Increasing financial capacity for UHC in Africa

Dr. Feng Zhao, PhD, MD, MPH
Manager for Health
African Development Bank

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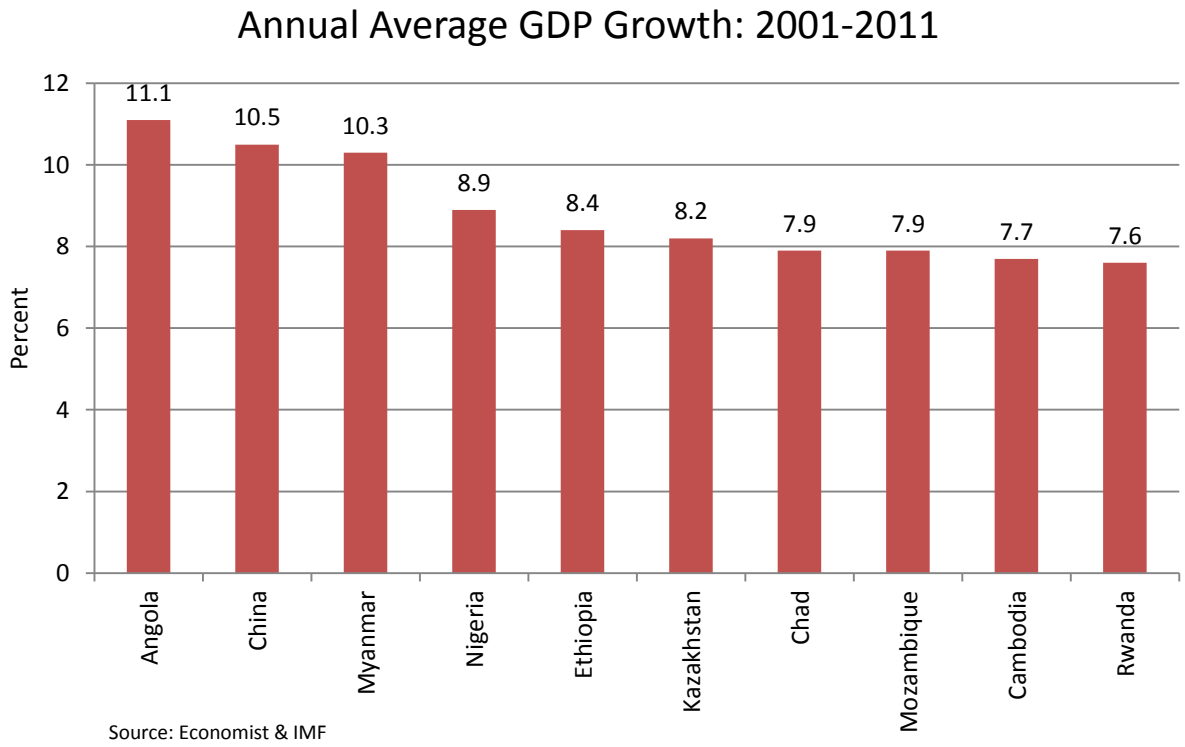
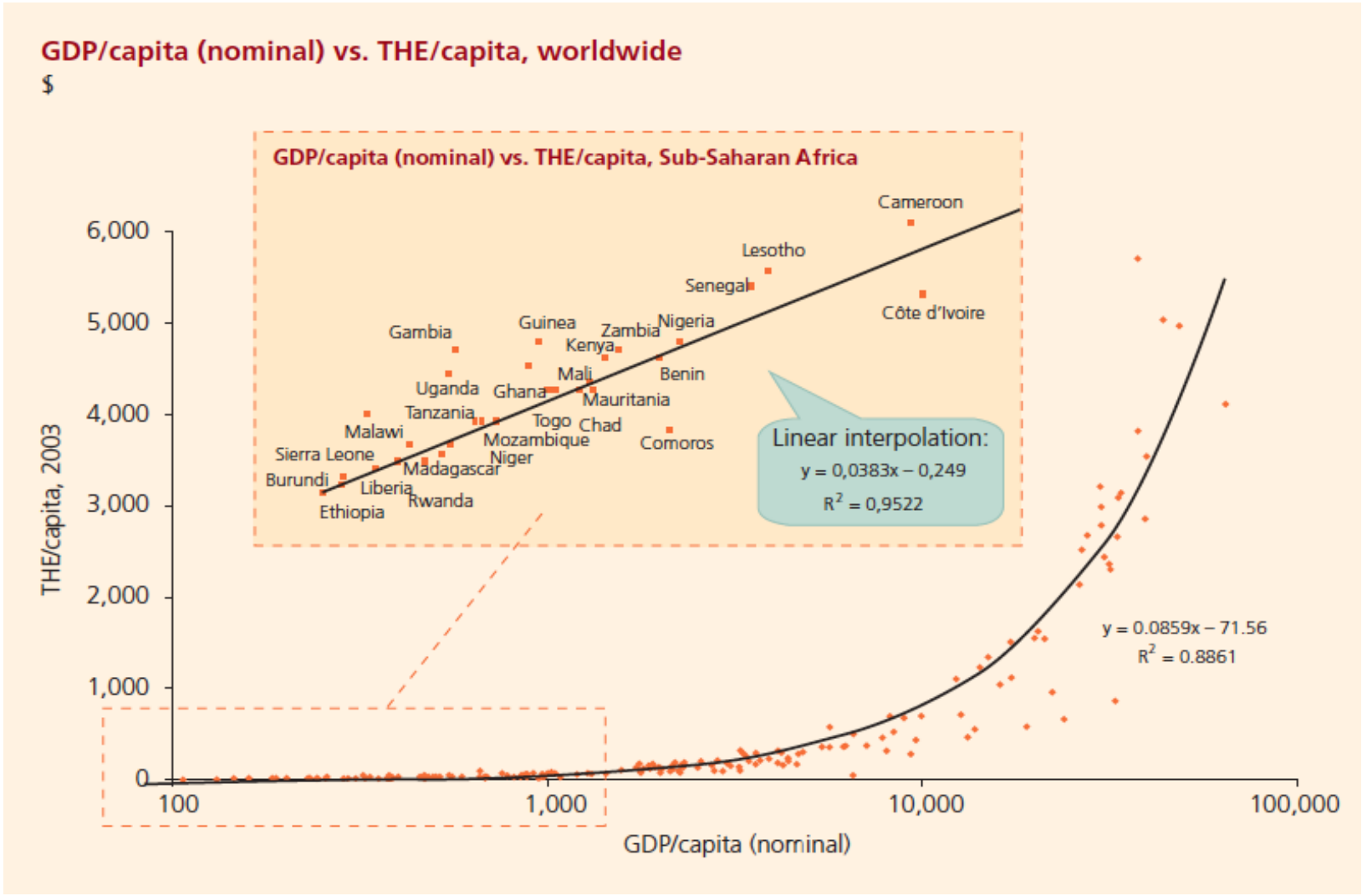
Africa Rising: Rapid Economic Growth

