



Health Financing in Africa: More Money for Health or Better Health For the Money?

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Harmonization For Health in Africa

OUTLINE

MORE AND BETTER MONEY: WHERE ARE WE?

A TALE OF ONE COUNTRY: RWANDA'S INNOVATIONS IN HEALTH FINANCING

FROM HERE TO THERE

OUTLINE

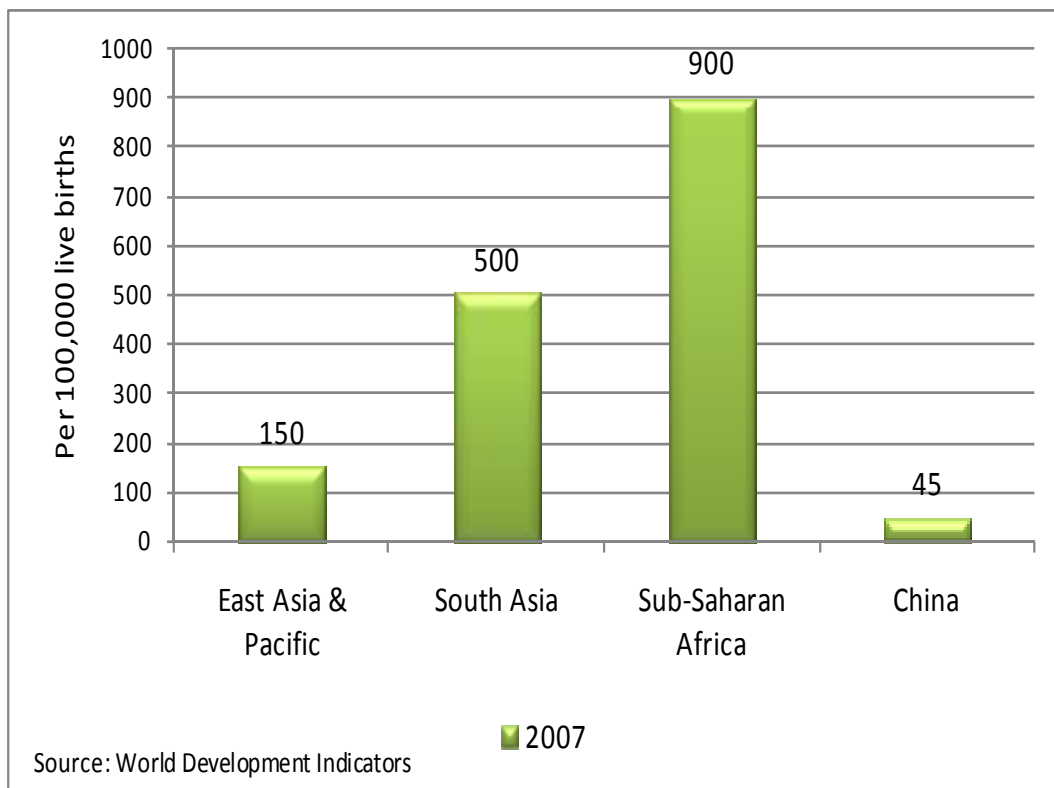


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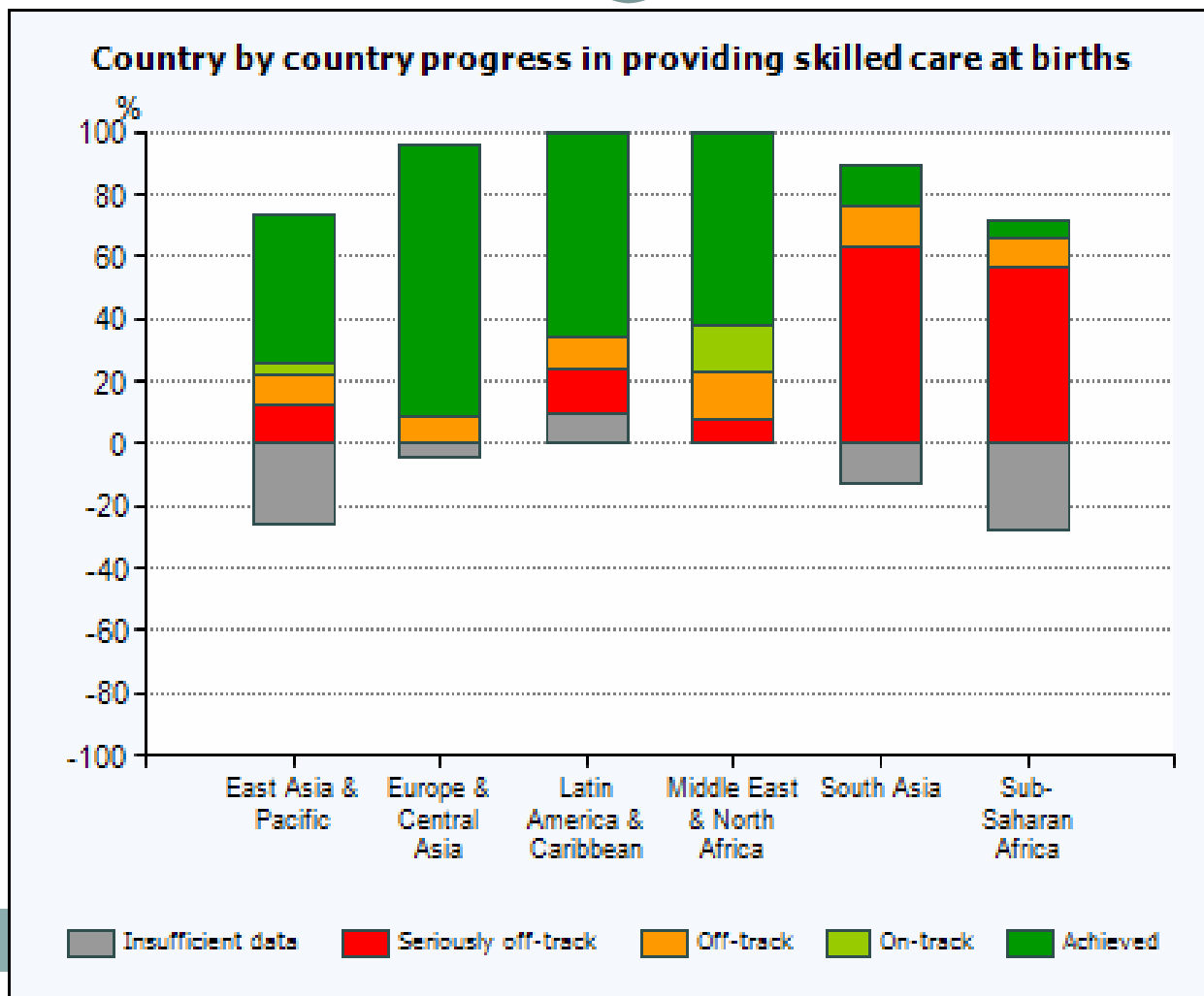
A TALE OF ONE COUNTRY: RWANDA'S INNOVATIONS

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Maternal Mortality Remains Very High in SSA



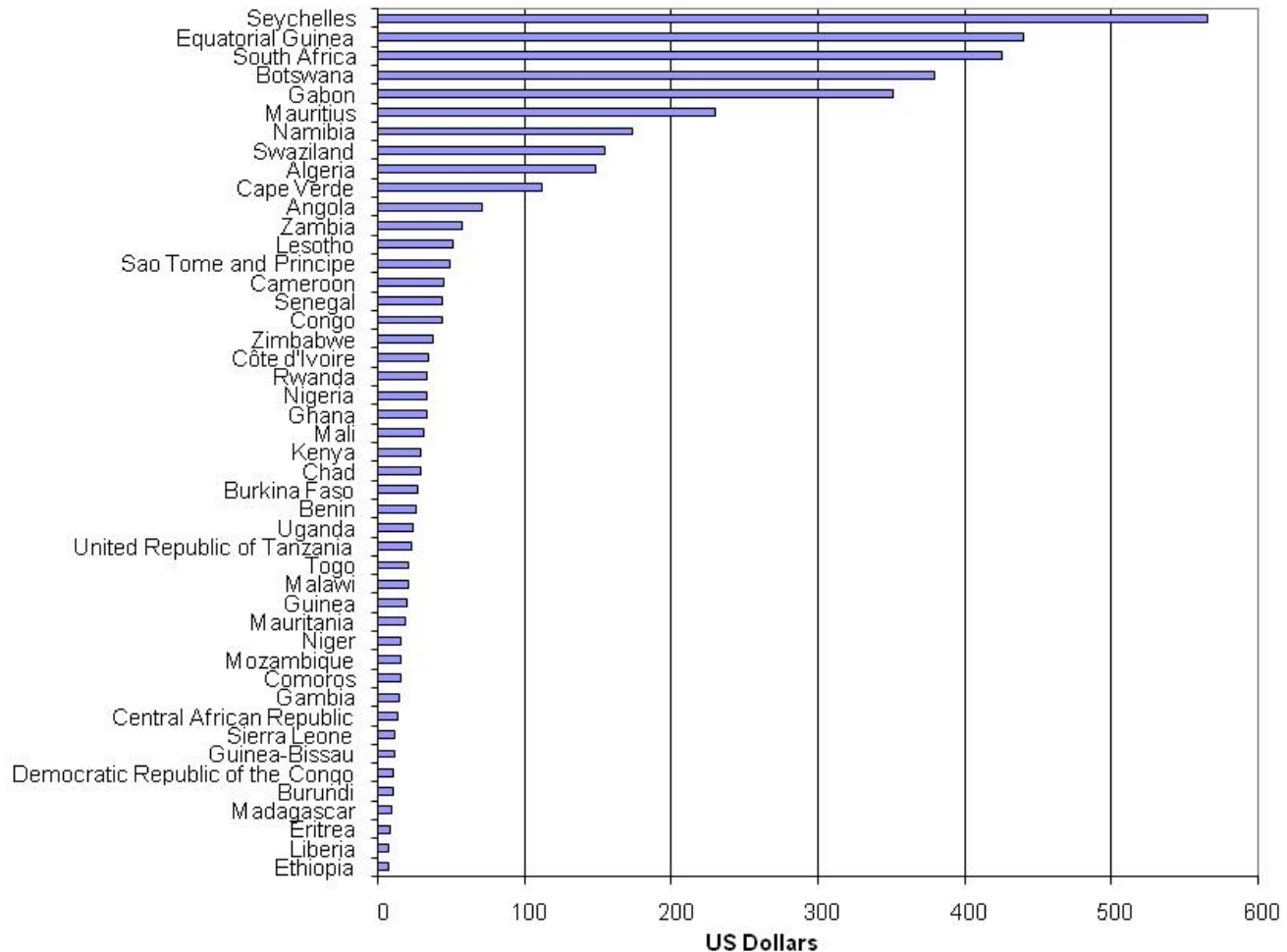
Most countries in SSA are off track to reach MDG5



