Regional Network for Equity in Health in east and southern Africa
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Are we making progress in allocating government health resources equitably in east and southern Africa?

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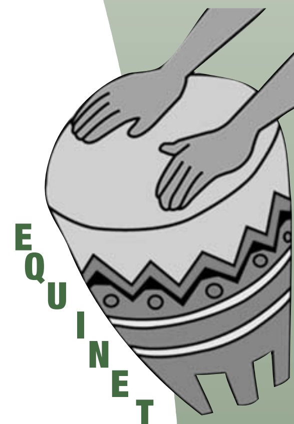

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Different districts, regions and provinces in a country have different health needs and available health care resources. Fairly distributing government funds for health thus calls for a resource allocation formula that calculates the share of total resources to be allocated to areas based on indicators of relative need for health care in that area. Many countries in the region use such formulae. They use different indicators of health need, including population size and composition, poverty levels and specific disease and mortality levels. Reviewing experience in selected countries in the region, this policy brief suggests that countries can strengthen equitable allocation of resources for health by increasing the overall share of government funding allocated to the health sector, bringing external aid and government funding into one pooled fund and allocating it through a single mechanism. Equitable resource allocation calls for governments to establish annual targets for equitable allocation of these public funds, and to collect information to monitor and report on progress in meeting these targets, including to parliaments and civil society. Resource allocation is a politicised process and requires careful management, including to plan, organise and provide incentives for redistributing health care staff to areas where health need is higher.

Why equitable allocation of government health care resources matters

In many African countries, health care spending levels are very different between different provinces, regions and districts. This is largely a historical inheritance. Health services, particularly hospitals which consume the major share of health care resources, are heavily concentrated in the largest urban areas, and rural areas are relatively under-resourced. Almost all countries in east and southern Africa have policy goals to provide equitable access to health care for their citizens. This goal implies that health care resources (financial, human and facilities) should be equitably distributed between geographic areas. This would ensure that citizens are not disadvantaged in their access to health care purely because of their place of residence.

Once a pattern of distribution of health care facilities has been established, health finances tend to be allocated towards *existing* facilities, existing staff establishments and/or utilisation patterns, rather than according to the distribution of population *health needs.*

Allocating resources equitably

Internationally, it has been found that using a needs-based resource allocation formula is a helpful strategy for breaking the historical inertia in resource allocation patterns. Such formulae are used to distribute public sector health care resources between geographic areas (such as provinces or regions and districts) according to the relative need for health services in each area.

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The indicators most frequently used in resource allocation formulae internationally to measure the relative need for health services between different geographic areas are:

- population size;
- composition of the population, as young children, elderly people and women of childbearing age tend to have a greater need for health services;
- levels of ill-health, with mortality rates usually being used as a proxy for illness levels; and
- socio-economic status, given that there is a strong correlation between ill-health and low socio-economic status and that poor people rely most on publicly funded services.

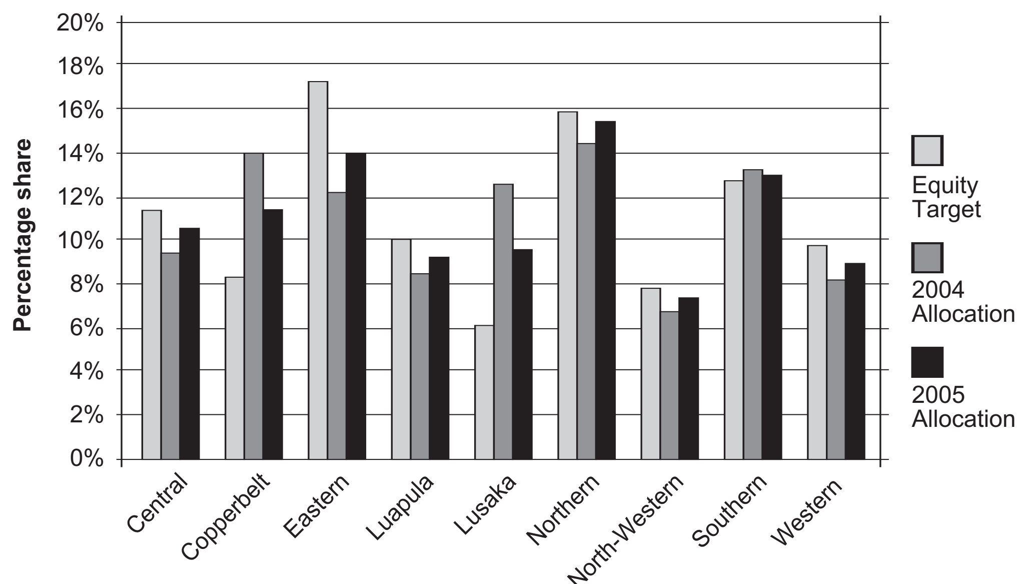
A growing number of African countries have adopted some form of needs-based formula to guide the allocation of health care resources, using a mix of these indicators. The choice of specific indicators depends on which have greatest power to show different levels of health need, where valid information exists, by area.

Are equitable resource allocation strategies being implemented?

