HEALTH CARE FINANCING AND COPING STRATEGIES IN SUB-SAHARAN AFRICA: A SYSTEMATIC ANALYTICAL REVIEW

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Abstract
Out-of-pocket payment, which has been dominant for meeting the health needs of individuals and households, is gradually crumbling due to non-affordability and equity concerns in the sub-Saharan African region. Most countries in the region are beginning to re-think on how to reform their health care financing in order to improve on coverage and equity. There is an active debate and considerable disagreement about the appropriate role of five approaches to health care financing at low-income levels in the region. This paper reviews the application of these health care financing mechanisms and suggests how best to protect the poor when they fall sick.

Introduction
Health care financing continues to be a key challenge in the developing world. Despite efforts to improve the provision of health services, many low- and middle-income countries are still far from achieving universal health coverage. As documented by World Health Organization, WHO (2005), an estimated 1.3 billion people do not have access to effective and affordable health care, including drugs, surgeries, and other medical facilities. Developing countries bear 93%

of the world's disease burden, yet, merely account for 18% of world income and 11% of global health spending. At the sub-national level, the rich often benefit more from public expenditure and subsidies on health care than the poor. And scarce public resources that are available to the poor in many low-income and middle-income countries are often squandered on ineffective care.

Meeting the basic health needs of the people has always been one of the greatest challenges faced by countries in Africa. Yet, in competing for resources, the health sector is often ranked relatively low among national development priorities. Currently, the proportion of the central government expenditure on health in Africa ranges from less than 5% to high 14%, with an average of 8%. Considering the high burden of diseases in the region, the allocation of financial resources for health must be critically assessed, especially in terms of equitable distribution. It must be recalled that the Heads of State and Government of the African Union committed themselves in the Abuja Declaration 2001 to allocate 15 % of their national budget to health. Progress on this commitment reveals that 4 countries are allocating less than 5 %, 25 countries between 5 and 10 % and 13 countries between 11 and 14 % **(**CAMH2, 2005**)**.

In relation to health care financing in Africa, as contained in the World Health Organization's 2001 National Health Accounts (NHA), McIntyre *et al* (2005) observed that the current level of health care funding from government tax revenue is relatively low in most African countries. In about 60% of African countries, the health sector share of total government expenditure is below 10%. There is still a reasonably high level of reliance on donor funding. Donor funding accounts for over a quarter of total health care funding in about 35% of African countries, with 5% of countries having more than half of all health care funding coming from external sources. There is limited insurance coverage, especially in relation to mandatory health insurance. However, community pre-payment schemes have been on the increase in recent years. One of the single largest sources of financing is that of out-of-pocket payments, which exceed 25% of total

health care expenditure in more than three-quarters of sub-Saharan African countries. Out-of-pocket payments include user fees at public sector facilities as well as direct payments to private providers, ranging from doctors working in private practice to informal drug sellers and traditional healers.

The critical question is how to improve the access to health care and financial protection of the poor in developing countries. Whereas formal statutory health insurance schemes have largely failed to reach the poor, private for profit and not-for-profit schemes are emerging in different regions of the world, offering a potential improvement in risk sharing for a larger part of the population (Drechsler *et al*, 2005). Developing countries rarely have the financial means and institutional capacity to provide state-based health insurance. A large amount of health costs is, thus, directly borne by patients. So-called "out-of-pocket-payments" account for one third of total health expenditure (THE) in two thirds of all low-income countries. This situation became even more prevalent after the introduction of cost sharing mechanisms in many developing countries (e.g. user fees, co-payments, or deductibles). Low-income families, in particular, suffer from these conditions as direct payments pose severe risks of impoverishment. Without sufficient social protection, many households are threatened by catastrophic health expenditures, especially considering the impact of indirect costs associated with illness (e.g. a loss of productive capital) (Drechsler *et al*, 2005).

In view of these perils, the current debate on health sector reform clearly emphasizes the need to move away from excessive reliance on point-of-service-payment to prepayment and risk-sharing. Private health insurance (PHI) offers a potential alternative to insure against the cost of illness and, lately, has been receiving increasing consideration from policy makers around the world (Drechsler *et al*, 2005). Many low-income countries are falling significantly behind in achieving the Millennium Development Goals (MDGs). Although no single mechanism of health care financing is likely to mobilize all the needed financial resources to achieve the MDGs, many local

communities are introducing micro-level health insurance as one – albeit small – contribution to this agenda. Such community financing schemes often evolve during severe economic constraints, political instability, and lack of good governance. Usually, government taxation capacity is weak, formal mechanisms of social protection for vulnerable populations absent, and government oversight of the informal health sector lacking. In this context, community involvement in the financing of health care provides a critical, but often insufficient, first step in the long march towards improved access to health care by the poor and social protection against the cost of illness (Tabor, 2005*).*

Although much is known about the issues and policy options for improving health financing in other regions and higher income levels, there is still a considerable knowledge gap on how best to approach this challenge in the context of the low-income levels and weak institutional capacity especially in the African context. Several factors relating to revenue collection, risk pooling, and spending at low income levels make the policy options for financing health care in the Africa region and other low income countries different from those of middle and higher income countries (Danida, 2007).

There is an active debate and considerable disagreement among policymakers at the country level, international donors, and others about the appropriate role of four approaches to health care financing at low-income levels in the sub-Saharan Africa. These approaches are *user fee*, *social health insurance*, *private finance*, and *new international donor mechanisms*. In addition, a fifth dimension in the realm of complimentary and alternative medicines will also be examined as a growing strategy of health care strategy. This paper has the objective of reviewing the application of these health care financing mechanisms in sub-Saharan Africa and making recommendations on equity and on how best to protect the poor when they fall sick. It is important to stress that health care financing mechanisms differ in each African country and that there are no 'one-size-fits-all' solutions (McIntyre *et al*, 2005).

