

# Progress in fair financing for health in East and Southern Africa

*Fair financing of health services requires that countries reduce their reliance on out-of-pocket (OOP) funding for health services and improve their pre-payment financing through general tax revenue and health insurance (particularly mandatory health insurance). While many countries in east and southern Africa (ESA) receive high levels of external funding, it is critical to increase domestic government funding for the health system to support this move away from out-of-pocket funding to provide effective financial protection from the costs of health care. This policy brief reviews progress in reducing out-of-pocket payments in ESA countries and in increasing government funding for health, particularly in terms of meeting the Abuja target of 15% of the government budget being devoted to the health sector and a target of government spending of US\$60 per capita. While there has been some progress in some countries, most ESA countries are still far from achieving these fair financing targets. The brief highlights areas that merit action to meet policy commitments on fair financing.*

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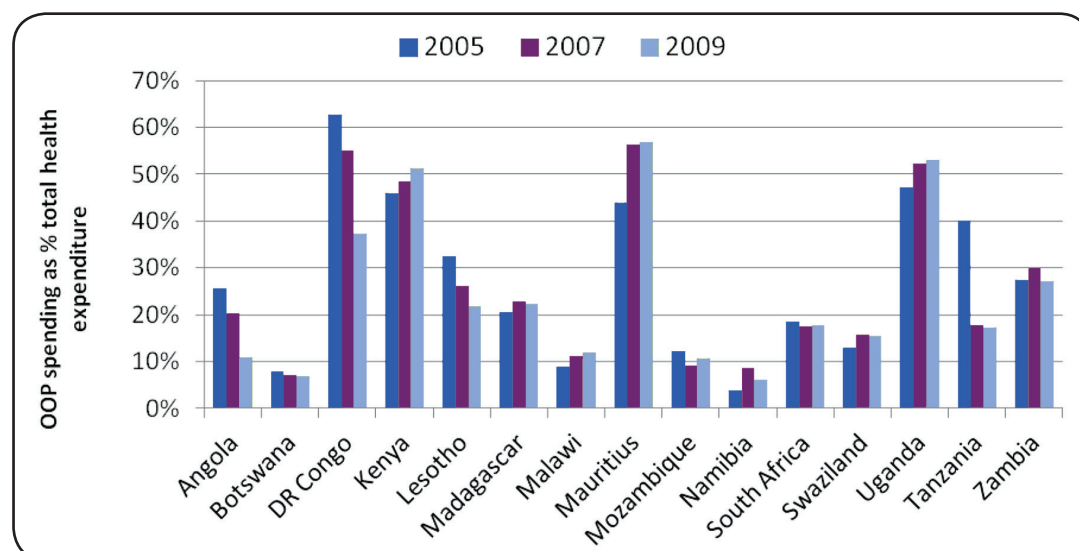
## Moving away from out of pocket spending on health services

In May 2005, the 58th World Health Assembly adopted a resolution urging member states to ensure that health financing systems are based on pre-payment financing mechanisms, with the aim of: sharing risk across the population and avoiding catastrophic health care spending and impoverishment of households. This call has been reiterated

in several other resolutions and in the 2010 World Health Report.

In East and Southern Africa, Figure 1 shows that Democratic Republic of Congo (DRC), Lesotho, Tanzania and Angola have made the most progress in reducing their reliance on Out of pocket (OOP) spending in health financing. Out of pocket spending includes direct payments that households make for health care. In other ESA countries, the share of OOP spending has remained the same or even increased.

Figure 1: Out of pocket spending as a percentage of total health expenditure



Source: Re-calculation of data from WHO National Health Accounts database 2012

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OOP spending ranges from less than 7% of total health care expenditure in Namibia and Botswana at the lower end to above 50% in Uganda, Kenya and Mauritius. These trends raise concern as OOP spending can place a catastrophic burden on households, and may drive some households into poverty or discourage uptake of health care.

In public health facilities, of the sixteen ESA countries reviewed, only three (Angola, Uganda and Malawi) have abolished user fees for all public sector services while the rest still have at least some user fees in place. Others, such as South Africa, have removed fees for primary care services only, or, as in Zambia, for all public sector services in rural areas. In most countries, there are only limited exemptions for specified groups such as poor or elderly people, or for specific diseases such as TB and HIV or services, such as immunisations.

EQUINET has called for the removal of user fees from public sector health services in ESA countries, accompanied by improved government funding for health care. Adequate government funding is needed to ensure that public sector health services are available and of acceptable quality so that households are not forced to use private providers and pay for these on an out-of-pocket basis, as has happened for example in Uganda.

