds – beyond replacing those lost by abolishing user fees – will likely be necessary to cover the costs associated with increased utilization. If lost revenue is not replaced, patients may be forced to purchase supplies or services elsewhere, which could result in increased costs for the patient.

As countries in Africa continue to develop and are able to allocate more public sector resources to health, abolishing user fees may seem to be a viable policy strategy, especially to relieve the burden on households. If countries pursue this option, corresponding policies should be implemented that ensure: (i) quality will be maintained, (ii) revenue lost from user fees will be replaced, and (iii) if utilization of services increases following the elimination of user fees, sufficient funds are provided to facilitate access.

Patterns of private spending are delineated further by sub-region and income category in Table 4, which shows the breakdown of private spending into out-of-pocket and “other” private expenditures. There is very little risk pooling through private health insurance in sub-Saharan Africa. Eighty percent of private spending, or 45 percent of total spending, comes directly from households as out-of-pocket expenditures. Out-of-pocket expenditures play a particularly dominant role in Western and Central Africa. In part, this reliance on out-of-pocket financing for health has encouraged the growth of community-based health insurance schemes in those regions as families seek financial protection to cope with the burden of out-of-pocket costs. The high “other private health expenditures” in the Southern Africa sub-region are indicative of the high prevalence of risk-pooling schemes in that part of the continent. The trends and characteristics of private pooled spending in the form of community-based and voluntary health insurance in sub-Saharan Africa are discussed in more detail in Section 3.

TABLE 4. PRIVATE HEALTH EXPENDITURES IN SUB-SAHARAN AFRICA, BY SUB-REGION AND INCOME GROUP (2005)

Sub-region	Out-of-pocket exp. as % of total health exp.	Other private health exp. as % of total health expenditures
Western	59%	7%
Central	48%	2%
Eastern	33%	16%
Southern	8%	25%
GDP per capita		
Less than \$250	35%	10%
\$250 to \$499	41%	14%
\$500 to \$999	58%	7%
\$1000 or more	19%	14%
Total	45%	10%

Sources: WHOSIS database and World Bank WDI database 2008

Notes: (i) Excludes South Africa, countries with populations <1 million, Sudan, and Somalia. (ii) Out-of-pocket expenditures are direct outlays (monetary and in-kind) by households for health services. (iii) Other private health expenditures include payments by private pre-paid plans, employers, and nongovernmental organizations (NGOs). (iv) Estimates are weighted by population size.

2.2 PROGRESS TOWARD FINANCING TARGETS IS SLOW

The appropriateness of global health targets and their relevance as measures of individual countries' capacities to address priority health problems have been called into question elsewhere.²¹ However, at a minimum these targets provide useful benchmarks against which current health financing levels can be referenced. Against all of the targets highlighted in this paper, financing levels in sub-Saharan Africa are low.

The Abuja target was set by African leaders in 2001 to demonstrate their commitment to addressing the health financing challenges on the continent.²² The Abuja target is achieved when general government expenditure on health is 15 percent or more of total government expenditure. It remains an elusive

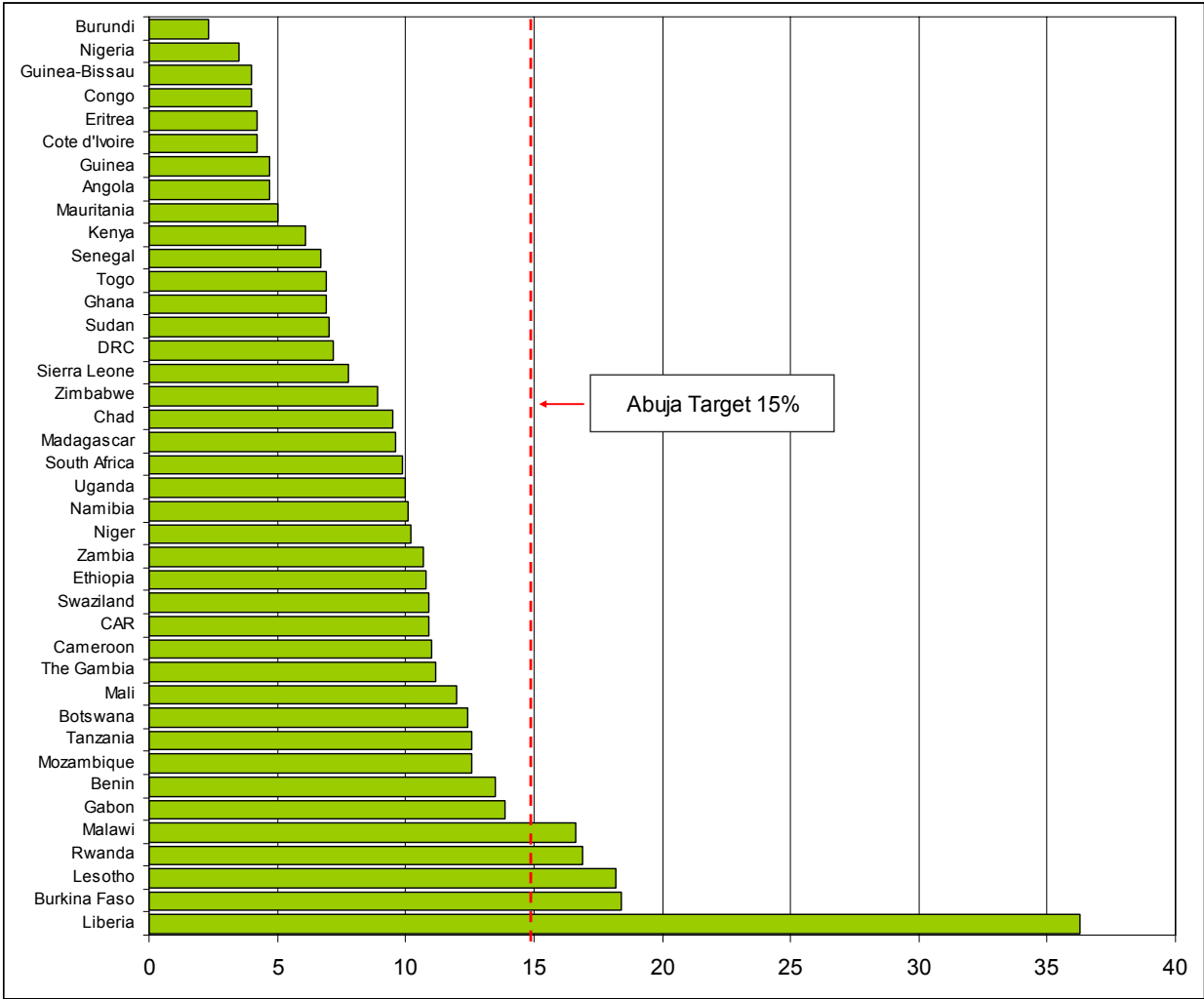
²¹ Christoph Kurowski. "The CMH Approach to Costing: A Critique." Presentation for World Bank Human Development Week. (Washington, DC: The World Bank, 2002)

[http://wbln0018.worldbank.org/HDnet/hddocs.nsf/2d5135ecbf351de6852566a90069b8b6/79fdcf231f4124085256e010051c3e4/\\$FILE/Cost%20approach%20CMH%20HD%20week%20final%20version.ppt](http://wbln0018.worldbank.org/HDnet/hddocs.nsf/2d5135ecbf351de6852566a90069b8b6/79fdcf231f4124085256e010051c3e4/$FILE/Cost%20approach%20CMH%20HD%20week%20final%20version.ppt). Accessed January 30, 2008; and Debabar Banerji. "Report of the WHO Commission on Macroeconomics and Health: A Critique." *International Journal of Health Services* 32(4), 2002).

²² While the Abuja target was committed to by African heads of state in 2001, the 15 percent target first received attention in 1999 at the WHO Regional Committee for Africa Meeting in Windhoek, Namibia. At that meeting, the then-Minister of Health of Namibia declared as evidence of Namibia's political commitment to the health of its population its allocation of 15 percent of the government budget to health – the highest in the region at the time. Thus, it was adopted informally as the new standard and achieved formal adoption in 2001 in Abuja. Interestingly, Namibia is not one of the countries that is indicated to have met the Abuja target in 1999, which provides further evidence for data discrepancies across sources.

goal for the majority of African countries. The data suggest that only five countries – Burkina Faso, Lesotho, Liberia, Malawi, and Rwanda – had achieved the Abuja target by 2005 (Figure 2). Eight other countries (Benin, Botswana, Cape Verde, Gabon, Mali, Mozambique, São Tomé and Príncipe, and Tanzania) were within 3 percentage points of the target.²³ For the 32 remaining countries in sub-Saharan Africa, achieving the Abuja target remains a distant goal. Since the target was set, general government health expenditures as a percentage of total health spending decreased in 20 countries in the region, increased in 18 countries, and remained the same in two countries. Thus, it is difficult to draw the conclusion that there has been substantial impact resulting from the Abuja target.

**FIGURE 2. PROGRESS TOWARD THE ABUJA TARGET:
GENERAL GOVERNMENT EXPENDITURE ON HEALTH AS PERCENTAGE OF
TOTAL GOVERNMENT EXPENDITURE, 2005**



Sources: WHOSIS database and World Bank WDI database 2008

²³ Cape Verde and São Tomé are not pictured in Figure 2 because the analysis for this portion of the paper excludes countries with populations of <1 million.

For the countries that have met the Abuja target, it is difficult to determine whether this was achieved by allocating increased domestic resources (from tax revenues or other domestic sources) to health spending, or by allocating donor-provided budget support to health spending.²⁴ However, it is likely that external assistance played a role in helping Burkina Faso, Lesotho, Liberia, Malawi, and Rwanda meet the Abuja target. Burkina Faso, Lesotho, Malawi, and Rwanda receive significant amounts of aid in the form of budget support – one study indicates that in 2004, Rwanda received over 60 percent of its official development assistance in the form of budget support.²⁵ Liberia, while not yet receiving budget support, is receiving significant amounts of aid through project support following the civil war and the ensuing collapse of government spending overall. In all of these countries, external assistance as a percentage of total health expenditures is among the highest in the region. Thus, it seems that for the five countries that have “met” the Abuja target, the achievement was not actually attained from allocating “pure” domestic resources to health but because significant external resources supplemented government spending.

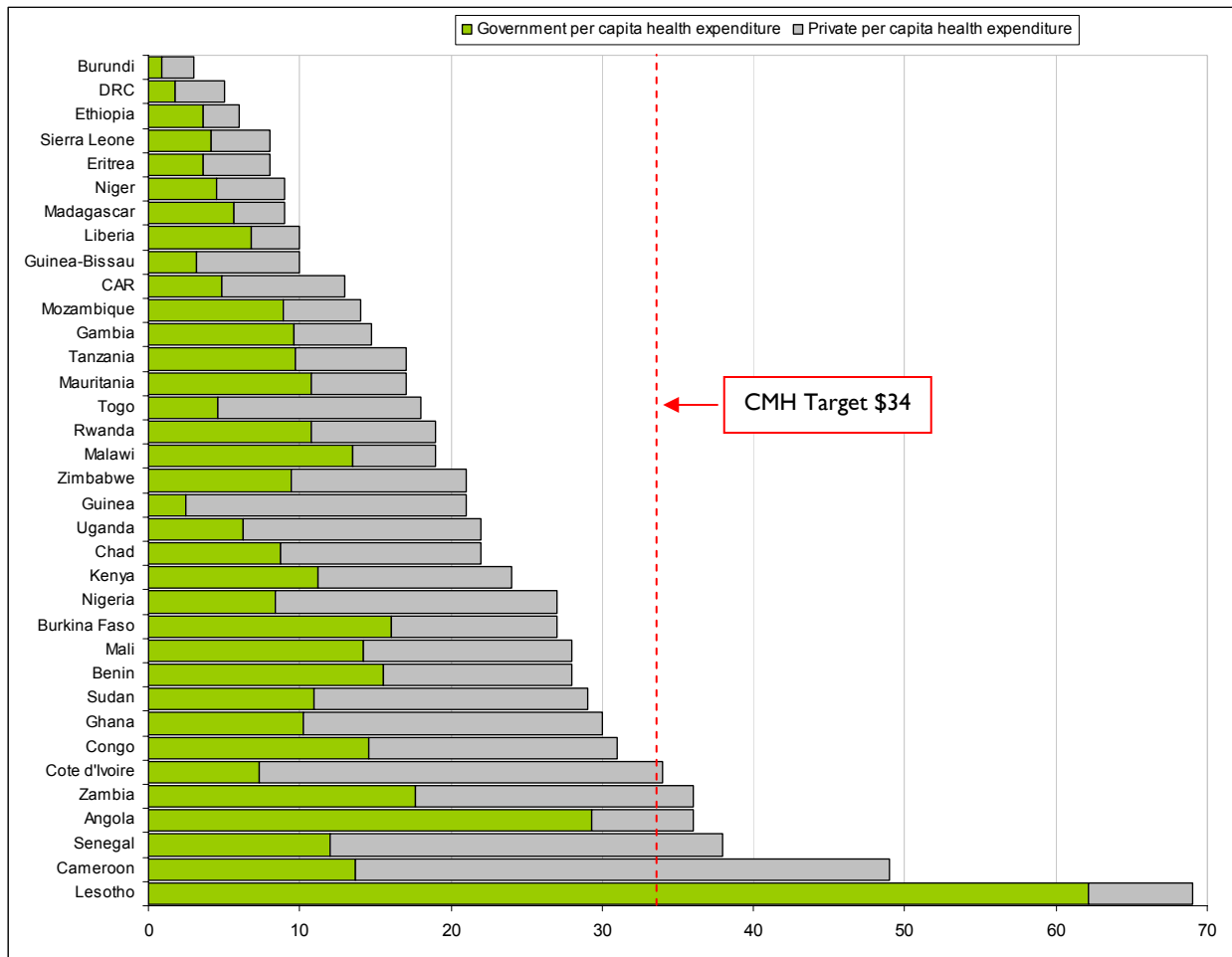
The next target for health spending comes from the WHO CMH, which in 2001 was tasked with “assessing the place of health in macroeconomic development.”²⁶ A critical component of this effort was to estimate the costs of scaling up essential health interventions in developing countries. From this came the \$34 estimate for a basic health package. Our analysis of WHO data on per capita health expenditures reveals there is a substantial gap between total per capita health spending and the WHO CMH estimate of \$34 per capita (Figure 3).

²⁴ National Health Accounts data, public expenditure reviews, and public expenditure tracking surveys, which are tools that could illuminate the composition of public sector expenditures on health, are not available for these countries for 2005.

²⁵ Ray Purcell et al. *Evaluation of General Budget Support 1994-2004: Rwanda Country Report*. (Birmingham, UK: University of Birmingham, 2006).

²⁶ World Health Organization. *Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health*. (Geneva: 2001).

**FIGURE 3. PROGRESS TOWARD THE CMH TARGET:
PUBLIC AND PRIVATE PER CAPITA HEALTH EXPENDITURES, 2005**



Sources: WHOSIS database and World Bank WDI database 2008

Note: Countries spending >\$90 total per capita and with populations of <1 million excluded to improve the graph's readability (Botswana, Cape Verde, Comoros, Equatorial Guinea, Gabon, Mauritius, Namibia, São Tomé, Seychelles, South Africa, and Swaziland).

The majority of all countries in the region (29 out of 45) are spending less than \$34 on health overall, including financing from government and household sources. Total per capita spending on health would need to increase by 62 percent, on average, to provide the \$34 package estimated by the CMH.²⁷ A projection analysis developed for this paper, which is based on relatively optimistic assumptions, further illuminates the challenges facing countries in trying to achieve the \$34 per capita spending target (Box 2).

²⁷ Gottret and Schieber, 2006

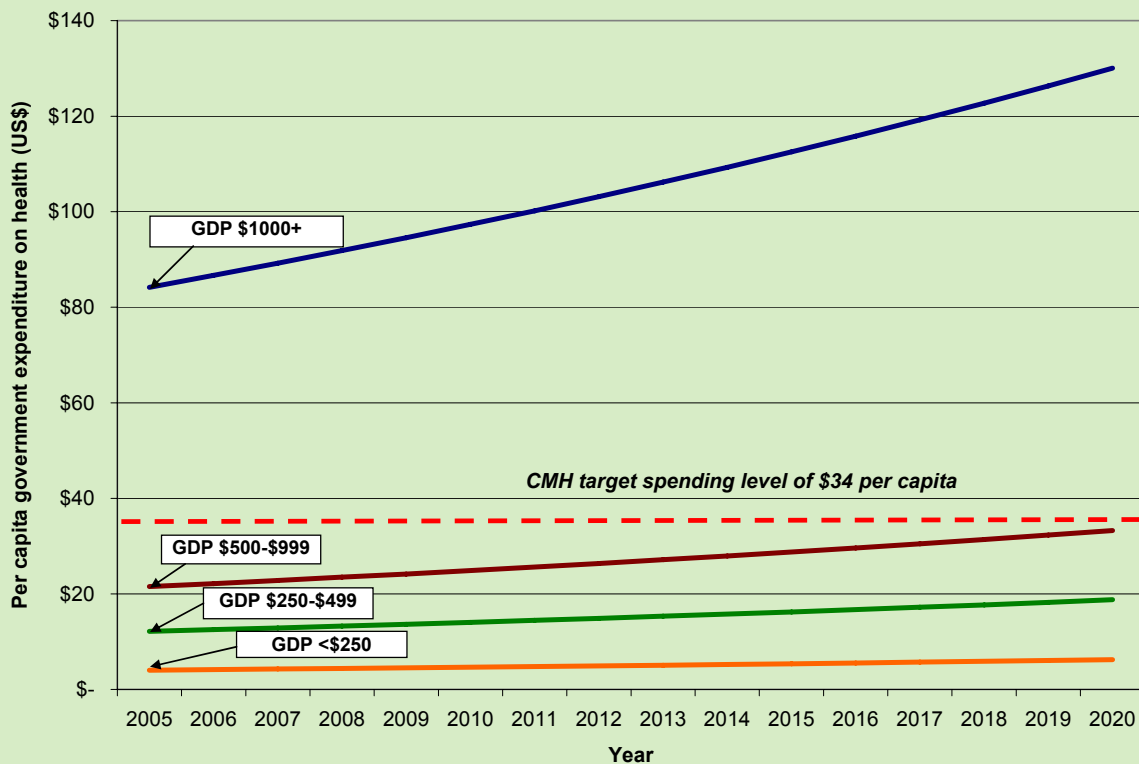
Box 2. What would it take to reach the CMH target?

Even under optimistic scenarios, few poor countries will meet the target by 2020

A quick projection exercise helps demonstrate the challenge of reaching the CMH target. Starting from actual GDP per capita levels in 2005, we estimated trends in government health spending from 2005 through 2020 under the following assumptions:

- ◆ 5 percent annual real GDP growth;
- ◆ 2 percent annual population growth;
- ◆ Governments capture 20 percent of GDP in tax revenues; and
- ◆ Governments allocate 15 percent of this total to health.

PROJECTED AVERAGE PER CAPITA GOVERNMENT SPENDING ON HEALTH (US\$), GROUPED BY GDP PER CAPITA IN 2005



Sources: WHOSIS database, World Bank WDI database 2008, and authors' calculations

The graph groups African countries according to their per capita GDP in 2005, and shows projected average increases in government health spending over time. All countries that had a per capita GDP of \$1,000 or more had already exceeded the \$34 threshold in 2005. But most countries with per capita GDP less than \$1,000 did not achieve the \$34 level – even by 2020. Of the 34 countries whose governments spent less than \$34 per capita on health in 2005, only three (Cameroon, Senegal, and Zimbabwe) would cross this threshold by 2020. Under these assumptions, per capita GDP must rise to \$1,133 for governments to reach the \$34 per capita health spending level.

A country with a per capita GDP of \$300 and government health spending of \$8 per capita in 2005 would end up with government health spending at about \$12 per capita by the year 2020, under these assumptions. If private households and employers were able to contribute an additional 20 percent of total health expenditures, there would still be a need for \$19 per capita in external assistance to fill the financing gap. In a country with a population of 20 million in 2020, that would imply an annual need for \$385 million in external assistance, just to provide the basic services contained in the \$34 package.