This review attempts to identify some common trends and challenges, illustrate important issues in relation to particular healthcare financing options through reference to specific country experience and propose possible policy options meant to address considerations within each country-specific. The paper provides a general overview of health care financing in Africa with particular reference to equity issues and challenges, a critical overview of the coping strategies adopted by the varying socio-economic groups of the population in fulfilling their health care financial obligations, and makes some contributions toward equitable health care financing and poverty reducing options pertaining to health care financing in Africa.

Research questions

1. Which health care financing option provides equity to the poor and protects them from impoverishments in cases of illness?
2. What are the challenges and coping mechanisms in health care financing in Sub-Saharan Africa?
3. How do we use the outputs from objectives 1 and 2 to improve policy options in health care financing in the sub-Saharan African region?

Methodology

A systematic review of the literature was undertaken to understand the level and usage of these health care financing options in the sub-Saharan African region. Documents made available by world bodies, like WHO, World Bank, African Union, etc., published researches and presentations were used in the review. The reviewed materials had clear statements on the usage of these health care financing options and the challenges encountered in the process, especially on coping strategies and equity.

Data identification mechanism

The following databases were searched: Google Scholar, Pub-Med, Embase/Medline.The list of the words or a combination thereof used in

the search were: health care financing in developing countries, coping mechanisms and health care financing, challenges of health care financing options, donor activities and health care financing in Africa.

Key Health Care Financing Options in Africa

User fee

According to Bennett and Gilson (2001: 5):

> *In the user fees system, patients pay directly, according to a set tariff, for the health care services they use. There is no insurance element or mutual support. This is the most common way of paying for privately provided services in developing countries and is also used as a component of financing for public sector services.*

User fees for health services are not new in Africa. A few countries in Anglophone Africa, such as, Ethiopia, Namibia, and South Africa, have had national user fee systems for years, while in many others, charges have historically been applied in both governmental and non-governmental facilities (Nolan and Turbat, 1995; Russell and Gilson, 1995; Gilson, no-date). However, since the 1980s, the number of African countries implementing some form of *user fee* system has grown considerably. Governments have come to see user fees as a critically important alternative to tax-based financing for government health services in Africa, even in countries, such as Kenya and Tanzania, which had previously provided government care free at the point of use.

Recent surveys show that most African countries have now introduced some form of fee system for government facilities (Russell and Gilson 1995). Fourteen of the 15 African countries (Russell and Gilson, 1995) and 28 of the 37 African countries (Nolan and Turbat, (1995) surveyed have done so. The out-of-pocket share is high on

average for low-income countries and accounts for 50-70% of total health expenditure, although this varies greatly (Musgrove and Zeramdini, 2001; Bennett and Gilson, 2001). In 1995, 28 out of the 37 African countries studied in a World Bank survey, had introduced user fees in government health facilities (Nolan and Turbat, 1995 in Arhin-Tenkorang, 2001). However, much of the out-of-pocket fees are spent in urban areas for non-essential services (Bennett and Gilson, 2001).

User fees are commonly regarded as the most "anti-poor" financing system, as it prevents the poor from using the services that they cannot pay for. This situation has been repeated in Africa continually, especially after the introduction of Structural Adjustment Programmes (SAPs) in 1980s, when cost recovery schemes were introduced. In particular, the problem was that the collection of out-of-pocket payment did not translate into an improvement of the health facilities (where the fees were collected) in most cases. Generally, although the fee is significant for the individual, especially if poor, the total revenue raised is low at the aggregated level. In Ghana where hospital fees were introduced as part of the government's Economic Recovery Programme with the target of raising 15% of recurrent budget, only 1-12% cost recovery ratios had been sustained and with the trade off of declining use of health facilities mostly in rural areas (Arhin-Tenkorang, 2001). In Nigeria, the absence of institutionalized National Health Accounting System (NHA) has amplified the weak basis for judgment on the adequacy or otherwise of health spending. Funding of the sector relies on a mixture of government budget, health insurance (social and private), external funding and private out-of-pocket spending to finance health care.

Despite the variety of financing sources, the level of health spending is relatively low at less than 5% of the gross domestic product (GDP) on health (WHO CCS. Federal Republic of Nigeria, 2008-2014). Household out-of-pocket expenditure, which includes user fee as a proportion of total health expenditure averaged 64.5% between 1998 and 2002. This indicates that the burden of health expenditure on households is very high. On average, about 4% of households are

estimated to spend more than half of their total household expenditures on health care and 12% of them are estimated to spend more than a quarter (WHO CCS. Federal Republic of Nigeria, 2008-2014).

Out-of-pocket spending (OOPS) is the major payment strategy for healthcare in Nigeria and the real challenge of health care financing in Nigeria as in many sub-Saharan African (SSA) countries lies not primarily in the acute scarcity of resources, but in the absence of intermediation and insurance mechanisms to manage risk, and inefficient resource allocation and purchasing practices (Soyibo, 2004). Thus, developing equitable financing approaches will depend on the assessment of the burden and determinants of OOPS on healthcare seeking by different socio-economic and geographic groups, leading to determining how best to protect the poor. User fees fall within the broader concept of "cost-sharing", a practice whereby beneficiaries contribute towards the cost of a public service and they are defined as payment of out-of-pocket charges at the time of use of services (Witter, 2005).

OOPS for healthcare increased with the introduction of user fees in the health sector and like most African countries, Nigeria introduced user fees as a mode of financing government health services within the framework of the Bamako Initiative revolving drug funds (Uzochukwu *et al*, 2002; Ogunbekun *et al*, 1996). The introduction of user fees was arguably in response to the severe problems in financing health services in Nigeria, like in most of the sub-Saharan Africa. Government health budgets declined in real terms in response to macroeconomic problems at the time, while demand for health services increased, partly because of population growth and successful social mobilization. Currently, user fees apply to government owned healthcare services in Nigeria with the major aim being to generate more funds for the health sector, so as to improve the quality of services (FMOH, 2005). In the private sector, patients are also charged fees, which they mostly pay out-of-pocket.