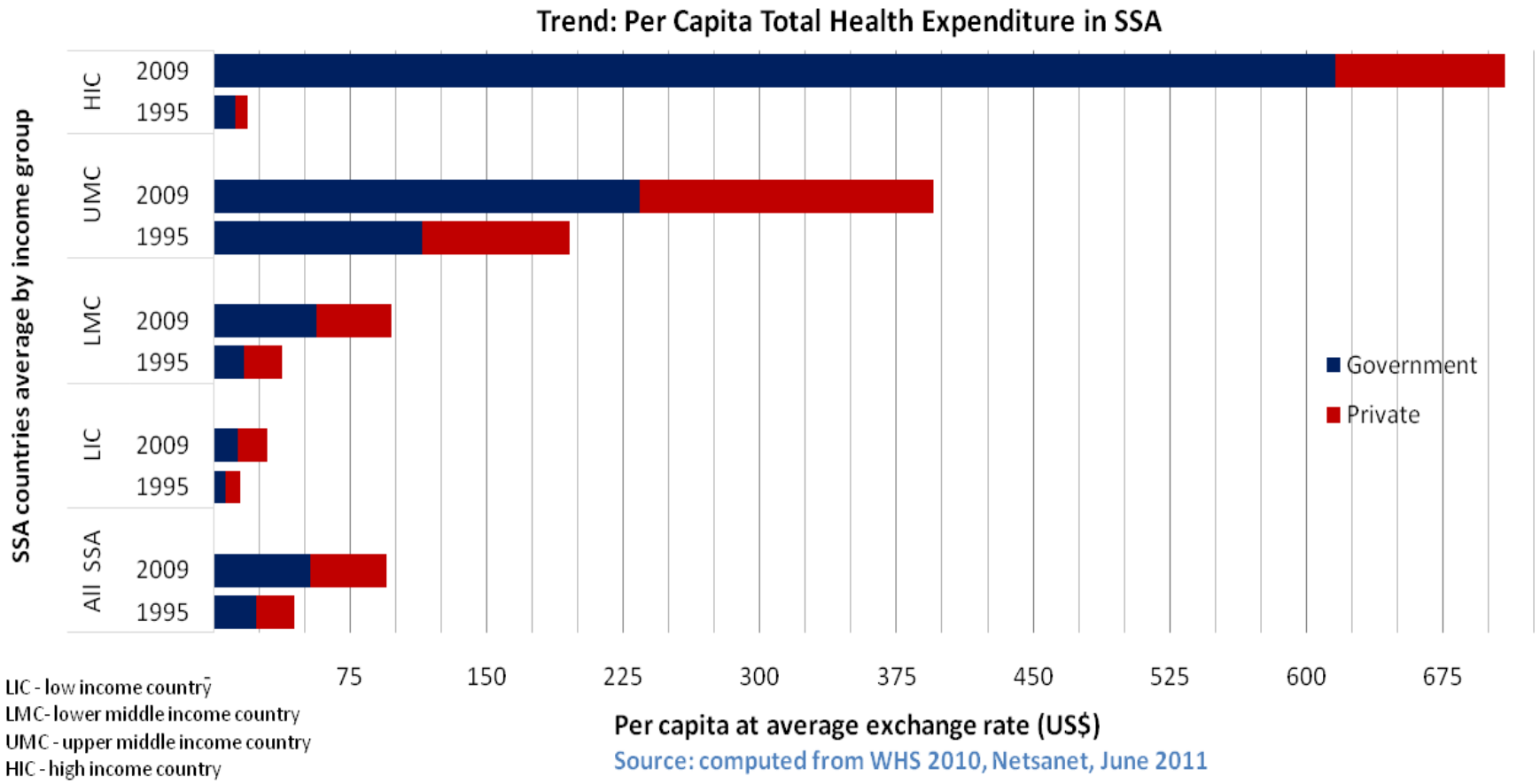
- Africa is growing rapidly at 5-8% per annum
- Six out of 10 world's fastest-growing economies are in Africa



