MATERNAL AND CHILD HEALTH: THE SOCIAL PROTECTION DIVIDEND

WEST AND CENTRAL AFRICA

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Overseas Development Institute

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REGIONAL THEMATIC REPORT 4 STUDY

MATERNAL AND CHILD HEALTH: THE SOCIAL PROTECTION DIVIDEND

WEST AND CENTRAL AFRICA

UNICEF Regional Office
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LIST OF ACRONYMS

AfD	French Development Agency
AIDS	Acquired Immunodeficiency Syndrome
AMO	Compulsory Health Insurance Programme (Mali)
CBHI	Community-based Health Insurance
CPIA	Country Policy and Institutional Assessment
CRC	UN Convention on the Rights of the Child
DFID	UK Department for International Development
DHS	Demographic and Health Survey
DPT3	Diphtheria–Pertussis–Tetanus
FAM	Medical Assistance Fund (Mali)
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GLSS	Ghana Living Standards Survey
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
ILO	International Labour Organization
IMF	International Monetary Fund
IRAI	IDA Resource Allocation Index
IRIN	Integrated Regional Information Networks
LEAP	Livelihood Empowerment Against Poverty (Ghana)
MDG	Millennium Development Goal
MTEF	Medium-term Expenditure Framework
MHO	Mutual Health Organisation
MMR	Maternal Mortality Rate
MSF	Médecins sans Frontières
NHIS	National Health Insurance Scheme (Ghana)
ODA	Official Development Assistance
ODI	Overseas Development Institute
OPP	Out-of-pocket Payment
ORT	Oral Rehydration Therapy
PEM	Public Expenditure Management
PEPFAR	(US) President's Emergency Plan for AIDS Relief
SHI	Social Health Insurance
Sida	Swedish International Development Cooperation Agency
SSNIT	Social Security and National Insurance Trust (Ghana)
SWAp	Sector-wide Approach
THE	Total Health Expenditure
U5MR	Under-five Mortality Rate
UN	United Nations
UNICEF	UN Children's Fund
UNRISD	UN Research Institute for Social Development
WCARO	West and Central Africa Regional Office (UNICEF)
WHO	World Health Organization

[1] Full titles are listed in the references.

PREFACE AND ACKNOWLEDGEMENTS

This is one of a series of reports produced by a regional study on social protection and children in West and Central Africa, commissioned by the United Nations Children's Fund (UNICEF) West and Central Africa Regional Office (WCARO) and carried out by the Overseas Development Institute (ODI) in London between November 2007 and November 2008, in partnership with local researchers in the region.

Social protection is now widely seen as an important component of poverty reduction strategies and efforts to reduce vulnerability to economic, social, natural and other shocks and stresses. It is particularly important for children, in view of their heightened vulnerability relative to adults, and the role that social protection can play in ensuring adequate nutrition, utilisation of basic services (education, health, water and sanitation) and access to social services by the poorest. It is understood not only as being protective (by, for example, protecting a household's level of income and/or consumption), but also as providing a means of preventing households from resorting to negative coping strategies that are harmful to children (such as pulling them out of school), as well as a way of promoting household productivity, increasing household income and supporting children's development (through investments in their schooling and health), which can help break the cycle of poverty and contribute to growth.

The study's objective was to provide UNICEF with an improved understanding of existing social protection mechanisms in the region and the opportunities and challenges in developing more effective social protection programmes that reach the poorest and most vulnerable. The ultimate aim was to strengthen UNICEF's capacity to contribute to policy and programme development in this important field. More generally, however, the study has generated a body of knowledge that we are hopeful will be of wide interest to policymakers, programme practitioners and researchers, both in West and Central Africa and internationally.

Specifically, the study was intended to provide:

- A situation analysis of the current situation of social protection systems and programmes in West and Central Africa and their impact on children;
- An assessment of the priority needs for strengthening social protection systems to reduce poverty and vulnerability among children in the region;
- Preliminary recommendations to inform UNICEF's strategy development in the region.