However, public expenditures in Nigeria account for just 20-30% of total health expenditures (THE), while private expenditures

accounts for 70-80% of THE and the dominant private expenditure is OOPS, which accounts for more than 90% of private health expenditures (Soyibo, 2004). The recently introduced national health insurance scheme is not expected to change the picture in the near future, since it presently covers a minority of federal government civil servants only. Hence, the excessive private share of expenditures in Nigeria is all the more alarming, as most of it takes place via non-pooled OOPS, the most regressive form of payment (Preker, 2005). Private expenditure on health has been exponentially increasing in Nigeria, with a revised THE over GDP range between 6.5-7.4% and private shares of THE between the 'low' of 66.5% (2001) and the high of 74.5% (2002), total private expenditure roughly accounts for between 4.3-5.5% of GDP (Onwujekwe and Velenyi, 2005). OOPS is about US$ 22.5 per capita, which accounts for 9% of total household expenditures and half of those who could not access care did not do so because of its costs (Federal Office of Statistics 2004).

Tax funding is a core foundation of all African health systems. The availability of adequate tax funding is critical if problems in equitably accessing health care are to be addressed. For example, tax funded health budgets are critical in promoting an equitable geographical allocation of recurrent resources. In particular, general tax revenue (sometimes combined with donor funds) is the only funding source that can be actively redistributed between geographic areas in order to promote equity. Tax funding can clearly also significantly reduce financial access barriers, particularly through reducing out-of-pocket payments (McIntyre *et al*, 2005).

The WHO National Health Account (NHA) database shows that in African countries, where there is a commitment to devoting a relatively large share of government resources to the health sector, the burden of out-of-pocket payments is kept relatively low. No African countries have reached the target of 15% of government budgets being directed to the health sector, as agreed to by African Heads of State in the Abuja declaration (OAU, 2001). One of the main constraints to achieving this is the high level of external debt experienced in many

countries that translates into levels of interest payments and debt repayments that consume a considerable share of government budgets (McIntyre *et al*, 2005).

Situations of conflict are often another constraint on increasing health's share of budgets, given that they result in a large share of government resources being directed to defence. It is interesting that the sub-Saharan African (SSA) countries that devote less than 5% of their government budget to the health sector (Nigeria, Sudan, Cote d'Ivoire, Eritrea, Ethiopia and Somalia) have very high levels of indebtedness and/or conflict situations. Debt relief efforts in many instances are wholly inadequate (McIntyre *et al*, 2005). The key development in relation to user fees in recent years is the removal of fees for some or all health services in some African countries, such as South Africa and Uganda, and the mounting pressure on other African countries to adopt a similar policy (McIntyre *et al*, 2005).

The experience in countries that have removed fees was that there were rapid and large utilisation increases, especially for the poor. For example in Uganda, an extensive study using the first and second Ugandan National Household Surveys (conducted in 1999/2000 and 2002/03 respectively) and data from the Health Management Information System, highlighted that the poor had particularly benefited from the removal of fees (Deininger and Mpuga 2004, McIntyre *et al*, 2005). A key finding of this study was that although there were substantial differences between the rich and the poor in use of health services when ill while fees were in place, these differences were completely eliminated in the case of children after the removal of fees (although inequities in service use continue for adults) (McIntyre *et al*, 2005).

Experience suggests that four groups of constraints undermine the effective implementation of fee systems (Collins *et al*, 1996; Gilson and Mills, 1995; Gilson, Russell, and Buse, 1995; Kutzin, 1995; Nolan and Turbat, 1995, Gilson, no-date) as follows:

Poor design of fee systems as shown in complex fee structures that are difficult to administer, for instance, itemized billing. Types of fees, such as general consultation fees, that deter patient utilization because they are not linked to care received. Failure to revise fees annually in line with inflation, thereby undermining the amount of revenue generated. Complex and/or unworkable exemption mechanisms, which require too much information and are costly to administer. Fees implemented at low levels within the system where little revenue can be generated and lack of coordination between fee levels across the health system, possibly generating perverse utilization incentives, for instance, to use higher level care before lower level care, and inequities, for example, inappropriately differentiated fee levels between areas.

Poor capacity for local-level financial management and fee system implementation as shown in lack of financial management skills throughout the health system, but especially at the district or community level. Absence of appropriate financial management information and audit systems that support management rather than simply seeking to prevent misuse of finances. Lack of information with which to target the poorest effectively through exemptions. Limited local authority to take appropriate resource use decisions without reference to higher authorities. Limited effectiveness in collecting fees, thereby undermining revenue generation rates and revenue use for quality improvements. Lack of guidance on financial management and control practices, for instance, on how to determine who is eligible for exemptions, on how to account for revenue generated, or on procedures for using revenues. Failure to retain

fees locally, thereby undermining the incentive to collect them and use them for local-level quality improvements. Total retention of revenues locally, leading to limited redistribution of resources between geographical areas with different capacities to raise revenues and absence of procedures that would allow monitoring of the impact of policy implementation.

Weak supporting systems as demonstrated by poor quality public services that undermine the population's willingness to use them, for instance, drug shortages or poor staff attitudes. Inadequate human resource policies that do not promote or sustain staff morale. Inadequate drug supply and distribution systems. Operational inefficiencies within the health system that contribute to quality failures, for example, drug wastage and abuse, leading to shortages. Limited funding for the supervision and support needed at the primary level. Inadequate management information systems that do not, for example, allow resource use to be related to services provided and organizational structures that generate weak and conflicting lines of accountability, both downward to the community level and upward to technical supervisors.