Harmonization For Health in Africa

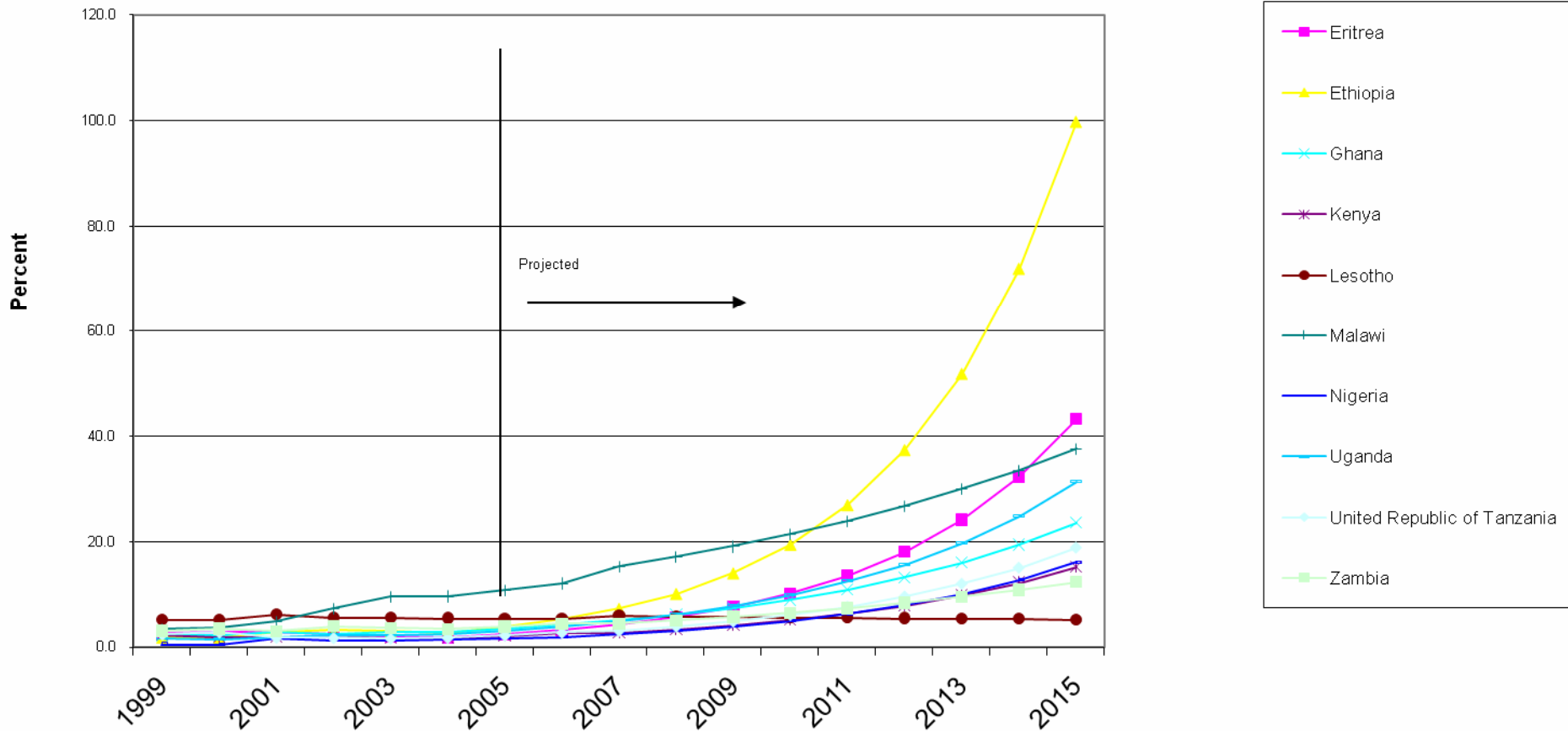
Most SSA countries spend less than US\$50 per capita on health

Per capita total expenditure on health at average exchange rate (US\$) in 2006

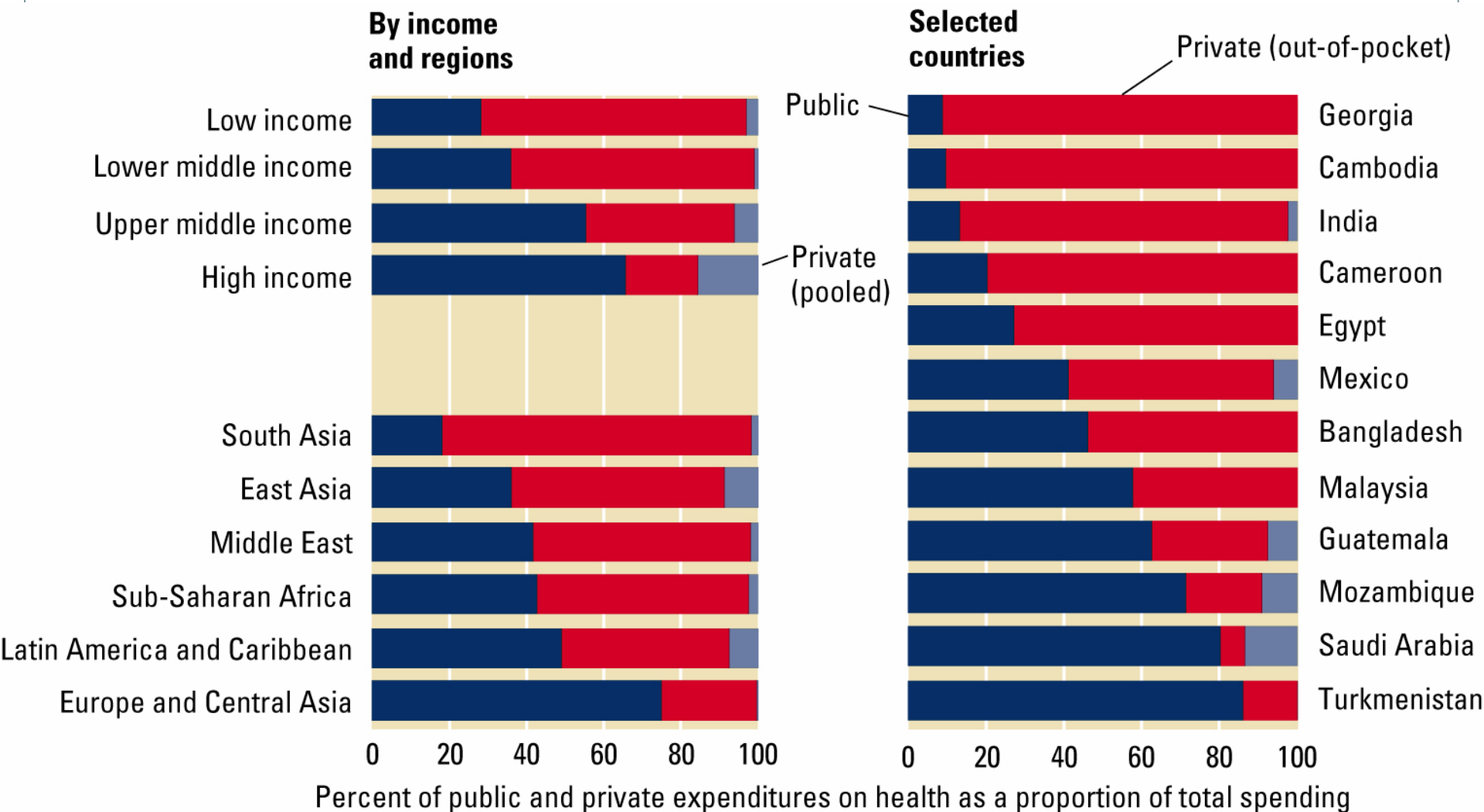


Some Countries Have Problems Accommodating even a Basic Package of Services

Government Health Expenditures/GDP
(assuming 5 percent annual GDP growth and total health expenditures of \$34 per capita)

