



Innovations in Domestic Health Financing and Efficient Use of Health Resources in Africa and Beyond

Introduction

Globally and in Africa, health¹ is recognised as critical for sustainable development and there has been growing pressure on governments to allocate adequate resources to health. This brief starts by highlighting global and regional commitments that African countries have ratified that focus on health and domestic health financing and the status, challenges and opportunities for African governments to translate these commitments at country level.

The brief then highlights three key innovations in domestic health financing and efficient use of resources being implemented and explored in Africa and elsewhere. This brief is based on a rapid review of existing evidence and offers some examples of domestic health financing innovations primarily to stimulate discourse and further action by decision-makers.



Out-of-pocket (OOP) spending on health exceeded 20% of the current health expenditure in 41 AU Member States, with some countries such as Uganda and Mauritius recording OOP expenditure of 40% of the current health expenditure (5).

One major problem is that African governments invest much less in the health sector in comparison to other sectors. For example, an analysis of the proportion of Kenya's government budget allocation by sector for the fiscal year 2020/21 revealed that the health sector was not among the top five sectors by level of government investment (6). The proportion of Kenya's government budget that was allocated to the health sector was 6.5% compared to nearly 30% to the education and energy sectors and around 10% to three other sectors.

Another key challenge is that the health budgets of many African countries constitute a large share that is supported by donor funding and, yet, at the same time development assistance for health is declining (7, 8). This pattern is illustrated in Figure 1, which presents the health budgets for select countries by source of funding.

African governments also tend to allocate a larger share of their health budgets to curative care and much less to preventive care (7). Yet, evidence shows that investing more in preventive care has potential to greatly improve health outcomes in the long term (9). Figure 2 illustrates the health budget allocation patterns for curative and preventive care.

Beyond the health budget allocation issues, African governments face challenges at all stages of the Public Financial Management (PFM) cycle including in aligning budget allocations with sector needs and ensuring effective

Global and regional commitments

In 2015, African leaders committed to achieve 17 Sustainable Development Goals (SDGs) by 2030 (1). The third SDG (SDG 3) focuses on health, "to ensure healthy lives and promote well-being for all at all ages", and includes targets for reproductive, maternal, neonatal, child and adolescent health, emergency preparedness, universal health coverage (UHC)² and health financing and workforce among others (1).

As it relates to domestic financing for health, in 2001, African leaders ratified the Abuja declaration, committing to allocate 15% of their government budgets to health (2). In 2019 under the African Union (AU), African heads of state and government launched a new initiative, the Africa Leadership Meeting (ALM) Declaration, aimed at increasing investments in health, improving the impact of spending, and ensuring the achievement of UHC across all countries on the continent (3).

Challenges and opportunities for advancing commitments at country level

The translation of global and regional commitments at country level in Africa has been slow and uneven. By 2019, no country had achieved UHC and only four out of the 54 AU countries had achieved the Abuja Declaration target (Ethiopia, Gambia, Malawi and Eswatini) (4; 5).

¹Health is defined by the World Health Organization (WHO) as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

²Universal health coverage is defined by the WHO as all individuals having access to required health services, of sufficient quality, without suffering financial hardship

disbursement, and accountability and transparency in the budget system (10).

Inefficient PFM results in suboptimal utilisation of health budgets. For example, Kenya’s National and County health budget analysis for the fiscal year 2020/21 revealed that the national government used only 70% of its budget. Collectively, Kenya’s 47 counties recorded a higher health budget utilisation rate of 91% but still below the desired 100% (6).

Nevertheless, a few African countries including Kenya, Rwanda, Burundi and Zimbabwe have been identified by the African Union as ready to improve their domestic investments in health and utilisation of health resources.

The 2019 COVID-19 pandemic presented both a challenge and an opportunity for enhancing and advancing domestic health financing and addressing inefficiencies in the use of health budgets. The COVID-19 pandemic underscored the dire need for African countries to strengthen the capacity of national healthcare systems in Africa (11).