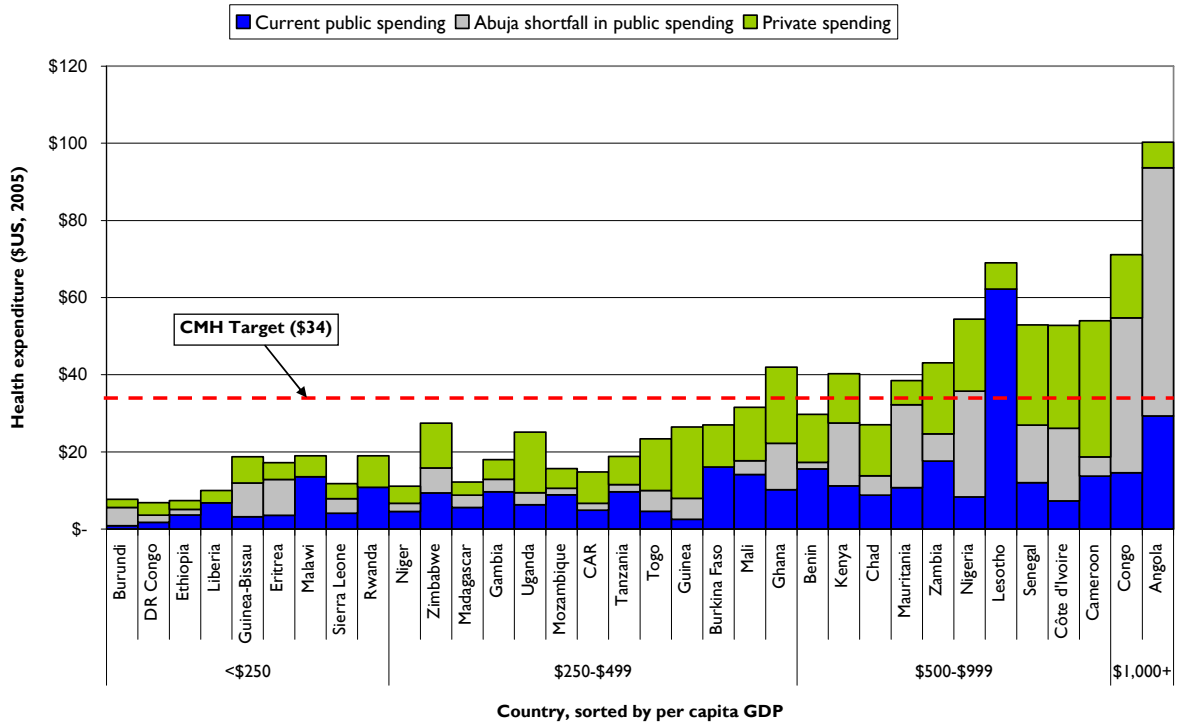
These simplistic – and relatively optimistic – scenarios serve only to highlight again the daunting financing challenge faced by African governments and international donors in the medium and long term. Trends in epidemiological profiles and political stability of countries in the region would have significant bearing on countries' ability to close the gaps and reach the \$34 target.

The CMH argued that the financing of this estimated \$34 basic health care package should come primarily from government sources because some of the components are public goods (e.g., infectious disease control) for which individuals may not be willing to pay, and because a large number of poor households may not have adequate financial resources to purchase such a package. However, as Figure 3 shows, the government contribution to total per capita health spending is often less than the private contribution. In 34 out of 45 sub-Saharan Africa countries, governments contribute less than \$34. As noted above, the bulk of health expenditures come from private sources, which are primarily households.

Targets that assert that a certain percentage of GDP or government budgets or a certain per capita amount should be allocated to health have varying levels of relevance for diverse regions like sub-Saharan Africa. A country's burden of disease, population size, economic status, and resource allocation decisions have significant implications for how far spending 15 percent of government budget on health or \$34 per capita could go. In countries heavily burdened by HIV, for example, the cost of providing antiretroviral therapy to the population would increase the cost of the package. Countries with different epidemiologic patterns may in fact be able to meet the basic health service needs of their population by spending less than \$34 per capita.

Perhaps more importantly, achieving one target, such as the Abuja target, may not ensure the achievement of other international targets, such as the CMH target of \$34 per capita. The data presented in Figure 4 show the contribution of current public spending levels, current private spending levels, and the increase in current public spending that would have to occur to meet the Abuja target, relative to the CMH target. Essentially, if current levels of public spending were to increase so that all countries met the Abuja target, and if private spending levels remained the same, 23 countries would still not reach the \$34 level of per capita spending. Of these, eight countries 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.

**FIGURE 4. EXPENDITURE ON HEALTH (2005) COMPARED TO \$34 CMH TARGET:
WHAT MEETING ABUJA MEANS FOR CMH**



Sources: WHOSIS database, World Bank WDI database 2008, and author's calculations
Note: Excludes countries with populations <1 million or total health spending >\$100 per capita in 2005.

Interestingly, in the five countries – Burkina Faso, Lesotho, Liberia, Malawi, and Rwanda – that data suggest have already met the Abuja target, total per capita health expenditures were \$27, \$69, \$10, \$19, and \$19, respectively – which suggests that only one of these countries has met the CMH target.

One other set of international targets deserves mention – the Millennium Development Goals (MDGs). Unfortunately, sub-Saharan Africa is not on track thus far to meet any of the MDGs, although some countries have made positive strides.²⁸ It has been estimated that for the region to achieve the MDGs, more than 12 percent of regional GDP would have to be spent on health.²⁹ Currently, the regional average for the percentage of GDP spent on health is 4.7 percent.³⁰ Estimates of the *global* costs associated with achieving the MDGs range from \$20-75 billion dollars annually³¹; one source finds that an additional \$20-25 billion per year would be needed for 30 or so countries in Africa that are poised to

²⁸ United Nations. *Africa and the Millennium Development Goals 2007 Update*. <http://www.un.org/millenniumgoals/docs/MDGafrika07.pdf>. Accessed January 17, 2008.

²⁹ Disease Control Priorities Project. *Achieving the Millennium Development Goals for Health: So far, progress is mixed – Can we reach our targets?* (February 2007). <http://www.dcp2.org/file/67/DCPP%20-%20MDGs.pdf>. Accessed December 16, 2007.

³⁰ George Schieber et al. "Financing Global Health: Mission Unaccomplished." *Health Affairs* 26(4, July/August 2007).

³¹ Adam Wagstaff et al. "Millennium Development Goals for Health: What will it take to accelerate progress?" In *Disease Control Priorities in Developing Countries 2nd Edition*, ed. Jamison et al. (Washington, DC: Oxford University Press and the World Bank: 2007).

use external assistance effectively.³² While recognizing that money is not the only, or even necessarily the most critical constraint, clearly a significant gap remains between current and “needed” financing levels with respect to achieving the MDGs.

This section has shown that:

1. Health spending in sub-Saharan Africa is low relative to other regions.
2. There is a heavy reliance on the private sector for health financing in Africa, especially on out-of-pocket payments by households. This has implications for equity, as out-of-pocket payments hit the poor the hardest.
3. Few countries in the region have met financing targets. There are large gaps between available and needed resources.

The policy implications of the overall health financing context in sub-Saharan Africa – low public spending on health relative to other regions and the health financing targets, heavy reliance on out-of-pocket spending by households, and low prevalence of risk-pooling arrangements – are numerous. As country governments continue to enact health system and health financing reforms, the goal of providing citizens with financial protection from the costs of catastrophic illness and a basic package of health services (as defined according to country-specific needs) in a way that is equitable, efficient, and sustainable should remain high on the agenda.

The next section examines some of the challenges facing countries in sub-Saharan Africa relative to financing health with resources from the public sector.

³² African Development Bank. *Achieving the Millennium Development Goals in Africa: Progress, Prospects, and Policy Implications*. (Washington, DC: African Development Bank, 2002).

3. CAPACITY OF GOVERNMENTS IN SUB-SAHARAN AFRICA TO FINANCE SUSTAINABLE AND FUNCTIONAL HEALTH SYSTEMS

Governments remain one of the key sources of funds to address health challenges in Africa. Governments direct resources to the health sector to improve health outcomes, but also to demonstrate political will via such resource allocation. In addition, public sector health financing, through financing services for the poor and providing financial protection, can help to improve equity. The public sector is the most efficient financier of public goods, such as infectious disease control and prevention programs, for which individuals may not be willing to pay.

However, the analyses presented in the previous section show that, in sub-Saharan Africa, the public sector is not the largest source of revenue for the health sector. Slow economic growth and a small taxable formal sector contribute to limited domestic resource revenue raising capacity and constrain public sector health financing in the region. What is the capacity of sub-Saharan Africa governments to increase their allocations to the health sector, and what factors constrain or enhance this capacity? This section examines some macroeconomic issues associated with the capacity of the public sector to finance health, with a focus on the creation of fiscal space.

As noted above, African countries have agreed to the Abuja target (allocating 15 percent of government spending to health) as the benchmark for gauging how much they are prepared to make available for the health sector. Increasing public sector financing for health partly depends on the fiscal space available for such increases – the budgetary room that allows a government to provide resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy.³³ In resource-poor settings, health is just one of many priorities that must compete for fiscal space within the government’s budget. The primary mechanisms available to governments for expanding fiscal space include: stimulating economic growth, increasing tax revenue, receiving donor grants, and borrowing. Seignorage, or printing money, is also an option though not one that is recommended. While the financial resources from grants and borrowing originate outside the country governments, these sources of funding can still provide the government with increased fiscal space overall and for the health sector. We shall examine all these factors in turn.

While all of these options are theoretically available to governments, the importance of macroeconomic stability and fiscal sustainability effectively limit which options a government can realistically pursue.³⁴

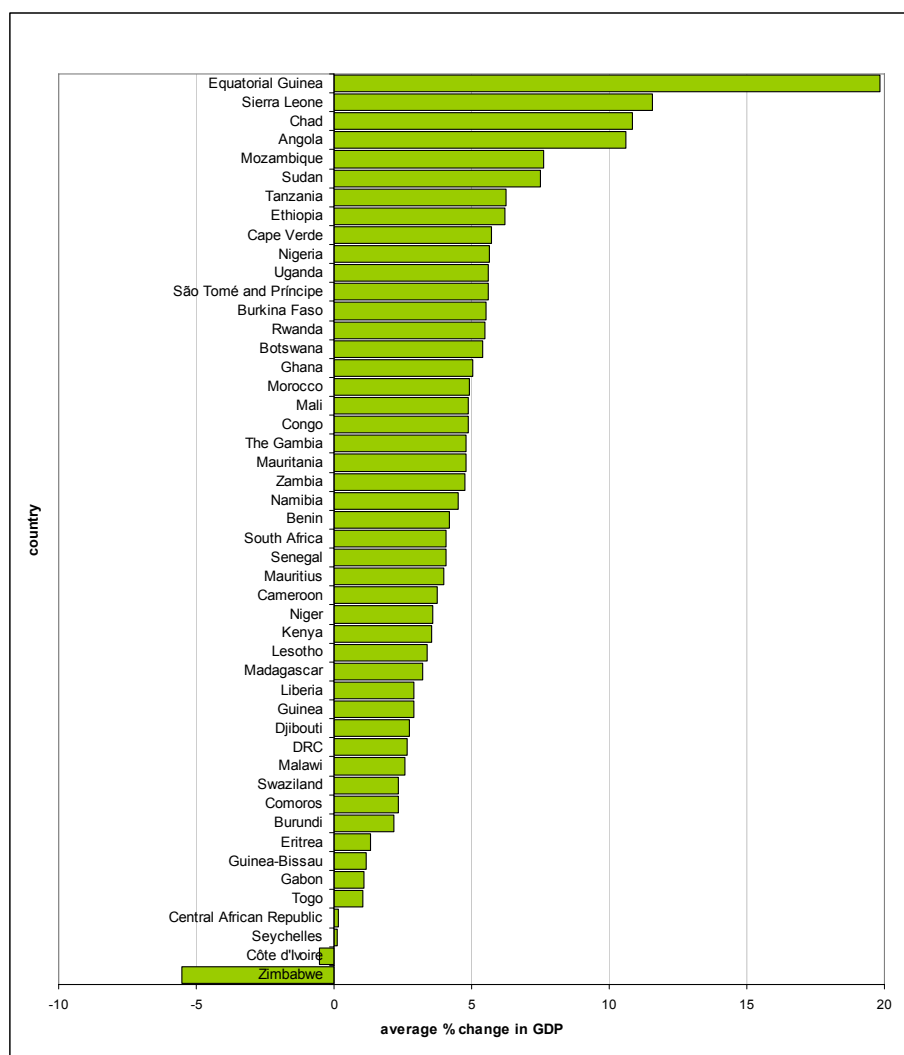
³³ Peter Heller. “Back to Basics: Fiscal Space – What it is and how to get it.” *Finance and Development*. 42(2). (Washington, DC: International Monetary Fund, June 2005).

³⁴ *Ibid.*

3.1 CAN ECONOMIC GROWTH AND TAX REVENUE INCREASE GOVERNMENT CAPACITY TO FINANCE HEALTH?

Throughout the 1970s and most of the 1980s, succeeding reports of the international financial institutions noted that growth rates in many sub-Saharan African countries were either stagnating, or increasing at anemic rates.³⁵ Given that background, it is interesting to note the much more optimistic reports coming out of those same sources regarding growth prospects in Africa in the course of this decade.³⁶ Figure 5 shows the average annual percent change in GDP (at constant prices) for 41 sub-Saharan Africa countries from 2000 to 2006.

FIGURE 5. AVERAGE ANNUAL PERCENTAGE CHANGE IN GDP (CONSTANT PRICES) IN SUB-SAHARAN AFRICA, 2000–06



Source: International Monetary Fund World Economic Outlook Database

³⁵ See for instance World Bank *World Development Report 1978: Prospects for Growth and Alleviation of Poverty* (Washington, DC: 1978); and World Bank, *World Development Report 1993: Investing in Health* (Washington, DC: 1993).

³⁶ See World Bank. *Global Economic Prospects 2008: Sub-Saharan Africa*. (Washington, DC: 2008).

<http://web.worldbank.org/external/default/main?contentMDK=20710298&menuPK=619756&theSitePK=612501&pagePK=2904583&piPK=2904598>. The Bank notes that economic growth in sub-Saharan Africa accelerated from 5.7 percent in 2006 to 6.1 percent in 2007, the region's fastest pace of growth in more than three decades.

At one end of the scale, two crisis-torn countries (Zimbabwe and Cote d'Ivoire) experienced negative growth. At the other end, four countries had growth records exceeding 10 percent per year. Of these, Sierra Leone and Angola were emerging from ruinous civil wars and so were mostly rebuilding destroyed capital stocks; Equatorial Guinea, Chad, and Angola saw massive investments into the natural resource sectors during that period. The majority of the countries, from Guinea at the lower end to Tanzania at the higher end, grew between 3 and 6 percent per year during this period. Such growth provides the potential for further resources to be made available for financing health priorities and improving outcomes by expanding the taxable formal sector. For example, steady economic growth patterns encourage foreign direct investment, which can indirectly contribute to the creation of fiscal space by generating tax revenue.

In most developed countries, the overall tax burden as a percentage of GDP is often in the range of 40 percent and above. However, as of 2006, the most recent year for which data is available, none of the countries in sub-Saharan Africa have tax revenues exceeding 40 percent of GDP. Including data from 2000-2006, almost half the countries in the region have tax revenue contributions of less than 30 percent. And, only six— or about one-sixth — of these countries exceed 20 percent.³⁷ Therefore, it appears that room exists for greater mobilization of tax revenues. But there are good reasons to believe that increasing tax revenues is easier said than done in sub-Saharan Africa, including the following:

- Tax administration systems are weak and inefficient.
- A substantial informal sector of many small businesses and enterprises that do not pay taxes and high rates of tax evasion by businesses or individuals in the private sector make it difficult to broaden the tax base.
- Higher tax rates are politically unacceptable, especially in the context of the very low incomes of the majority of the population.
- Increasing taxes has the potential to distort incentives in the economy and to impact negatively on the private sector.

In recent years, many African countries have been working with the International Monetary Fund and World Bank on tax reform, with the object of improving their tax receipts.³⁸ The fruits of those reforms are expected to increase fiscal space by making more revenues available for allocation to all sectors, including health. In the interim, generating additional domestic revenue for the health sector from taxes may have potential in only a few countries. However, with encouraging economic growth rates in the region, tax reform may become an increasingly higher priority on the policy agenda.

3.2 BORROWING CAN CREATE FISCAL SPACE BUT HAS COSTS

Governments of all income levels borrow to help fund their priorities, and many African governments have done so extensively in the past. Borrowing money to invest in current health priorities can increase a country's human capital and productivity, and thereby enhance its ability to repay the loan in the future. Much of the borrowing in sub-Saharan Africa countries consists of highly concessional loans such as those

³⁷ World Bank. *World Development Indicators* (Washington, DC: 2008). Data on this indicator is not available for all countries in the region, nor from all years. Data is from 2006 or most recent year available. In 2005, Lesotho was the only country with tax revenue above 40 percent. Data not available for Lesotho in 2006.

³⁸ The World Bank. *IDA at Work: Tax Reform*. <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/0,,contentMDK:21273378~menuPK:3949144~pagePK:146736~piPK:226340~theSitePK:258644,00.html>. Accessed January 30, 2008; and Jacoby, Ulrich. 2007. "Africa: Sustaining the Momentum". *IMF Survey Magazine*. <http://www.imf.org/external/pubs/ft/survey/so/2007/CAR0629B.htm>. Accessed January 30, 2008.

of the World Bank International Development Association (IDA), which have very low interest rates and very long repayment periods. Over the long term, these loans function almost as grants.

While borrowing is a legitimate way to expand fiscal space and therefore the room for spending on health priorities, the amount that can be safely borrowed without jeopardizing future development is limited by countries' ability to repay the loans. Governments must carefully consider whether the long-term return on a given type of health expenditure justifies the cost of borrowing. Many low-income countries are already highly indebted and do not have room for much additional borrowing.³⁹

The complement to additional borrowing is debt relief, which can "release" domestic resources for investment in health and other social sectors.⁴⁰ Currently, the primary vehicle for debt relief is the Heavily Indebted Poor Country (HIPC) Initiative, which was launched in 1996 to provide debt relief to countries with unsustainable debt overhangs, in return for commitments on their part to increase spending on poverty-related areas including health. Between 1989 and 2003, low-income countries received \$100 billion in debt relief.⁴¹ A movement has also emerged to campaign for debt cancellation.⁴² Partly as a result of this, the Group of Eight (G8) agreed to cancel the debt of some very poor countries at their meeting in Gleneagles, Scotland, in 2005.

The stated objectives for much of this debt relief are to reduce debt overhang and to free up recipient government resources for development spending that would otherwise have been used for debt service.⁴³ Therefore debt relief has the clear potential to expand fiscal space and make additional resources available for health, although the evidence suggests that this does not happen automatically.⁴⁴ Hinchliffe examined the impact of debt relief on spending on health and other social sectors and found that in the 20 countries reviewed that had obtained debt relief, health expenditures as a share of total government expenditures increased on average between 6.2 and 8.1 percent.⁴⁵ However, Chauvin and Kraay's econometric assessment using data from 62 countries did not find strong evidence that debt relief has affected the level and composition of public spending in recipient countries.⁴⁶

Sub-Saharan Africa has several country-specific success stories on how debt relief can provide additional resources for health. In Tanzania, resources "released" by debt relief allowed the government to allocate an additional \$40 million to immunization.⁴⁷ In Burkina Faso, funds released by debt relief through the HIPC Initiative resulted in a greater allocation of public sector resources to health: funds earmarked for health rose from 13.1 to 16.8 percent of total budget between 2001 and 2002⁴⁸. In real terms, approximately 4.4 percent of the total health budget came from HIPC funds. The Ministry of Health

³⁹ Gottret and Schieber, 2006.

⁴⁰ Ibid.

⁴¹ Nicolas Depetris Chauvin and Aart Kraay. "What Has 100 Billion Dollars Worth of Debt Relief Done for Low- Income Countries?" Manuscript (September 2005).

⁴² See <http://www.data.org/> and <http://www.jubileedebtcampaign.org.uk/>

⁴³ Though many countries were effectively not paying their debt, it nevertheless constituted an impediment to progress because their failure to pay rendered them less credit-worthy and had a potential impact on their ability even to access concessional lending facilities.

⁴⁴ Debt relief is a multi-step process involving interim relief at the initial "decision point" before a country fully benefits from the relief at the "completion point." Of 41 African countries eligible for the HIPC Initiative as of the end of March 2008, 19 of them were by that date already in post-completion stage, 8 were in the interim phase (between decision and completion points), and 6 were in the pre-decision point phase. See Annex 3 for list of countries involved.

⁴⁵ K. Hinchliffe. *The Impact of the HIPC Initiative on Public Expenditures in Education and Health in African Countries*. (Washington, DC: World Bank, Human Development Network, Africa Region, 2004).

⁴⁶ Chauvin and Kraay, 2005.

⁴⁷ President of Tanzania's Message to Debt Campaigners.

<http://www.jubileedebtcampaign.org.uk/President%20of%20Tanzania's%20message%20to%20debt%20campaigners+559.twl>

⁴⁸ International Monetary Fund. *Burkina Faso: Poverty Reduction Strategy Paper Progress Report*. IMF Country Report No. 04/78. (Washington, DC: March 2004).

prioritized addressing human resources for health shortages in rural areas, and used funds released from debt relief to recruit personnel and fund salaries. In addition, HIPC funds were used for disease prevention and control programs, including disease surveillance equipment. Nigeria also used debt relief funds to program a variety of pro-poor interventions, of which the health sector was a primary recipient (see Box 3).

With the volume of debt relief that has and will continue to flow to countries in the region, there is potential for health sectors in a variety of countries to receive additional revenue from funds released by debt relief.

Box 3. How Nigeria used debt relief funds for health

Nigeria used the Debt Relief Savings Fund (DRSF), created in response to its receipt of debt relief in the early 2000s, to finance pro-poor interventions. The health sector received 21, 20, and 17 percent of the total DRSF in the three years since it began disbursing funds in 2006. This constitutes an increase of 20 and 12 percent to the regular budgetary allocation to health in 2006 and 2007, respectively.