Contextual constraints such as the population's lack of experience in paying for public health services, which generates an unwillingness to pay for them, especially when they perceive the services as providing only low quality care. The weak banking and communication systems, which undermine local-level financial management and the potential for support a variety of sociocultural and political constraints at both the local and national levels that allow richer groups to be

> incorrectly exempted and prevent the reallocation of resources to primary health care, which would benefit the poorest members of society the most.

Social insurance

In recent years, there has been a growing emphasis among international organizations on health insurance as a financing mechanism. For example, the principles for fair financing in the WHO's 2000 World Health Report, such as revenue collection in the form of pre-payment, pooling resources to promote cross-subsidies and strategic purchasing, imply that the main alternative to tax funding should be some form of health insurance (World Health Organization 2000, McIntyre *et al*, 2005).

Health insurance is still relatively limited within Africa. Private voluntary insurance schemes for formal sector workers are mainly concentrated in Southern Africa (particularly South Africa, Zimbabwe and Namibia) but also exist, to a more limited extent, in some East and West African countries. Experience of these types of schemes has not been entirely positive, with very limited coverage levels, fragmentation of risk pools and rapid, uncontrolled cost spirals threatening their sustainability. For these reasons, limited attention is being paid to expanding this form of health insurance within the African context (McIntyre *et al*, 2005).

Social health insurance is seen in Nigeria as a recent development and is manifested in the activities of the national health insurance scheme. From the support to develop National Health Account in Nigeria, evidence was adduced to indicate high level of out-of-pocket funding for the sector leading government to accelerate the launch of the National Health Insurance Scheme not only to mitigate catastrophic health expenditure but also provide pool of funds for the health sector (WHO CCS. Federal Republic Nigeria 2008-2014).The national health insurance scheme in Nigeria has met with little or no success as the coverage is low-mainly for limited formal sector, and the scheme is limited in the procedures covered.

The few examples of National Health Insurance schemes in sub-Saharan Africa have evolved from two distinct approaches to insurance: social health insurance (SHI), which is typically mandatory for groups of individuals and funded through payroll taxes earmarked for health; and community-based health insurance schemes, described in the section below. Social health insurance, based upon the European model, is more likely to be more successful in contexts with large formal sector employment, high wages and salaries, low poverty rates, low dependency ratios and high capacity to provide health care (Fourth Session of the African union conference, 2009 CAMH/EXP/13a (IV). CBHI schemes can operate successfully in the informal sector, but have historically been difficult to scale up beyond the community level. These two patterns help explain why countries in Sub Saharan Africa historically faced considerable challenges in successfully and sustainably implementing health insurance schemes at the national level (Fourth Session of the African union conference, 2009 CAMH/EXP/13a (IV).

Nonetheless, several countries in sub-Saharan African countries are now experimenting with new and innovative forms of health insurance, including variations on social health insurance and community-based health insurance schemes. Whereas previous attempts at implementing social health insurance in Africa were confined to the formal sector, new National Health Insurance Schemes or Funds (NHIS or NHIF) are attempting to enroll rural and informal sector workers. In Ghana, Rwanda and Tanzania NHIS schemes were preceded by CBHI pilot schemes (Fourth Session of the African Union Conference, 2009 CAMH/EXP/13a (IV).

Rwanda's is arguably one of the most dramatic recent experiences of CBHI-based National Health Insurance in sub-Saharan Africa today, at least in terms of population coverage. After successfully initiating pilot schemes in 1999, the Government decided to go to scale in a rapid fashion. As of October 2007, it is reported that the schemes had enrolled 6,702,391 beneficiaries out of a total population of 8.9 million, that is, about 75% of the total population.

To support the growth of the schemes, the Government has created a special solidarity or risk pooling fund, into which transfers from the Ministry of Finance via the Ministry of Health are made to cover the costs of indigents and people living with HIV/AIDS. The Global Fund to Fight AIDS, Tuberculosis and Malaria is providing financial support for five years to cover the Government subsidy. It will be important to assess the success of this solidarity fund in covering vulnerable population groups, as more data regarding the socio-economic and demographic profile of schemes and members become available in the future(Fourth Session of the African union conference, 2009 CAMH/EXP/13a (IV).

A 2003 National Health Insurance Act set up the Ghana NHIS after a period of autonomous CBHI development. Membership in the NHIS is not mandatory for all Ghanaians, although making enrollment compulsory is part of the government's long-term vision. Presently, the NHIS encompasses district mutual health schemes, private insurance schemes and private mutual health insurance, giving Ghanaians the freedom to choose among them. The government defines the minimum benefits package, certifies providers and regulates the insurance schemes. It has also set up a separate National Health Insurance Fund (NHIF), financed by a special 2.5% National Health Insurance VAT levy and 2.5% of the social security contributions of formal sector workers (Fourth Session of the African Union Conference, 2009).

The NHIF is used to subsidize the membership of formal sector employees, pensioners, children under the age of 18, indigents and those over 70. In practice, however, this means that informal sector workers and their families are the only people who pay cash to join the schemes. Revenues from the NHIF are also used to reinsure district health funds and to support programs that improve access to health care. Since the Ghana NHIS is a relatively recent development, evidence on its performance is limited. The available information indicates that there has been a rapid growth in membership, totaling about 7.8 million people or nearly 40% of the total population by March 2007.

But this rapid growth in membership is driven mainly by the subsidized groups: children under 18 make up 47% of members, and formal sector workers are automatically enrolled and constitute 22% of members. Those over 70 make up about 8% of members. In addition, despite the subsidy for indigents, only around 2% of registered scheme members are said to be indigent, an indication that equity is not being fostered by this scheme despite the fact that an estimated 40% of the population lives below the national poverty line. Some concerns about the design of the Ghanaian NHIS have been raised. It has been argued that the minimum benefits package may be too expensive to be sustainable in the long term. The question of how to cover the indigent also remains a clear problem that is highlighted by the data on scheme enrollment presented above. The government estimates that indigents who are entitled to subsidized premiums account for 9% of the population, but this seems very low (Fourth Session of the African union conference, 2009 CAMH/EXP/13a (IV)).