The study combined a broad desk review of available literature, official documents and data covering the region as a whole on five key dimensions of social protection systems, with in-depth case studies in five countries, resulting in 11 reports produced overall. These are as follows[1]:

Five regional thematic reports:

- R. Holmes and T. Braunholtz-Speight (2009) 'Strengthening Social Protection for Children in West and Central Africa';
- G. Handley (2009) 'Fiscal Space for Strengthened Social Protection in West and Central Africa';

- R. Holmes and A. Barrientos (2009) ' Child Poverty: A role for cash transfers?';
- C. Walsh, with N. Jones (2009) 'Maternal and Child Health: the Social Protection Dividend'; and
- N. Jones (2009) 'Promoting synergies between Child Protection and Social Protection'.

Five country case study reports:

- E. Villar and B. Makosso with R. Holmes, N. Jones and P. Pereznieto (2009) 'Social Protection and Children in West and Central Africa: Case Study Republic of Congo';
- R. Holmes and E. Villar (2009) 'Social Protection and Children in West and Central Africa: Case Study Equatorial Guinea';
- N. Jones, W. Ahadzie and D. Doh (2009) 'Social Protection and Children in West and Central Africa: Opportunities and Challenges in Ghana';
- P. Pereznieto and V. Diallo (2009) 'Social Protection and Children in West and Central Africa: Case Study Mali'; and
- P. Pereznieto and A. Fall (2009) 'Social Protection and Children in West and Central Africa: Case Study Senegal'.

A final synthesis report:

- R. Holmes and N. Jones (2009) 'Child-sensitive Social Protection in West and Central Africa: Opportunities and Challenges'.

For this current report on child protection and broader social protection linkages, valuable research assistance was provided by Hannah Marsden, Jessica Espey and Emma Broadbent and is gratefully acknowledged. Similarly, helpful comments were provided by Anthony Hodges and Joachim Theis of UNICEF WCARO and Alexandra Yuster of UNICEF New York.

We would also like to thank Carol Watson for her valuable editorial support. While we have done our best to reflect the valuable insights and suggestions they provided, we alone are responsible for the final text, which does not necessarily reflect the official views of either UNICEF or ODI. Finally, we would like to thank Roo Griffiths of www.griffiths-saat.org.uk for copyediting all of the papers.

EXECUTIVE SUMMARY

HEALTH AS A HUMAN RIGHT IN JEOPARDY

The equitable provision of affordable and accessible primary health care is central to human development, critical to meeting the Millennium Development Goals (MDGs) and a basic human right. Health care forms a cornerstone of social protection as a protective, preventative and promotive element of the livelihood and well-being of vulnerable populations. Attention to the equity dimension of health care is especially important in West and Central Africa, in view of the region's widespread poverty, extremely high under-five and maternal mortality rates, low levels of basic health care utilisation and serious obstacles in accessing care, especially among rural and lower quintile population groups. Children specifically are recognised as having the right 'to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health' according to the United Nations Convention on the Rights of the Child (UN CRC). Yet, every year, 9.7 million children under five continue to die of preventable and treatable diseases. West and Central Africa currently has the highest regional under-five mortality rate in the world and accounts for more than 30% of global maternal deaths. Without a major increase in resources and dramatically enhanced political will by governments and development partners alike, MDGs 4 and 5 on child and maternal mortality will not be achieved by 2015.

THE IMPORTANCE OF ALTERNATIVE HEALTH FINANCING MECHANISMS

Although affordability remains only one measure of the accessibility of health services, it is the most significant obstacle to health service utilisation in West and Central Africa and so financing progressivity can play a powerful role in shaping the degree of protection for vulnerable populations from health expenditure shocks and ensuring access by children and women to health services. Health financing mechanisms have profound impacts on the functioning of the health sector, particularly regarding the equity of the financial burden of health care and the accessibility of health services for different groups of the population. Over the past decade, there has been an increasing focus on health insurance and other forms of social protection as a potentially promising way to deal more effectively with health risks in developing countries. However, analysis of the extent to which social health insurance (SHI) and other health financing and social protection mechanisms can play a role in reducing poverty and vulnerability among children and their carers is scarce. This report – one of a series of reports produced by a regional study on social protection and children in West and Central Africa – examines arguments and reviews the evidence on the relative effectiveness of the different types of health financing mechanisms from the perspective of equity and the aim of achieving universal access to essential health services.