Concurrently, the economic impact of the pandemic, due in part to the ‘lock downs’ that governments in Africa and beyond implemented, illustrated the importance of the health sector in economic development of countries (11). Many countries were forced to reallocate resources including within the health sector to respond to the pandemic (11).

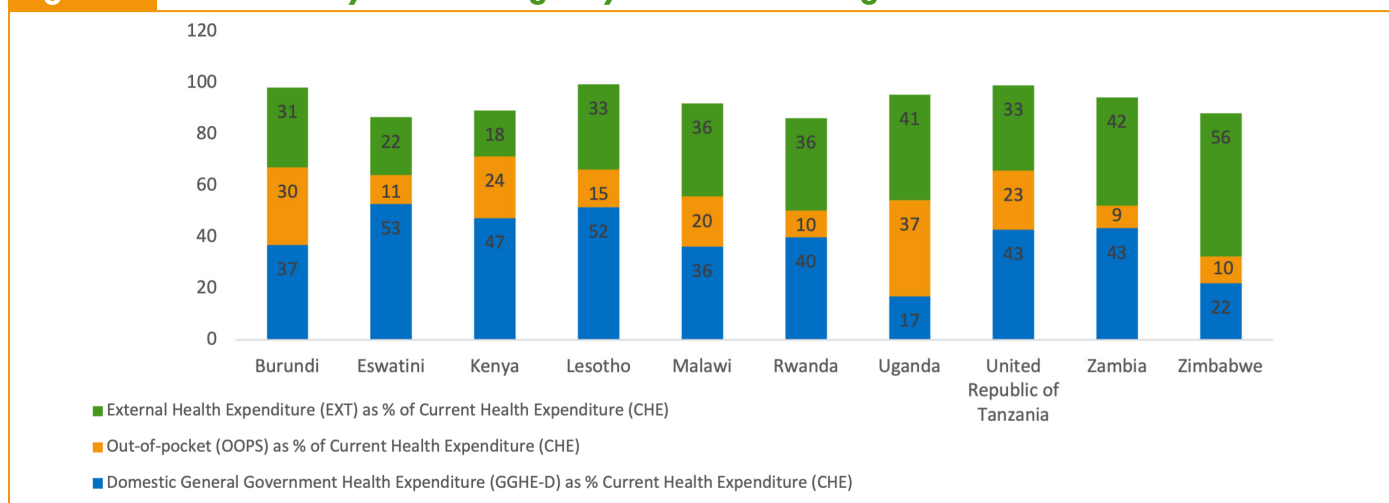
African governments are now focusing on post-COVID-19 economic recovery, but this is in the midst of a global economic downturn and huge public debt, which they are struggling to repay (11). This macro-fiscal outlook has the potential to reduce government investments in health, which will reverse any progress made thus far towards achieving UHC (11).

There is a need for greater and continuous advocacy to make the investments case for increased and efficient use of domestic health financing and generation of evidence to support the advocacy and decisions and practices of African governments.

Innovations in domestic health financing and efficient use of resources

Several innovations for improving domestic health financing and its efficient use are being implemented or explored in low- and middle-income countries (LMICs) including African countries (12, 13, 14). In this brief we highlight three innovations that appear to be the most common ones being implemented or explored: 1) using government tax revenues to fund health care; 2) universal health insurance coverage; 3) a public-private partnerships model in health financing in which the private sector offers services to the public and not just to private-paying service users. We also highlight some key lessons and considerations for bolstering domestic health financing initiatives in Africa (Box 1).