Within the health sector, the programs and interventions receiving the largest shares of the allocation were primary care (for construction of new facilities and refurbishing of existing ones); immunizations (largely for the purchase of vaccines and routine immunizations); and for the National AIDS Programme (largely for the purchase of commodities and scaling up coverage).

ALLOCATION OF DRSF TO HEALTH PROGRAMS AND INTERVENTIONS IN NIGERIA, 2006–08 (PROVISIONAL)

Health Programme/Interventions	Years (₦)		
	2006	2007	2008
Roll Back Malaria	1,280,000,000	950,000,000	1,844,701,500
Child Health excluding Immunization		430,000,000	1,600,238,600
Reproductive Health	-	100,000,000	2,080,000,000
Nutrition	-	20,000,000	-
Gender	-	10,000,000	-
Nursing	-	100,000,000	-
NLS	-	100,000,000	-
National Programme on Immunization	5,500,000,000	4,425,000,000	5,500,000,000
National Primary Health Care Development Agency	9,043,000,000	4,018,000,000	202,000,000
National AIDS Programme	4,750,000,000	3,602,000,000	5,613,261,000
TB & Leprosy	505,000,000	160,000,000	150,000,000
Cross-cutting	210,000,000	-	-
Federal Medical Centre	-	-	1,050,000,000
TOTAL	21,286,000,000	15,223,000,000	16,999,999,700

Source: Federal Ministry of Health and Office of the Senior Special Assistant to the President on MDGs. Special thanks to Professor Eyiayo Lambo, Former Minister of Health of Nigeria for sharing these data.

3.3 GRANTS CAN CREATE ADDITIONAL FISCAL SPACE

Grant aid is another way to expand fiscal space and therefore the room for governments to increase spending on health and other priorities. While grants originate with international donors, the funding flows provided expand the room in government budgets to allocate resources for a desired purpose. Given the global commitment to help countries achieve health and poverty-reduction goals, especially as embodied in the MDGs, grant aid is an increasingly available option for the creation of fiscal space. In addition, grants offer the potential to create more fiscal space than borrowing, which comes with concerns about debt sustainability, even when loans are highly concessional.

However, ensuring donor commitment to a consistent and predictable flow of grants is particularly important to achieving greater fiscal space; governments must be convinced that a grant is not simply a one-time event.⁴⁹ Further, there is a risk that large inflows of grant aid and other types of foreign assistance could actually foster disincentives for governments to increase their domestic resource mobilization efforts as various sectors become increasingly reliant upon donor financing. The dynamics associated with grant aid and other forms of external assistance are discussed in more detail in Section 4, Challenges with External Assistance in Africa, and the opportunities associated with new, innovative mechanisms for delivering grants are discussed in Section 5.4.

To summarize the discussion on the capacity of governments to finance health, economic growth rates in Africa, while generally higher than in earlier decades, have not yet pulled countries out of poverty to generate the domestic resources necessary for achieving health goals. Taxation, borrowing, debt relief, and grants can increase fiscal space for government health financing, but alone are unlikely to address the financing gap.

To assist the public sector in its endeavor to finance health, donors provide significant external assistance for the region. The characteristics and challenges associated with this source of financing are discussed in the next section.

⁴⁹ Peter Heller. "Understanding Fiscal Space," International Monetary Fund Policy Discussion paper. (Washington, DC: 2005).

4. CHALLENGES WITH EXTERNAL ASSISTANCE FOR HEALTH IN SUB-SAHARAN AFRICA

In recognition of the massive shortfalls between the resources available and needed to achieve health and poverty reduction targets in low-income countries, the international community has renewed its commitment to increase financing for development. This renewed attention is reflected in the MDGs, the Monterrey Consensus,⁵⁰ the Gleneagles G8 meeting,⁵¹ the Paris Declaration on Aid Effectiveness,⁵² as well as in numerous other global partnerships and initiatives that have come into existence over the past several years. While this section reviews international donor contributions to health financing in sub-Saharan Africa and explores some of the problems associated with heavy reliance on donor funding in some countries, it is important to recognize the commitment African nations have made parallel to the renewed commitment from the international community. In particular, the setting of the Abuja target, the creation of the New Partnership for Africa's Development (NEPAD), and the African Union's African Peer Review Mechanism (APRM)⁵³ represent the region's dedication to doing its part to address its own needs.

4.1 PATTERNS IN DONOR ASSISTANCE FOR HEALTH IN SUB-SAHARAN AFRICA

Donor support has been an important part of financing for many sectors in Africa – and especially health – for decades. Total official development assistance (ODA) to sub-Saharan Africa has historically accounted for approximately 20 percent of total global ODA. In sub-Saharan Africa, the health sector is particularly heavily reliant upon donor funding. Over the past two decades, ODA for health has been steadily increasing and in 2006, reached a high of \$3.7 billion (Figure 6). The more rapidly increasing trend, starting in the late 1990s, is consistent with the donor response to the HIV/AIDS pandemic as well as the MDGs. While the volume of financial resources for the health sector has reached unprecedented levels and continues to rise, significant bottlenecks to efficiency, effectiveness, and high-quality service provision remain, and health outcomes in many countries are stubbornly poor.

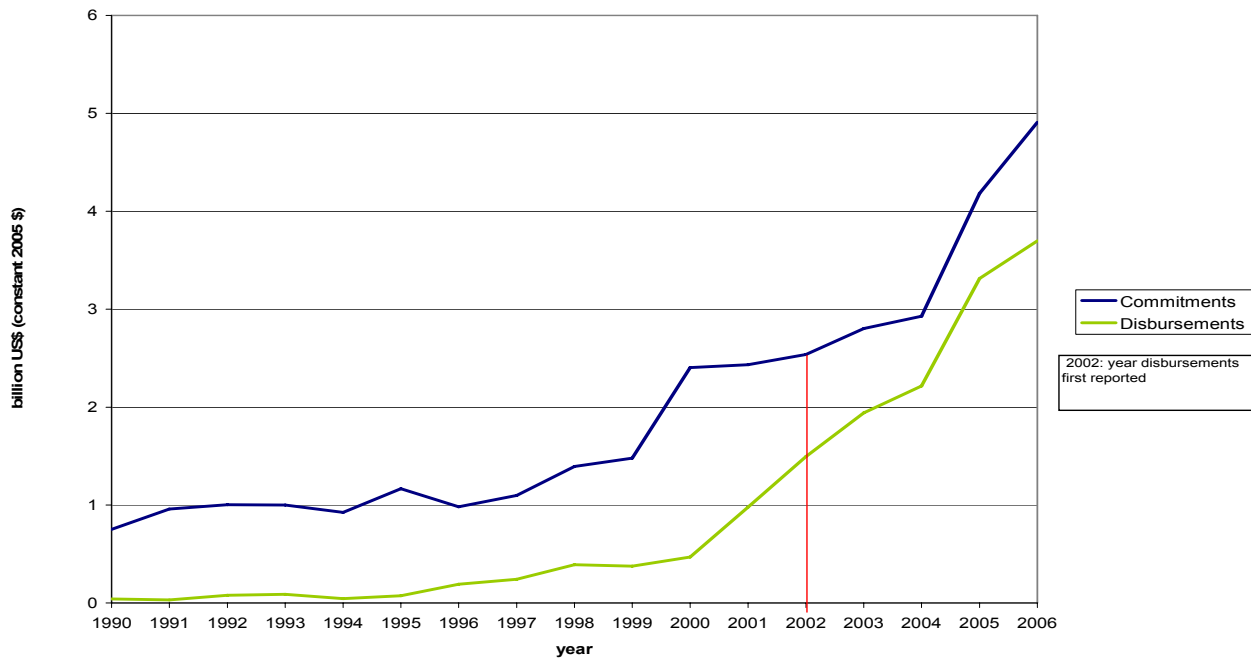
⁵⁰ The Monterrey Consensus established that developed countries would provide 0.7 percent of gross national product as official development assistance to developing countries.

⁵¹ In July 2005, the G8 nations agreed that aid for all developing countries would increase by \$50 billion a year by 2010, of which at least \$25 billion extra would go to Africa on an annual basis. In addition, France, Germany, Italy, the UK, and the European Union all reaffirmed their commitments to meeting the Monterrey Consensus by 2015.

⁵² The Paris Declaration, endorsed on March 2, 2005, is an international agreement to which more than 100 ministers, heads of agencies, and other senior officials committed their countries and organizations to continue to increase efforts in harmonization, alignment, and managing aid for results with a set of monitorable actions and indicators.

⁵³ The APRM is a mutually agreed instrument voluntarily acceded to by the Member States of the African Union as an African self-monitoring mechanism. The APRM is a “bold, unique and innovative approach designed and implemented by Africans for Africa.” The mandate of the APRM is to ensure that the policies and practices of participating countries conform to the agreed values in the following four focus areas: democracy and political governance; economic governance; corporate governance; and socio-economic development. See <http://www.nepad.org/aprm/> for more information.

**FIGURE 6: HEALTH ODA TO SUB-SAHARAN AFRICA:
COMMITMENTS AND DISBURSEMENTS, 1990–2006**



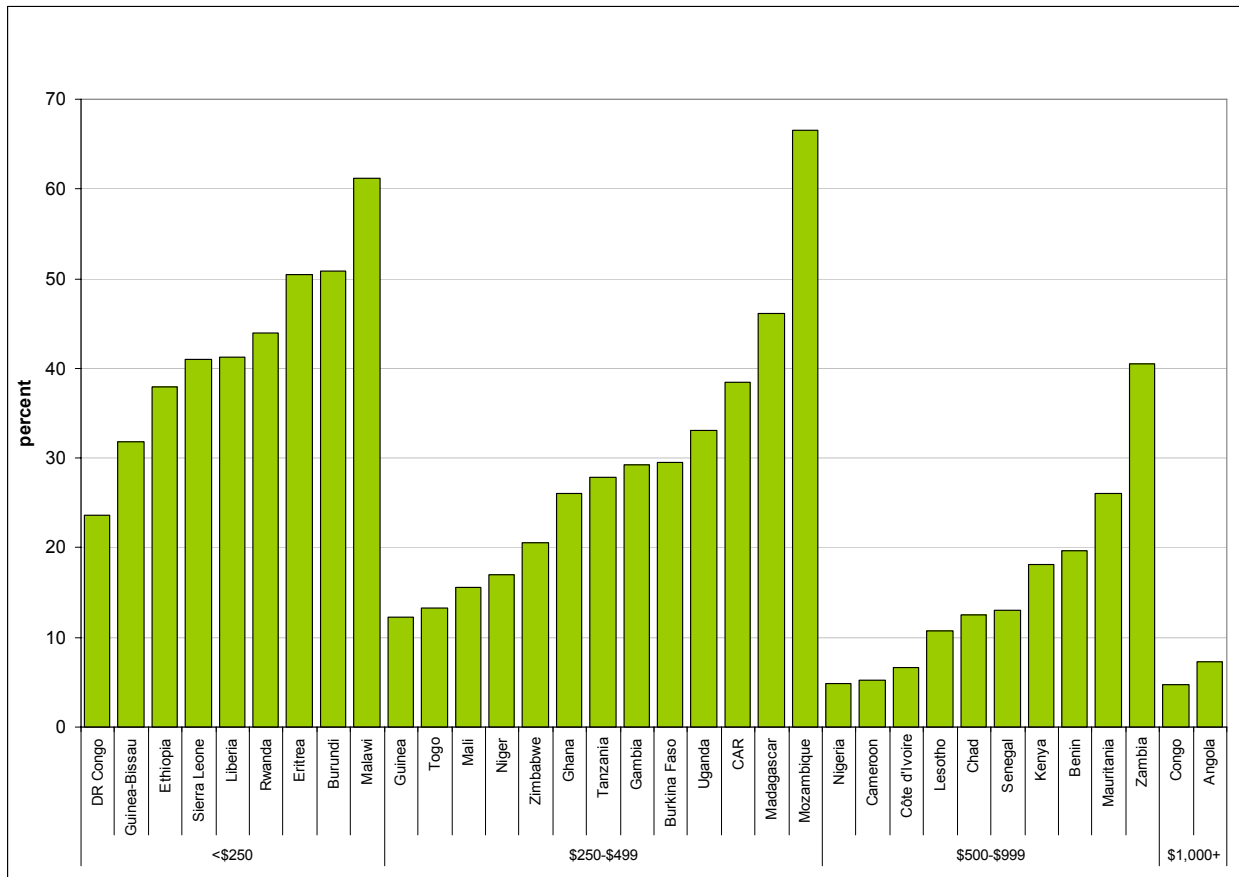
Source: Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) Creditor Reporting System (CRS) database

Notes: (i) Includes activities in basic health, general health, and population programs. (ii) Bilateral and multilateral donors included in both commitments and disbursements. Data do not include private foundations such as the Bill and Melinda Gates Foundation or faith-based organizations.

To some extent, the way donor aid is delivered complicates efforts to address these country-level bottlenecks. As Figure 6 shows, there is a gap between the resources that are committed by donors and the resources that are actually disbursed. While disbursements were first officially reported in 2002, the data suggest that the discrepancy between commitments and disbursements is not an artifact of lack of reporting, as the disparity is present after 2002. This discrepancy complicates countries' ability to plan for the medium to long term.

There is considerable variation across countries in external assistance as a share of total health expenditures. The data in Figure 7 show that, in 17 countries, external assistance accounts for 25 percent or more of total health expenditures, and in 11 of these 17 countries, external assistance accounts for more than 35 percent of total health expenditures. Without exception, these highly aid-dependent countries have low per capita GDP. On a per capita basis, aid for health is quite low even in highly aid-dependent countries – not more than a few dollars per person in most countries.

FIGURE 7. EXTERNAL ASSISTANCE FOR HEALTH AS PERCENTAGE OF TOTAL HEALTH EXPENDITURES BY INCOME CATEGORY, 2005



Source: WHOSIS database.

Note: Countries with population <1 million and those with GDP per capita > \$2,000 excluded.

4.2 WHAT ARE THE CHALLENGES POSED BY AID FOR HEALTH?

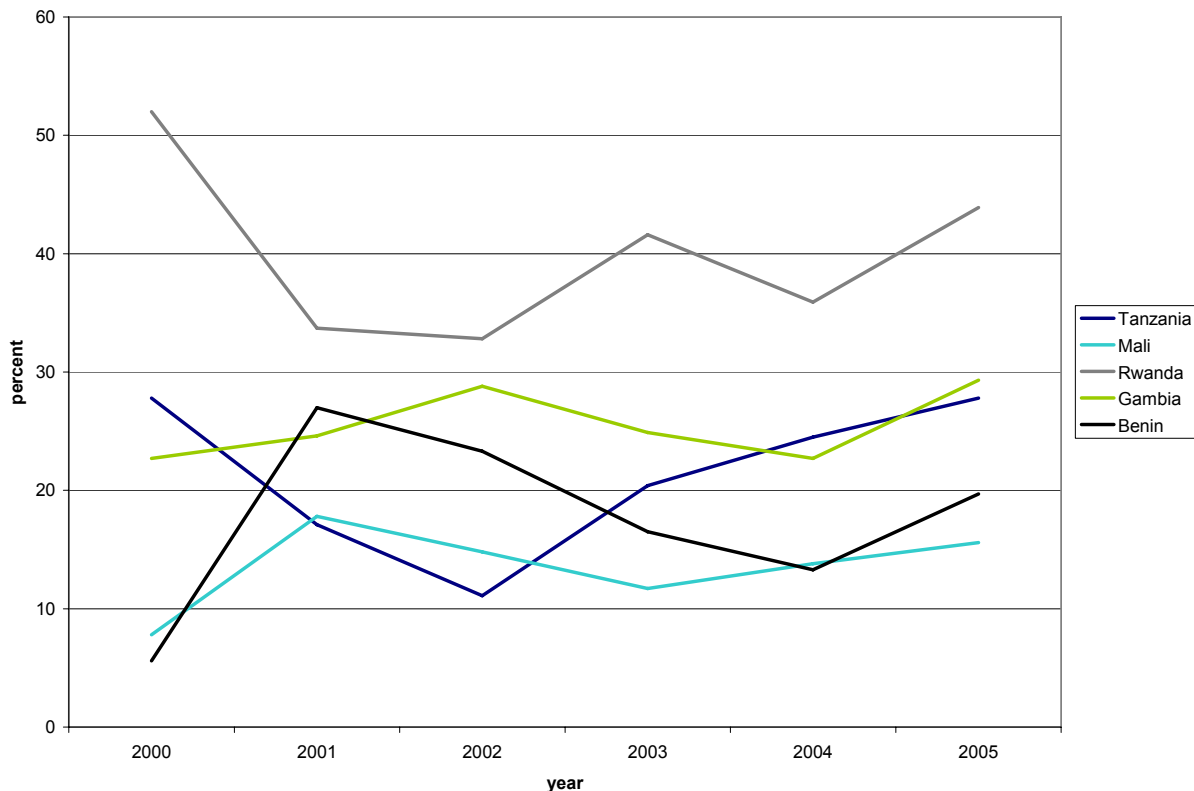
External assistance accounts for 16 percent of total health expenditures in sub-Saharan Africa, far higher than any other region in the world (Table 2)⁵⁴. Africa’s high dependence on donor aid for health sector financing raises several concerns. First, the volatility of aid flows over time challenges countries’ ability to plan for the long-term. Countries may be disinclined to invest in projects that generate recurrent costs (e.g., by hiring additional staff) because the donor funding is not guaranteed to be available once the project ends – but the recurrent costs continue. Volatility in aid for health is a result of multiple causes, including the budget cycles and political processes of donor organizations and absorptive capacity constraints of the recipient country.⁵⁵

⁵⁴ The region with the next highest share of total health expenditures from external assistance is Southeast Asia at 1.5 percent.

⁵⁵ Innovative financing mechanisms used by donors are increasingly focused on relieving the volatility of health aid, as well as improving the effectiveness of aid for health. These mechanisms are discussed in more detail in Section 5 and in Annex 6.

Figure 8 displays time series trends in external assistance for health as a share of total health expenditures in select countries in sub-Saharan Africa. This graph shows the volatility and unpredictability in aid within countries over time, but it also shows that there is a significant difference across countries in the aid received for the health sector. For example, in 2005, external assistance as a share of total health expenditures was nearly three times greater in Rwanda than in Mali.

FIGURE 8. EXTERNAL ASSISTANCE AS A PERCENT OF TOTAL HEALTH EXPENDITURES IN SELECT SUB-SAHARAN AFRICA COUNTRIES, 2000-05



Source: World Bank WDI database 2008

The political nature of donor assistance limits the sustainability of this type of financing. The relative political stability of a recipient country as well as foreign policy considerations of the donor country can play an important role in which countries receive aid, what types of aid modalities are used to deliver the aid, and what types of programs and interventions the aid can finance. For example, in countries like Madagascar, Malawi, and Mozambique, all considered “donor darlings,” external assistance accounts for up to 50 percent of total health expenditures. In contrast, in countries such as Guinea-Bissau, Togo, and Zimbabwe, external assistance accounts for approximately 7 percent of total health expenditures.

The politics of donor assistance plays a particularly significant role for bilateral donors, which are accountable to a constituency of voters and taxpayers. The need to be accountable to voters and the related drive for ensuring strong links between aid delivered and results obtained is reflected in the fact that much external assistance for health over the past 10 years has tended to be tied to specific diseases or health interventions which are easy to “sell” to voters back home. While attention to priority diseases has initiated much-needed increases in donor assistance for health, these priorities are not necessarily in line with the recipient country government’s overall plan for the sector. In Rwanda, for

example, donors earmarked \$46.6 million for HIV/AIDS in 2005, when the country had a 3 percent prevalence rate, and only \$18.3 million for malaria, which was the biggest cause of mortality.⁵⁶

A second related concern is the fungibility of donor aid and the extent to which aid is actually reaching the populations or activities it is intended to assist. Fungibility refers to the “diversion of funds to public expenditures other than those for which the aid is intended, including tax reduction or debt repayment.”⁵⁷ Essentially, aid, once received, may displace other domestic resources, which in turn are then used for other priorities. As a result of the fungibility of donor assistance, donor funding may not actually be additional to domestic spending, or at least to the extent that donors intend. Fungibility may not necessarily be “bad” – governments may decide to allocate the funds released by donor funding to locally important priorities that have been historically underfunded. However, the volatility of aid increases the potential that resource allocation is not optimal. For example, if donors stop or decrease funding levels in a country where the government diverted funding to another area upon the receipt of donor funding, the government may be hard-pressed to quickly re-allocate resources to finance the gap left by the decrease in donor funding. Studies show that in Africa, governments do not spend all sectoral aid in the targeted sector, and that the fungibility of donor aid is related to the number of donors active in the country and the relative importance of donor aid in government expenditures.⁵⁸

Third, the large influx of external financing since 2000 has strained ministry of health staff and systems. There has been increased focus recently among the donor community on implementing the recommendations of the Paris Declaration to harmonize and align external assistance efforts and reduce the monitoring, evaluation, and reporting burden placed on countries. Shifting aid modalities from project-based funding to modalities such as budget support (general or sector-specific) or sector-wide approaches (SWAp), which place funding in the hands of the government, could help to streamline reporting requirements as well as build accountability and capacity within the government. Budget support, an aid modality that is being used increasingly by some bilateral (e.g., U.K. Department for International Development) and multilateral (e.g., the World Bank) donors, has particular promise as a form of aid that can help to create fiscal space. Budget support is linked to sector or national priorities rather than to a specific project or budgetary line item. Budget support can also be funneled through a SWAp, which helps to coordinate donor funding and focuses on, among other things, linking sector reform to public sector management.