Growing Health Care Needs

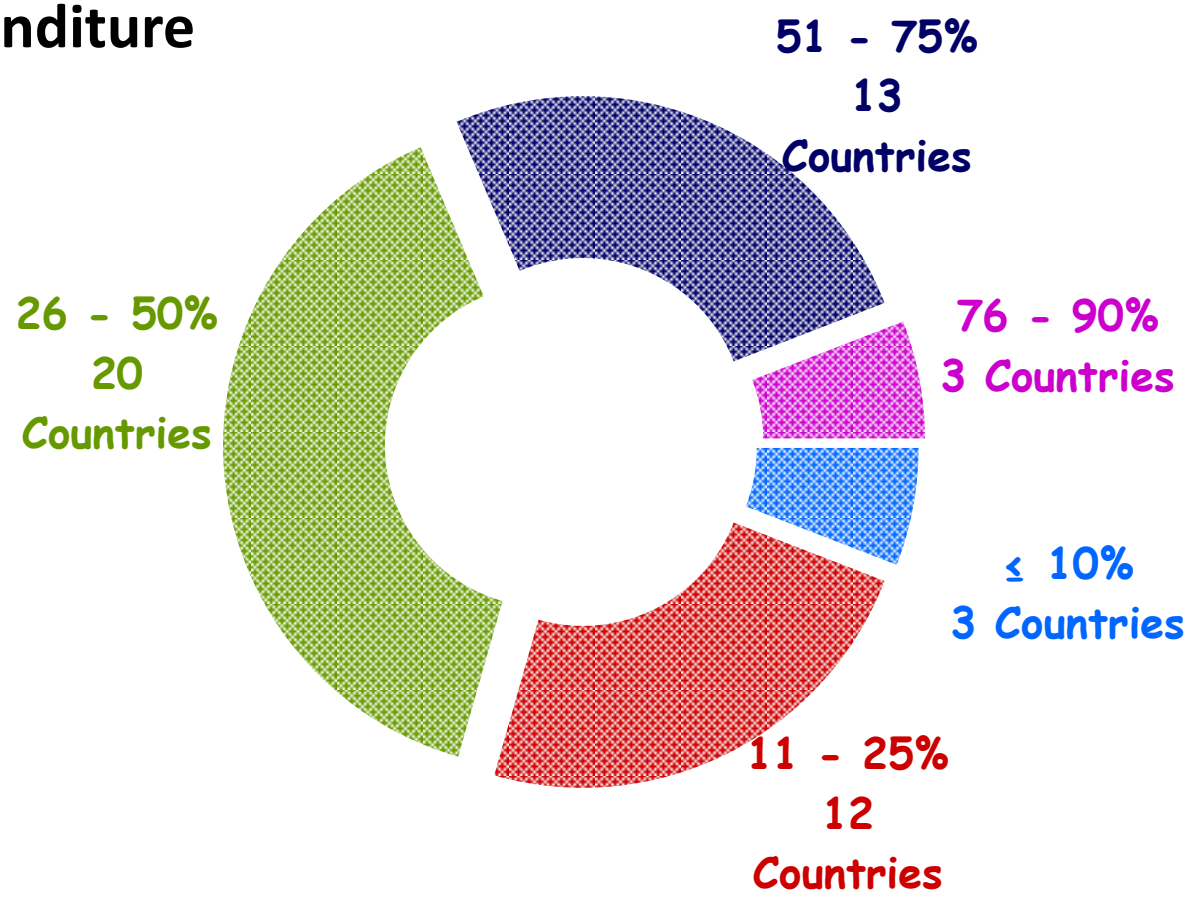


Health spending in SSA has more than doubled since 1995

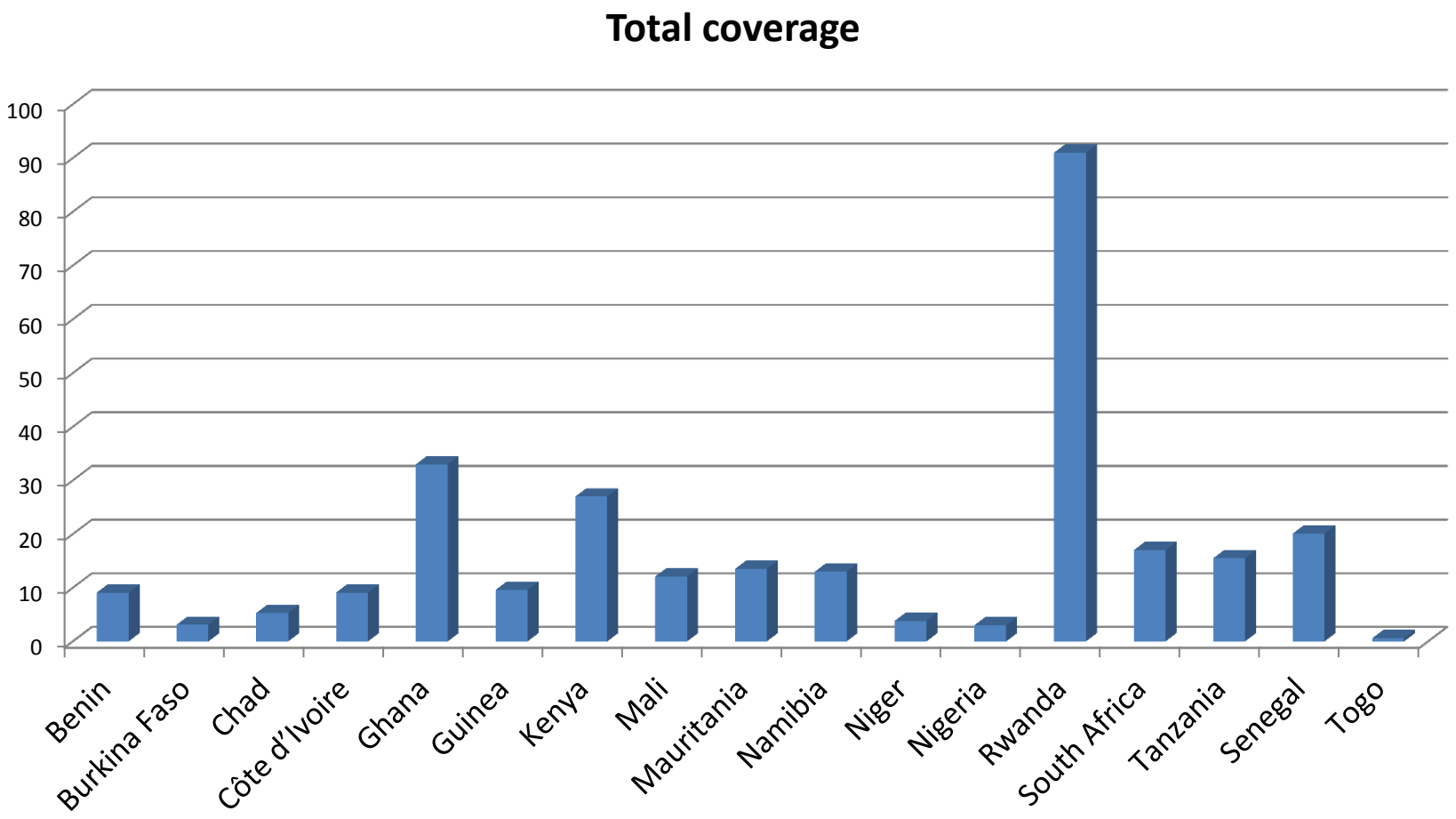


….. and High OOPs, little pooling

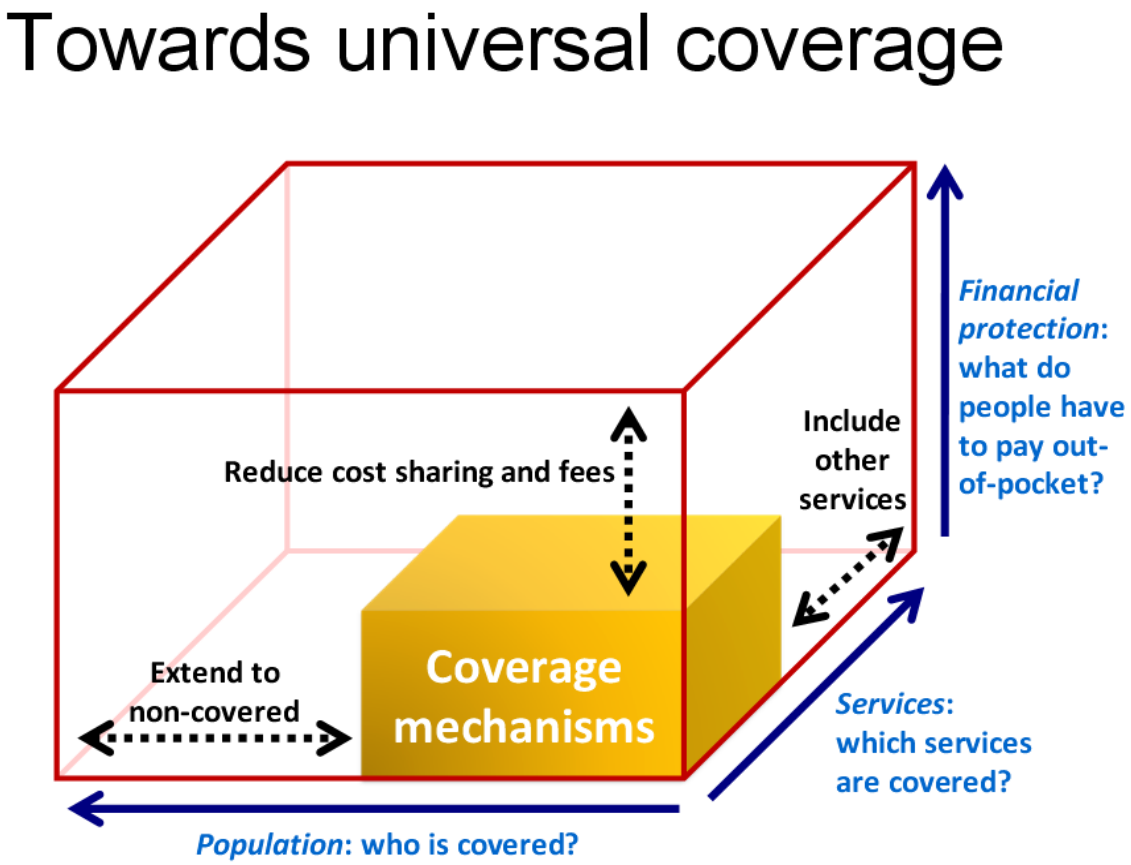
Share of OOPs in
Total health expenditure