Figure 1: Select country health budget by source of funding

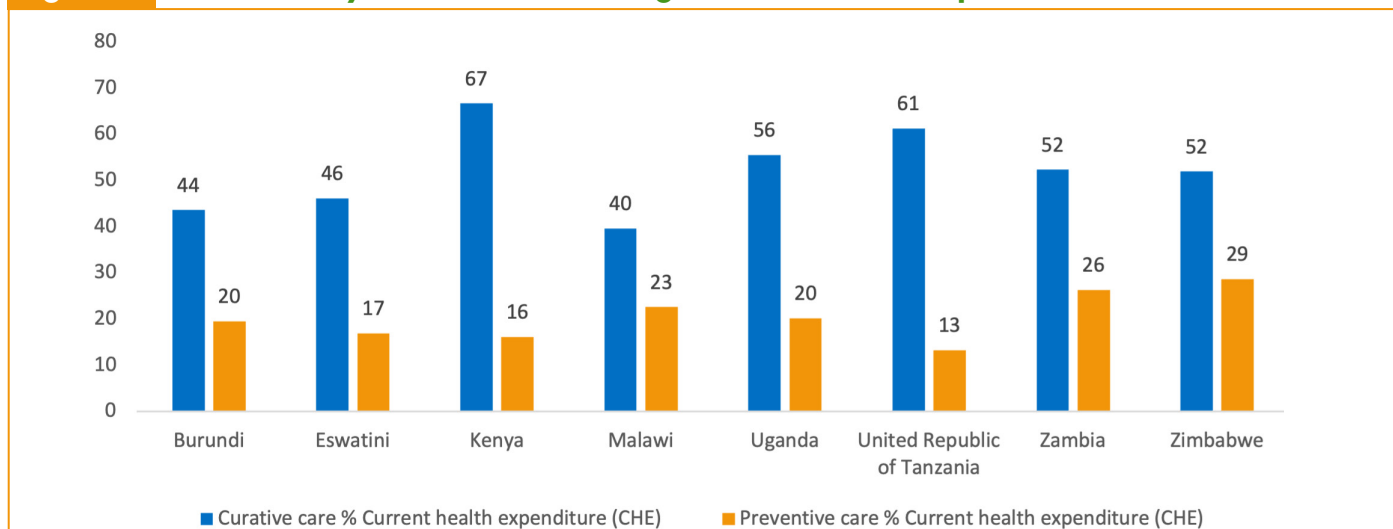


Using government tax revenues to fund health service provision

A few countries are exploring tax-based health systems that involve the government financing health care using tax revenues (12). This model is being considered as the principal mechanism for achieving UHC in Nigeria. In Kenya, it is being considered for subsidies for the poor and would be operationalised using a framework for identifying the poor (12). Ethiopia is considering a “sin tax” on “khat”, a stimulant substance that is traditionally used in the country (12).

Similarly, some countries in the Western Pacific region are using tobacco and alcohol taxation to expand their health budgets and are exploring the same approach for sugar-sweetened beverages (12). For example, the Philippines uses a percentage of tobacco and alcohol taxes and gambling revenues to subsidise health insurance coverage for poor populations and inpatient care (12).

Other tax-based innovations that have been suggested include levies on mobile phone call tariffs, and taxing profitable sectors, such as the banking or petroleum industry (12).

Figure 2: Select country national health budgets, curative versus preventive functions


Universal health insurance coverage

Several insurance models have been adopted or are being explored including national health insurance (NHI), social health insurance, community-based health insurance, voluntary health insurances, private health insurance and micro health insurance (12, 13). NHI is a government-run health insurance program that all citizens fund through a premium or tax (15). NHI control costs by limiting the medical services they pay for and/or requiring patients to wait to be treated (15). NHI has been found to be the most equitable and a common model already established or being adopted/ strengthened in some African and Western Pacific region³ countries (12, 13).

Social health insurance (SHI) is a compulsory system that deducts contribution payments directly from employee payroll taxes (12). Some countries are exploring SHI but it has been found not to be suitable for contexts with a small formal sector and large informal sector as is the case in LMICs in Africa (12, 13). Community-based health insurance (CBHIs) such as the Rwandan 'Mutuelles de Santé' and in Kenya have had minor success because of low enrolment rates, difficulty retaining members, and high dependence on donor funding (in Kenya, CBHIs have collapsed after donor funding ended) (12).

Voluntary health insurance, private health insurance and micro health insurance, which are being implemented in some countries, have been found to be less equitable and not a viable option for moving toward achieving UHC (12, 13).