There is great potential in sub-Saharan Africa for national and sub-national health insurance systems. However, there may be stark trade-offs between revenue raising to ensure financial sustainability and ensuring coverage of the poor in countries with high levels of poverty. Collecting premiums from individuals in the informal sector is administratively difficult. Subsidizing premiums of the poor is challenging given the limited tax base. The feasibility of heavy cross-subsidization depends on a high level of social capital and strong sense of social solidarity, which may exist at the community level but are difficult to translate to the national level. Morever, identifying whose premiums should be subsidized can be difficult; the challenges associated with operationalizing exemptions for user fees suggests that administrative capacity to accurately distinguish the poor from non-poor is frequently lacking in low-income country settings. Thus, while the equity, access, financial protection and revenue generation benefits of national health insurance make this strategy appealing to pursue, it is an approach that is rife with challenges (Fourth Session of the African union conference, May 2009 CAMH/EXP/13a (IV).

Private health insurance

Whereas formal statutory health insurance schemes have largely failed to reach the poor, private for profit and not-for profit schemes are emerging in different regions of the world offering a potential improvement in risk sharing for a larger part of the population (Drechsler *et al*, 2005). Private health insurance (PHI) offers a potential alternative to insure against the cost of illness and lately has been receiving increasing consideration from policy makers around the world. This trend is being further accelerated by: the inclusion of an insurance component into microfinance- institutions; health sector reforms and decentralization and the increasing recognition of the importance of health security for pro-poor growth.

Apart from rare exceptions (notably South Africa, Namibia, Zimbabwe), private health insurance in sub-Saharan Africa occurs on a low membership, contributions, and coverage scale (Drechsler *et al*, 2005). Community-based health insurance scheme which is also privately organized has been on the increase especially in the eastern, southern and western sub-regions of Africa. The increasing emergence of community-based health insurance during the past couple of years has been particularly strong in these regions (Jütting, 2004, Drechsler *et al*, 2005).

Micro insurance schemes were recently implemented in Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Ghana, Guinea, Mali, Nigeria, Senegal, Tanzania, Togo, and Uganda. Owing to the non- or low-profit nature of most schemes, premiums are relatively moderate, which explains the low level of PHI expenditure in sub-Saharan Africa. Although coverage is limited to a few people (generally below 1 per cent of the population) and services (moderate coverage for only certain types of treatment), community-based health insurance might become a building block in future health financing; especially considering that – due to financial and institutional constraints – private (community-based) health insurance is often the only available form of risk-pooling (Drechsler et al, 2005).

In a study conducted by Johannes P. Jutting in 2003 in a rural Senegal pertaining to community based health insurance, the findings suggest that membership has a strong positive effect on the probability of going to a hospital when sick, even though the magnitude, with a higher probability of 2% points, is quite moderate. More important from the perspective of the functioning of the mutual is the expected strong negative effect on expenditure in the case of hospitalization. The findings also show that in such a situation, members pay on average less than half of the amount nonmembers pay. This is an impressive finding and is an indication that the mutuals seem to reach the objective of better financial protection against hospitalization risk. Mutual members also had to pay lower out-of-pocket payment compared with non-members. The analysis of the impact of the mutuals on access to health care has shown in this study that members frequent the hospital more often than nonmembers and pay less per visit.

But an extensive WHO review made in 1998 tells a different story concerning 82 non-profit health insurance schemes for people outside formal sector employment in developing countries. It was observed that very few of these schemes covered large populations or did not even cover high proportions of the eligible population. From a subset of 44 of the schemes, the median value of the percentage of the eligible population covered was 24.9%; 13 schemes had a coverage rate below 15%, and 12 schemes had a coverage rate above 50% (WHO, 2003). Another conclusion was that adverse selection was more affecting the schemes that insured against high-cost low frequency events than schemes that covered low-cost high-frequency events. One of the main reasons was that many people tended to sign up with the CHIs, at the moment of illness. It follows that the members with high risks tended to be over-represented in the CHIs (WHO, 2003).

Further information became available since 1998. Low percentages of enrolment were observed in a study on 5 CHIs in East and Southern Africa. In four schemes, enrolment percentages vary

between 0.3% to 6.5% of the target population; one scheme is very small with 23 members out of a target population of 27 cooperative society members. In Rwanda, a project was launched, establishing 54 CHIs in three districts in July 1999. By the end of the first year of operation, the enrolment rate reached in the three districts was 7.9% (88,303 members out of a total target population of 1,115,509 (WHO, 2003).

Another study was made in nine West and Central African countries on 22 CHIs. From the available information on beneficiaries and target membership, one CHIs in Benin reached an enrolment rate of 24% in 1998, whereas another achieved an enrolment rate of 8%; the target population in these CHIs was 13,000 and 7,300, respectively. In one CHIs in Ghana and Mali, 53% and 25% of the target population of 25,000 and 200,000 was covered, respectively (WHO, 2003). And in Senegal, one CHIs reached a coverage rate of 26% after three years of operation whereas another achieved an enrolment rate of 82%; the target population was 13,650 and 1,200, respectively. A recent study was also made on 4 out of 16 CHIs in the area of Thiès, Senegal. In the year 2000, the average household enrolment percentage in these villages was 68%, with enrolment rates varying between a minimum of 37.4% and a maximum of 90.3 % (WHO, 2003).