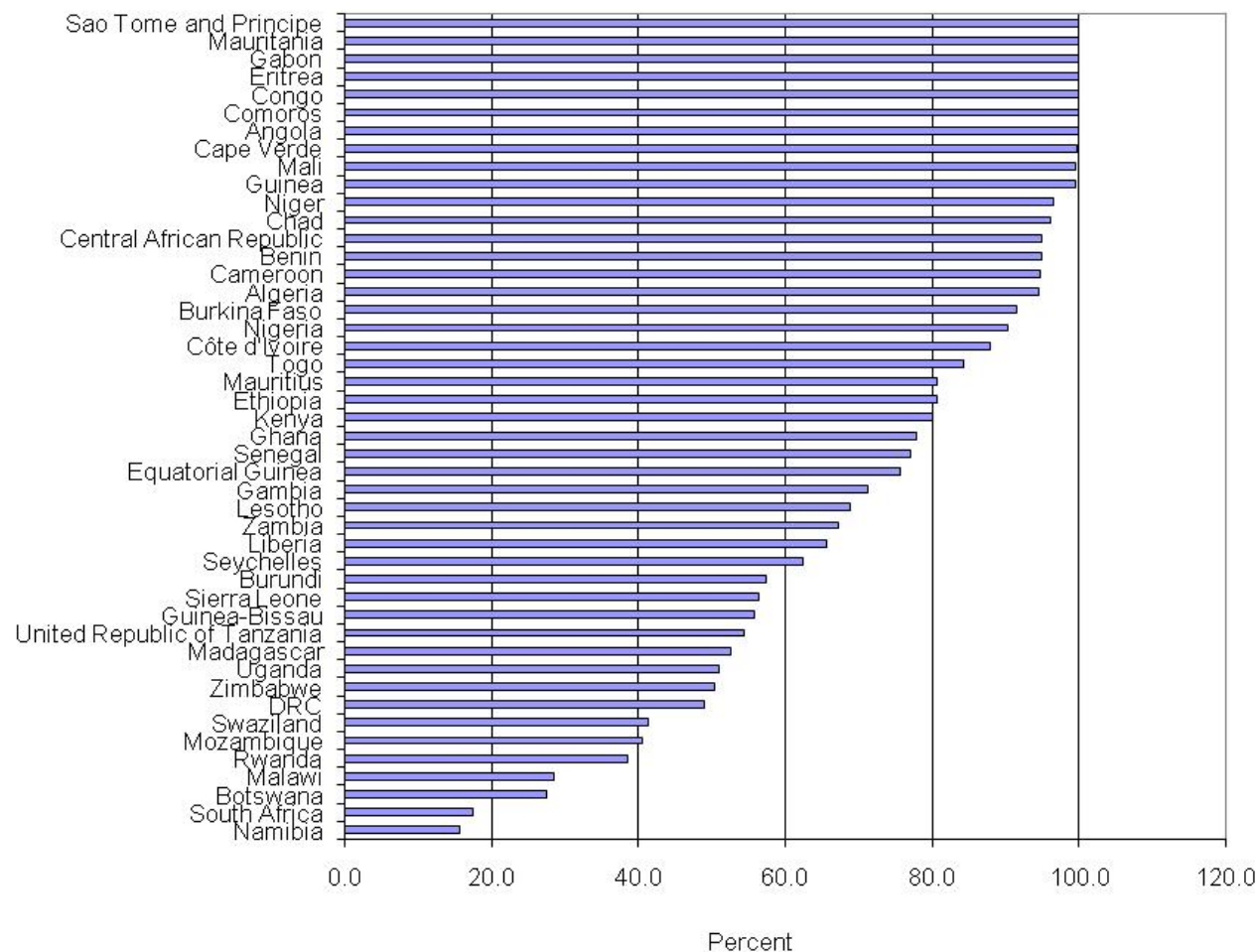


More than half of health expenditures in SSA are private



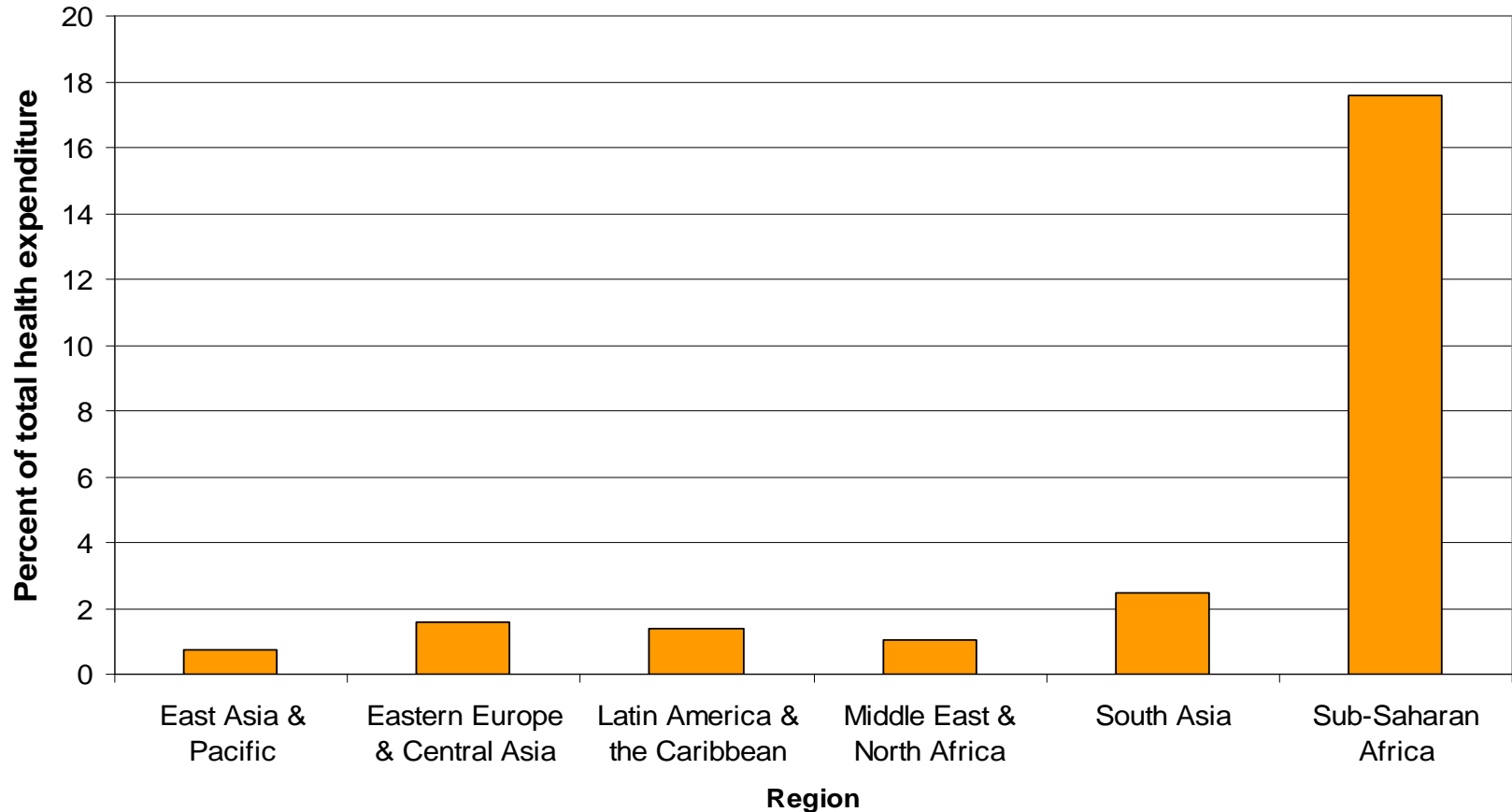
Out of Pocket Spending dominates private financing in most countries

:Out-of-pocket expenditure as % of private expenditure on health



External aid is an important source of health spending in Sub-Saharan Africa

External aid as % of total health spending (2002)



Six years to the MDGs



- The MDGs horizon is six years away: what are the low hanging fruits? What is most effective ? What can be quickly scaled up?
- The health sector does not produce results. Why is it? It does not need to be so: some countries are doing much better than others..
- Some countries give very little priority to health..why? What needs to be addressed?

Critical issues to be addressed

- Fragmentation and donors' processes disconnected from country processes
- Planning and Budgeting not based on evidence and analysis of country specific constraints to delivering high impact interventions
- Public money benefits richer groups
- Public Financial Management frontline providers do not have resources (PETS)
- Post colonial civil service models reach their limits. Dramatic lack of linkage between performance and incentives..