Total health coverage is low



Road to universal health coverage



Country experience and different policy options

Community-based health insurance in Rwanda

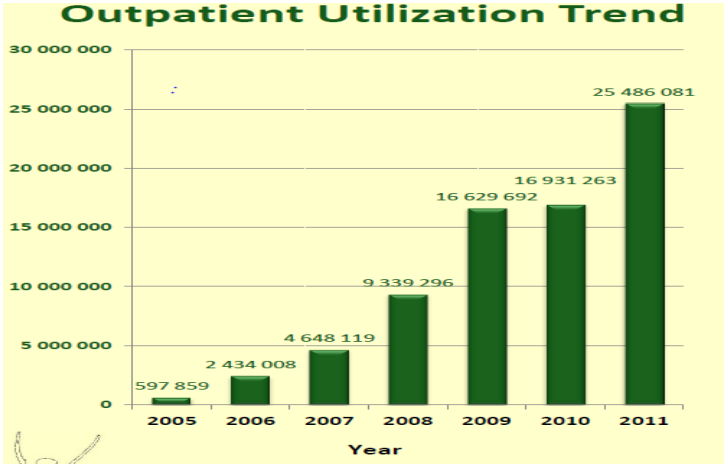
- ✓ Rwanda has one of the largest experiments in community-based risk-sharing mechanisms in Sub-Saharan Africa for health-related problems.
  - It has scaled up its coverage from around 35% of the target population in 2006 to close to over 90% now.
  - It has been successful in increasing utilization of modern health services and reducing catastrophic spending.