Fourth, the acceptance of external financing comes with a certain level of involvement of the donor in the setting and implementation of policy. Ministries of health may over-rely on technical assistance provided by the donor in key departments such as planning. Such reliance can compromise consistency in policy priorities over the long term, as changes in donor project cycles are often accompanied by shifts in perspectives on key issues.

Fifth, with massive inflows of aid, there are concerns about “Dutch disease,” i.e., the appreciation of a country’s currency and the decline in its worldwide competitiveness following the receipt of large aid inflows into specific sectors⁵⁹. While typically applied to natural resources, the concept is relevant to development in any sector receiving large increases in foreign aid flows. In Zambia, for example,

⁵⁶ Jean-Damascène Ntawukuliryayo. “Scaling Up to Reach the Health MDGs in Rwanda.” Presentation delivered at the Follow-on Meeting to the Post-High-Level Forum on the Health MDGs, Tunis, Tunisia. June, 2006.

⁵⁷ Gottret and Schieber, 2006.

⁵⁸ Vinaya Swaroop et al. *What Does Aid to Africa Finance?* Policy Research Working Paper 2092, Africa Region. (Washington, DC: World Bank, 1999).

⁵⁹ Christine Ebrahim-zadeh. “Dutch disease: too much wealth managed unwisely.” *Finance and Development* 40 (1). (Washington, DC: International Monetary Fund, March 2003).

<http://www.imf.org/external/pubs/ft/fandd/2003/03/ebra.htm>. Accessed April 15, 2008; and Owen Barder. “A Policymakers Guide to Dutch Disease.” Working Paper 91. (Washington, DC: Center for Global Development, 2006).

evidence suggests that large aid inflows and external debt relief, among other factors, played a role in the appreciation in the real exchange rate of the Zambian kwacha⁶⁰ and decline in Zambia's competitiveness worldwide following increases in copper prices. Evidence from Tanzania, Uganda, and Mozambique, however, suggests that country governments can take measures through macroeconomic policies to avoid this phenomenon.⁶¹ Additional analysis is needed on this issue and the extent to which it is occurring and plays a role in the long-term benefits or negative consequences for country's economic growth.

Finally, the capacity of many governments in sub-Saharan Africa to absorb large influxes of donor funds is limited. As a result, some countries in sub-Saharan Africa have had difficulty using funds received from donors, such as the GAVI Alliance for Immunization Services Support (ISS). A GAVI-funded evaluation of the program found that the key factors affecting whether funds were allocated strategically were related to absorptive capacity issues: the availability of strong technical assistance to support the National Immunization Program and a well-organized, functioning Inter-Agency Coordinating Committee were present in countries that were most successful in allocating and using funds.⁶²

While the experiences with the Global Fund (see Box 4) and GAVI ISS are not necessarily indicative of what is happening with all donor funds, given the needs in the health sector, the situation is worrisome. The dimensions of absorptive capacity that require attention include human capacity constraints, weak budgeting and planning processes, local political interference, and excessive donor requirements for reporting and monitoring and evaluation. These factors are discussed in detail in Section 5.

Box 4. How absorptive capacity constraints can limit the effectiveness of donor financing

The difficulties countries are demonstrating in drawing down on their Global Fund to Fight AIDS, Tuberculosis, and Malaria allocations also attests to the problem of absorptive capacity. An analysis by Aidspan in January 2008 indicates that of the 43 Global Fund grant recipients in sub-Saharan Africa, only one (Rwanda), was on schedule with its grant disbursements. The table below shows that, on average, sub-Saharan Africa countries were 8.6 months behind schedule and, since Round 1 in 2002, only 46 percent of approved funds have been disbursed as of January 2008.

GLOBAL FUND GRANTS DISBURSEMENT LAG

Months behind	No. countries
0	1
> 0 - 6	18
>6 - 12	11
>12 - 18	8
>18 - 24	5

Source: Aidspan.org. <http://www.aidspan.org/index.php?page=gfgrants&menu=globalfundgrants>. Dated January 8, 2008

⁶⁰ Massimiliano Cali and Dirk Willem te Velde. "Is Zambia Contracting Dutch disease?" Working Paper No. 279. (London: Overseas Development Institute, February 2007). http://www.odi.org.uk/publications/working_papers/wp279.pdf. Accessed April 15, 2008.

⁶¹ Shekar Aiyar et al. "The Macroeconomic Challenge of More Aid." *Finance and Development* 42(3, September 2005). <http://www.imf.org/external/pubs/ft/fandd/2005/09/aiyar.htm>. Accessed April 15, 2008.

⁶² Grace Chee et al. *Evaluation of GAVI Immunization Services Support Funding*. (Bethesda, MD: Abt Associates Inc., 2004).

Aid for health is much needed to supplement public and private sector financing for health, which remain dismally low in comparison to financing targets even several years after the targets were set. Policymakers and donors must find the balance between pushing back to protect their own countries' interests, needs, and priorities knowing that donor assistance remains key to financing health in sub-Saharan Africa.

Having examined some of the challenges sub-Saharan African countries face in mobilizing and spending public and external resources for health, we now turn to a discussion of complementary approaches to health financing that can serve to increase the overall revenue available for health as well as make the currently available resource envelope more effective.

5. COMPLEMENTARY APPROACHES FOR HEALTH FINANCING: POSSIBILITIES IN THE SUB-SAHARAN AFRICAN CONTEXT

Previous discussions have shown that the public sector is constrained in its capacity to mobilize domestic revenue and, while remaining a keystone of health sector financing, is unlikely to be able to provide sufficient resources to meet the goals for health financing in Africa in the short to medium term. Grants and loans from donors help to fill financing gaps, but bring their own set of challenges. In this context, it is useful to examine other financing sources and approaches that have emerged both in Africa and internationally which could complement traditional public sector service delivery and financing. These include additional sources of revenue for health as well as mechanisms to make existing health spending go further.

In this section, we first review opportunities that can primarily bring *new or additional resources* into the health sector in sub-Saharan Africa. Next, we explore approaches that both *generate additional resources* and *enhance the effectiveness* of health spending. We then turn to national and community-based risk-pooling efforts, some of which may add to the total resource envelope for health but which can also improve the efficiency of household spending and enhance risk protection. Finally, we conclude by examining approaches whose primary aim is to *increase the efficiency and effectiveness of health spending*. These we have grouped under the unifying heading of “health systems strengthening,” since these approaches work to build up the structures and processes that facilitate effective utilization of resources to achieve health outcomes.

Throughout this section, we explore the contribution each approach is making or could make toward closing the gap between financing needs and available resources.

5.1 LEVERAGING THE PRIVATE SECTOR FOR HEALTH CARE FINANCING

As noted in section 2, approximately 56 percent of all health expenditures in sub-Saharan Africa originate from private sources, primarily through out-of-pocket payments from households. There is increasing potential to partner with the organized private sector for health financing in the region. While the private sector already plays an important role in the *provision* of health services in Africa – approximately 50 percent of total health care spending goes to private providers and they are often the health systems entry point for poor and rural populations – efforts to facilitate the organized private sector’s role as a *financier* of health care are still incipient.

This section will briefly discuss possibilities for new investments in the health sector by private entities, as well as the potential for employers and faith-based organizations (FBO) to play a more significant role in health financing. (We discuss approaches for generating and pooling private household revenues more equitably and effectively for health financing in section 5.3. Public-private partnership mechanisms such as performance-based contracts that can increase the effectiveness of health spending are discussed in section 5.4.)

5.1.1 PRIVATE SECTOR ENTITIES AS INVESTORS IN THE HEALTH CARE SYSTEM

As noted in the introduction to this paper, there have been clear improvements in the macro-economic climate in African countries recently, with 5–6 percent annual economic growth rates.⁶³ A recent report by the International Finance Corporation⁶⁴ posits that economic growth is increasing the size of the market for health care in Africa while political stability and reform are increasing its attractiveness to investors. The report estimates that between \$25 billion and \$30 billion dollars in new investments will be required if the new demand for health care is to be met, of which \$11 billion to \$20 billion of the new investment could come from the private sector.

According to the report, the largest investment opportunities for private investors are associated with building physical capacity to provide health services. Other potentially profitable opportunities include investments in distribution and retail systems, as well as pharmaceutical and medical supply production facilities. The report suggests that about half of these opportunities could attract for-profit investors, while the remaining investors would be equally spread between social enterprises and NGOs.

Private investment could be a potential source of capital for the health sector in Africa, although the actual magnitude of investment flows is unknown and will only become evident over time. Certainly at present the role of the organized private sector as a financier of health is very limited. 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 enhance the capacity of public and private regulatory bodies, foster risk-pooling programs, 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.⁶⁵

5.1.2 EMPLOYER-FINANCED HEALTH CARE

Another potential source of additional resources for the health sector in sub-Saharan Africa is employers who finance health services for their workers. Given high prevalence rates of HIV and malaria, companies in many parts of sub-Saharan Africa feel the costs of poor health through employee absenteeism or lowered productivity because of illness. This creates incentives to invest in providing or subsidizing health services for employees and their families – both out of self-interest and a sense of social responsibility. To date, there is little published data available on the extent of employer-financed health care in the region.⁶⁶ Relative to current total health spending in sub-Saharan Africa, employer financing is likely quite limited because the formal labor market is relatively small. However, with economic growth, the potential contribution of employer-sponsored health care to health financing may increase. Annex 5 provides several examples of companies that subsidize health services for their workers in sub-Saharan Africa.

One limitation of this approach to health financing is that it is unlikely to reach the poor, even if the formal economy is growing. Those employed by large firms in the formal economy in most sub-Saharan African countries typically do not include the poorest groups in the population. Nevertheless, efforts to

⁶³ OECD Development Center and the African Development Bank. *Afrocam Economic Outlook 2005/2006*. (May 16, 2006). Published by the OECD Development Center and the African Development Bank with financial support from the European Commission.

⁶⁴ International Finance Corporation. *The Business of Health in Africa*. (Washington, DC: World Bank Group, 2007). www.ifc.org/HealthinAfrica

⁶⁵ Ibid.

⁶⁶ The Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria has presented 20 individual case studies of for-profit supported health services in the Africa region. However, this is certainly an underestimate of the number of initiatives that exist.

encourage employers to provide such subsidies should be promoted. In some instances, it may also be possible to create public-private partnerships with employer-sponsored health care initiatives that can leverage employer resources to reach beyond their immediate workforce. Some of the examples in Annex 6 reflect initiatives that benefited a wider population.

5.1.3 FAITH-BASED ORGANIZATIONS AS HEALTH CARE FINANCIERS

FBOs have a long-standing place as health care service *providers* in Africa,⁶⁷ but they also have potential to serve as *financiers* of health care. FBOs can mobilize external resources for health through church networks and external individual donors. In addition, the networks of facilities, equipment, and personnel in FBO-owned or -managed facilities can bring much-needed resources to support public health interventions. Many FBOs pursue a mission to serve specific populations, especially the poor, and provide subsidized services to these groups.⁶⁸

Unfortunately, there is a critical lack of data on the nature, scale, and scope of FBOs' involvement in financing health care in sub-Saharan Africa. Managerial and organizational capacity constraints are perceived to be an important impediment to public sector efforts to partnering with FBOs. Some have argued that scaling up through partnerships with these organizations may be relatively expensive and inefficient.⁶⁹ However, it is important to acknowledge the diversity in FBO managerial and organizational capacity. The available evidence on the scale of FBO *provision* of health care and the focus that these organizations frequently have on poor populations makes them a logical potential partner for financing public health initiatives.

5.2 INNOVATIVE INTERNATIONAL FINANCING MECHANISMS

Today, global awareness of the acuteness of the funding crisis is unprecedented. Several reports have highlighted the danger that the MDGs will not be met, both because of the shortfall in funding and because existing funds are not spent as effectively or efficiently as possible.⁷⁰ As a result, the international community, donors, charitable foundations, and the private sector have developed innovative mechanisms that complement existing efforts by adding significant additional resources for health financing in low-income countries, including Africa, and encouraging more efficient solutions to the health problems confronting these countries.⁷¹

⁶⁷ Only recently has there been increased awareness of the magnitude of the role of FBOs as service providers in Africa. A 2007 WHO report estimates that they may own 30–70 percent of the health care infrastructure on the continent. In Kenya, for example, the FBOs like Kenya Episcopal Conference (KEC) and Christian Health Association of Kenya (CHAK) provide more than 40 percent of the country's health services. In Malawi, the Christian Health Association of Malawi (CHAM) provides about 37 percent of health services in the country. See World Health Organization. *Appreciating assets: mapping, understanding, translating and engaging religious health assets in Zambia and Lesotho* (2007); and The Capacity Project. *Working with Faith Based Organizations to Strengthen Human Resources for Health*, (2007). <http://www.capacityproject.org/images/stories/files/fbo.pdf>.

⁶⁸ In Uganda, for instance, the Catholic health network and its umbrella organization, the Uganda Catholic Medical Bureau, decided to reduce user fees for children, women, and mothers in its hospitals in response to data suggesting that rising user fees prevented access to services for poor populations. See Daniele Giusti, Peter Lochoro, John Odaga, and Everd Maniple. *Pro-poor health services: The Catholic health network in Uganda* (Washington, DC: World Bank Group, World Bank Institute, Development Outreach, 2004), <http://www1.worldbank.org/devoutreach/march04/textonly.asp?id=237>

⁶⁹Giusti et al., 2004

⁷⁰ United Nations. Africa and the Millennium Development Goals 2007 Update. Online.

<http://www.un.org/millenniumgoals/docs/MDGafrika07.pdf>. Accessed January 17, 2008; Adam Wagstaff and Mariam Claeson. *The Millennium Development Goals for Health: Rising to the Challenges*. (Washington, DC: World Bank, 2004).

⁷¹ Lane, Christopher and Amanda Glassman. "Bigger and Better? Scaling Up and Innovation in Aid for Health". *Health Affairs* Vol. 26, No. 4. (Project Hope: Bethesda, MD: 2007).

Much of the renewed interest in global health financing has been driven by the appearance of new actors in the global health arena, especially richly endowed private foundations such as the Bill and Melinda Gates Foundation. Indeed, a significant amount of the funding behind some of the mechanisms described below (e.g., GAVI and the Global Fund) comes from grants from the Gates Foundation. These new players have initiated major changes in the global health aid architecture. In addition, traditional players such as bilateral donors have also made a concerted effort in recent times to increase their commitments for health, particularly in Africa.

We have broadly classified these mechanisms under the following categories to briefly present their purpose, opportunities, and challenges.

- *Global Health Partnerships* include the GAVI Alliance, the Global Fund, the Roll Back Malaria Partnership (RBM), and the International Health Partnership Plus (IHP+). These partnerships have been formed through a coalition of donors and foundations to address either specific diseases or health interventions or, as is the case with the IHP+, to coordinate and harmonize donor activities and align donor priorities with those at the country level for greater aid effectiveness. The IHP+ is part of a larger “Global Campaign for the Health MDGs,” which was launched formally in September 2007. The Global Campaign represents an enhanced effort to coordinate overlapping initiatives, with the country national health plan at the center of each initiative, so that donor efforts are better harmonized and aligned with the priorities of developing countries. The Global Campaign is designed to encompass a number of interrelated initiatives. For instance, Norway has launched a component of the campaign, called Deliver Now for Women and Children, which focuses on MDGs 4 and 5. Germany and France are leading the Providing for Health Initiative, which aims to improve sustainable and equitable financing structures for health in developing countries, with a focus on Africa.
- *United States Global Health Initiatives* include the President’s Emergency Plan for AIDS Relief (PEPFAR), and the President’s Malaria Initiative (PMI). They are designed to accelerate the scale-up of resources for interventions in HIV/AIDS and malaria and represent the majority of the United States’ bilateral investments in these two priority diseases. Both programs have target countries, PEPFAR’s mostly in Africa and PMI’s exclusively in Africa.
- *Debt and performance-based aid modalities* include Debt2Health and IDA buy-downs⁷² and concessional lending or grants designed in such a way as to encourage a focus on achieving specific results. In most cases, they are meant to improve the effectiveness of existing sources of financing rather than provide new aid.
- *New global taxes* have been proposed in recent years to finance global health priorities. These include airline ticket taxation, a “Tobin tax” on the trade of currency across borders, and taxes on global “bads” (for example, environmental pollution). These proposals would raise new financing to be used to fund global priority health interventions. UNITAID is one example of a new global tax that is in the early phases of implementation.
- *New mechanisms to address market failures in drug and vaccine availability* include Advance Market Commitments (AMCs), the Affordable Medicines Facility-malaria (AMFm), the International Finance Facility for Immunizations (IFFIm), and the Global TB Drug Facility. They mainly support development or access to quality vaccines and drugs and aim to make up for long-recognized market failures in providing for international public health goods and the pharmaceutical needs of low-income countries.

⁷² The International Development Association (IDA) is the concessional lending arm of the World Bank. An IDA “buy-down” refers to a third-party donor paying off all or part of a specific IDA credit on behalf of a government.⁷² A country receives an IDA credit to help support specified development activities, such as polio eradication.

This list is by no means exhaustive. For reference, see Annex 6 for more detailed information about the objectives, funding levels, and accomplishments to date of each financing mechanism.

The international innovative financing mechanisms listed above have shown the potential to mobilize tremendous support and goodwill from donor governments, the private sector, charities, foundations, and the general public behind new efforts to tackle the health financing challenges of many poor countries, especially those in sub-Saharan Africa. In addition, they have raised large amounts of resources relatively quickly, or redirected existing sources of financing in more efficient or more effective ways. In addition, these mechanisms offer promise in addressing some of the challenges with external assistance for health described in Section 4 by ensuring more predictable sources of revenue for meeting health challenges in the future (in the case of the new global taxes and mechanisms to address market failures, for instance).

However, these mechanisms by and large continue the disease-focused model for donor aid that some allege causes distortions for country programs and planning and fails to strengthen health systems. The issues of sustainability remain acute for at least some of these mechanism, such as the Global Fund model of five-year funding cycles and country application processes. For some pharmaceutical purchase mechanisms, it is sometimes claimed⁷³ that these are no more than straightforward subsidies for private industry, with the potential to distort markets. Given the plethora of new mechanisms, there is now more than ever a need to focus on harmonization and alignment, streamlining reporting and procurement processes, conducting joint missions, etc., to reduce the burden on countries. The prevalence of new and innovative health financing initiatives that direct funding to priority diseases shows that much more progress is needed in making health systems strengthening a priority. While new sources of funding are crucial to address the huge gap between financing needs and available resources, improving *how* funds are spent is equally important to achieving sustainable health outcomes. In the next section, we discuss how insurance mechanisms can help to accomplish this.

5.3 REVENUE RAISING AND RISK POOLING THROUGH INSURANCE

As noted throughout this paper, most health systems in sub-Saharan Africa rely heavily on private household out-of-pocket spending – indeed, household out-of-pocket spending *exceeded* public expenditures on health across the region in 2005. Families usually pay out-of-pocket for services provided in the private sector, and may pay user fees at public sector facilities. The disadvantages of this heavy reliance on out-of-pocket spending are that it may reduce access to health services among the poor, and catastrophic costs may push families into poverty.

One approach generate additional resources for health while improving the efficiency and effectiveness of spending, and to address household vulnerability to burdensome health expenditures, is risk pooling through insurance. In addition to providing financial protection and, potentially, increasing equity, channeling health spending through insurance can:

- Improve the effectiveness of health spending by driving improvements in the quality of service provision and increasing the predictability of resource flows from users to providers;
- Reap economic efficiency gains, relative to individual out-of-pocket spending;

⁷³ As with every endeavor, there are critics of these new mechanisms but so far these critics do not appear to have had a great deal of mainstream impact. See, for example, Prof. Chris Whitty. “An Inquiry into an Affordable Medicine Facility for Malaria (AMFm). Presentation at The All-Party Parliamentary Malaria Group meeting, October 9, 2007, at the U.K. Parliament.

- Mobilize additional resources for the health sector.

Some countries in sub-Saharan Africa have piloted or implemented different insurance innovations, including community-based health insurance (CBHI), also known as *mutuelles*, and even national health insurance schemes or funds (NHIS/NHIF).

5.3.1 COMMUNITY-BASED HEALTH INSURANCE

CBHI schemes have aimed to extend the benefits of insurance to populations that have been excluded from traditional social protection schemes, i.e., to rural populations and those working in the urban informal sector. These previously uncovered or under-covered groups account for the majority of the population in most sub-Saharan African countries. The potential benefits of CBHI schemes include their ability to mobilize resources for health, provide financial protection from catastrophic health costs, and negotiate quality gains for their members.