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Rwanda

- A small country in Central Africa
- Genocide in 1994
- In 2005 , 4/10 births attended by a health professional.
- Infant Mortality : 86 per 1,000
- HIV : 3.1%



Rwanda

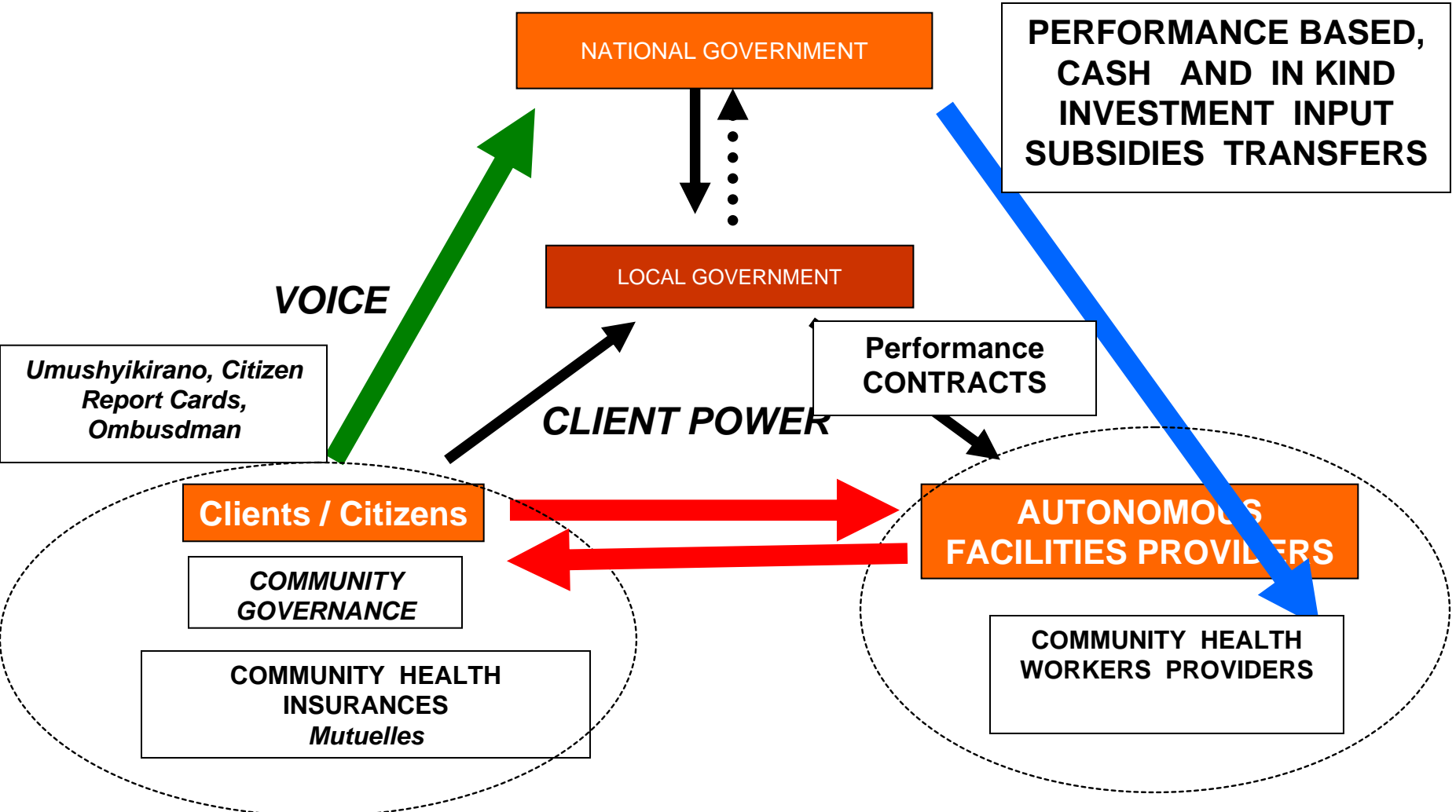
- Shortage of human resources for health services
- No cash resources in health facilities
- Low levels of productivity and motivation among medical personnel
- Low user satisfaction & poor quality of service leading to low use.

Rwanda has undertaken major reforms to strengthen accountability of all institutional and individual actors for MDGs related results...

..through a shift of paradigm..

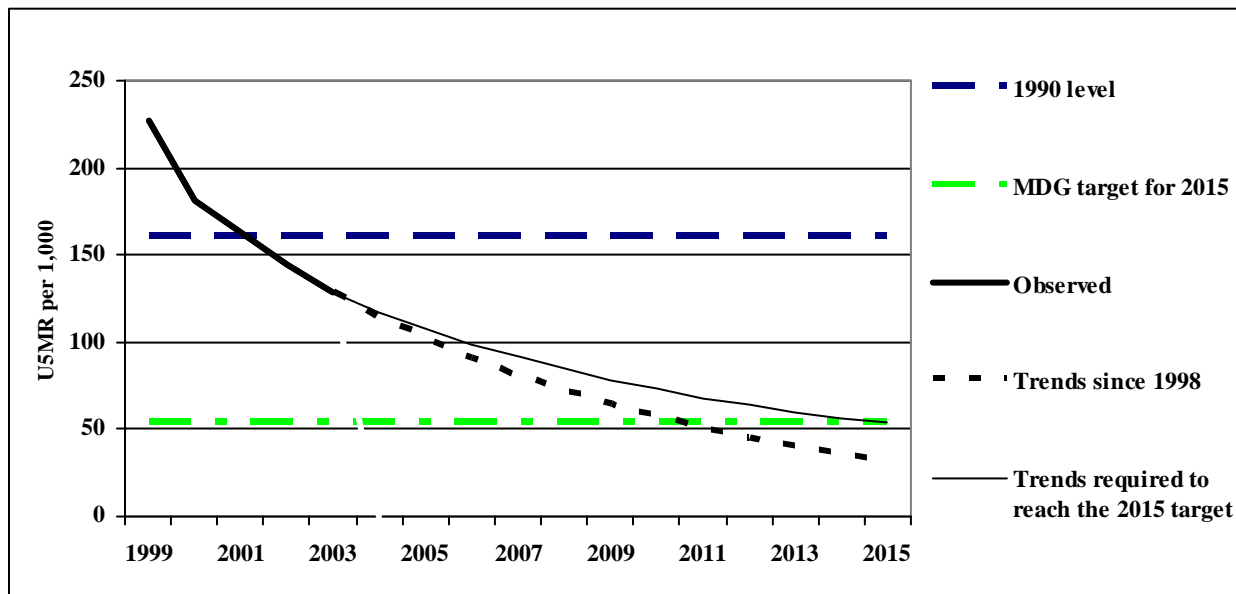
- **Fiscal Decentralisation** with strong governance structures and community participation.
- **IMIHIGO**: Performance contracts between President of the Republic and mayor of Districts;
- **PBF**: Performance Based Financing;
- **CBHI**: Community Health Insurance;
- **Autonomy** of health facilities, including hiring and firing of health personnel;

Strengthening accountability in the health sector in Rwanda



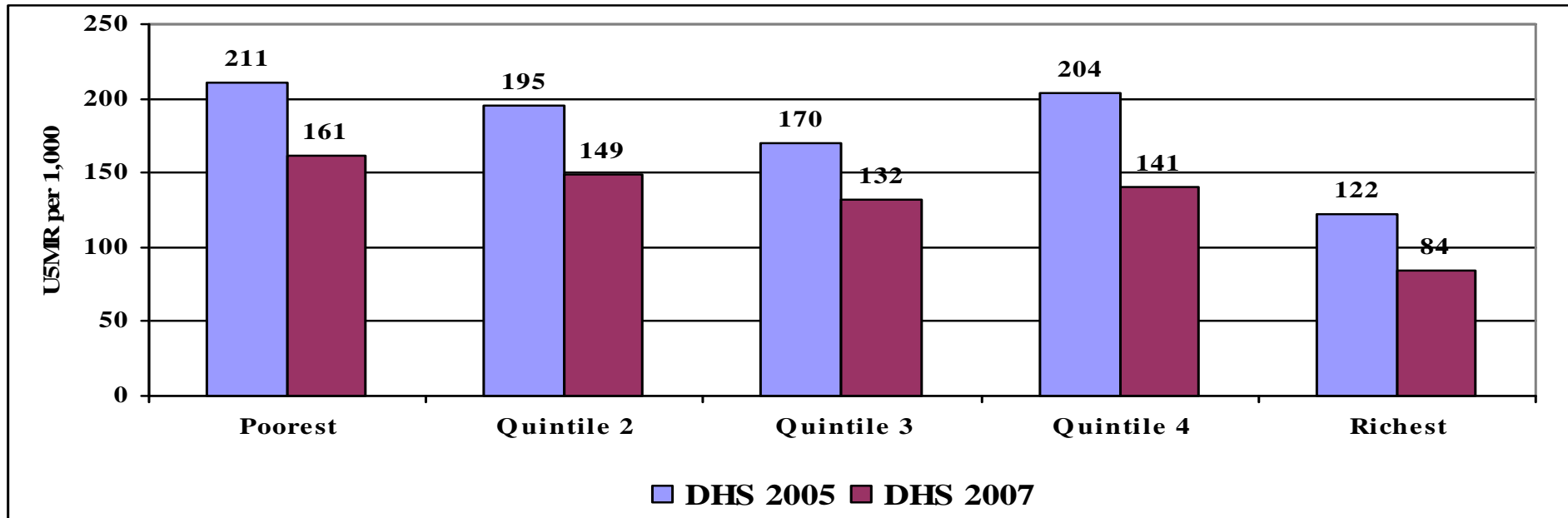
Results show Rwanda is now back on track towards the health MDGs...

Under five mortality trends with MDG target for 2015



All income groups benefit although inequities still persist ...