From the WHO Study, information about the prepayment ratio, but through household contributions only, was available for 24 CHIs. Thirteen CHIs had a ratio lower than or equal to 60%. This means that, without subsidies or grants from sources other than households, the share of out-of-pocket payments (co-payments or user fees) in health expenditure would be 40% and higher (WHO, 2003). If community-based insurance may not be pro-poor, private insurance is even less so, being a privilege for those with stable income. This is largely absent in low and middle-income countries, although exceptions exist. In South Africa and Zimbabwe the large income disparities have allowed higher income groups to use private health insurance. Indeed, it is argued that the use of private insurance may free the public systems from expensive non-essential demands (related to high income groups) and

thus having a positive impact on health budgets. However, because private insurance is closely linked to the most affluent population, issues of political governance may not facilitate that the very poor benefit from the design of this scheme (Irurzun-Lopez, 2003)**.**

Donor activities

Because of the limited extent to which domestic resources can be reached, and the need for additional financial resources to fight rising epidemics, external resources are necessary, and need to be effectively disbursed. Commission on Macroeconomic on Health (CMH) (2001) calculated that out of the extra funds needed to combat AIDS, TB, and malaria, US$ 2.2 – 2.4 billion needed to come from external grants and concessional lending. Whereas financing public health sector budgets from total identifiable ODA is 7% in low income countries, it is up to 12% for Sub-Saharan Africa on average (Roberts, 2003); in 2000, ODA commitments explicitly earmarked $2.6 billion to be added to national health budgets (Roberts, 2003).

There is a general feeling of scepticism in African countries about the recycling of aid instead of an actual increment in aid. In addition, even when extra resources are mobilised from outside to increment health budgets, there is the danger that public expenditure planners may compensate for this increment by reducing domestic allocations. Therefore, even if aid is earmarked for health, it may not lead to an increment in expenditure (Irurzun-Lopez, 2003). In spite of this, international concern of rising epidemics has also created a positive momentum in terms of mobilising new sources. Several new initiatives have been created to mobilise extra funds to tackle AIDS, TB, and malaria, such as *the Global Fund to fight AIDS, Tuberculosis and Malaria, Roll Back Malaria Partnership and Bill and Melinda Gates Foundation* (Irurzun-Lopez, 2003).

The Global Fund is a new approach to international health financing that exemplifies the extraordinary intentions and mobilisation and efforts at the international and domestic levels to effectively and quickly channel funds to these diseases. However,

these initiatives, including the Global Fund, are just disease-specific funds that may even disestablish national health budgets. Rather, what is needed is not to lose track of strengthening overall health systems as a necessary condition (Irurzun-Lopez, 2003).

A key problem linked to external resource mobilization is conflicting conditionalities attached to donor funding. The politics of international aid have an influence on the operations of national institutions as well as on crucial social and political dimensions, limiting effective national leadership. Aid effectiveness varies from country to country depending on the robustness of national policies and the tightness and feasibility of conditions attached. The unpredictability and conditionalities attached to overseas development assistance present a major constraint to effective interventions against diseases in Africa (Irurzun-Lopez, 2003).

More often than not, recipient countries are unable to predict the availability (or even the amount) of donor contributions. Conditionality of donors´ support may take several forms, structural reforms, macroeconomic conditions, areas and ways of intervention, including geographical areas. For example, the linkage of aid to district projects can be a problem if this does not reflect the country's needs (Pearson 2002, Irurzun-Lopez, 2003). This can be avoided if project-support is substituted by donors budget support, as for example in Uganda, where "central allocations to districts receiving large inputs from NGOs and donors were reduced as a means of promoting greater equity in overall resource flows" (Pearson p. 10). Both conditionality and lack of predictability have a negative effect on the expenditure planning processes. For example, for countries where donor budget support is high such as Mozambique (60-70 percent), and Ghana (40 percent), the availability and timeliness of information on donor contribution is critical. Notwithstanding this, Ghana is an interesting example of how donor budget support is managed in an efficient manner, in terms of ownership and coordination (Irurzun-Lopez, 2003).

There is currently a shift in international aid to move from programme-linked aid towards supporting national budgets, leaving the country to make the decision regarding the distribution of the funds (Irurzun-Lopez, 2003). In the mid 1990s, sector-wide approaches (SWAPs) became the sought form of support by donors as a response to the fragmentation of aid. Even more comprehensive is the budget support system that pools together the whole national budget increasing the ownership in the decisions by the national government, even more than SWAPs (Roberts 2003, Irurzun-Lopez, 2003).

Complementary and Alternative Medicines

The complementary and alternative medicine is a growing strategy in healthcare provision in Africa. The African Union, member states and the Regional Economic Communities (RECs) will use this Strategy as the inspirational framework within which they will fulfil their roles pertaining to health care provision. The Strategy provides a focus for all health initiatives to converge around. Ministers of Health are calling on multilateral agencies, bilateral development partners and other partners in Africa's development to build their health contribution around this Strategy. Such a co-ordinated response is critical to ensure maximum benefit from the resources mobilised and to prevent fragmentation and duplication. This Strategy thus provides an overarching framework to enable coherence within and between countries, civil society and the international community (Third Session of the Africa Union Conference, 2007 CAMH/MIN/5(III).

Development partners have increased their development aid for health in Africa beyond US10 billion per annum and the move towards funding of core public health budgets based on national plans, such as through Sector Wide Approaches (SWAPS) integrated intersectorally, offers a major opportunity to move away from fragmented and inefficient vertical projects and programmes, which is supported by the international commitment on aid effectiveness as agreed at the High Level Forum in Paris in 2005. The benefit is enabled by alignment of donor funding with nationally determined plans and priorities. Funding

opportunities such as Global AIDS Vaccine Initiative (GAVI) could also be utilized (Third Session of the Africa Union Conference, 2007 CAMH/MIN/5(III)).

The goal of this Africa Health Strategy is to contribute to Africa's socio-economic development by improving the health of its people and by ensuring access to essential health care for all Africans, especially the poorest and most marginalised, by 2015. The overall objective of this strategy is to strengthen health systems in order to reduce ill-health and accelerate progress towards attainment of the Millennium Development Goals in Africa; More specifically: a. To facilitate the development of initiatives to strengthen national health systems in member states by 2009 b. To facilitate stronger collaboration between the health and other sectors to improve the socio-economic and political environment for improving health c. To facilitate the scaling up of health interventions in member states including through regional and intergovernmental bodies (Third Session of the Africa Union Conference, 2007CAMH/MIN/5(III)).