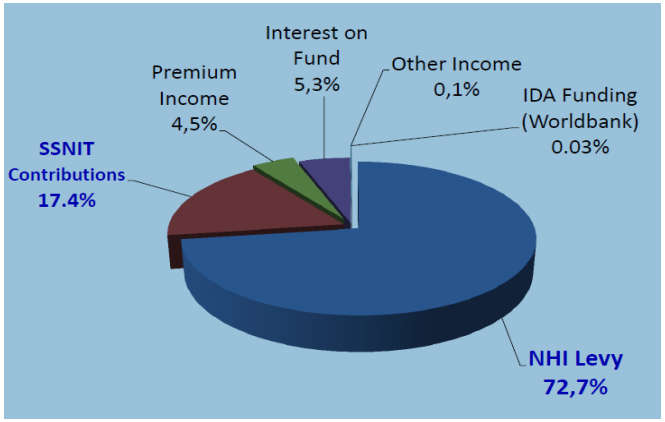
- ✓ CBHI is an integral part of the country's health program, with strong administrative and political support for its expansion and functioning.
  - The emphasis is on the rural population and the informal sector.
  - The district is the main administrative unit, where each of the 30 districts of Rwanda has a *fonds de mutuelle de santé.*

- ✓ The system overcomes the low purchasing power of the great majority of Rwandans through subsidies provided by the government and development partners.

Ghana's NHIS

- **NHIS operational since 2004**
- **Current coverage 35% (active members, NHIS 2012)**





Earmarked Funding (NHIL/VAT) & Social Security contributions constitute over 90% of NHIS revenue

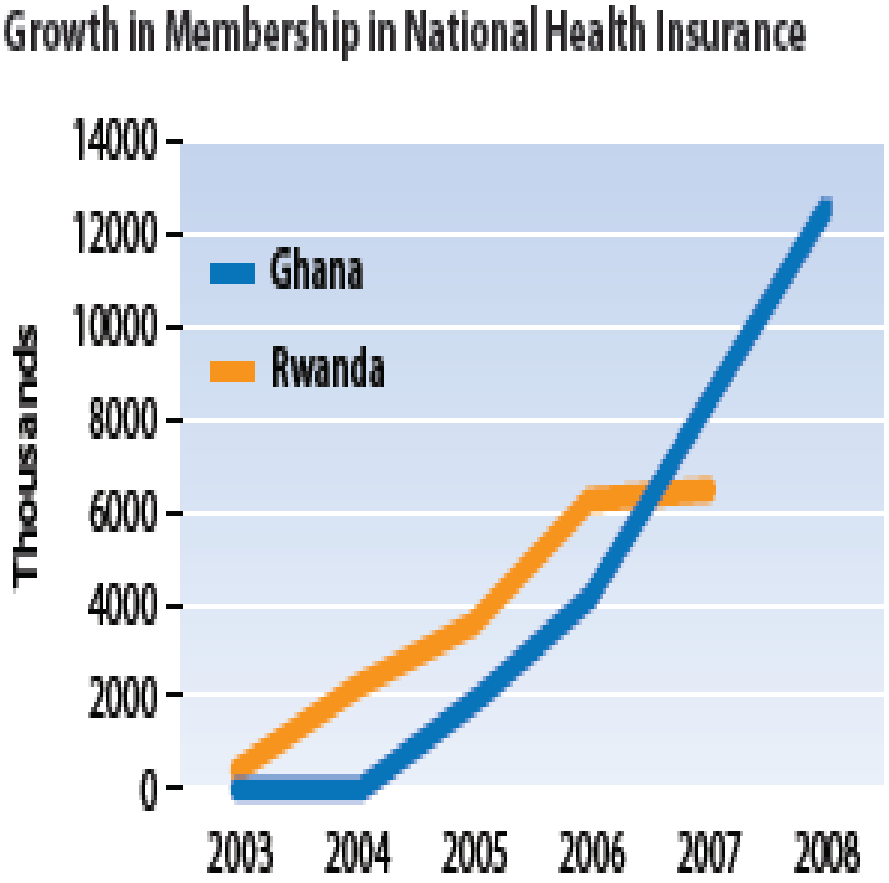
Contribution mechanisms

- National Health Insurance Levy (NHIL) - 2.5% VAT
- 2.5 % out of 18.5 % Social Security Contributions
- Graduated premiums for the informal sector based on ability to pay