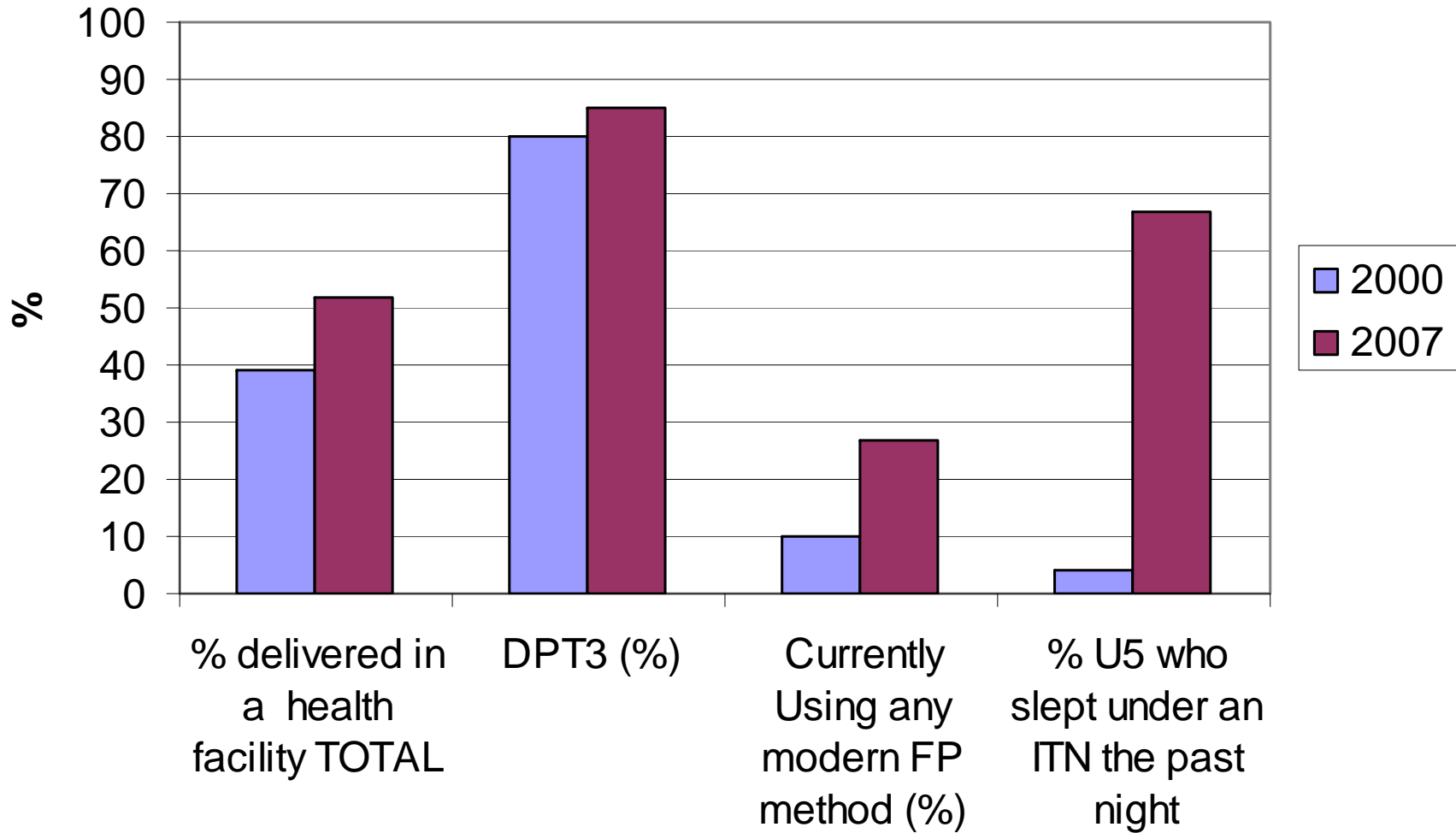
Under five mortality trends by income quintile (2005-2007)



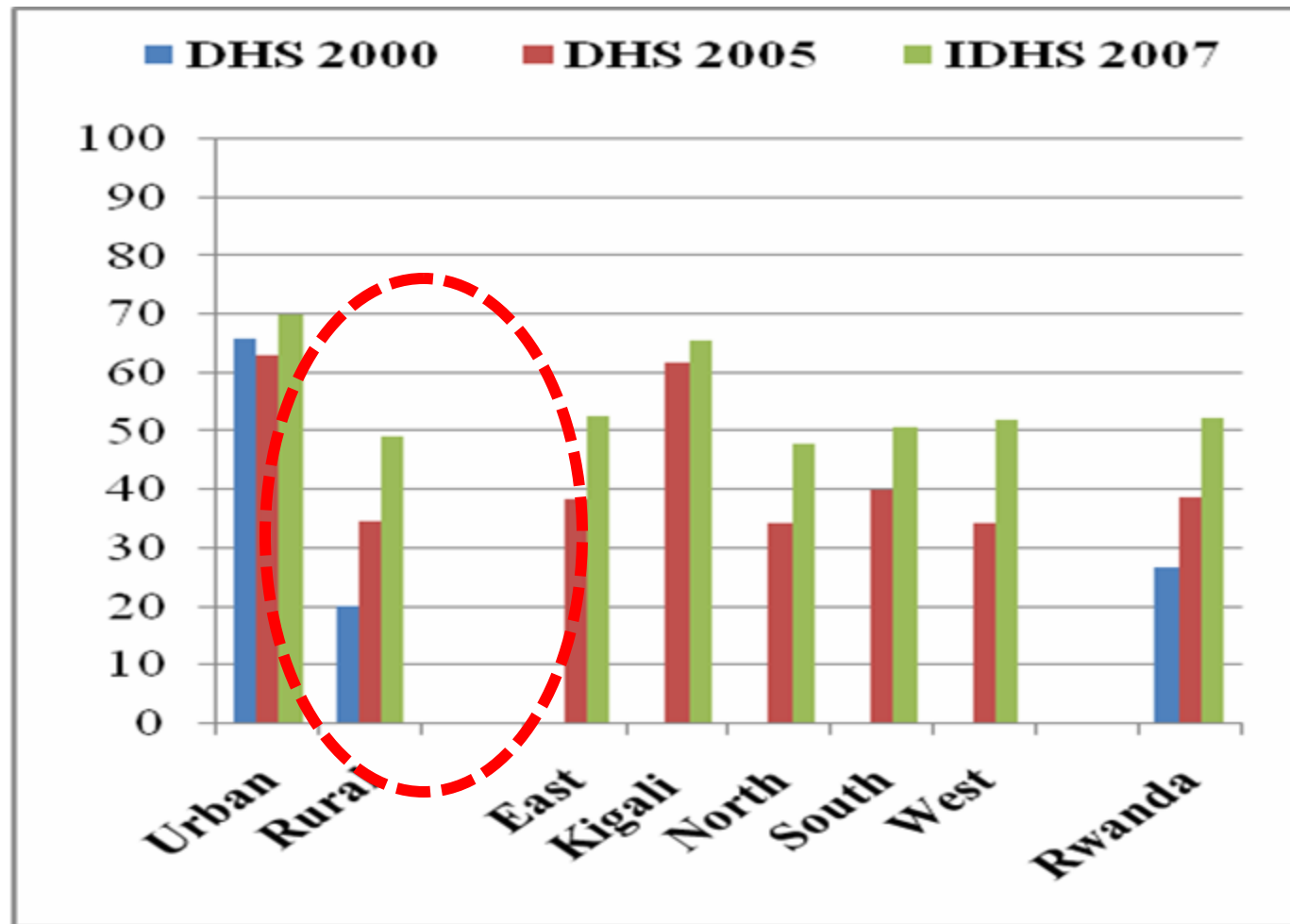
Source: DHS 2005 and 2007.

Rwanda: Coverage with MDGs High

Impact Interventions increases



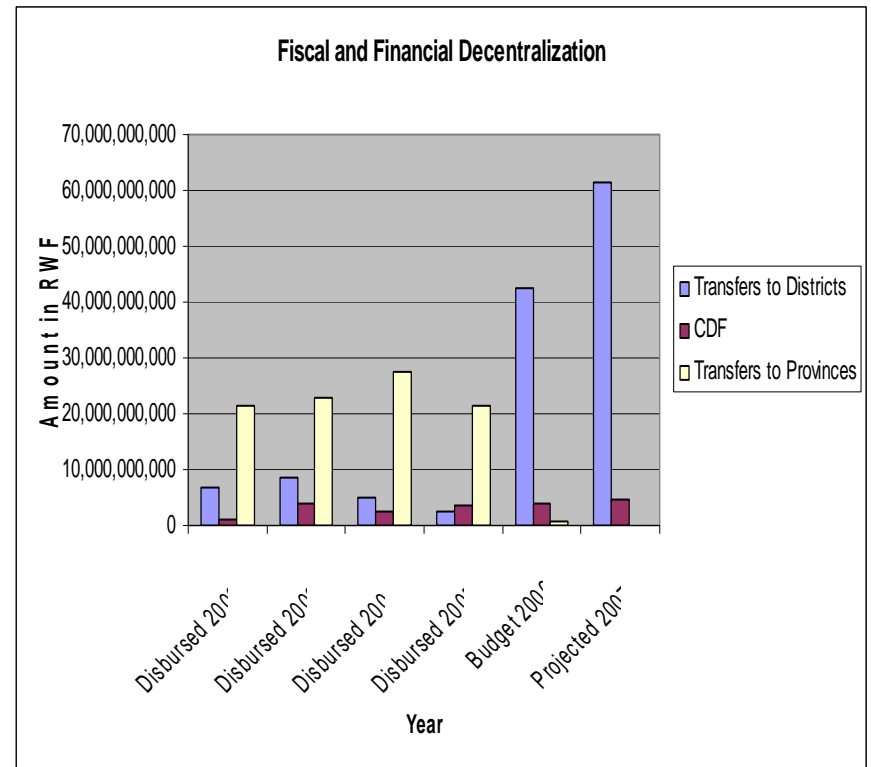
Increase in utilization of assisted deliveries