The rapid growth of CBHI schemes in many sub-Saharan African countries is a relatively recent development, although the history of such schemes in Africa goes much further back.⁷⁴ Their innovativeness is partly due to the central role played by communities and local health facilities operating independently of the government during their initial growth and development. CBHI schemes have tended to grow where user fees are high, good-quality health care is available, solidarity networks are strong, and a tradition of self-help and organization exists. Typically, schemes exhibit a tendency to start with a small benefits package (frequently mainly hospitalization) but rapidly expand and diversify to include other services, especially outpatient care.

To date, population coverage by CBHI schemes in most countries is relatively low. Regional or multi-country analyses of the African experience with CBHI schemes are rare; the last reasonably complete inventory of CBHI schemes in 11 countries of Francophone west and central Africa in 2003 identified 622 *mutuelles*, of which 366 were considered “active” and the remainder under development, planned, failing, or otherwise inactive.⁷⁵ Senegal, Ghana, and Burkina Faso reported the highest numbers of *mutuelles* in this inventory, while Cote d’Ivoire, Mali, and Senegal had the largest numbers of beneficiaries covered by *mutuelles*. The estimated population covered by all *mutuelles* in the sub-region, calculated by applying a country-specific average *mutuelle* size to the total number of respondent *mutuelles* in each country, was just over 1,900,000 beneficiaries. In terms of total population coverage, a peer-reviewed systematic review by Ekman⁷⁶ found that the effective population coverage is rather small, on average around 10 percent of target populations. However, Rwanda’s experience stands in contrast to the limited coverage and small size of most West African *mutuelles*. The nation was able to rapidly scale up CBHI coverage – *mutuelles* were piloted in 1999⁷⁷ to reach more than 75 percent coverage by 2007.⁷⁸ We describe the Rwandan example in greater detail below in Section 5.3.2, National Health Insurance Schemes, as we feel that given this level of population coverage (along with the greater involvement of the government) the Rwanda case fits better there.

⁷⁴ Some CBHI schemes were started in Belgian-ruled Congo and Burundi in the 1950s.

⁷⁵ La Concertation. *Inventaire des mutuelles de santé en Afrique: Synthèse des travaux de recherche dans 11 pays*. (October 2004). An attempt to update this inventory in 2007 was less successful; this exercise should be repeated in order to have a better picture of the most recent situation with regards to the development of these schemes.

⁷⁶ Björn Ekman. “Community-based health insurance in low-income countries: a systematic review of the evidence,” *Health Policy And Planning* 19(5) (2004): 249–270. The schemes reviewed by Ekman covered both Africa and Asia; however the majority of schemes were African.

⁷⁷ J.O. Schmidt et al. “Thresholds for health insurance in Rwanda: who should pay how much?” *Tropical Medicine & International Health*, 11(8) (2006).

⁷⁸ Rwanda Ministry of Health. *Cellule Technique d’Appui aux Mutuelles de Sante*.

Most of the mutuelles in the West African inventory could be described as small in size, with the median number of beneficiaries at less than 700, and the majority of mutuelles covering fewer than 1000 people.⁷⁹ The data indicated that mutuelles were somewhat more likely to operate in rural areas: 41 percent covered rural areas exclusively, compared with 34 percent covering urban populations exclusively. The health services covered by the mutuelles in the 2003 survey tended to favor drugs (about 78 percent of mutuelles offered this benefit) and maternity care (around 58 percent of mutuelles covered normal delivery and 55 percent covered cesarean operations). Next most common were outpatient and inpatient services with at least 55 percent of mutuelles offering each of these services.

CBHI schemes may be able to mobilize additional resources for the health system. Ekman's 2004 review of CBHI schemes⁸⁰ found moderate evidence to suggest that CBHI schemes have a positive effect on resource mobilization. However, it was also clear that the actual amounts raised were limited. The average cost-recovery ratio (defined as the share of total provider costs covered by insurance premiums)⁸¹ was only around 25 percent, with only two studies reporting ratios in excess of 50 percent. A review by Preker et al. in 2002 had similar findings.⁸² In only one scheme were more than 50 percent of recurrent costs covered by prepayment. However, many of the providers associated with these schemes were government providers who could only charge user fees that were far less than operating costs. The CBHI schemes were therefore able to cover the charges their members faced while contributing only a limited proportion of facility operating costs.

Other evidence shows that cost recovery may actually be more of a preoccupation for provider-based schemes than community-owned and community-run schemes. Cost recovery is often the main rationale for providers to set up insurance schemes. In Uganda, where the schemes are generally provider-based, cost recovery rates in relation to treatment costs are generally over 60 percent and sometimes over 100 percent.⁸³

CBHI schemes can provide financial protection and increased access to health care. A 2006 study of the impact of CBHI schemes in Ghana, Mali, and Senegal found that while MHO membership had no effect on out-of-pocket expenditures for curative outpatient care, it did have a strong protective effect against the potentially catastrophic expenditures related to hospitalization.⁸⁴ In an earlier analysis, Jakab et al. found that community financing reduced financial barriers to health care as demonstrated by higher utilization and lower out-of-pocket expenditure among scheme members, controlling for a range of

⁷⁹ It should be stressed that while it is often taken to be a shortcoming of CBHI schemes that they have such small risk pools, this may not be a disadvantage in practice, especially in so far as the aims of the mutuelles themselves are concerned. It is arguable that smaller schemes may find it easier to control certain risks and remain viable, while bigger ones may suffer from widespread abuses. See C. Atim, F Diop and S Bennett (2005) for a discussion of financial stability of CBHI schemes in Senegal.

⁸⁰ Ekman, 2004

⁸¹ While calculating the total premiums collected is fairly straightforward, it is not similarly clear what is included in the "provider's costs," whether this includes both recurrent and capital costs or just the former.

⁸² Alex Preker et al. "Effectiveness of community health financing in meeting the cost of illness," *Bulletin of the World Health Organization* 80(2) (2002): 143-150.

⁸³ Yann Derriennic et al. *An Assessment of Community-Based Health Financing Activities in Uganda*. (Bethesda, MD: Partners for Health Reformplus, Abt Associates Inc., February 2005). The denominator used most likely differed from the one used in the Ekman studies.

⁸⁴ Françoise Diop et al. *The Impact of Mutual Health Organizations on Social Inclusion, Access to Health Care, and Household Income Protection: Evidence from Ghana, Senegal, and Mali*. (Partners for Health Reformplus, Abt Associates Inc., September 2006).

socio-economic variables.⁸⁵ A similar comparison from a household survey in Rwanda found that mutuelle members in three pilot districts enjoyed considerably better access to curative health care.⁸⁶

The systematic review by Ekman found strong evidence that CBHI schemes “do provide effective protection to the members of the schemes by significantly reducing the level of OOP [out-of-pocket] payment for care,” even though some of the evidence was mixed. There was also moderately strong evidence to suggest that CBHI schemes provide financial protection by increasing access to health care in their operating areas. Access to care was assessed mainly by measuring utilization rates, comparing members and non-members, and conducting before-after appraisals of utilization of services.

An important health systems objective, fostering equity, is not always a key objective of CBHI schemes. The review by Ekman suggested that most schemes failed to cover the least well-off groups in the catchment areas. This has been noted by other observers as well.⁸⁷ The unaffordability of premiums is an important constraint for the poorest of the poor, and many accounts suggest that the better-off in rural populations are more likely to join CBHI schemes than the poorest households.⁸⁸ However, not all studies find that CBHI schemes fail to cover the poor. The findings of a study conducted in Mali indicated that households from all income groups joined mutuelles, with those from the richest quintile only slightly more likely to enroll than those from the four lower quintiles. The high cost of premiums was only cited as a reason for non-enrollment by 13 percent of the population.⁸⁹ Nevertheless, given widespread poverty in the region, the affordability of premiums for the poorest remains an important concern. The premiums of the poor may need to be subsidized by the government or through external assistance to better enable the poorest to benefit from risk pooling.

Financial sustainability has presented challenges for the mutuelle movement. A study designed to explore the question of financial stability of mutuelles in the Thiès Region of Senegal in 2005 found that 66 percent of responding mutuelles reported difficulty collecting premiums. Mutuelles’ performance depended crucially on the ability to control certain risks (adverse selection, moral hazard, cost escalation) and abuses (fraud).⁹⁰ There was no obvious correlation between the size of the mutuelle and its performance; smaller mutuelles, with potentially greater social control, may have an advantage in controlling some of these risks and abuses, and therefore keeping costs down. Other related findings are that 55 percent of active mutuelles reported having some financial reserves, 7 percent had some type of reinsurance, and 15 percent had some type of external guarantor. Potential approaches to improving the sustainability of mutuelles include: (i) broadening the enrollment base to mitigate adverse selection and better distribute risk, (ii) developing reinsurance and links between insurance pools, and (iii) ensuring competent and trained management for CBHI schemes.

⁸⁵ Melitta Jakab et al. “Social inclusion and financial protection through community financing: initial results from five household surveys,” World Bank Health Nutrition and Population Discussion Paper. (Washington, DC: World Bank 2001). <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Jakab-SocialInclusion-whole.pdf>

⁸⁶ Pia Schneider and François Diop. *Impact of Prepayment Pilot on Health Care Utilization and Financing in Rwanda: Findings from Final Household Survey*. Technical Report 002. (Bethesda, MD: Partners for Health Reformplus, Abt Associates Inc., October 2001).

⁸⁷ See for instance Jakab, Preker, Krishnan, et al., 2001

⁸⁸ See for instance Preker et al., 2002

⁸⁹ L.M. Franco et al. *Equity initiative in Mali: Evaluation of the Impact of Mutual Health Organizations on Utilization of High Impact Services in Bla and Sikasso Districts in Mali*. (Bethesda, MD: Partners for Health Reformplus, Abt Associates Inc., September 2006).

⁹⁰ Chris Atim et al. *Determinants of the Financial Stability of Community Based Health Insurance: A Study in Thies, Senegal*. (Bethesda, MD: Partners for Health Reformplus, Abt Associates Inc. September 2005).

5.3.2 NATIONAL HEALTH INSURANCE SCHEMES

The few examples of NHIS in sub-Saharan Africa have evolved from two distinct approaches to insurance: social health insurance, which is typically mandatory for groups of individuals and funded through payroll taxes earmarked for health; and CBHI schemes, described in the section above. Social health insurance, based upon European models,⁹¹ is more likely to be more successful in contexts with large formal sector employment, high wages and salaries, low poverty rates, low dependency ratios, and high capacity to provide health care.⁹² CBHI schemes can operate successfully in the informal sector, but have historically been difficult to scale up beyond the community level. These two patterns imply that countries in sub-Saharan Africa face considerable challenges in successfully and sustainably implementing health insurance schemes at the national level.

Nonetheless, several sub-Saharan African countries are now experimenting with new and innovative forms of health insurance, including variations on social health insurance and CBHI schemes. Whereas previous attempts at implementing social health insurance in Africa were confined to the formal sector, new NHIS are attempting to enroll rural and informal sector workers. In Ghana, Rwanda, and Tanzania, NHIS were preceded by CBHI pilot schemes.⁹³

Rwanda's is arguably the most dramatic recent experience of CBHI-based national health insurance in sub-Saharan Africa today, at least in terms of population coverage. After successfully initiating pilot schemes in 1999, the government decided to go to scale in a rapid fashion. As of October 2007, it was reported that the schemes had enrolled 6,702,391 beneficiaries out of a total population of 8.9 million – about 75 percent of the total population. To support the growth of the schemes, the government has created a special solidarity or risk-pooling fund, into which transfers from the Ministry of Finance via the Ministry of Health are made to cover the costs of indigents and people living with HIV/AIDS. The Global Fund is providing financial support for five years to cover the government subsidy. It will be important to assess the success of this solidarity fund in covering vulnerable population groups, as more data regarding the socio-economic and demographic profile of schemes and members become available in the future.

Ghana's NHIS also evolved out of a period of autonomous CBHI development. The National Health Insurance Act set up the NHIS in 2003. Membership in the NHIS is not mandatory for all Ghanaians, although making enrollment compulsory is part of the government's long-term vision.⁹⁴ Presently, the NHIS encompasses district mutual health schemes, private insurance schemes and private mutual health insurance. The government defines the minimum benefits package, certifies providers and regulates the insurance schemes. It has also set up a separate NHIF, financed by a special 2.5 percent National Health Insurance value-added tax (VAT) levy and 2.5 percent of the social security contributions of formal sector workers (Table 5). The NHIF is used to subsidize the membership of formal sector employees, pensioners, children under the age of 18, indigents, and those over 70. In practice, however, this means that informal sector workers and their families are the only people who pay cash to join the schemes.⁹⁵

⁹¹ For a good overview of six basic features normally associated with social health insurance schemes, see J. Costa. *The resurgence of Social Health Insurance in the Balkans: Lessons from the Federal Republic of Yugoslavia*. (London: DFID Health Systems Resource Centre, 2002). The International Labour Organisation (ILO), on the other hand, has traditionally considered the key defining feature of social health insurance to be a health insurance system mandated by government. See C. Normand and C. Weber *Social Health Insurance. A Guidebook for Planning*. (Geneva: WHO and ILO, 1994).

⁹² Ibid.

⁹³ It is interesting to note that William Hsiao et al. included Ghana's experience in their review of "traditional" social health insurance schemes around the world, without feeling the need to justify the inclusion. See William C. Hsiao and R. Paul Shaw (eds.). *Social Health Insurance for Developing Nations*. (Washington, DC: IBRD, World Bank Institute Development Studies, 2007).

⁹⁴ S. Ramchandra and W. Hsiao in Hsiao and Shaw (eds.), 2007

⁹⁵ NHIS Statistics, June 2007

Revenues from the NHIF are also used to reinsure district health funds and to support programs that improve access to health care.⁹⁶

TABLE 5. FUNDING SOURCES OF NHIS IN GHANA

Source of NHIF income	% of NHIF income in 2006
National Health Insurance (VAT) levy	76%
Social security contributions of formal sector workers	24%
Premiums paid by informal sector members	0.01% (est.)

Source: Ghana Health Sector Review 2007

Since the Ghana NHIS is a relatively recent development, evidence on its performance is limited. The available information indicates that there has been a rapid growth in membership, totaling about 7.8 million people or nearly 40 percent of the total population by March 2007. But this rapid growth in membership is driven mainly by the subsidized groups: children under 18 make up 47 percent of members, and formal sector workers are automatically enrolled and constitute 22 percent of members (Figure 9a). Those over 70 make up about 8 percent of members. In addition, despite the subsidy for indigents, only around 2 percent of registered scheme members are said to be indigent, an indication that equity is not being fostered by this scheme⁹⁷ despite the fact that an estimated 40 percent of the population lives below the national poverty line (Figure 9b).⁹⁸

FIGURE 9A. INFORMAL SECTOR AND EXEMPTED TO TOTAL MEMBERS

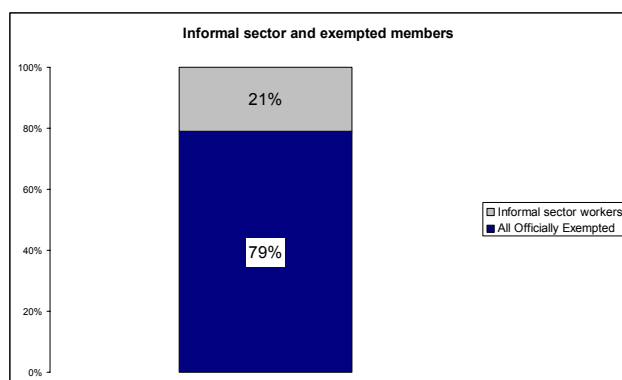
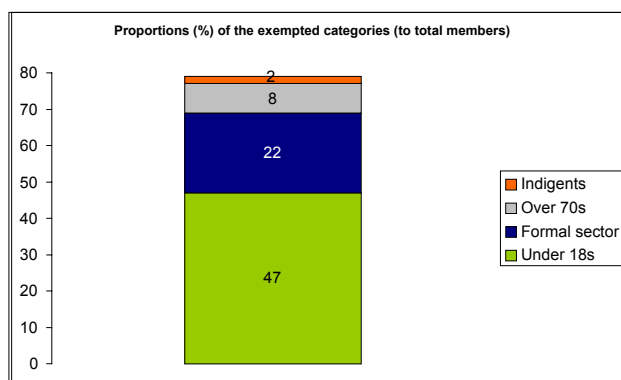


FIGURE 9B. PROPORTIONS (%) OF THE 'EXEMPTED' CATEGORIES (TO TOTAL MEMBERS)



Source: NHIS Statistics, June 2007

Note: Figure 9b is the share of the exempted categories over the total population, and add up to 79 percent as shown in Figure 9a. Also note that formal sector workers, despite their social security contributions, are officially considered 'exempted' in Ghana, in that they do not pay cash at the point of joining a scheme.

There are concerns about the design of the Ghanaian NHIS.⁹⁹ The minimum benefits package may be too extensive to be sustainable in the long term. The question of how to cover indigents also remains a

⁹⁶ Ramchandra and Hsiao, 2007

⁹⁷ NHIS Statistics, June 2007

⁹⁸ See [http://en.wikipedia.org/wiki/List_of_countries_by_percentage_of_population_living_in_poverty#_note-worldbank](http://en.wikipedia.org/wiki/List_of_countries_by_percentage_of_population_living_in_poverty#_note-worldbank;); and World Bank 2006. World Development Indicators 2006. CD-ROM. Washington, D.C.

⁹⁹ Ramchandra and Hsiao, 2007

clear problem that is highlighted by the data on scheme enrollment presented above. The government estimates that indigents who are entitled to subsidized premiums account for 9 percent of the population, but this seems to be an underestimate.

There is great potential in sub-Saharan Africa for national and community-based health insurance systems. However, there may be difficult trade-offs between raising sufficient revenue to ensure financial sustainability and ensuring coverage of the poor in countries with high levels of poverty. Collecting premiums from individuals in the informal sector is administratively difficult, and subsidizing premiums of the poor is challenging given the limited tax base. The feasibility of heavy cross-subsidization depends on a high level of social capital and strong sense of social solidarity, which may exist at the community level but are difficult to translate to the national level. Moreover, identifying whose premiums should be subsidized can be difficult; the challenges associated with operationalizing exemptions for user fees suggests that administrative capacity to accurately distinguish the poor from non-poor is frequently lacking in low-income country settings. Thus, while the equity, access, financial protection, and revenue generation benefits of national health insurance make this strategy appealing to pursue, many challenges must be addressed to ensure successful and sustainable implementation.

5.4 HEALTH SYSTEMS STRENGTHENING AND PERFORMANCE-BASED FINANCING TO IMPROVE EFFICIENCY AND EFFECTIVENESS

Until recently, insufficient attention has been paid to strengthening the overall health system in African countries. Certain components of the health system supporting disease- and intervention-specific programs have received greater attention and resources in the past decade, but “siloes” sub-systems may have actually weakened the larger health system. Strengthening the overall health system can bring significant gains in how much can be achieved with both government and donor financing. In particular, health systems strengthening through improving government leadership and effectiveness, increasing the efficiency of the flow of funds within the system, and mitigating absorptive capacity constraints and the human resource for health crisis can impact the *effectiveness and efficiency* of available funding.

In addition, performance-based financing (PBF) is an emerging approach for aligning financing incentives with desired health or health systems outcomes. It is another key tool in policymakers’ arsenal for improving *how* money is spent on health, and making resources go further. PBF dovetails with health systems strengthening by seeking to reward actions that lead to results, leading households and providers to find on-the-ground solutions to health systems challenges.

This section reviews some of the key health system strengthening and performance-based financing approaches that governments and donors could explore in sub-Saharan African countries to improve the efficiency and effectiveness of health financing.

5.4.1 HEALTH SYSTEMS STRENGTHENING

Health systems strengthening is increasingly a high-priority for donors and country policymakers alike. At a high-level meeting in 2007, African Union Health Ministers endorsed the importance of health systems strengthening and urged African governments to “concentrate on five areas in pursuing health systems development: governance; financial and human resources; ensuring availability and appropriate use of commodities; community empowerment; and health information systems and use there of.”¹⁰⁰

¹⁰⁰ Third session of the African Union Conference of Ministers of Health. “*Strengthening of health systems for equity and development in Africa*”. Johannesburg, South Africa, April 2007. Camh/min/4(iii).

Going forward, the challenge will be to maintain this priority, especially if external financing remains focused on specific diseases and interventions.

Government leadership and effectiveness are widely recognized as key factors that determine whether health sector goals are achieved. Existing analyses of the relationship between governance and health service delivery highlight the importance of good health governance, including the following key features¹⁰¹:

- Responsiveness to public health needs and beneficiaries'/citizens' preferences while managing divergences between them
- Responsible leadership to address public health priorities
- The legitimate exercise of beneficiaries'/citizens' voice
- Institutional checks and balances
- Clear and enforceable accountability
- Transparency in policymaking, resource allocation, and performance
- Evidence-based policymaking
- Efficient and effective service provision arrangements, regulatory frameworks, and management systems.