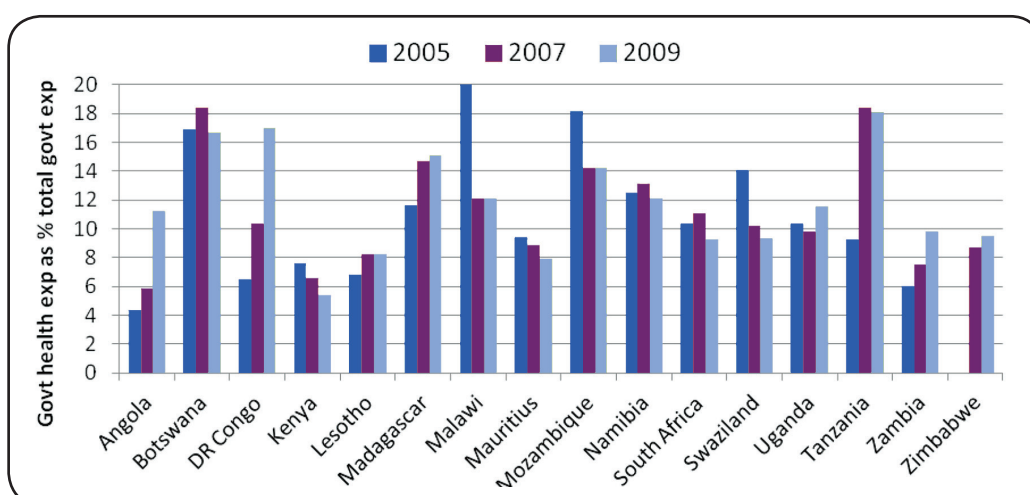
## Meeting the Abuja commitment

African Heads of State committed themselves in 2001 to allocate at least 15% of their national annual budgets to funding the health sector (known as the Abuja target). Very few countries have yet achieved this target.

Figure 2 shows the mixed performance in ESA countries between 2005 and 2009. Of the sixteen countries, only four - Botswana, DRC, Madagascar and Tanzania - had reached the 15% target by the end of 2009, and Mozambique and Namibia had come close in spending 14% and 12% respectively. The remaining twelve countries were far from meeting the target, although five had improved their share of spending in the period.

Most ESA countries have high levels of external funding and the WHO information on government spending on health includes the external funding that is channelled through general budget support. The trends in Figure 2 thus overestimate spending on health by government alone. WHO has recently made available data for some ESA countries that indicates spending by government excluding budget support by external funders, shown in Figure 3. on the next page This data indicates that no ESA country has achieved the Abuja target when assessed in terms of spending by government alone.

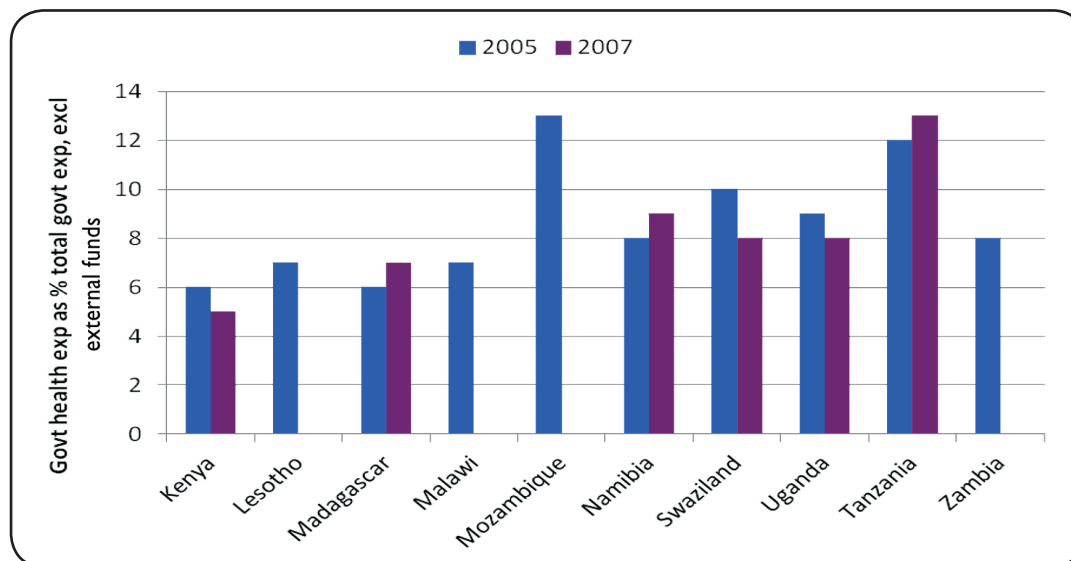
**Figure 2: Progress towards the Abuja target *including* external funding**



Source: World Health Organisation National Health Accounts dataset 2012



Figure 3: Progress in meeting the Abuja target *excluding* external funding



Source: WHO Global Health Expenditure database 2012 <http://apps.who.int/nha/database>  
Data for other ESA countries not available

## Achieving US\$60 per capita spending on health

The 2000 World Health Report estimated that US\$60 per capita was needed for a comprehensive health system, including a minimally adequate set of interventions and the infrastructure to deliver them. Figure 4 shows that eight of fifteen ESA countries for data is available remain below the US\$60 per capita health sector expenditure level in 2009.