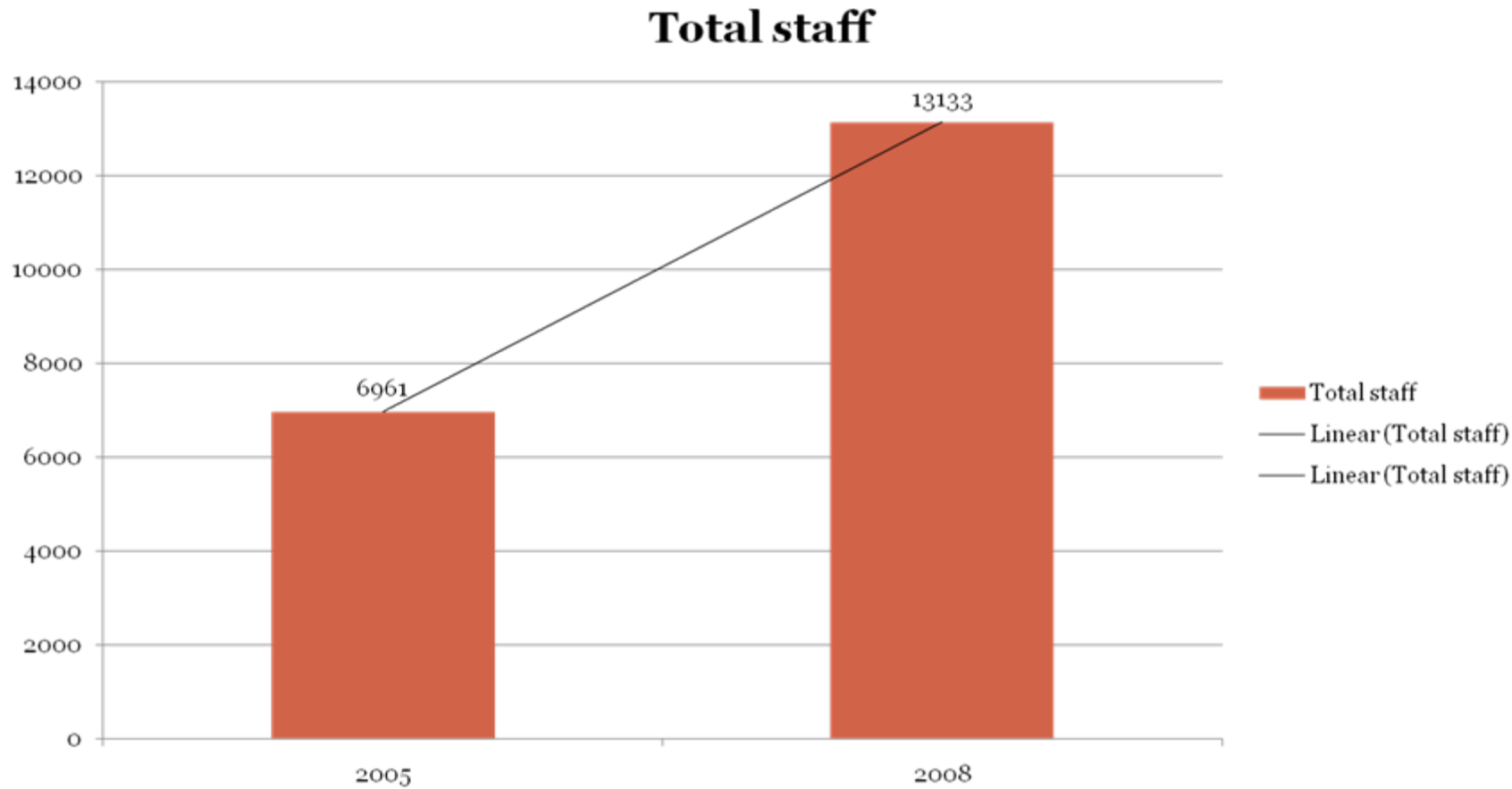
Trends in assistance at delivery : Years 2000, 2005, 2007. Percentage (%) of women delivered by a health professional

Decentralization

- Administrative, fiscal and financial decentralization has provided large sums of money to local levels of government and given them much flexibility by providing them with block grants

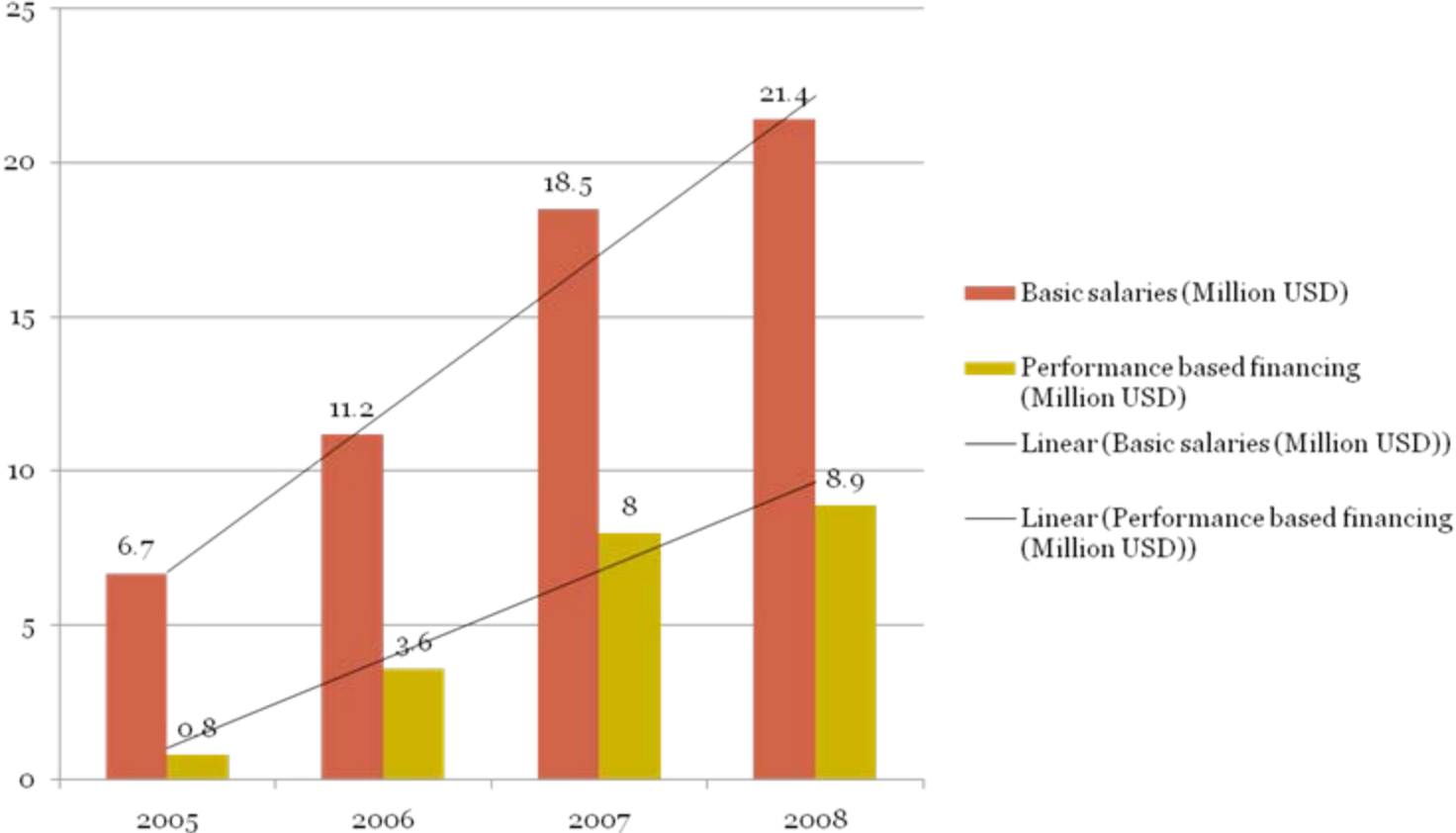


Total health personnel in publicly funded facilities has almost doubled in 3 years ...



Source: Public Expenditures Review Rwanda; 2005

**Financing has more than tripled in four years
(going from USD 7.5 to 30.3 millions, of which the PBF
has grown more than tenfold from USD 0.8 to 8.9 millions)**



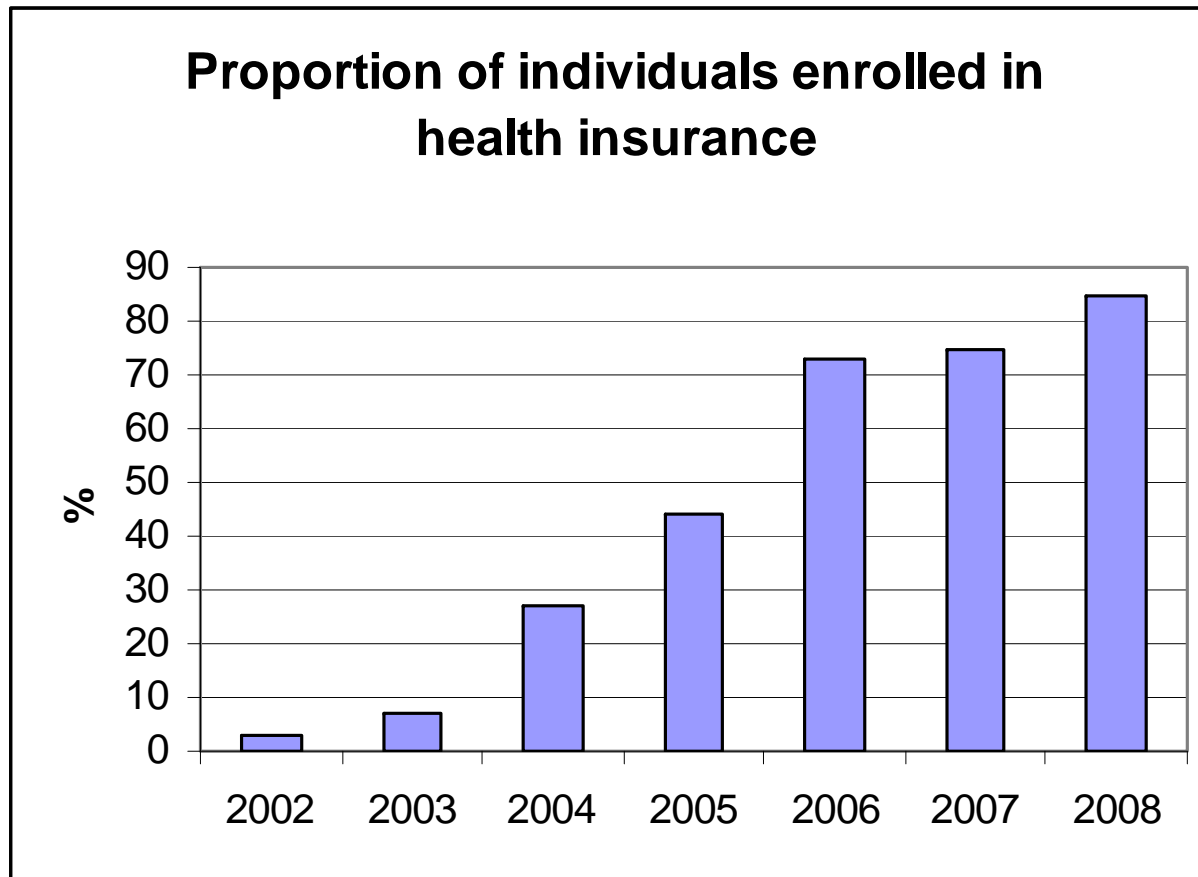
Source: Public Expenditures Review Rwanda; 2005