The experience of selected countries in the region (Namibia, South Africa, Zambia and Zimbabwe) was reviewed through a questionnaire survey of researchers and senior government officials. This showed that there has been progress in the equitable allocation of public sector health care resources over the past few years, although the extent of progress and pace of change varies between countries.

By way of illustration, the experience of Zambia is presented here. Zambia adopted a needs-based resource allocation approach in 1993/94 but recently revised their formula in 2003/04 to include indicators of material and social deprivation. Relatively ambitious targets were set for achieving equitable resource allocation. While the pace of change has been slower in practice than planned, substantial progress has been made. The figure below shows this progress. It compares the share of total public sector health care resources that each province *should* receive based on the needs-based resource allocation formula with what was actually allocated in 2004 and in 2005.

Resource allocation trends in Zambia, 2004, 2005



Source: Data from Zambian Ministry of Health (collected by B. Chitah and F. Masiye)

All provinces that had financial allocations in 2004 above their target share of resources according to the needs-based formula saw a relative decline in their allocations in 2005. Conversely, all provinces that were below their equity target allocations in 2004 received relative increases in allocations in 2005. This signals progress in equitable resource allocation.

Namibia and Zimbabwe both have needs-based formulae. Namibia is not yet formally implementing it. Nevertheless, a relative redistribution of health care resources between regions has been initiated in 2005. There is a strong commitment to redressing historical disparities, and information on the distribution of disease and of deprivation between regions has facilitated an increase in allocations to most under-resourced regions, gradually reducing allocations to relatively over-resourced regions. Progress in Zimbabwe towards equity targets has been constrained by the absolute shortfall in health care resources due to wider economic difficulties.

South Africa has a different system for the allocation of domestic public sector resources, within its 'fiscal federal' system. National level resources are allocated as a 'block grant' to provinces, which then have autonomy in deciding how to allocate these resources between the health and other sectors. Allocations to provinces are based on a formula which includes indicators of need for health, education and other services for which the provinces are responsible. While there were initial concerns that provincial autonomy in determining allocations to the health sector may increase inequities in the distribution of health care resources, there has been considerable progress towards equity in the past few years.

These examples indicate the presence of such formulae in the region, and some progress in their application. Given the significant gain for people with high health needs and poor communities from equitable resource allocation, it is important for information on how resources are being allocated and the formula used to be made public, especially to parliaments and civil society.

Overcoming barriers to implementing equitable resource allocation strategies

An explicit policy commitment to equity and to redistribution of resources needs to underpin the successful implementation of equitable resource allocation. For example, the Namibian 1998 health policy states that *"Particular emphasis shall be paid to resource distribution patterns in Namibia to identify and accelerate the correction of disparities"*. There are similar commitments in health policy documents in South Africa, Zambia and Zimbabwe. These policy commitments are supported by Medium-Term Expenditure Frameworks (MTEF) that provide allocation guidelines for the next three years and allow for planning on how to appropriately use resources that will be allocated to each geographic authority.

Experience from countries in the region point to some of the actions countries need to take to overcome barriers in implementing equitable redistribution of health care resources.

Countries need to set explicit annual allocation targets to provide clear goals against which progress can be planned and monitored. These targets need to set a reasonable pace of change for the relative redistribution of health care resources to facilitate appropriate planning and avoid unnecessary disruption to services.

Even where these targets exist, countries may face difficulties in successfully pursuing these targets due to:

- a lack of senior staff at the national level to drive the process;

- the existence of numerous vertical programs, which protect allocations to specific services and reduce the pool of general health sector funds that are available for equitable allocation between geographic areas; and
- failure to translate budget shifts into real changes in expenditure by neglecting the more difficult task of also changing the distribution of staff, given their importance in the uptake of resources.

Technical staff need appropriate skills to regularly update the resource allocation formula to factor in the key environmental changes. Active support for equitable resource allocation needs to be obtained from bilateral and multilateral donor agencies. Strategies must be put in place to facilitate a relative redistribution of staff. This may include negotiations with trade unions and initiatives such as offering additional allowances, preferential training opportunities and other incentives to attract health workers to rural areas.

Mobilising support for equitable resource allocation

Resource allocation is a highly politicised process and the resource allocation policy development and implementation process requires careful management in order for it to be successful.

It is politically and technically easier to address these issues and redistribute health care resources when the overall health budget is increasing. The still limited progress by 2008 towards achieving the Abuja target of devoting 15% of government funds to the health sector constrains progress on equitable resource allocation whilst increasing the overall allocations to the health sector gives governments more leeway to effectively redistribute health care resources. All of the additional budget available annually can be allocated to the most under-resourced areas while keeping the budgets of relatively over-resourced areas static in real terms (only allowing a small increase to take account of inflation).

Most importantly, governments need to engage with key stakeholders in developing and implementing an equitable resource allocation strategy to ensure their 'buy in' and commitment to an equitable sharing of available resources. This needs a 'policy champion' in the form of a very senior Ministry of Health official who will motivate for and monitor progress in an equitable resource allocation strategy. It is also valuable to involve the parliamentary committee on health and civil society to commit to and monitor progress in the attainment of annual allocation targets.

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