Lewis¹⁰² identified three governance factors as particularly relevant to health service delivery: voice and accountability, government effectiveness, and control of corruption. Lewis' regression analyses showed that increasing government effectiveness is correlated with higher immunization rates and lower child mortality.¹⁰³ Wagstaff and Claeson¹⁰⁴ found that health spending reduces under-five mortality only where governance, as measured by the World Bank's Country Policy and Institutional Assessment (CPIA) score,¹⁰⁵ is sound.

The government also plays a critical role as a steward of the health sector, through enacting and enforcing policies that facilitate quality service delivery, health workforce training, and other investments in the health sector. This involves, among other things, working with the private sector and harnessing non-health agencies and actors to achieve larger public health goals. Brinkerhoff and Bossert identify the role of health ministries in particular as stewards of the health system, and the need to redefine their roles as such with input from citizens, civil society, and the private sector; and establish oversight and accountability mechanisms.¹⁰⁶

With stronger government leadership, effectiveness, and stewardship, financial resources allocated to health can have a greater impact on health outcomes, the ultimate goal of health financing.

¹⁰¹ Derick Brinkerhoff and Thomas Bossert. *Health Governance: Concepts, Experience, and Programming Options*. Policy Brief. (Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc., February 2008).

¹⁰² Maureen Lewis. *Governance and Corruption in Public Health Care Systems*. Working Paper Number 78. (Washington, DC: Center for Global Development, January 2006). See also Chris Atim. *A USAID Study: Efficient and Transparent Service Delivery in Public Hospitals in Benin, Mozambique and Tanzania. Volume I: Overall, Comparative Report, Final Draft*. (January 2007).

¹⁰³ Lewis (2006) noted that while immunization is a fairly robust indicator of health system effectiveness, child mortality is the outcome of many factors, some of them outside the health sector.

¹⁰⁴ Wagstaff and Claeson, 2004.

¹⁰⁵ The CPIA is scored 1-5 based on performance, part of which is corruption and governance; a CPIA above 3.25 is considered sound.

¹⁰⁶ Brinkerhoff and Bossert, 2008.

Efficient and transparent funding flows in the health sector¹⁰⁷ are closely linked to government leadership and effectiveness, and can have significant implications for how money is spent.

Governments have available a variety of instruments for tracking health expenditures and monitor whether they achieve desired results. In addition to ensuring that health sector priorities receive adequate budgets, governments can implement Public Expenditure Reviews (PER) and Public Expenditure Tracking Surveys (PETS) to assess how resources are spent. These tools are not health specific, but can provide information on the composition of and trends in sector-specific resource allocation. National Health Accounts (NHA) are health-sector specific, and can track both public and private expenditures on health to ascertain how health system resources are used; they provide information about who spends, how much, for what, and for whom. These tools are discussed in more detail below.

PERs and PETS are useful for assessing sectoral allocations and whether budgets reach the operational levels that are needed. A PER is concerned with the revenues and expenditures in the public sector, as expressions of public sector involvement in the economy. PERs can identify whether health sector disbursements match the priorities outlined in the medium-term expenditure framework. The 2004 PER in Uganda,¹⁰⁸ for instance, found that between 2002 and 2003, there was a 3 percentage point decline in health sector budget performance. This was caused by lower than planned wage releases to referred district hospitals, which in turn was caused by unfilled vacancies due to staff shortages.¹⁰⁹

PETS follow the flow of public sector resources to determine how much of the originally allocated resources actually reach the service delivery point. PETS also provide information on *why* resources may have been diverted as they flowed through the system. A review of PETS in Africa found massive leakages of non-wage funds in the health and education sectors.¹¹⁰ Findings of other PETS in Africa, reported by Transparency International, imply that about half of all funds allocated for health efforts in sub-Saharan Africa never reach the clinics and hospitals at the end of the line. A particularly striking example is that of the Ghana PETS, which found that 80 percent of non-salary funds did not reach health facilities. Reasons for the leakage were not easy to identify but could have been a result of poor budget execution, diversion of funds to other legitimate ends, and corruption.¹¹¹ Similar problems were also found in Tanzania and Rwanda. This problem of “local capture,” where government officials and politicians at higher levels of the health system (provincial/regional or district) divert funds meant for lower levels (especially the health facilities), undermines the quality of health care and creates user disaffection with public health facilities.

PETS can highlight low budget execution rates, wherein a sector ministry is unable to spend the entire budget that has been allocated by the finance ministry in the course of a year. This could be due to factors such as long and complex procedures or lack of capacity within the sector ministry or at the level of the finance ministry, and is often characterized as one of “low absorptive capacity,” discussed in more detail below. PETS can also reveal problems of long delays in releasing funds for activities at the operational levels such as districts and health institutions.¹¹² Funds meant to be released in the first quarter may actually be available only in the third or fourth quarter of the fiscal year. As ministry of finance regulations usually require that budgets cannot be carried over to the next fiscal year,

¹⁰⁷ This section draws in part on Chris Atim. 2007. *A USAID Study: Efficient and Transparent Service Delivery in Public Hospitals in Benin, Mozambique and Tanzania. Volume I: Overall, Comparative Report (Final Draft)*. January 2007.

¹⁰⁸ World Bank. *The Republic of Uganda Country Integrated Fiduciary Assessment 2004, Volume II: Public Expenditure Review 2004. Poverty Reduction and Economic Management*. (Washington, DC: 2004).

¹⁰⁹ Gottret and Schieber, 2006

¹¹⁰ Ibid.

¹¹¹ See Magnus Lindelow’s contribution in *Global Corruption Report 2006*. (Transparency International, 2006).

http://www.transparency.org/publications/gcr/download_gcr/download_gcr_2006#download

¹¹² Chris Atim, 2007

operational units are often suddenly compelled to spend considerable sums of money over a relatively short period of time. As a result, normal procedures are sometimes circumvented, checks and controls that might have been in place in normal times may be temporarily suspended, and similar deviations from good practice create an enabling environment for corrupt practices and abuse.¹¹³

Given competing priorities for resources within the health sector, improving the way in which health sector resources are allocated can also give governments more “bang for their buck.” Knowing how resources are actually allocated is an essential first step for improving future allocation. NHA is a tool that can be used to monitor fund flows and estimate all national health expenditures. NHA can therefore be understood as a monitoring and evaluation tool for the health sector as a whole. It allows assessments of how health is financed, what goods and services are bought, who manages funds for health, and who ultimately benefits from public and private sector health spending. NHA can therefore inform government actions to allocate resources to areas that are most consistent with policy priorities and likely to yield the greatest benefit. Several countries that have conducted NHA have successfully advocated for increased health sector allocations. Following the institutionalization of NHA in Rwanda, for example, the Ministry of Health lobbied for increased health sector resources and doubled its health budget between 1999 and 2002. Similarly, Kenya secured a 30 percent increase in its 2006 health budget – the biggest annual increase since 1963.¹¹⁴

These tools – PETS, PERs, and NHA – can help to identify some of the factors contributing to health system-level bottlenecks that inhibit the effectiveness and efficiency of health financing and ideally, can be used in a complementary fashion to inform the design and implementation of health financing policy and reform.

Finally, fiscal decentralization – transferring fiscal responsibility to the district level and sometimes even further to the health facilities themselves – has been attempted in a number of African countries (e.g., Ghana, Senegal, Tanzania, Uganda, and Zambia). The rationale for fiscal decentralization is that devolving fiscal responsibility and authority to lower levels of the health sector can improve efficiency and equity in service delivery as decision-makers are closer to the target population (Robalino et al., 2001).¹¹⁵ Fiscal decentralization may be beneficial where local governments are given the authority to generate revenue. Capacity to cope with new responsibilities at lower levels of the health systems must be developed in tandem.¹¹⁶

Increasing the absorptive capacity of the health system. *Human capacity constraints* in most countries in Africa contribute to ineffective use of financial resources. Sufficient high-quality service delivery cannot take place without the effective deployment of appropriately qualified and motivated staff at all levels of the health system. In particular, a lack of management skills is a critical bottleneck, running through the health sector from the ministry of health headquarters to the smallest health facilities; the not-for-profit health sector is not spared either. It is not uncommon for newly qualified doctors to become the medical officer in charge of a district hospital and hence to be the chief executive of an organization that requires business skills that he/she does not possess. A recent WHO paper calls for strengthening of management capacity by ensuring an adequate number of managers at all

¹¹³ Ibid.

¹¹⁴ Minister of Health of Kenya Charity Ngilu. Keynote address at the Barcelona International NHA Symposium, July 2005 and Former Minister of Health Secretary General of Rwanda Desire Ndushabandi. Keynote Speech at the 2003 National NHA Dissemination Conference in Kigali, Rwanda.

¹¹⁵ David A. Robalino, et al. "Does Fiscal Decentralization Improve Health Outcomes? Evidence from a Cross-Country Analysis." World Bank Policy Research Working Paper No. 2565. (Washington, DC: World Bank, March 2001).

¹¹⁶ This could include revamping management systems and health information systems and enhancing management and monitoring and evaluation at lower levels of the health system.

levels of the health system, building existing managers' competences, improving management support systems, and creating a more supportive work environment.¹¹⁷

Institutional and policy weaknesses can also present obstacles to absorbing and making effective use of large inflows of financing into the health sector. Such weaknesses can be in the laws and regulations that govern public expenditure as well as in the overall process of budgeting and resource allocation. These reduce absorptive capacity when they present an environment that is not conducive to the expeditious release of funds where they are needed.

Donors themselves can work to increase the ability of African governments to absorb aid money by improving the coordination of their efforts. The lack of coordination of donor requirements for supervision, reporting, and monitoring and evaluation exerts great pressure on recipient countries, as over-stretched staff have to duplicate efforts to respond to multiple donor demands. As Clemens and Radelet have noted: "aid missions make huge demands on policymakers – especially the most talented ones."¹¹⁸ Senior staff are left with little time to focus on how smoothly funds are flowing to the lower levels of the health system. The ongoing efforts to implement the recommendations of the Paris Declaration will help to address some of these weaknesses.

In summary, strengthening the underlying health system – through improving the leadership and effectiveness of government, tracking how resources flow through the health sector, and mitigating absorptive capacity constraints by addressing the human resource for health crisis – is a critical component to improving the efficiency of health financing.

5.4.2 PERFORMANCE-BASED FINANCING FOR HEALTH

PBF a specific strategy that has shown promise in sub-Saharan Africa for improving *how* money is spent on health, and making resources go further. PBF links health funding to actual results, rather than the traditional approach of linking funding to inputs. To achieve health results, households, health workers, health facilities, and the systems that knit these partners together need to take effective action. By providing financial incentives to achieve results, PBF seeks to change behaviors of health system actors and reward actions that lead to results. Part of the potential "magic" of PBF is that it provides incentives to households and providers to find on-the-ground solutions to health systems challenges.

The terms "performance-based financing" and "pay for performance" (P4P) refer to a variety of mechanisms by which funds for health care can be tied to concrete, measurable results. PBF can potentially increase utilization of priority services, enhance equity, improve quality, and increase efficiency.¹¹⁹ PBF can address household behaviors, or the "demand side," by stimulating households to take health related actions such as immunizing children and giving birth with the assistance of a skilled attendant. PBF can also address provider behaviors, or the "supply side," by linking part of the payment to health workers and facilities to attainment of pre-determined health targets. PBF can be used to link funds transferred from national to local levels of government and has been used to link funding from an external donor to a government. Below is a sample of interventions in each category¹²⁰:

¹¹⁷ Dominique Egger and E. Ollier. *Making Health Systems Work*. Working paper 8. (Geneva: WHO 2007).

¹¹⁸ Steven C. Radelet. "Absorptive capacity: how much is too much?" Chapter 7 in *Challenging Foreign Aid: A policy makers guide to the Millennium Challenge Account*. (Washington, DC: Center for Global Development, 2003).

¹¹⁹ Rena Eichler and Ruth Levine. *Performance Incentives for Health—Potentials and Pitfalls*. Forthcoming.

¹²⁰ Rena Eichler. *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. February 2006.

- Household or community: Conditional cash transfer (CCT) programs pay monthly subsidies to poor households contingent on children receiving medical check-ups or attending school.
- Service provision: Payments to contracted NGOs or public health facilities can be linked to indicators such as increased immunization coverage; increased deliveries with a skilled attendant; increased use of intermittent presumptive treatment (IPT) to prevent malaria in pregnancy; and appropriate management of long-term or chronic conditions such as HIV/AIDS or TB.
- Health sector: Funds transfer from higher to lower levels of government can be linked to increased utilization of priority services overall or for a priority group.
- Performance-based aid: International aid can also be linked to achievement of health objectives. The GAVI Alliance's performance-based immunization funding is one example of this.

PBF can also be a mechanism to partner with the private sector (e.g., through performance contracts with NGOs or for-profit providers to deliver public health programs) or to address performance issues in the public sector (e.g., through performance incentives to public sector workers or to regional/local governments).

Interest in implementing PBF mechanisms in developing countries has grown considerably in recent years, driven partly by the realization that business as usual is not generating intended improvements in health. Many pilot studies have been implemented, and some of these pilots have been expanded to cover larger proportions of country populations. This section summarizes available evidence, both in Africa and internationally, on the potential contribution of PBF mechanisms to increase technical efficiency and equity in health.

Demand-side PBF interventions

The classic example of a demand-side PBF intervention are CCTs. CCTs give funds to households conditional on evidence of taking defined actions, such as attending health education talks or bringing children to have their growth monitored. A recent systematic review of CCTs to increase the use of health services identified only one instance of CCTs in sub-Saharan Africa. A cluster randomized study in Malawi assessed whether financial incentives would increase the number of people returning to learn the status of their HIV test in rural areas. The incentives increased the percentage of individuals returning to learn the outcome of their test by 50 percent irrespective of the size of the incentive.¹²¹

Because experience with CCTs is so limited in sub-Saharan Africa, we will discuss evidence from other regions. The largest body of evidence for CCTs comes from Latin America. Since 1997, seven Latin American countries have implemented and evaluated CCT programs with health and nutrition components.¹²² A recent review in this region found evidence to suggest that CCTs have consistently increased the use of preventive health services, nutritional and anthropometric outcomes, and preventive behaviors.¹²³ The evidence for improvements in other health status indicators are less consistent.

In Mexico, the CCT scheme *Progres*a (now called *Oportunidades*) provides a fixed monetary transfer to poor households of roughly \$15.50 per month,¹²⁴ provided that children regularly attend school and

¹²¹ R. Thornton. *The demand for and impact of learning HIV status: evidence from a field experiment*. <http://www.stanford.edu/~jayachan/econ214/thornton.pdf>. Accessed March 20, 2008.

¹²² Amanda Glassman et al. *Performance-Based Incentives for Health: Conditional Cash Transfer Programs in Latin America and the Caribbean*. Working Paper. (Washington, DC: Center for Global Development, 2007).

¹²³ Mylene Lagarde et al. "Conditional Cash Transfers for Improving Uptake of Health Interventions in Low- and Middle-Income Countries," *JAMA* 298(16) (2007): 1900-1910.

¹²⁴ This is less than 0.3% of per capita gross national income in Mexico in 2006.

preventive health care appointments, and caregivers participate in health education sessions. An evaluation of the project showed that there was an increase in the average number of preventive health care visits by members of the beneficiary families and a reduction in the likelihood of hospitalization.¹²⁵ Apart from better nutrition, evidence from Mexico also shows that required health education sessions contribute to improved adult health by stimulating healthy behaviors.

One of the first CCT programs implemented in a low-income country, Nicaragua's *Red de Protección Social* (RPS) combines demand-side and supply-side incentives. Monetary transfers are provided to poor households conditional on their children attending school and visiting health care providers, while health care providers are paid on the basis of their performance against predetermined targets. A comprehensive evaluation of the program showed that health outcomes and utilization of health services were substantially improved.¹²⁶

The cost-effectiveness of CCTs relative to standard supply-side interventions is unclear since CCTs have typically been implemented in contexts with relatively adequate health infrastructure and personnel.¹²⁷ Studies from Latin America indicate high costs per beneficiary with high administration costs.¹²⁸ It is important to note that in Latin America, CCTs were implemented as part of social protection programs and are therefore broader in their objectives than CCTs that seek to encourage a specific health action or actions. Unfortunately, there is no information on the cost-effectiveness of CCTs that are not nested in larger social protection programs. Nevertheless, given that public health spending is more restricted in most countries in sub-Saharan Africa than in Latin America, evaluating the cost-effectiveness of CCTs relative to other approaches may be an essential first step in these countries.

A related question is whether cash transfers need to be conditional to improve health service use, given that monitoring conditionality is likely to increase costs. There is some evidence from an *unconditional* cash transfers pilot scheme in Zambia to suggest that cash transfers do not need to be conditional on school attendance to increase attendance.¹²⁹ However, these questions need to be evaluated more comprehensively.

Effective CCT programs also depend on the availability of well-functioning systems to identify eligible families, make conditional payments to them, and account for these payments at lower levels of the health system.¹³⁰ The administrative capacity to carry out these functions well without substantial resource leakages presents an important challenge for sub-Saharan Africa countries. Furthermore, targeting based on criteria such as income involves high costs. This is further complicated by the possibility that a very large proportion of rural populations may meet eligibility criteria in settings with high levels of poverty. In such contexts supply-side approaches or broader demand-side transfer approaches that do not attempt to restrict benefits to a defined sub-group may be more relevant. This is supported by simulation analyses of cash transfer programs to increase school attendance in African countries.¹³¹

¹²⁵ Eichler, 2006

¹²⁶ Glassman et al., 2007; Eichler, 2006

¹²⁷ Lagarde et al., 2007

¹²⁸ Ibid.

¹²⁹ School attendance increased by 16 percent in the first nine months of this pilot. See K. Chapman. *Using social transfers to scale up equitable access to education and health services*. Background paper. (Scaling up services team, DfID Policy Division, 2007).

¹³⁰ Ibid.

¹³¹ Nanak Kakwani, Fabio Soares, and Hyun H. Son. "Cash Transfers for School-Age Children in African Countries: Simulation of Impacts on Poverty and School Attendance." *Development Policy Review* 24 (5) (2006): 553–569.

Supply-side PBF interventions

Supply-side PBF approaches seek to change behavior among public sector and private sector organizations, managers and health workers by linking their payment to measurable indicators of performance.¹³² Supply-side PBF approaches in developing countries have included performance contracts with facility managers and health workers, performance-based contracting of management services from private sector entities for public sector facilities, and performance contracts for the delivery of specified health and nutrition services to private sector organizations like NGOs (“contracting-out”). Countries that have pilot-tested or implemented supply-side PBF in sub-Saharan Africa include Democratic Republic of Congo (DR Congo), Rwanda, and Zambia. We focus on the Rwandan example here because little information is available in the public domain on the impact of PBF in the DR Congo¹³³ or Zambia.¹³⁴

PBF in Rwanda began with pilots in Cyangagu province in 2001 and in Butare province in 2002. In Cyangagu province,¹³⁵ health centers and hospitals entered into performance contracts with a “fundholder” organization that purchases health services. The health facilities were given considerable autonomy to manage service delivery. Each health facility had to create a business plan detailing how it would deliver a good-quality essential health package, which had to be approved by the fundholder before performance contracts could be signed. Service outputs were monitored by the fundholder, while community-based organizations monitored client-perceived quality. High-performing facilities were rewarded with more subsidies by the fundholder. Household surveys conducted in 2003 and 2005 showed that out-of-pocket expenditure decreased by 62 percent, and the proportion of women delivering in a health facility increased from 25 percent to 60 percent.¹³⁶ In Butare province, performance contracts were specified at the institution level with payments linked to the quantity of services provided. Individual health workers also entered into contracts wherein their payments were linked to service volumes for a pre-determined set of services.¹³⁷ Performance was measured through fee-for-service claims submitted and verified by an independent steering committee. Pilot health centers in Butare showed increases of 44 percent in consultations, 221 percent in deliveries referred to hospital, and 84 percent in family planning users.¹³⁸

The Ministry of Health began to expand PBF in May 2006 to all facilities in Rwanda based on the promising pilot results.¹³⁹ Pay is linked primarily to performance on antenatal care, growth monitoring, vaccinations, institutional deliveries, and referrals.¹⁴⁰ Twenty-three of 30 districts were covered by PBF by May 2007.¹⁴¹ The national roll-out is ongoing, but early accounts of the process suggest that findings are positive.¹⁴²

¹³² Eichler, 2006

¹³³ For more information on contracting arrangements in DR Congo see R. Eichler. *Performance based contracting to strengthen health service delivery in the Democratic Republic of Congo*. (Arlington, VA: BASICS Project, August 2004).

¹³⁴ Rebecca Furth. “Zambia Pilot Study of Performance-based Incentives”.
<http://www.who.int/management/zambiapilotperformance.pdf>

¹³⁵ Robert Soeters et al. “Performance-based financing and changing the district health system: experience from Rwanda”. *Bulletin of the World Health Organization* 84(11) (November 2006).

¹³⁶ Ibid.

¹³⁷ Eichler, 2006

¹³⁸ B. Meessens and Health Net International, cited in Eichler, 2006

¹³⁹ L. Rusa. “Rwanda: Performance-Based Financing in Health.” In *Sourcebook: Emerging good practice in managing for development results*. (2007). http://www.mfdr.org/sourcebook/2ndEdition/SourceBook_2E_17_Sept_07_EN.pdf

¹⁴⁰ Author unknown. “Performance-based financing in Rwanda: the country experience.” Presentation at the Performance-based financing workshop, Kigali, Rwanda, May 2, 2007.