LOW REGIONAL HEALTH EXPENDITURES

Total health expenditure remains low across the region, with a weighted average of US$28 per capita total health expenditure and US$10 per capita government expenditure on health. Out of 24 countries in the region, government expenditure on health is less than US$10 per capita in 11 countries and between US$10 and US$20 per capita in nine countries. This is of significant concern, as the World Health Organization (WHO) Commission for Macroeconomics and Health (2001) has estimated that a minimum government expenditure of US$34 per capita per year is necessary to provide a basic package of essential health services in order to meet the health-related MDGs. African heads of state set a target in the Abuja Declaration (2001) to allocate 15% of their annual budgets to the health sector. This commitment was reaffirmed by the Maputo Declaration (2003), but no country in West and Central Africa has allocated more than 10% of its budget to health, with seven countries allocating as little as 0-3% of their budget to the sector. Moreover, with the exception of São Tomé and Príncipe, all countries in West and Central Africa spent less than 7% of gross domestic product (GDP) on health in 2006, and half of the countries in the region spent less than 4.5%

HIGH – AND INEQUITABLE – PRIVATE AND OUT-OF-POCKET EXPENDITURES

The composition of sources of health financing is an important marker for the equity of the system, with implications for the ability of the poorest to afford access to critical health services. In West and Central Africa, on average, private health expenditure (64.5% of total health expenditure) is much higher than government health expenditure (35.5%: WHO, 2008b). In a region where the proportion of people living below the poverty line of US$1 per day ranges from 15% in Côte d'Ivoire to 90% in the Democratic Republic of Congo, the negative equity impacts of this degree of private health expenditure are significant. On average in the region, 92.2% of private expenditure comes from out-of-pocket payments (OPPs) made at the point of service and only 2.4% of private health expenditure is through prepaid mechanisms. In half the countries in the region, a greater proportion of health expenditure comes from OPPs than from government expenditure. Moreover, OPPs incurred by the lowest wealth quintiles comprise a greater percentage of household expenditure than in upper wealth quintiles. Studies have found a positive correlation between levels of OPPs and the degree of catastrophic health expenditure (defined as greater than 40% of household expenditure), pushing households below the poverty line or deeper into poverty.

DONOR SUPPORT FOR HEALTH

Part of the gap in health financing is being addressed by donor support, including from bilateral donors, multilaterals such as the World Bank, WHO and UNICEF and public/private partnerships such as the Global Fund and the GAVI Alliance (Global Alliance for Vaccines and Immunisation). A recent assessment of progress towards MDGs 4 and 5 reported that official development assistance (ODA) levels have increased for maternal, newborn and child health, with a 28% increase worldwide in 2005. The volume of ODA to child health increased by 49% and to maternal and newborn health by 21%. However, a closer look at aid flows to West and Central Africa in these areas suggests a more mixed picture. Of the 22 West and Central African countries included in the analysis, only half saw increases in funding for child health; the other half experienced declines. Only 55% received greater ODA for maternal health in the same year.

VARYING DEGREES OF SOCIAL PROTECTION IN HEALTH FINANCING

In order to address health financing gaps and to improve service coverage, including among vulnerable populations, developing countries are increasingly considering a variety of social health protection mechanisms. These range from the free provision of tax-funded national health services, to vouchers and cash transfer schemes, contribution-based mandatory SHI and mandated or regulated private non-profit health insurance schemes, as well as mutual and community-based non-profit health insurance schemes. The insurance-based mechanisms involve the pooling of risks among persons covered – and in some cases include cross-subsidisation between the rich and the poor. Currently, most countries in West and Central Africa have middling to low degrees of social protection in health financing, with a wide variety of mixed health financing mechanisms, including SHI, mutual health organisations (MHOs), user fees and tax-financed government expenditure. It is important to note that the countries with higher levels of protection have the highest total investment in health as well as the lowest overall OPPs. Moreover; countries with higher social health protection also have significantly better under-five mortality rates (U5MRs), maternal mortality rates (MMRs) and antenatal care indicators.