Health Insurance in Rwanda



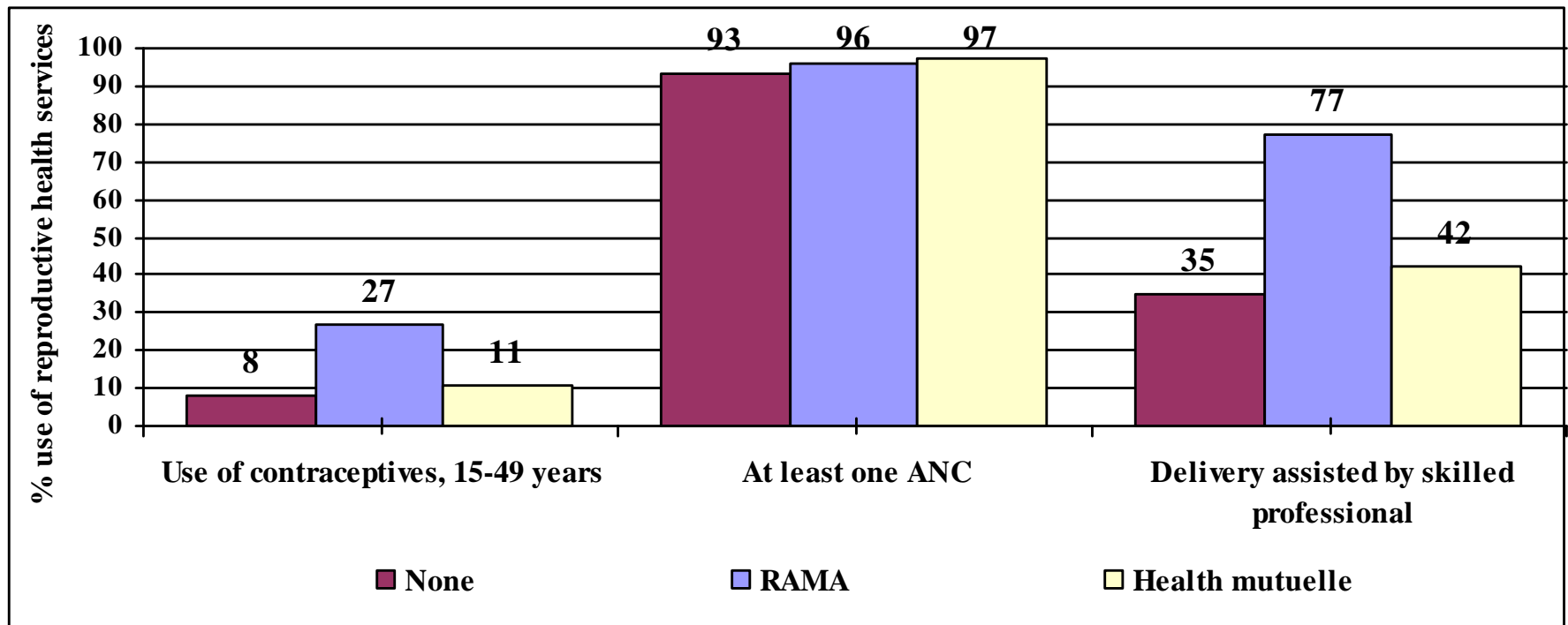
- Micro-Insurance model with two levels of re-insurance funds
- Tax subsidy and crosssubidy from formal sector insurance
- Rapid increase in enrollment from 7% in 2003 to 91% in 2008
- Mutuelle enrollment significantly improves access to health care at all income levels, including the poorest – and reduces inequality in access, particularly among the top four quintiles.
- Mutuelle enrollment significantly reduces the risk of catastrophic health expenditures.

Rwanda: Scaling up of community health insurance



Source: MOH Rwanda; 2005 EICV 2005

At all income levels, those enrolled in “mutuelles” are much more likely to use health services.



Performance-based Financing (PBF)

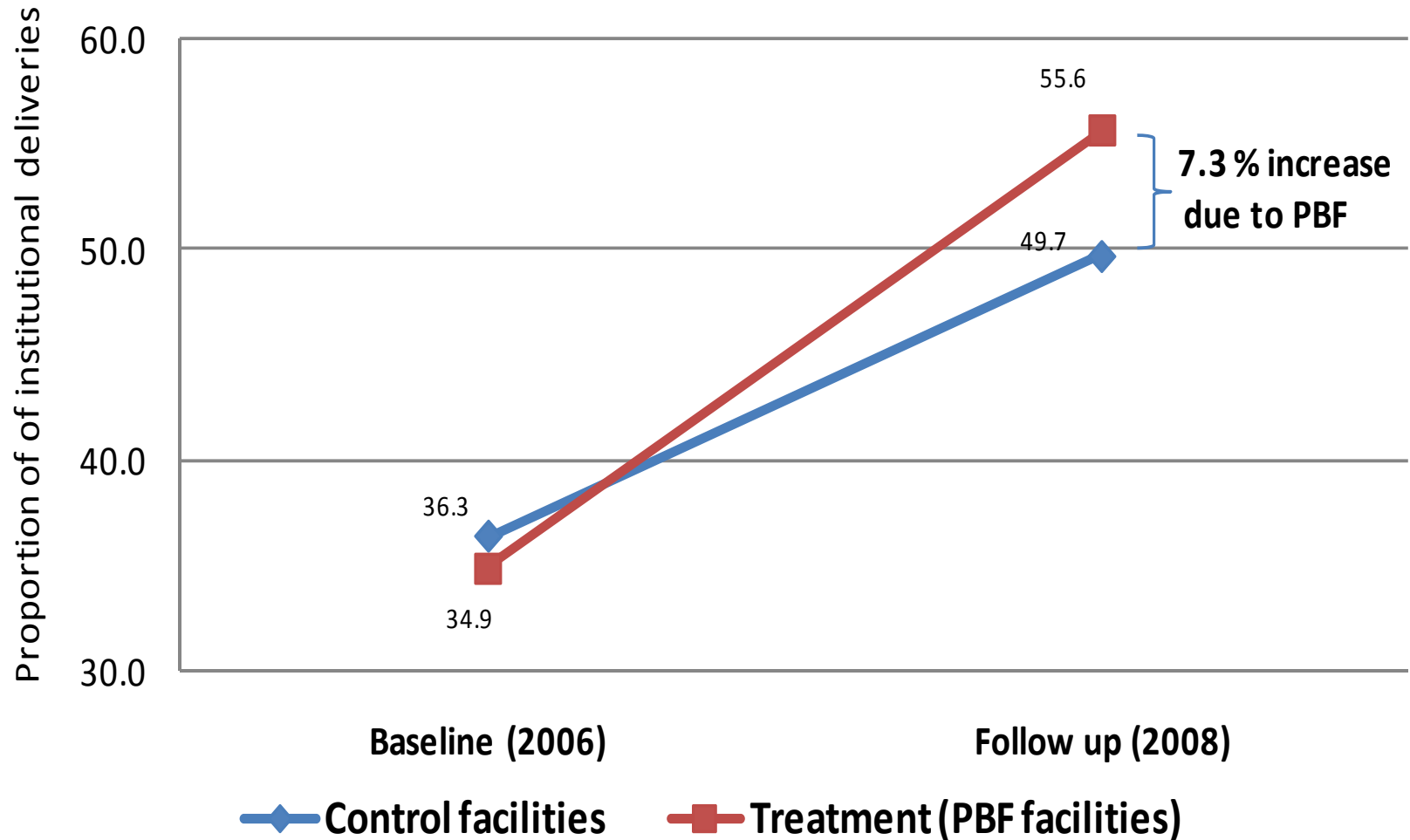
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- **Developed after extensive piloting from 2001-2005**
- **Objectives**
 - Focus on maternal and child health as well as communicable diseases (MDGs 4 & 5)
 - Increase quantity and quality of health services provided
 - Increase health worker motivation
- **Financial incentives to providers to see more patients and provide higher quality of care**
- **Operates through contracts between**
 - Government
 - Health facilities providing services