¹⁴¹ Rusa, 2007

¹⁴² Ibid.

The effectiveness of PBF strategies depends critically on the strength of the link between performance and payments. This implies that each arrangement must be carefully designed to create the right incentives to address contextual performance problems, and performance must be objectively measured. Furthermore, PBF intervention design needs to take into account the technical and managerial capacity of the entity responsible for monitoring and assessing performance if monitoring is to be credible and effective. The operational implications of monitoring and evaluation capacity include the number and types of performance indicators that can be feasibly assessed and the performance assessment methods that are most appropriate for a given context.¹⁴³

PBF also necessitates a strategic transformation in the role of the entity that is paying for health services from passive funder to active overseer. When PBF is taken to scale, this may require changes in the roles of ministries of health or other public sector entities in developing countries. Ironically, it is precisely in those contexts where PBF is proposed to address performance problems that the ministry of health and other public sector entities often have limited capacity to specify, measure and monitor performance through contracts.¹⁴⁴ One potential short- to medium-term alternative would be to contract a private organization, like an international NGO or local university, to manage and monitor performance contracts. More evidence is needed on the effectiveness and costs of this approach to managing and monitoring performance contracts.

An important gap in the evidence for PBF relates to the costs of measuring and monitoring performance. There is little information on the total costs of implementing PBF, which should also include the costs of specifying performance contracts, managing performance contracts, and measuring performance. On the one hand, independently collected performance data is desirable to ensure objectivity and credibility. On the other hand, third-party evaluation approaches are expensive and do not build the in-house capacity of contracted organizations to monitor their own performance for management purposes.

In balance, the Rwandan experience and experience from other low-income countries like Cambodia¹⁴⁵ suggest that supply-side PBF approaches have tremendous potential for giving governments in sub-Saharan Africa more mileage from resources that are already allocated to health. Gaps do exist in the evidence supporting PBF, but this does not detract from the strong case for learning by doing with phased, evidence-based scale-up.

¹⁴³ In Rwanda, for instance, Soeters et al. 2006 (see above) suggest that the number of output indicators should not, ideally, exceed 25.

¹⁴⁴ N. Palmer, L. Strong, A. Wali, and E. Sondrop. "Contracting out health services in fragile states." *British Medical Journal* 332 (718) (2006).

¹⁴⁵ E. Bloom et al. "Contracting for health: evidence from Cambodia." In: Unpublished Working Paper (Washington, DC: Brookings Institution, 2006); and I. Bhushan et al. "Achieving the twin objectives of efficiency and equity: contracting health services in Cambodia." ERD Policy Brief Series, Number 6. (Manila: Asian Development Bank, Economics and Research Department, 2002).

6. CONCLUSION

This paper comprehensively summarizes the state of health financing in Africa. Slow progress to date on improving health outcomes and meeting financing targets has raised concerns about governments' capacity to finance sustainable health systems, especially given their ability to mobilize domestic revenue.

Only five countries have met the Abuja target as of 2005. However, even if all countries in the region met the Abuja target today, 23 countries would still be spending less than \$34 on health. And given optimistic assumptions about economic growth, tax collection, and allocating 15 percent of government budgets to health, most governments still will not reach the \$34 per capita spending level by 2020.

Meeting these targets would likely require additional resources from donors. A variety of new global aid mechanisms have emerged in recent years, many of which aim to improve coordination among donors and increase the effectiveness of donor spending. However, there are still challenges associated with external assistance for health, such as year-to-year volatility in commitments and disbursements, disease- and intervention-oriented funding, and mismatch with country priorities. The proliferation of new aid mechanisms should not detract from African governments' commitment to finance health care for their citizens.

Given the magnitude of the financing gaps in Africa, it is unlikely that the targeted volume of resources will be available in the foreseeable future. For this reason, equal attention should be paid to the efficiency, predictability, and sustainability of financing flows for health, as well as to the extent to which the appropriate priorities are targeted. A country's resource allocation decisions and health system capacity have significant implications for "how far" spending on health could go.

Currently, the private sector contributes more than half of all health financing in sub-Saharan Africa, but much more could be done to leverage this spending and make it more equitable. Most private spending comes in the form of out-of-pocket spending by households, which can result in impoverishment or prevent individuals from seeking care when needed. To improve the efficiency and effectiveness of household out-of-pocket spending, governments should consider establishing risk pooling arrangements. These may be able to generate new resources for the health sector, and will provide greater financial protection to the poor. In addition, opportunities for formal private sector investment in the health sector are increasing, especially given rapid economic growth rates in much of Africa. Governments should foster these investment opportunities and work to develop public-private partnerships for health service delivery.

Health systems in many African countries are weak. Strengthening health systems is a fundamental step towards increasing the efficiency and effectiveness of health spending. Improving government stewardship and effectiveness, increasing absorptive capacity, and building the capacity of the health workforce makes existing and additional resources go farther. Increased attention to resource tracking, using tools such as NHA, tracks the burden of health financing placed on households as well as reveals the sources and uses of health funds. Using PERs and PETS can help ensure the efficiency and transparency of resource flows to the operational levels where services are delivered.

One promising approach for improving the efficiency of public and private health spending is performance-based financing. Experience to date in Rwanda and in Latin America shows potential for

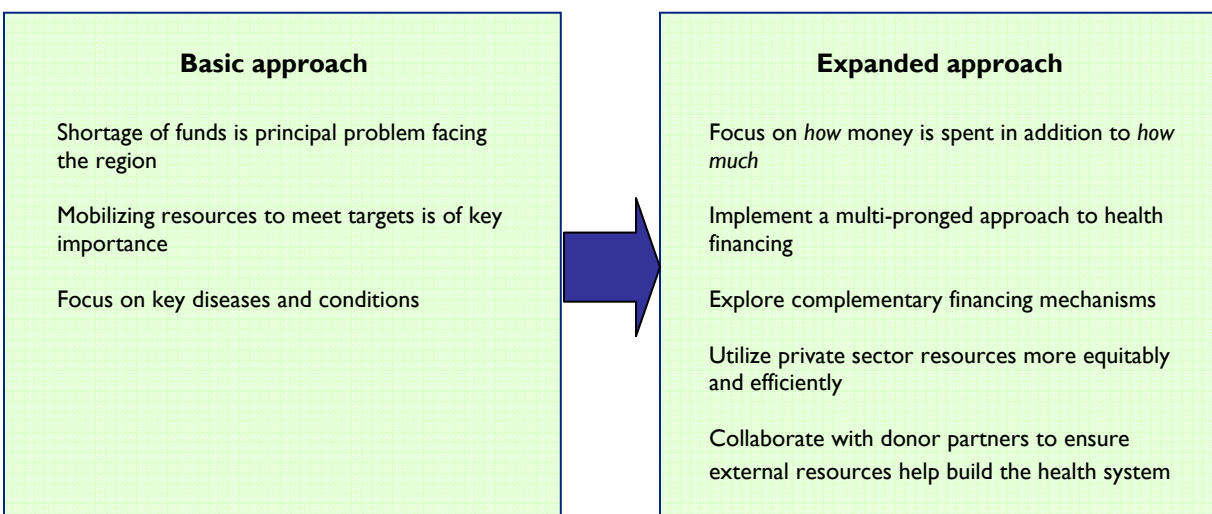
increasing the technical efficiency of service provision, improving the quality of care delivered, and stimulating demand for priority services.

An expanded approach to health financing for sub-Saharan Africa

In the last few decades the international community has emphasized the shortage of health financing in sub-Saharan Africa, international health financing targets, and a focus on key diseases known to take the highest toll in these countries – specifically HIV, TB, and malaria. The result has been greater government financing and an astounding influx of foreign assistance for health in SSA without commensurate improvements in health outcomes. What’s next?

Given the challenges with traditional public sector and donor financing detailed in this paper, it is our conclusion that an expanded approach is warranted. To resolve the health financing constraints that Africa continues to face, this expanded approach would emphasize the following:

1. More money is needed but money alone is not enough. The focus must be on *how* money is spent in addition to *how much*.
2. A multi-pronged approach to health financing reform is essential. Governments, donors, and the private sector all have a role to play.
3. Governments should lead the effort to explore, assess, and implement complementary mechanisms and approaches to health financing, such as risk-pooling initiatives and PBF.
4. Private sector resources should be leveraged more efficiently and equitably for health. The private sector plays a significant role in health financing in Africa, but out-of-pocket payments are burdensome and inequitable. Private investment, public-private partnerships, and risk pooling of household health expenditures should be encouraged.
5. Donor financing is critical to health financing in Africa. The effectiveness of these resources could be increased if funding helped to strengthen the overall health system.



RECOMMENDATIONS

We suggest that **governments** should:

- Demonstrate their commitment to health by increasing budgetary allocations to the health sector;
- Prioritize actions that reflect their unique position to address market failures by ensuring funding for public goods and targeting the poor;
- Take leadership in coordinating health activities in their country within the context of a comprehensive national health plan;
- Take tangible steps to reduce waste and improving the efficiency of service delivery, administration and all other areas of the health system. This will free up resources that can be devoted to productive public expenditures, enhance governments' credibility, and thereby increase their ability to borrow and attract increased external assistance;
- Institute public expenditure management systems and undertake regular tracking of health expenditures to monitor the sources and uses of funds (e.g., through use of NHA). This is particularly important in identifying the burden that households are bearing in paying for their health care;
- Collaborate with the business community where the businesses are financing and/or providing health services and explore whether they can expand their role. Partnerships could be a means to harness private resources for public health goals;
- Maximize the collection of tax revenues by improving tax compliance and administration, upgrading systems and staff capacity, and upholding accountability and anti-corruption measures;
- Promote risk-pooling initiatives, either at the community level or above as appropriate, 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;
- Implement pilot tests of PBF arrangements, engaging technical assistance as necessary to ensure careful design and effective monitoring and evaluation systems.

We suggest that **donors** should:

- Channel their development assistance to health systems strengthening;
- Provide more predictable funding with regard to the sustainability of the programs they support;
- Promote government leadership by continuing tangible progress towards implementing the Paris Principles for donor coordination and building the capacity of MOH staff to effectively manage and/or coordinate activities in the sector;
- Offer technical assistance to strengthen public expenditure management within the health sector in order to promote effective design and execution of health sector programs.

ANNEXES

ANNEX I. A NOTE ON DATA LIMITATIONS

The health expenditure information presented in this paper was taken primarily from the World Health Organization's Statistical Information System (WHOSIS, <http://www.who.int/whosis>) and the World Bank's World Development Indicators (WDI, <http://www.worldbank.org>). Both sources in turn derive their estimates from several sources, including International Monetary Fund data, United Nations statistics, National Health Accounts (NHA), public expenditure reviews, and other public and private reports – and use estimation and extrapolation to fill in missing data. According to WHOSIS, about 100 countries have produced at least one full NHA or have reported their health expenditures to the Organisation for Economic Co-operation and Development (OECD). Some portion of the time series from 1998 to 2005 presented on the WHOSIS and WDI Web sites are therefore based on extrapolation of available data.

This extrapolation has particular implications when drawing inferences from these data. According to the NHA methodology, total health expenditures consist of three mutually exclusive categories – public, private, and “rest of the world” (i.e., primarily international donors). However, WHOSIS channels “external resources” into either public or private spending and thus they do not constitute a mutually exclusive category. Because public and private expenditures include some external assistance, it is difficult to ascertain whether a country has (for instance) reached the Abuja target because a significant amount of donor resources are being counted as “public” expenditures, or whether additional domestic resources have been allocated to health. As readers interpret the statistics in this paper, it is important to keep these caveats in mind. Institutionalizing the NHA process at the country level would greatly facilitate generating sound evidence to inform policy priorities and planning for the health sector.

ANNEX 2. DISTRIBUTION OF COUNTRIES BY SUB-REGION AND INCOME CATEGORY

Distribution of countries by sub-region of Africa

Western		Central	Eastern		Southern
Benin	Mali	Angola	Burundi	Rwanda	Botswana
Burkina Faso	Mauritania	Cameroon	Comoros	Tanzania	Lesotho
Cape Verde	Niger	CAR	Eritrea	Uganda	Namibia
Côte d'Ivoire	Nigeria	Chad	Ethiopia	Zambia	South Africa
Gambia	Senegal	Congo	Kenya	Zimbabwe	Swaziland
Ghana	Sierra Leone	DR Congo	Madagascar	Seychelles	
Guinea	Togo	Gabon	Malawi		
Guinea-Bissau	Eq. Guinea	Sao Tome &	Mozambique		
Liberia		Principe	Mauritius		

Distribution of countries by GDP per capita (2005)

<\$250	\$250-\$499		\$500-\$999	\$1,000+	
Burundi	Madagascar	Mali	Nigeria	Angola	South Africa
DR Congo	Niger	Guinea	Chad	Congo	Seychelles
Ethiopia	Uganda	Burkina Faso	Benin	Cape Verde	
Eritrea	Gambia	Ghana	Comoros	Swaziland	
Liberia	Mozambique	Zimbabwe	Lesotho	Namibia	
Malawi	Tanzania		Senegal	Eq. Guinea	
Sierra Leone	CAR		Cameroon	Mauritius	
Guinea-Bissau	Togo		Côte d'Ivoire	Gabon	
Rwanda	Sao Tome &		Mauritania	Botswana	
	Principe		Zambia		
			Kenya		

ANNEX 3. TABLES INCLUDING SOUTH AFRICA

Annex Table 3.1. Key population health characteristics in Sub-Saharan Africa, by sub-region and income group

Sub-region	Number of countries	Total population (000s)	Adult HIV prevalence (2005)	TB prevalence per 100,000 population (2004)	Maternal Mortality Ratio (2000 estimates)	Infant Mortality Rate (2004)	Life expectancy at birth (male) (2004)	Life expectancy at birth (female) (2004)	Population growth rate (2005)
Western	15	271,992	3.0%	505	860	104	46.5	48.3	2.6%
Central	7	111,868	3.7%	456	1044	122	43.4	47.2	2.5%
Eastern	13	278,059	7.9%	581	1019	93	47.5	49.1	2.5%
Southern	5	53,860	17.4%	532	242	55	46.5	48.6	1.2%
GDP per capita (2005)									
Less than \$250	9	179,384	4.1%	554	1032	118	45.2	48.3	2.7
\$250 to \$499	13	202,113	5.7%	494	1016	90	47.7	49.6	2.6
\$500 to \$999	10	260,163	4.7%	557	821	98	46.4	47.6	2.4
\$1000 or more	8	74,118	13.2%	472	564	77	45.6	48.2	1.6
Total	40	715,779	5.9%	530	902	99	46.4	48.4	2.4

Source: World Bank World Development Indicators (WDI) database 2008 and WHO Information System (WHOSIS), <http://www.who.int/whosis/en/>

Includes South Africa. Excludes countries with populations <1 million, Sudan and Somalia. Estimates are weighted by population size.

Annex Table 3.2. Health financing in Sub-Saharan Africa, by sub-region and income group (2005)

Sub-region	Number of countries	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.	External resources for health as % of total health exp.
Western	15	271,992	\$598	\$26	5%	34%	66%	11%
Central	7	111,868	\$684	\$22	7%	50%	50%	9%
Eastern	13	278,059	\$314	\$16	10%	51%	49%	33%
Southern	5	53,860	\$4,879	\$405	10%	43%	57%	1%
GDP per capita								
Less than \$250	9	179,384	\$152	\$7	11%	55%	45%	41%
\$250 to \$499	13	202,113	\$340	\$19	11%	44%	56%	29%
\$500 to \$999	10	260,163	\$693	\$30	5%	35%	65%	10%
\$1000 or more	8	74,118	\$4,222	\$310	9%	44%	56%	1%
Total	40	715,779	\$823	\$50	8%	43%	57%	7%

Notes:

1. Includes South Africa. Excludes countries with populations <1 million, Sudan and Somalia.
2. Total health expenditures are broken down into government and private expenditures. External resources for health include all grants and loans for health goods and services, in cash or in kind. These pass through governments or private entities and are not mutually exclusive categories. As a result, government health expenditures are likely overstated as a percent of total health expenditures.
3. All estimates are weighted by population size.
4. Source: World Bank World Development Indicators (WDI) database 2008 and WHO SIS, <http://www.who.int/whosis/en/>.

Annex Table 3.3. Private health expenditures in Sub-Saharan Africa, by sub-region

Sub-region	Out-of-pocket exp. as % of total health exp.	Other private health exp. as % of total health expenditures
Western	59%	7%
Central	48%	2%
Eastern	33%	16%
Southern	10%	47%
GDP per capita		
Less than \$250	35%	10%
\$250 to \$499	41%	14%
\$500 to \$999	58%	7%
\$1000 or more	11%	44%
Total	20%	38%

Notes:

1. Includes South Africa. Excludes countries with populations <1 million, Sudan and Somalia.
2. Out-of-pocket expenditures are direct outlays (monetary and in-kind) by households for health services.
3. Other private health expenditures include payments by private pre-paid plans, employers, and NGOs.
4. Estimates are weighted by population size.
5. Source: World Bank World Development Indicators (WDI) database 2008.

ANNEX 4. HIPC ASSISTANCE TO AFRICAN COUNTRIES

AFRICAN COUNTRIES THAT HAVE QUALIFIED FOR, ARE ELIGIBLE OR POTENTIALLY ELIGIBLE, AND MAY WISH TO RECEIVE HIPC INITIATIVE ASSISTANCE (MARCH 2008)

Post-Completion-Point Countries (19)		Interim Countries (Between Decision and Completion Point) (8)	Pre-Decision-Point Countries (6)
Benin	Mauritania	Burundi	Comoros
Burkina Faso	Mozambique	Central African Republic	Côte d'Ivoire
Cameroon	Niger	Chad	Eritrea
Ethiopia	Rwanda	Democratic Republic of the Congo	Somalia
The Gambia	São Tomé & Príncipe	Guinea	Sudan
Ghana	Senegal	Guinea-Bissau	Togo
Madagascar	Sierra Leone	Republic of Congo	
Malawi	Tanzania	Liberia	
Mali	Uganda		
	Zambia		

Source: <http://www.imf.org/external/np/exr/facts/hipc.htm>

ANNEX 5. EXAMPLES OF PRIVATE EMPLOYERS FINANCING HEALTH CARE IN SUB-SAHARAN AFRICA

Below are selected examples of employer involvement in the financing of health care in Africa.

- *AngloGold, Ghana:* AngloGold, a mining company, financed and implemented a broad-based malaria control program in Ghana that incorporated both staff and surrounding communities.¹⁴⁶ The AngloGold Ashanti Obouasi mine identified between 6,000 and 7,000 cases of malaria monthly among its employees, their families, and its contractors and subsequently implemented an integrated malaria control program that covers a population of about 230,000 both in the mining town and in the surrounding districts. Between program commencement in April 2006 and January 2007, malaria cases in the community declined by 49 percent.
- *BHP Biliton, Mozambique:* In 1999, a tri-national malaria control program was launched with support from the Mozal aluminium smelting project (BHP Biliton). The program focuses on reducing new malaria infections in Southern Mozambique and the border areas of South Africa and Swaziland. Within two years of program commencement, average malaria infection rates dropped by 40 to 50 percent in program areas.¹⁴⁷
- *CocaCola:* CocaCola is the largest private sector employer in Africa.¹⁴⁸ In 2000, CocaCola announced the provision of health care benefits (including antiretroviral drug coverage) to its employees. In 2002, these benefits were extended to the employees and spouses of 40 CocaCola bottlers across Africa at an estimated cost of \$4-5 million.¹⁴⁹
- *Shell Petroleum Development Corporation, Nigeria:* Shell's major oil and gas fields are located in the malaria-endemic Niger delta region of Southern Nigeria. In 2004, Shell implemented a malaria/health integration project which seeks to reduce malaria morbidity and mortality among vulnerable groups such as women and children under 5. The project interventions are in line with Roll Back Malaria strategies and include both prevention and treatment services.¹⁵⁰ Shell has also established health facilities to provide general health services to local communities. In 2003, Shell estimates that over 135,000 patients were treated in its facilities and close to 740,000 children were immunized.¹⁵¹

¹⁴⁶ Global Business Coalition case studies. <http://www.businessfightsaids.org/live/cases/cases.php?id=41> . Accessed March 17, 2008.

¹⁴⁷ <http://www.bhpbiliton.com/bb/sustainableDevelopment/socialResponsibility/communityProjects/malariaControlInMozambique.jsp>. Accessed March 17, 2008.

¹⁴⁸ J.J. Asongu. "CocaCola's Response to HIV/AIDS in Africa: A case study in corporate social responsibility." *Journal of Business and Public Policy* 1(1) (2007).

¹⁴⁹ Ibid.

¹⁵⁰ Global Business Coalition case studies. <http://www.gbcpact.org/live/cases/cases.php?id=48>. Accessed March 17, 2008.

¹⁵¹ http://www.shell.com/home/Framework?siteId=nigeria&FC2=/nigeria/html/iwgen/society_environment/health/zzz_lhn.html&FC3=/nigeria/html/iwgen/society_environment/health/basic_healthcare.html. Site accessed March 17, 2008.