USER FEES IN THEORY AND PRACTICE

Since their implementation, user fees have been subject to debate regarding their effectiveness and equity in practice, as well as their potential impacts on health service utilisation and – ultimately – health outcomes. When user fees were first initiated, they were expected to increase revenue with higher efficiency, counteract moral hazard, improve the quality and coverage of services, rationalise the pattern of health care-seeking

behaviour and safeguard equity through exemptions for the poor. The Bamako Initiative, launched in 1987, sought to introduce an element of community participation and management into user fee schemes, through the retention of funds at the community level. Although this had benefits in terms of the delivery of care at a community level, the equity implications of user fees remain problematic. It is estimated by the WHO that worldwide 178 million people each year – particularly women – are unable to pay for the services they would need to restore their health; it is moreover estimated that at least 5% of the African population has never had sufficient resources to afford access to primary health care, and that some 25-35% of the population with unstable incomes has faced periodic exclusion from accessing primary health services. User fees, in which service users pay according to the level of service utilisation (i.e. the degree and frequency of illness) rather than their ability to pay, stand as the most regressive form of health financing: health expenditure payments comprise a larger percentage of household expenditure for the poor than for the better-off.

The multilayered impoverishing impacts of OPPs (including user fees) have been well documented, as have the negative equity impacts of user fees on the poor. The positive effects of removing user fees have also been demonstrated, with large increases in service utilisation after their removal, confirming the substantive nature of financial barriers. Further studies have shown that service usage increases more within poorer quintiles than richer quintiles when such fees are abolished, with concurrent reductions in household expenditure on health in the poorest quintiles. Recent research also highlights the direct linkages between the removal of user fees (with subsequent increases in service utilisation) and the potential reduction in child mortality. It is estimated that, with the removal of user fees in 20 African countries, 233,000 under-five deaths could be prevented annually, amounting to 6.3% of under-five deaths in those countries.

The majority of countries in West and Central Africa either charge for all services or provide limited exemptions for specific services and/or for particular segments of the population. However, management of selective exemptions is prone to costly and complex administrative procedures, and potential corruption, with no incentive for service providers to enforce exemptions, owing to the potential loss of revenue this represents for them. Nevertheless, exemption mechanisms for the poor and particularly vulnerable populations requiring health services (e.g. pregnant women and children under five) are essential as a means of mitigating the negative equity impacts of user fee systems as a step towards developing more progressive health financing systems.

Resistance to the removal of user fees often stems from the perceived loss of revenue expected to occur. User fees in practice, however, have generated less revenue than was anticipated, providing, according to recent studies, only 1-20% of ministry of health budgets. Removal of user fees would require not only replacement of this lost revenue, but also increased government expenditure to respond to increased demand. This would be manageable if accompanied by improvements in the prioritisation and efficiency of health expenditure.

THE PROMISE OF SOCIAL HEALTH INSURANCE

SHI is a progressive means of health financing with the objective of universal coverage for a population regardless of income or social status. Contributions are collected from workers, the self-employed, enterprises and the government, and are then pooled into a single 'social health insurance fund'. Universal coverage is achieved when contributions are made on behalf of each member of the population and the entire population is covered for service access. The pooling mechanism is redistributive, as contributions typically constitute a percentage of income. SHI is thus underpinned by the values of equity and solidarity in risk sharing. Membership in SHI schemes is mandatory and, as such, avoids the adverse selection problems typically associated with voluntary schemes, in which those in perceived good health opt out of the health insurance

scheme, thus overburdening insurance schemes with high-risk individuals. Under ideal conditions, all SHI scheme members are provided guaranteed and effective access to health care, household expenditure on health is smoothed and protection from catastrophic expenditures is achieved.