Countries may design multiple schemes targeting different population groups including the formally employed, the poor and vulnerable, informal sector workers, etc. This approach can expand access to services but could increase inequity between the subgroups (13). To address this challenge, Lao PDR is introducing a tax-based national health insurance scheme that will replace its CBHI and at the same time integrate the health equity funds and free maternal and

child health services (13). Mongolia, the Philippines, and the Republic of Korea are implementing nationwide subsidies across subgroups that provide a uniform benefit package and result in lower administrative costs (13). However, Vietnam's uniform benefit package resulted in perverse cross-subsidisation in which the poorer rural provinces subsidise the richer, more urban provinces, because of low health service utilisation in the rural areas (13).

Public-private partnerships

The idea of public-private partnerships (PPPs)⁴ elicits unease among some and rightfully so as there is strong evidence showing that unregulated private health markets can result in failures that are harmful to the welfare of the general public (14). Some of the challenges that have been identified in PPPs are the exclusion of people with pre-existing conditions from coverage, insurance premiums or service charges that lower income groups cannot afford and supplier-induced demand and excessive price escalation (14).

Despite these concerns, there is growing recognition that private markets, whether for profit or not-for-profit, offer opportunities for the public sector to improve their services through supporting governance, infrastructure, technology, inclusive financing, health inputs and service management (14).

PPPs work best when there is a supportive legal framework and policy guidance to regulate and ensure their effectiveness and capacity to manage PPPs (13). Many countries already have a legal framework for PPP project evaluation, procurement, management and monitoring and evaluation. Countries looking to enhance what they have in place or establish one, a standard framework has been developed by a collaborative led by the African Development Bank (14).

India has many examples of health PPPs including in health financing that the region could learn from (14). For example, India's PPP in health financing through health insurance entails the government partially or fully financing the health insurance premium for families below the poverty line, which insures them

³Western Pacific region covers region covers 37 countries and areas in East Asia, Southeast Asia, and the Pacific islands.

⁴Public-private partnerships (PPP) can be defined from the perspective of their inherent features and functional aspects of the contract. The features of a PPP include an ongoing agreement between government and private sector organizations in which the private organization participates in the decision-making and production of a public good or service that has traditionally been provided by the public sector and in which the private sector shares the risk of that production. The functional aspects of a PPP are that the private partners are responsible for financing; multiple tasks (financing, construction, operations) are assigned to the private party or consortium; and that the private party operates the facility.

against expenses related to health events and hospitalisation, up to a certain amount. The private sector provides the insurance for a

range of health services pre-determined by the government for services delivered at public or private health facilities.

Box 1. Some Key lessons and considerations in domestic health financing

- » A major benefit of a single fund like NHI is the greater bargaining power in purchasing better quality services from providers that it offers if managed effectively and pooled together with the government budget (13).
- » Economic development does not automatically translate to larger health budgets (13). Countries must be deliberate in increasing their allocations to health as their economies grow.
- » Improved efficiency in tax collection and effective use of public funds can play a role in increasing fiscal space for health (12, 13).
- » Governments in the Western Pacific Region of Asia have subsidised heavily access to health care for vulnerable and poor populations and, in some cases, the informal sector, which has contributed greatly to expanding social health insurance coverage (13). Countries with large informal sectors struggle to increase population coverage and are addressing this by expanding coverage within the formal sector and increasing government funds to cover the poor and vulnerable populations and providing subsidies to the informal sector to enroll.
- » How resources are allocated and health services are purchased is critical to ensure efficiency and quality (13). A few countries, such as the Republic of Korea, have a single purchaser system that is separate from the Ministry of Health (i.e., a purchaser-provider split), which eliminates conflicts of interest and results in better quality services. However, this approach requires coordination and alignment between ministries of health and health financing policies between the purchasers and providers. Some countries like Cambodia, China, and Lao PDR are moving toward performance-based financing. In Cambodia and Mongolia, ministries of health are piloting program-based budgeting. Mongolia has prioritised primary health care (PHC) for both spending from government budget and health insurance funds and are grappling with how to define and pay for the identified PHC priority issues and ensure efficiency and effectiveness.

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