Mitigating financial risks of diseases is possible in practice

- In Ghana Health insurance enrollment reduced OOPs by 86% and protected households against catastrophic expenditure by 3%
  - The number of OP care visits increased from 12 million to 18 million while hospital admissions rose from 0.8 million to 0.85 million between 2005 and 2008.

- In Rwanda 29-36% of uninsured households incurred catastrophic expenditure vs. 7-18% of insured households



The interesting 20-20 scenario in South Africa

- ✓ OOPs is <20% of THE, but only <20% actually prepay for healthcare.
- ✓ In effect, about 45% of healthcare resources or 4% of GDP are on offer for curative care for the uninsured as well as for public health for all.
- ✓ The uninsured population neither contribute (tax or insurance premium) nor receive sufficient care that are not free.
- ✓ South Africa is contemplating a National Health Insurance program

Changing landscape in Egypt

- ✓ Egypt is looking for a new comprehensive national health financing system in place
- ✓ Total health spending is low at 5.9% of GDP; budgetary share of health is very low at 2.8%.
  - 59% of the population is covered under health insurance of some form with only < 10% of the insured make any contribution.
  - Still, OOPs is high at 71.8% even while health insurance coverage is increasing; medicines alone accounts for 34.2% of total health expenditure.
- Since health insurance in Egypt is not governed by a single unified law, it currently operates under many different forms of laws, regulations and ministerial decrees.
  - Health insurance uses a mix of financing sources including premiums, tobacco tax, pollution tax, license fee, recreation tax, road tax and crime tax.
  - The number of insured is constantly growing without proportionate investments in the infrastructure and systems to meet these ever-growing demands.