ANNEX 6. INNOVATIVE INTERNATIONAL FINANCING MECHANISMS

Innovative International Financing Mechanisms					
A. Mechanisms aimed primarily at providing new resources for specific diseases or interventions					
Mechanism	Description	Objectives	Funding Level	Achievements	Key Source
President's Emergency Plan for AIDS Relief (PEPFAR) ¹⁵²	PEPFAR is a multifaceted approach to combating the global HIV/AIDS pandemic in more than 120 countries around the world. PEPFAR has a very strong emphasis on the provision of treatment and care for people with AIDS, with only a fifth of the money oriented to HIV prevention work.	To support the multisectoral national responses in host nations, adapting U.S. support to the individual needs and challenges of each nation where the PEPFAR is at work.	Original commitment of \$15 billion across 5 years, and a final funding level of \$18.8 billion. Divided along following priorities: 55% for the treatment of individuals with HIV/AIDS; 15% for the palliative care of individuals with HIV/AIDS; 20% for HIV/AIDS prevention (of which at least 33% is to be spent on abstinence until marriage programs); and 10% for helping orphans and vulnerable children. For the years 2006 through 2008, 41% of the total money is to be spent on the purchase and distribution of antiretroviral drugs.	Supported prevention of mother-to-child transmission (PMTCT) for women during more than 10 million pregnancies. For PMTCT clients who have been found to be HIV-positive, antiretroviral prophylaxis has been provided in over 827,000 pregnancies, preventing an estimated 157,000 infant HIV infections. With PEPFAR support, focus countries have scaled up their safe blood programs, and 11 of them can now meet more than half of their annual demand for safe blood, up from only four when PEPFAR started. PEPFAR has supported	http://www.pepfar.gov

¹⁵² Achievements cover FY2004-FY2007.

¹⁵³ The Power of Partnerships: Fourth Annual Report to Congress on PEPFAR (2008) http://www.pepfar.gov/press/fourth_annual_report/.

Innovative International Financing Mechanisms

A. Mechanisms aimed primarily at providing new resources for specific diseases or interventions

Mechanism	Description	Objectives	Funding Level	Achievements	Key Source
				<p>HIV counseling and testing for over 33 million people to date, and supported care for more than 6.6 million people infected or affected by HIV/AIDS, including 2.7 million orphans and vulnerable children.</p> <p>Through September 2007, PEPFAR partnerships have supported antiretroviral treatment (ART) for approximately 1.45 million men, women, and children, approximately 1.36 million of whom live in 15 PEPFAR focus countries, and over 1.33 million of whom are in sub-Saharan Africa.¹⁵³</p>	
President's Malaria Initiative (PMI)	PMI uses a comprehensive approach to prevent and treat malaria, supporting four key areas – indoor spraying of homes with insecticides, insecticide-treated mosquito nets, lifesaving antimalarial drugs, and treatment to	To reach 85% of the most vulnerable groups (children under 5 years of age and pregnant women) with proven and effective prevention and treatment measures To reduce deaths due to malaria by 50% in 15 African countries.	In June 2005, President Bush pledged to increase U.S. funding for malaria by more than \$1.2 billion over five years.	In Zanzibar , ¹⁵⁴ among children tested, laboratory-confirmed malaria dropped to 1% in 2007 from 25% in 2005; in a 2007 household survey, no pregnant women were found to have malaria. Malaria is considered to be “controlled” in	http://www.fightingmalaria.gov/

¹⁵⁴ It should be noted that Zanzibar is an island with a population of less than one million people.

¹⁵⁵ Source: President's Malaria Initiative E-Newsletter. March 2008. <http://www.fightingmalaria.gov/news/enews/index.html>

Innovative International Financing Mechanisms

A. Mechanisms aimed primarily at providing new resources for specific diseases or interventions

Mechanism	Description	Objectives	Funding Level	Achievements	Key Source
	prevent malaria in pregnant women. PMI is active in six African countries: Tanzania, Uganda, Rwanda, Benin, Liberia, and Ghana. The last three have only recently (2007/2008) started activities.			Zanzibar. In Uganda , a total of 1,358,982 nets have been procured and distributed by PMI. PMI has procured and distributed more than 220,000 artemisinin-based combination treatments (ACTs) to health facilities and to community drug distributors. In Rwanda , PMI supported the training of 250 health workers on how to prevent malaria in pregnancy and procured and distributed a one-year national supply of IPTp (1.75 million tablets of sulfadoxine-pyrimethamine). ¹⁵⁵	
UNITAID	UNITAID is an international drug purchase facility, and will be funded primarily by a solidarity levy on airline tickets. Initially suggested by the French government, so far 18 countries (including African countries Côte d'Ivoire, Congo,	To provide long-term, sustainable and predictable funding to increase access and reduce prices of quality drugs and diagnostics for the treatment of HIV/AIDS, malaria, and TB in developing countries.	Budget for 2006/2007 was \$383.2 million and is anticipated to reach \$500 million in 2009.	The project has negotiated reductions in the price of antiretroviral drugs (ARVs) on average by 40%. It is funding the supply of diagnostics and treatment for more than 102,000 children, including more than 62,000 new treatments, in 38	http://www.unitaid.eu/

Innovative International Financing Mechanisms

A. Mechanisms aimed primarily at providing new resources for specific diseases or interventions

Mechanism	Description	Objectives	Funding Level	Achievements	Key Source
	<p>Madagascar, Mauritius, and Niger)¹⁵⁶ have announced plans to support this initiative. The core donor group comprises Brazil, Chile, France, Norway and the United Kingdom. France set the tax in December 2005 for flights originating in France at one Euro (\$1.6) and 10 Euro (\$16) for economy and business/first class seats respectively for flights within the European Union (EU); for flights to destinations outside the EU the tax is 4 Euro (\$6.4) for economy and 40 Euro (\$64) for business/first class. UNITAID does not fund countries directly but its Board selects project proposals from partners such as UNICEF, the Clinton Foundation, the WHO, and the Global Fund and it is these</p>			<p>developing countries.¹⁵⁷</p>	

¹⁵⁶ Additionally, the following African countries are also in the process of implementing such a tax: Benin, Burkina Faso, Cameroon, Gabon, Guinea, Liberia, Mali, Namibia, Central African Republic, Senegal, São Tomé and Príncipe, and Togo.

¹⁵⁷ UNITAID Fact Sheet. January 2008. <http://www.unitaid.eu/images/action/factsheet.pdf>

Innovative International Financing Mechanisms

A. Mechanisms aimed primarily at providing new resources for specific diseases or interventions

Mechanism	Description	Objectives	Funding Level	Achievements	Key Source
	partners who deal with country requests.				
Advance Market Commitments (AMCs)	AMCs are a new approach to public health funding designed to stimulate the development and manufacture of vaccines for developing countries. Donors commit money to guarantee the price of vaccines once they have been developed, thus creating the potential for a viable future market.	To provide incentives for vaccine developers to accelerate the development of promising vaccines or bring such products to markets where the returns would otherwise have been considered too low or unpredictable to justify the investments – particularly where the demand for the vaccine is only in low-income countries.	Initial commitment by donors of \$1.5 billion. ¹⁵⁸ Developing country governments will take on an increasing share of the cost over time according to ability to pay; GAVI Alliance will provide a subsidy. ¹⁵⁹	A pilot project is currently under development for pneumococcal vaccine, and if successful, could be extended to similar vaccines currently in the pipeline such as malaria or TB. During the pilot stage, donors, the GAVI, and developing country recipients of the vaccine will share in the cost.	http://www.vaccineamc.org/

¹⁵⁸ Donors include: Canada, Italy, Norway, Russia, the United Kingdom, and the Bill and Melinda Gates Foundation. On February 9, 2007, these donors committed US\$1.5 billion.

¹⁵⁹ Source: <http://www.vaccineamc.org/mechanism.html>

<p>The Affordable Medicines Facility-malaria (AMFm) *formerly the Global ACT Subsidy</p>	<p>AMFm is a proposal to increase the use of ACT and other effective antimalarial combinations, and to eliminate the use of ineffective drugs and monotherapies. Developing countries will be able to access this mechanism when they purchase ACTs from approved manufacturers by making a co-payment with the balance paid by AMTm. First-line buyers will place orders for ACTs with manufacturers; eligibility for purchase will be established; orders will be fulfilled by manufacturers; and (upon receipt of product by the buyer, e.g., ministry of health) co-payment will be sent to the manufacturers by both buyers and the AMFm.¹⁶⁰</p>	<p>To reduce the price of ACT by providing a co-payment to manufacturers, which would allow first-line buyers to purchase effective antimalarials at prices comparable to ineffective older drugs, such as chloroquine.</p>	<p>The total resource requirements for the AMFm will be \$1.4–1.9 billion for the first five years. Donors have committed themselves to finance the AMFm fund with an initial deposit of \$1.5 billion. Technical work on the implementation of the facility is still in progress as of April 2008.</p>	<p>None yet at country level. A preliminary draft of the Global Malaria Business Plan (GMBP) will be presented at the 14th Annual Roll Back Malaria Board Meeting in May 2008. This document will set the strategy, vision, and goals as well as the specific actions needed to achieve them.</p>	<p>http://www.rbm.who.int/globalsubsidytaskforce.html</p>
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160 Affordable Medicines Facility-malaria (AMFm). Technical Design. November 2007. Roll Back Malaria Partnership. <http://www.rollbackmalaria.org/partnership/tf/globalsubsidy/AMFmTechProposal.pdf>

International Finance Facility for Immunization (IFFIm)	IFFIm was created in 2006 to raise capital for GAVI Alliance by frontloading government donations to introduce new and underused vaccines and support country-specific programs through the sale of bonds on the open market. Countries cannot apply directly to the IFFIm but rather have to apply to GAVI as they normally would. GAVI makes requests to the IFFIm depending on its needs for funding. In 2006 it requested funding amounting to \$525 million which was disbursed for approved programs including: yellow fever and polio vaccine stockpiles; measles mortality reduction; maternal and neonatal tetanus elimination; pentavalent procurement guarantee; and country-specific	To raise funds through private financial markets that would be serviced essentially by future donor government aid budgets.	Seven donors and others have committed to pay a total of approximately \$3 billion within the next 20 years.	A total of \$1 billion was raised in the first offering in November 2006 and nearly \$900 million has been disbursed in 43 countries. ¹⁶¹ As of December 31, 2006, IFFIm's financial base consisted of irrevocable and legally binding grants from six Sovereign Grantors, and the aggregate net present value of the grants, after year end fair value adjustment, was \$2.15 billion. ¹⁶² IFFIm bond worth \$223 million offered on Japanese market.	http://www.iff-immunisation.org/
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¹⁶¹ As of January 2008.

¹⁶² The International Finance Facility for Immunization. Report of the Trustees and Financial Statements For the period ended 31 December 2006.

	programs.				
Global Drug Facility	The Global Drug Facility was established in 2001 and is administered by the WHO through the Stop TB Partnership.	Its mandate is to “build new international approaches towards ensuring universal access to, and efficient national systems of procurement and distribution of anti-TB drugs.” ¹⁶³ It accomplishes its mandate by addressing three constraints to the availability of TB drugs: 1) lack of financial resources for anti-TB drugs; 2) inefficient procurement systems; and 3) inadequate quality assurance procedures. ¹⁶⁴	Between 2001 and 2006 various partners put in \$128 million into the facility. ¹⁶⁵	According to Matiru and Ryan (2007), ¹⁶⁶ through its Grant Services and Direct Procurement Services the GDF had provided 9 million life-saving anti-TB drug treatments in 78 countries as of 2006, covering 20% of the world’s TB patients. It has secured competitive prices for high-quality anti-TB drugs through the use of international tendering mechanisms, pooled demand, and systematized forecasting. The GDF’s prices for anti-TB drugs were, on average, one-third less than previous international tenders. Through its technical assistance services, it has also strengthened	http://www.stoptb.org/gdf/

¹⁶³ R. Matiru and R. Ryan. “The Global Drug Facility: a unique, holistic and pioneering approach to drug procurement and management.” *Bulletin of the World Health Organization* 85(5) (May 2007).

¹⁶⁴ Ibid.

¹⁶⁵ World Health Organization. *GDF Achievements Report*. (Geneva: 2007).

¹⁶⁶ <http://www.gavialliance.org/vision/policies/hss/index.php>

¹⁶⁶ Matiru and Ryan, 2007

				supply chain systems in recipient countries as well as training staff in drug procurement, thus helping to strengthen health systems.	
Global Fund to Fight AIDS, Tuberculosis, and Malaria	The Global Fund is an independent public-private partnership that was first proposed by UN Secretary-General Kofi Annan in 2001 and officially established in 2002. ¹⁶⁷	To raise funds and pool money from governments, businesses, and individuals around the world, and channel them into grant programs to fight the three key diseases.	Around 50 countries have pledged money to the Global Fund so far, many of which are developed nations but pledges have also been received from countries directly affected by AIDS, TB, and malaria. The biggest single donor country is the United States, whose donations make up around 33% of the funds pledged every year. Contributions also come from large organizations such as the Gates Foundation. As of January 2007, about 55% of the Global Fund's money was going to sub-Saharan African nations.	Global Fund funding was paying for 1.4 million people on ARVs and 3.3 million people receiving directly observed TB treatment, and for the purchase of 46 million bed nets. ¹⁶⁸	http://www.theglobalfund.org/

¹⁶⁷ See AVERT Web site: <http://www.avert.org/global-fund.htm>

¹⁶⁸ Michel Kazatchkine, Executive Director of the Global Fund, during a presentation at the UK Parliament's All Party Malaria Group (APPMG) meeting on January 21, 2008.

			<p>After the first 7 rounds of Global Fund funding allocations (December 2007), the Global Fund Board had approved \$10.1 billion, signed \$8 billion in grants and disbursed \$5 billion. Global Fund allocations to the three major diseases were as follows: HIV/AIDS 61%; TB 14%; malaria 25%.</p>		
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Innovative International Financing Mechanisms

B. Mechanisms aimed primarily at providing new resources for improving aid effectiveness and efficiency

Mechanism	Description	Objectives	Funding Level	Achievements	Key Source
GAVI Alliance and the GAVI Health System Strengthening Initiative (GAVI HSS)	<p>The GAVI Alliance is an international coalition of partners in both the private and public sectors.</p> <p>This fund is available to all GAVI-eligible countries and has the potential to significantly impact on the health systems bottlenecks that impede not only immunization coverage, but health services delivery in general. This is an example of an intervention-specific source of funding reaching beyond its vertical objectives and developing the health system as a whole.</p>	<p>GAVI: To improve access to sustainable immunization services; expand use of all existing cost-effective vaccines; accelerate introduction of new vaccines; accelerate research and development on vaccines for developing countries; and make immunization coverage a centrepiece in international development efforts.</p> <p>GAVI HSS: To help countries overcome health system weaknesses that impede sustainable increases in immunization coverage.¹⁶⁹</p>	<p>GAVI: The GAVI multi-year commitments to GAVI-eligible countries totaled \$1.48 billion. They include \$343 million for immunization services support, \$115 million for injection safety and US\$1.02 billion for new and underused vaccines. The total resources actually disbursed to GAVI-eligible countries amounted to US\$712 million.</p> <p>GAVI HSS: Alliance Board has committed US\$800 million over a five-year period.</p>	<p>GAVI: An estimated 115 million additional children were vaccinated; an estimated 15 million additional cumulative children reached with basic vaccines; more than 1 billion auto-disable syringes were provided to GAVI-eligible countries; and, Some countries have begun to show some commitment to financing of national immunization programs. In 2005, 11 of 72 countries voluntarily contributed government resources to new and underused vaccine financing.¹⁷⁰</p> <p>GAVI HSS: Support through this fund only became available in 2007 and therefore it is not possible to evaluate its impact thus far.</p>	<p>http://www.searo.who.int/en/Section1243/Section2448.htm</p>

¹⁶⁹ <http://www.gavialliance.org/vision/policies/hss/index.php>

¹⁷⁰ GAVI Secretariat. *GAVI Alliance Strategy (2007-10)*. (GAVI, June 6, 2006).

Innovative International Financing Mechanisms

B. Mechanisms aimed primarily at providing new resources for improving aid effectiveness and efficiency

Mechanism	Description	Objectives	Funding Level	Achievements	Key Source
International Health Partnership Plus (IHP+)	Launched on September 5, 2007, in London, the IHP+ is a coalition of international health agencies, governments, and donors committed to improving health and development outcomes in developing countries and getting back on track to reach the health-related Millennium Development Goals.	To better harmonize and align international support to strengthen health systems in developing countries.	Bilateral donors include the UK, Norway, France, Canada, Germany, Italy, and the Netherlands. The development agency signatories are: African Development Bank, European Commission, the Gates Foundation, GAVI Alliance, the Global Fund, the World Bank, WHO, UNAIDS, UNDP, UNFPA, and UNICEF.	None as yet at country level. Seven 'first wave' countries in Africa and Asia announced that they would join: Burundi, Cambodia, Ethiopia, Kenya, Mozambique, Nepal and Zambia.	http://www.who.int/healthsystems/ihp/en/index.html
Debt2Health	The Global Fund identifies and negotiates debt conversion opportunities and then facilitates a three-party agreement among creditors, the beneficiary country, and the Global Fund. Under a Debt2Health agreement, creditors forgo repayment of a portion of their sovereign debts on the condition that the beneficiary country invests an agreed upon amount in health through a Global Fund-approved program.	To free up domestic resources through debt relief that can be invested in urgent public health needs in the fight against HIV/AIDS, TB, and malaria.	Debt volume offer of US\$250 million is expected. It is difficult to estimate how much this will translate into in funds for Global Fund programs, as the conditions of the debt swap will vary among creditors. A conservative estimate is US\$125 million.	The Debt2Health pilot phase is being implemented in Indonesia, Kenya, Pakistan, and Peru. Germany has made the first offer to forgo repayment of 50 million Euro on the condition that Indonesia invests the equivalent of 25 million Euro in health through approved Global Fund programs.	http://www.theglobalfund.org/en/files/about/replenishment/berlin/English-QA-D2H.pdf http://aidsalliance.bluestatedigital.com/page/-/PDFs/Debt2Health_Factsheet_August_2007.pdf

Innovative International Financing Mechanisms

B. Mechanisms aimed primarily at providing new resources for improving aid effectiveness and efficiency

Mechanism	Description	Objectives	Funding Level	Achievements	Key Source
International Development Association (IDA) Buy-downs	An IDA “buy-down” refers to a third-party donor paying off all or part of a specific IDA credit on behalf of a government. ¹⁷¹ A country receives an IDA credit to help support specified development activities, such as polio eradication.		A partnership of the United Nations Foundation, Rotary International, and the U.S. Centers for Disease Control and Prevention (CDC) has established a trust fund with US\$25 million from the Gates Foundation and US\$25 million from Rotary International and the United Nations Foundation. This US\$50 million investment has the potential to buy down roughly US\$125 million in IDA loans. ¹⁷² Each dollar of the buy-down has the potential to ‘unlock’ approximately US\$2.50 for polio eradication.	To date, the buy-down mechanism has been piloted for polio eradication projects in Nigeria and Pakistan,	http://www.ncbi.nlm.nih.gov/books/bv.fcgi?indexed=google&rid=dcp2.box.1541
Roll Back Malaria (RBM)	The RBM Partnership is a coalition of partners including malaria-endemic countries, their	To work together to enable sustained delivery and use of the most effective prevention and	The Partnership has a budget of approximately US\$8 million annually. Advocacy efforts involve	successfully mobilized the collective efforts of the international agencies, bilaterals, the	http://www.rollbackmalaria.org

¹⁷¹ Excerpt from: Delhi GAVI Board meetings 6-7 December 2005. GAVI Secretariat, 22 November 2005. Doc A.9 IDA Buy-downs.

¹⁷² Robert Hecht and Raj Shah. “Disease Control Priorities in Developing Countries.” Chapter 13 in *Recent Trends and Innovations in Development Assistance for Health*. (The World Bank/Oxford University Press, 2006).

Innovative International Financing Mechanisms

B. Mechanisms aimed primarily at providing new resources for improving aid effectiveness and efficiency

Mechanism	Description	Objectives	Funding Level	Achievements	Key Source
	<p>bilateral and multilateral development partners, the private sector, nongovernmental and community-based organizations, foundations, and research and academic institutions.</p>	<p>treatment for those affected most by malaria by promoting increased investment in health systems and incorporation of malaria control into all relevant multisector activities.</p>	<p>calling for increasing in donor and country resources for prevention, treatment and research and increasing research and development for new drugs, vaccines, and diagnostics.</p>	<p>NGO community and others to promote a 'can-do' attitude that represents a sea-change in perspective compared with the fatalism of just a decade before. generating a broad consensus among partners around a strategy to organize malaria control activities.¹⁷³</p>	

¹⁷³ World Health Organization. "Final Report of the External Evaluation of Roll Back Malaria: Achieving Impact – Roll Back Malaria in the Next Phase". Chapter 2: Roll Back Malaria to Date. http://rbm.who.int/cmc_upload/0/000/015/905/ee_toc.htm. Accessed May 8, 2008.