Table 1: Output Indicators (U's) and Unit Payments for PBF Formula

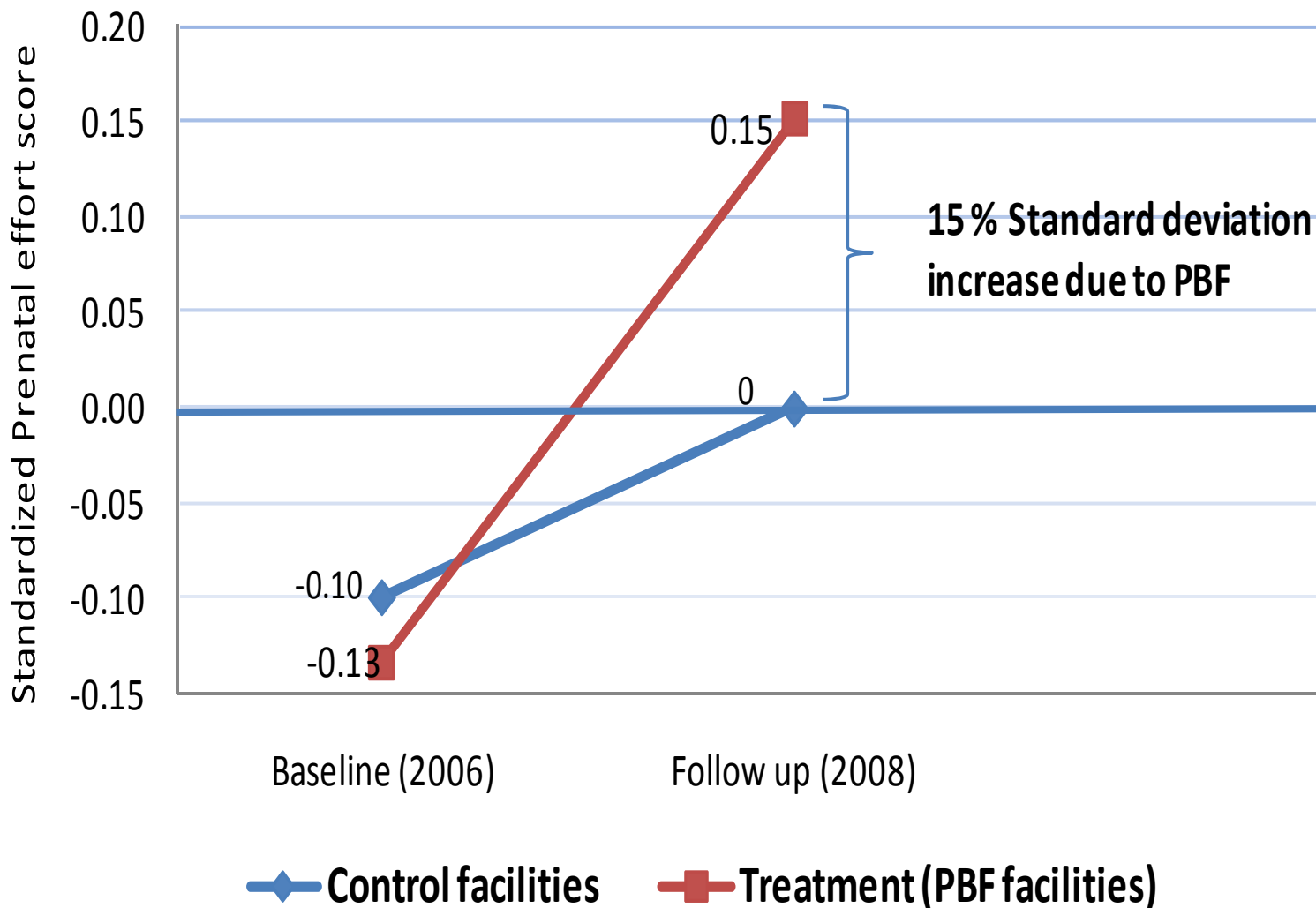
OUTPUT INDICATORS		Amount paid per unit (US\$)
Visit Indicators: Number of ...		
1	curative care visits	0.18
2	first prenatal care visits	0.09
3	women who completed 4 prenatal care visits	0.37
4	first time family planning visits (new contraceptive users)	1.83
5	contraceptive resupply visits	0.18
6	deliveries in the facility	4.59
7	child (0 - 59 months) preventive care visits	0.18
Content of care indicators: Number of ...		
8	women who received tetanus vaccine during prenatal care	0.46
9	women who received malaria prophylaxis during prenatal care	0.46
10	at risk pregnancies referred to hospital for delivery	1.83
11	emergency transfers to hospital for obstetric care	4.59
12	children who completed vaccinations (child preventive care)	0.92
13	malnourished children referred for treatment	1.83
14	other emergency referrals	1.83

Delivery at the health facility increased overall in Rwanda, but 7% more in PBF facilities between 2006-2008....



In the last years, PBF has increased prenatal care quality significantly ...

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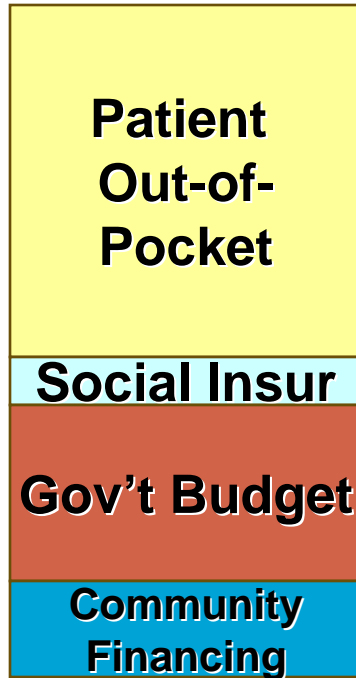
MDGs are ambitious: scaling up will be challenging to implement



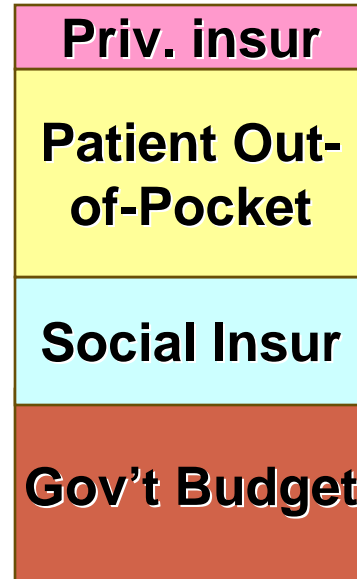
- SSA Countries require increased and better allocated domestic and external funding for strengthening their national health systems in order to achieve the MDGs.
- Most resources are to come from countries' contributions:
 - need for domestic advocacy to raise attention to national budgeting processes
 - Need to channel private spending into risk pool
- Importance for external aid to be catalytic: need to focus on results and efficiency gains

Evolution of Health Financing Systems

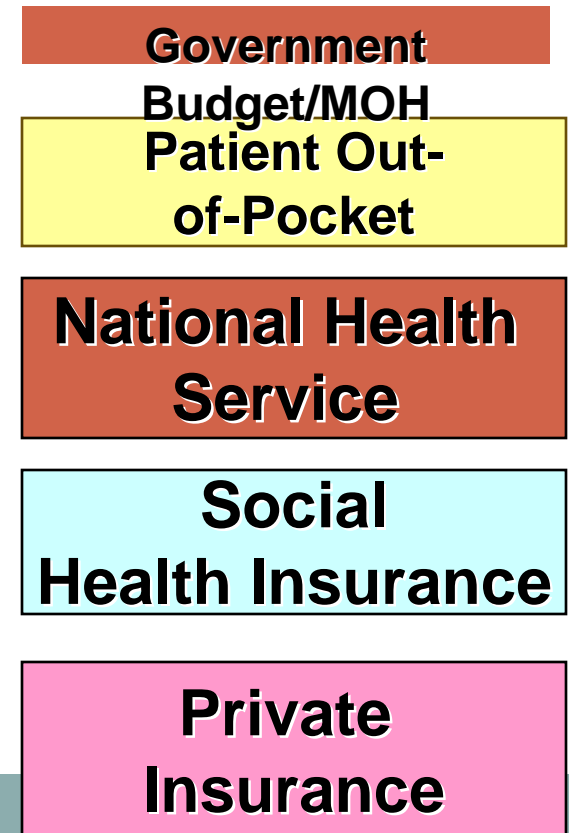
Low Income Countries



Middle Income Countries



High Income Countries



Harmonization For Health in Africa

Making private money more efficient: Health Insurance



- As out of pocket spending has been growing recently, the need for pooling emerges as a main policy priority in SSA
- Two African countries (Ghana and Rwanda) are achieving ground breaking success on health insurance pushing the limits of the innovation “frontier”
- These countries demonstrate that it is possible to achieve rapid scale up of health insurance with actual effect on health utilization and income protection

Making public money more efficient: Results Based Financing



- Purchasing of results and outputs replacing input based financing
- Promising results in Afghanistan, Burundi, DRC, India, Haiti, Nepal, Zambia
- Adopted and initiated in Benin, Ghana, Eritrea, Ethiopia,
- Scaled up in Rwanda and positive results from rigorous Impact Evaluation

Conclusion



- With the MDGs finish line in view, a strong dialogue between MOH and MOF is more needed than ever
- Dialogue can be centered around the production of results: the health sector can do it
- Both supply and demand side financing need to be tapped
- Some hard issues need to be tackled: budget reform, a new vision for public workers, PFM reform around decentralization, autonomy and results focus



THANK YOU!