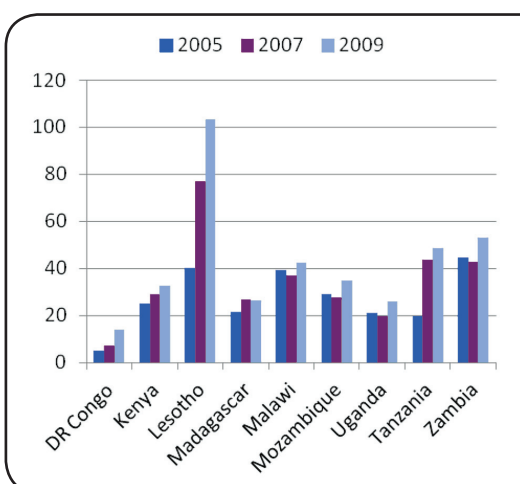
Only seven ESA countries, that is Lesotho, Angola, Botswana, Mauritius, Namibia,

South Africa and Swaziland, spend more than US\$60 per capita on health. The substantial increases in expenditure in Botswana partly relate to the rapid growth in spending on HIV and AIDS.

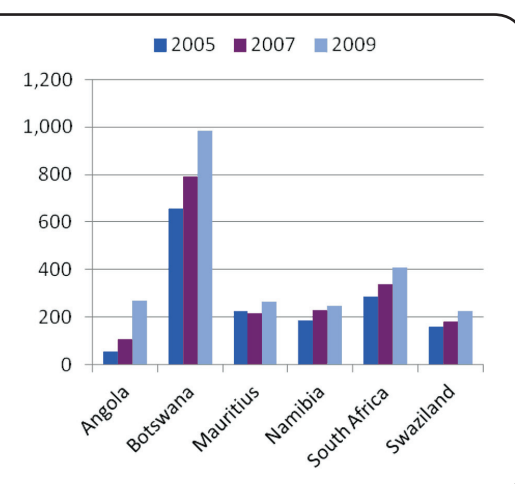
The seven countries spending above the US\$60 per capita, with the exception of Lesotho, are classified as low-to-middle income countries. This may partially explain their relatively higher spending levels compared to their lower income counterparts in the region.

Figure 4: Per capita government expenditure on health (PPP international US\$)

Low Income Countries



Low - middle income countries



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Source: WHO Global Health Expenditure database 2012 <http://apps.who.int/nha/database>  
Data for Zimbabwe not available



For the eight countries spending less than \$60 per capita, there are mixed trends over the years reviewed. Some countries showed increased per capita public health spending, particularly DRC - although from a low base- Tanzania, Madagascar and Mozambique. Others have, however, showed little change in their per capita health spending in the period.

The WHO dataset on per capita spending in health does not distinguish in its estimates of government expenditure between external funding that is channelled via government mechanisms and domestic public funding. It is thus not possible to determine from this data the extent to which increased funding in the DRC, Lesotho, Mozambique, Tanzania, Angola and Botswana is due to improved domestic or external funding.

## Recommendations for improving fair financing

Given the trends found in fair financing in the past 5 years, we propose the following actions to governments, parliaments, civil society and other non state actors:

1. To continue to advocate for the removal of user fees on all public health services backed by alternative sources of pre-payment health care financing to ensure good quality services in public sector facilities.
2. To monitor and review household spending on health, including catastrophic health spending, particularly at times of changing fee charges.
3. To consistently improve domestic public funding for the health sector from general tax revenue and, where appropriate, mandatory health insurance.
4. To monitor, publicly report on and advocate for achieving the Abuja commitment and the US\$60 per capita funding to the health sector, including through Ministry of Finance reporting on the progress and measures towards achieving these commitments as was implemented, for example, in the 2012 Budget statement in Zimbabwe.

5. To ensure that domestic, regional and international reporting on the Abuja commitment, and the US\$60 per capita health spending separate domestic and external funding so that it is possible to track the levels of domestic spending on health, given their importance in meeting state obligations for health service entitlements.

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