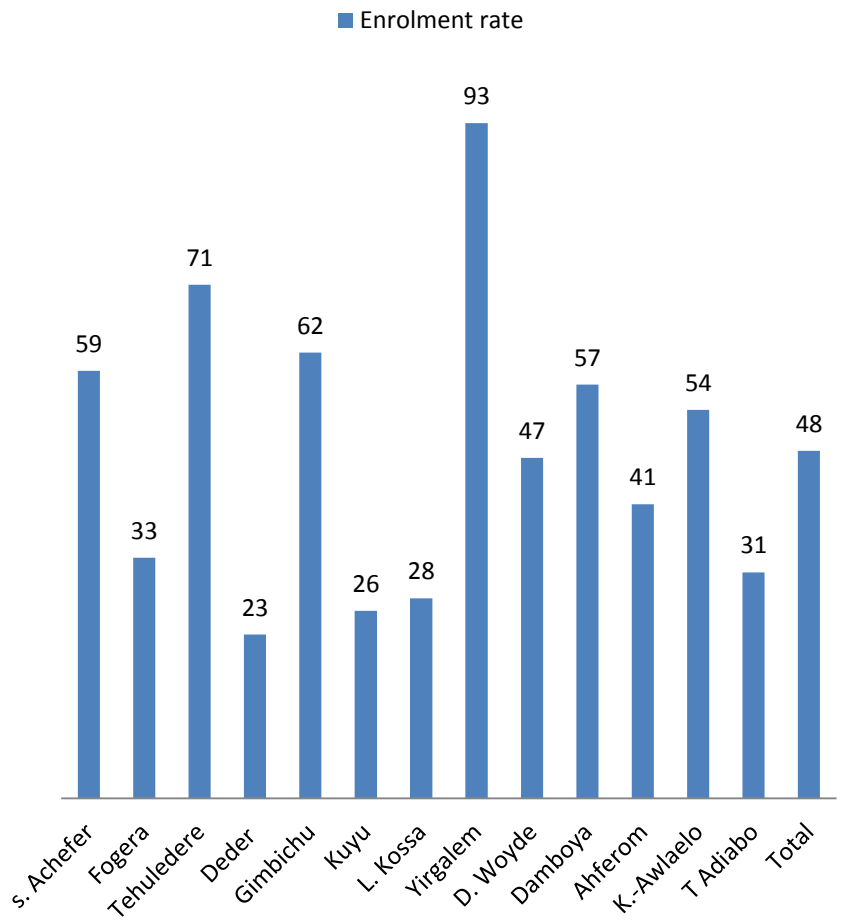
Health financing model in Tanzania

- ✓ The NHIF (since 1999) covers formal public/private sector employees
  - It covers about 2.5 million people and has grown by an average of 11% a year.
  - Service coverage is comprehensive and the provider network covers public/private facilities.
- ✓ CHFs (since 2001) allow district governments to establish a CHF through by-laws.
  - Managed by local councils, coverage is about 3.5 million people
  - District councils define premiums and the benefit package.
  - Primary level services are included in all districts, services at the first referral level in some.
- ✓ NSSF-SHIB (since 2006) serves the formal private sector.
  - The premium is included in the general 20% deduction by NSSF, but only 10% have completed the separate enrollment and are thus able to access the benefit.
  - A comprehensive set of services is included in the benefits.
- ✓ Micro-insurance schemes by cooperatives/nonprofit organizations cover a negligible proportion of the population.
  - Benefits and premiums are often limited and schemes face sustainability issues.
- ✓ Private health insurance provides risk-based (corporate-sponsored) insurance to the formal sector.
  - Benefit packages are often comprehensive and include services from premium providers.
  - Total coverage is below 150,000 and stagnant (while costs and premiums have escalated).
- ✓ % of prepayment in health spending is low, but has grown in recent years.

SHI+CBHI in Ethiopia

- Community based health insurance (CBHI)
  - More than 85% informal sector
  - CBHI considered the main vehicle to remove financial barrier and progress toward UHC
  - CBHI under pilot test in 4 Regional states and 13 districts
  - 141, 000 households registered
  - More than 2 million USD collected
- Proclamation and regulations passed for SHI
- preconditions being fulfilled to launch Social Health insurance for formal sector

Enrolment rate in 13 Pilot Districts in 15 Months



Take-home Messages

Several “No”s:

-No one perfect health care system

-No one-size-fits-all financing model

-No an universal pathway

-No a right or wrong starting point

Still

-Need a holistic strategy regardless the status

-Need innovative and sustainable financing arrangements

-Need special efforts to cover the poorest segment of the population

Political Leadership --Tunis Declaration (5 July 2012)

- Intensify dialogue between MOFs and MOHs for improved health spending
- Focus on high impact interventions
- Improve systems efficiency
- Ensure equitable investments
- Accelerate move towards Universal Coverage
- Etc.

http://hha-online.org

Increasing Financial Capacity

Go beyond resource mobilization and financing, including:

-Efficient service delivery system

-Value for money and accountability

-Transparent financial management and procurement system

-Expenditure data for analysis and decision-making

Favorable Factors:

-Continuous growth, larger fiscal space
-Increased resources for health
-Discovery of natural resources

Challenging Factors:

-High disease burden; double jeopardy
-Weak health system
-Quality of care
-insufficient resources

Instruments to support UHC efforts at country level

- Knowledge products - South-south exchange, status reports, results framework, guidelines, sourcebook, e-learning etc.
- Policy development - Policy design, institutional framework, evidence generation, piloting, etc.
- Provision of finance – Capacity building, infrastructure development, R&D, training, institutional development, start-up finance, working capital, etc.
- Facilitation of dialogues – Inter-ministerial round table, community empowerment, partnership, community-to-community learning, etc.

AfDB's Budget Support Program to support the reform of social protection in health in Morocco

- **In Morocco, access to health care is limited by a poor coverage of social protection mechanisms.** 32% of the population is insured:
  - 22% is affiliated with the compulsory health insurance or a private insurance
  - 10% is covered by the scheme targeting the most vulnerable (RAMED) and providing free care in public facilities

- **Health expenditures in Morocco represent a heavy burden for households and expose them to impoverishment.**
  - Households out of pocket expenditures represent 53.6% of total health expenditures.
  - Health insurance is only 18.8% of THE
  - Public spending is 25.2% of THE.
  - 1.9% of the Moroccan population incurs catastrophic expenditure

- **Since 2002, when the reform of the social protection in health in Morocco was started, AfDB supports the reform through budget support operations to the health sector.**
  - The Bank is currently preparing the third phase of that program (2013-2014) to assist the country in the establishment of a social safety net for the population.

- **Characteristics of the program:**
  - Budget support to the Ministry of Health
  - Over EUR 115 million in 2 tranches
  - Objective: To provide financial and medical protection of Moroccans, especially the most vulnerable, through the extension of basic social health insurance and access to quality health services.
  - Targeted technical assistance to facilitate the implementation of the program (e.g. support to the development of the health financing strategy of the MOH)