This Strategy presents an approach for addressing avoidable disease, disability and death in Africa and for strengthening Health Systems for equity and development, especially for the poorest, most marginalised and displaced people.

To achieve the goals of this Strategy, a number of strategic interventions need to be concurrently implemented towards achieving an effective and sustainable health sector, synchronised with an integrated focus on the major health burdens and vulnerable groups. The intention is to incorporate best practices for promotion, prevention, care and rehabilitation into country health plans in line with national circumstances. There should be special attention to post-conflict countries and those caring for refugees and internally displaced persons. The Strategy must apply the life-cycle approach for cost-effective disease prevention (Third Session of the Africa Union Conference, 2007CAMH/MIN/5(III)).

Countries are committed to enhancing the performance of their health system to achieve the best value with the resources available.

Each country will update and cost their national health plan, following a gap analysis between existing plans and this Strategy and other commitments, taking into account an agreed minimum package of core interventions. These National Health Plans will be the centre of health development in the country, and the basis for strengthening the health system, its implementation continuously monitored and its content regularly reviewed and updated (Third Session of the Africa Union Conference, 2007CAMH/MIN/5(III)).

In declaring a Decade of African Traditional Medicine in 2001, Governments have recognized the wide use and hence importance of integrating traditional medicine into their national health systems and creating an enabling environment for optimising its contribution. The latter includes mobilizing and connecting all stakeholders. It is essential to strengthen structures of traditional medicine through analysis of the prevailing systems and with the involvement of traditional health practitioners and communities, focussing on strengthening the best practices of traditional medicine. Organizational requirements include the establishment of a national multidisciplinary body responsible for the coordination of traditional medicine; formulation of a policy and legal framework; allocation of adequate resources; development of regulations for the local production and rational use of traditional medicines and protection of intellectual property rights (Third Session of the Africa Union Conference, 2007CAMH/MIN/5(III)).

Another strategy employed CAM is performance-based financing. Performance-based financing (PBF) is a strategy for improving *how* money is spent on health, and making the resource 'go farther'. PBF links health funding to actual results, rather than linking funding to inputs, which is the traditional way health care has been financed. To achieve health results, households, health workers, health facilities, and the systems that knit these partners together need to take effective action. By providing financial incentives to achieve results, performance based financing seeks to change behaviors of health

system actors and reward actions that lead to results (Fourth Session of the African union conference, May 2009 CAMH/EXP/13a (IV)).

At this juncture, global awareness of the acuteness of Africa's funding crisis is high. The international community, donors, charitable foundations and the private sector have displayed an unprecedented interest in innovative international health financing mechanisms to complement existing efforts and to encourage more efficient solutions to the health problems confronting low-income countries. Much of the renewed interest in global health financing has been driven by the appearance of significant new actors in the global health arena, especially richly-endowed private foundations such as the Bill and Melinda Gates Foundation. Indeed, a significant amount of the funding behind some of the new mechanisms described below (e.g. GAVI and the Global Fund) has been provided by the Gates Foundation. Bilateral donors have also made a bigger effort in recent times to increase their commitments. The United States continues to be the biggest health donor in absolute terms, while France, Norway and the United Kingdom are the primary donors behind three new innovative mechanisms – the airline tax, the International Health Partnership Plus (IHP+) and the Global Campaign for the Health MDGs, respectively(Fourth Session of the African union conference, May 2009 CAMH/EXP/13a (IV)).

Coping Strategies

In the face of mounting problems on accessibility of healthcare considering the different modes of payments, individuals and households and even countries have devised ways of coping with payments for health care. In the constrained economic contexts, many African countries face, household strategies for coping with the parallel demands of reduced household income and increased prices for basic household needs are already overstretched (Kanji and Jazdowska 1993; Pinstrup-Anderson 1993 and Gilson, no-date). Thus, payment of increased health care fees will represent an unacceptable burden on households that may lead them to delay seeking treatment,

to use informal, and less effective sources of health care, or to marginalize impoverished families further (Booth and others 1995; Gilson 1988; Russell 1996 and Gilson, no-date).Many families have also undertaken to cope with increasing health payment burdens by disposing of valuable property and livestock.

According to Russell and Gilson (1995, p. 68), researchers should pay more attention to understanding better the mechanisms mediating the impact of fees on ability to pay:

In particular, their [fees'] potential effect on different types of household and user behavior needs to be assessed. This may involve willingness and ability to pay studies and more qualitative research exploring community responses to user fees. Such research may indicate, for example, that fees in some rural settings within a country are inappropriate due to the large proportion of patients who would need exemptions, the lack of revenue such fees would generate, and the impact that such fees would have on financial access to essential services in the area (Adams and Harnett 1995 and Gilson, no-date).

Discussions

Out-of-pocket payment has been the dominant mode for health care payment in the majority of Sub-Saharan African nations and its feasibility is waning in the face of mounting health care costs. Many households and individuals are finding it difficult coping with this mode of payment. The feasibility of making out-of-pocket payment work for the poor will depend on the proper design and implementation of the scheme, especially if governance issues as well as the combined utilization with other systems and exceptions mechanisms for the very poor are considered (Irurzun -Lopez, 2003). For example experiences in Kenya where more attention has been drawn on appropriateness and implementation show how user fees may bring benefits to the poor. In areas with low average income it will naturally be difficult to make this system work for the poor. Similarly, where the mechanisms to ensure equitable redistribution of revenues are not put in place, or exceptions for the very poor are not common,

the pro-poor potential of this system is not likely to succeed (Irurzun-Lopez, 2003).

Nowadays efforts in Africa are to move away from user fees and invest more on community-based and social insurance schemes, as a mean to reach and protect the majority of the poor. Although moving in the right direction, the need remains to ensure the protection of the very poor in the design and implementation of the schemes. Because of the non-universal coverage of insurance of any kind, it is often the case that the poor and very poor tend to be left-out and thus it will further the health gap between the poor and the rest of the population (Irurzun-Lopez, 2003).

Strengthening more participatory and accountable institutions is expected to address this problem. The Community Health Fund (CHF) established in several districts of Tanzania exemplifies a scheme that is affordable to the majority of the population while including exemptions mechanisms. It combines three financing mechanisms: user fees, insurance contributions, and matching subsidies from the government and it is governed at the district level but also coordinated from the Ministry of Health (Arhin-Tenkorang 2001, Irurzun-Lopez, 2003).

Finally, the adequate design of the financing system is hindered by lack of information of who is paying the services and what kind of services, and thus a bias assessment of the capacity to pay of the population. To deal with it, South Africa, for example, has started the exclusion of some employment-related members that are generally well-off, from the base population when formulating the allocation of public funds. However, this requires good quality data on population and health related, often not available, even more on time, for most African countries (Irurzun-Lopez, 2003).

On the issue of donor activities, my contribution and as was raised in the Experts Meeting of the African Ministers of Finance Conference, Addis Ababa 29-30 May 2003, the non-sustainability of funds suggests that the way to tackle the health needs for African countries may not rely on these promises from international partners,

but rather the solution may lie 'in house'. The dangers attached to conditional aid may supersede their benefits. Thus, budget support systems that respect national ownership and provide accountable decision-making processes should be enhanced. In so doing, there are some preconditions that need to be met to ensure the final success. Two key issues relate to the technical capacity to introduce the reforms and maintain systems of regular monitoring, and to put in place institutional arrangements to ensure the allocation of funds is achieved as desired (Irurzun-Lopez, 2003).

Having a limited capacity for raising funds domestically through fees or social health insurance schemes, the options left are national budget or donor support. Recently fiscal restrictions to expanding health expenditures seemed to focus the debate on deflationary policies having priority over increasing access to health. But further than that, the debate lies on how fast to increase the budget of the Health Ministry, a much more complex issue. The solution to what level of spending is non-inflationary is difficult without more precise information. Decisions are difficult to take when the estimations change for different actors (Irurzun-Lopez, 2003).

In many African countries revenue generation levels are constrained by the need to keep fees low, because household income levels are low. In addition, the administrative costs of implementing a fee system, including the costs of the exemptions necessary to safeguard equity and public health objectives, further reduce cost recovery levels (Gilson, Russell, and Buse 1995, Gilson no-date). Poorer, rural areas will inevitably generate lower levels of income as a result of both influences. Weak accounting and resource management practices and skills further undermine revenue generation levels. Assessing the impact of fees on system sustainability, therefore, also requires consideration of the contribution of fee systems to the development of the other capacities required to achieve sustainability. Yet this is an area that few studies have specifically assessed. A few country experiences demonstrate the limited impact of user fees on system sustainability (Gilson, no-date).

Conclusion

User-fee which is the dominant mode for health care payment in Sub-Saharan Africa needs reforming. Overall, therefore, the evidence suggests that governments should exercise caution in introducing fees for three main reasons. First, reviewing the level of the health system at which to introduce fees remains important, even where the alternatives seem limited. Second, seeing fees as part of a wider package of health care financing policies rather than as the central or only strategy for addressing current resource constraints is also important. Within this package, fees may be a first step toward, for example, developing risk-sharing mechanisms, but should not be seen as an end in themselves. Third, as "managerial and organizational factors are central determinants" (Kutzin 1995, p. 16, Gilson no-date) of the impact of fees on key health sector goals, any fee system must be devised carefully. The evidence suggests that user fees alone are unlikely to accomplish equity, efficiency, or sustainability objectives.

Moreover, when fee policies are poorly designed and implemented, they can actually undermine equity goals. Fees should, therefore, be seen as only one element in a broader health care financing package that should, in particular, include some form of risk sharing (Gilson no-date). Although fees may be a critical step in allowing the development of other financing mechanisms, for instance, high hospital fees promote insurance coverage, their implementation must be tied to this broader package to limit the possible equity dangers that are clearly associated with them. Within this package fees have a greater potential role within hospitals than at the primary care level.

Achieving equity, efficiency, and, in particular, sustainability requires implementing a broader policy package to develop the skills, systems, and mechanisms of accountability critical to ensure effective implementation. Some local control of revenues, particularly if fees are introduced at the primary level, is an element of this package, but equally important are supporting systems, such as those associated

with drugs and human resources (Gilson no-date). In addition, the process of policy development and implementation is itself an important aspect of this package, as it enables the development of the full range of capacities necessary to ensure sustainability (Gilson no-date).

Complementary and Alternative Medicine is a growing option to healthcare provision and African nations are reviewing their strategy in that direction. The Strategy provides a focus for all health initiatives to converge around. Ministers of Health who are the pivotal points in this strategy are calling on multilateral agencies, bilateral development partners and other partners in Africa's development to build their health contribution around this Strategy for such a co-ordinated response is critical to ensure maximum benefit from the resources mobilised and to prevent fragmentation and duplication. This Strategy as already stated thus provides an overarching framework to enable coherence within and between countries, civil society and the international community. Working part of this strategy is to improve on African traditional medicines and promote performance-based health care financing to achieve optimal contribution of traditional medicine and prudence in the allocation of fund for health care expenditure respectively.

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Abbreviations

CCS		Country cooperation Strategy
GFATM	-	Global Fund to Fight AIDS, Tuberculosis and Malaria
GAVI		Global Alliance for Vaccine and Immunization
CMH		Commission on Macroeconomic on Health
CAM		Complimentary and Alternative Medicines
RECs		Regional Economic Communities