While SHI has of late been widely promoted as a promising health financing mechanism for the developing world, it is critical to note the difficulties associated with its implementation as well as its inherent limitations. The most significant disadvantage is the difficulty of covering those with unreliable or limited incomes, in particular those working in the informal sector and agriculture and the chronically unemployed or underemployed, who, in West and Central Africa, constitute the overwhelming majority of the population. Currently, SHI schemes in the region, set up as part of broader social security systems, cover mainly workers in the public sector and the formal private sector, with very limited enrolment beyond this. Enrolment in SHI schemes is lower among the poorer quintiles, and this inequity does not necessarily decrease with increases in overall national coverage rates. Ghana is the only country in West and Central Africa to have made real progress in extending health insurance to the broad population beyond the formal sector, but even in that case about 50% of the population is not yet enrolled.

SHI implementation furthermore requires economies of scale for effective risk pooling, and thus a reasonably large resource base in terms of numbers of members and contribution levels, as well as considerable administrative capacity to enrol members and manage contributions and reimbursements. But poverty levels are high in West and Central Africa, making it difficult for the poor to enrol without substantial government subsidies, which in turn are subject to fiscal constraints in most countries. These problems are compounded by poor governance and weak administrative capacity in many countries of the region, as well as the inherent administrative difficulties of enrolling and managing contributions from large numbers of people outside formal employment payroll systems. Service provision itself must also be available and of sufficient quality, so that members can be guaranteed acceptable benefits in return for their insurance contribution. And finally, the success of SHI hinges on solidarity within a population and a willingness to contribute to a national funding pool in order to share risks and benefits. In low-income countries with substantial inequalities in incomes and assets, resistance to the cross-subsidisation of services by the rich for the poor is a very real issue.

MUTUAL HEALTH ORGANISATION AS COMMUNITY-BASED MECHANISMS

Given limitations in coverage of the informal sector and rural and poor populations with SHI, community-based health insurance schemes (CBHI) – commonly termed MHOs – have been developed to serve as complementary social health protection and financing systems. These schemes aim to mobilise revenue and provide the protection of health insurance while smoothing expenditure patterns on health for vulnerable populations typically excluded from SHI. MHOs often utilise pre-existing solidarity groups, such as burial associations and microfinance organisations, as the basis for health insurance, as these groups offer prior experience with management and administration, as well as already established trust among members. This also serves to reduce the administration and transaction costs of collecting premiums, as collection can take advantage of structures already in place. While MHO/CBHI schemes still rely upon private expenditure, they aim to counteract some of the negative effects of private expenditure on user fees. Furthermore, the community management of MHOs provides the flexibility to structure payment plans according to the income patterns of their members.

MHOs have grown exponentially in the West and Central African region over the past decade, from 76 active schemes in 1997 to 199 in 2000 and 366 in 2003, with another 220 schemes in the early stages of development. In total, this amounts to coverage of almost two million people. However, this is only a very small proportion of

the estimated regional population of 900 million: in the majority of countries, MHOs cover less than 1% of the population. MHOs have been promoted with much optimism regarding their ability to provide access to health services for those vulnerable populations most often excluded from SHI schemes and negatively impacted by user fees. While they do offer much potential, however, the limitations surrounding their operation in practice draw into question the relevance and feasibility of MHOs for vulnerable populations.

The cost recovery of MHOs is very limited: a recent analysis estimated this to be about 25% on average, with only two out of 36 schemes reviewed achieving a cost recovery ratio greater than 50%. While the level of financial contribution is a significant determinant of the attractiveness of MHO membership, it is essential to the sustainability of schemes that this be sufficient to cover high-cost treatments that are largely responsible for catastrophic health expenditure. The 'catch-22' is that those members of the insurance scheme most in need of protection from these catastrophic health expenditures are the poorest members, who are also those least able to pay the higher premiums necessary to subsidise coverage of high-cost treatments. Cross-subsidisation across income groups is low, though, as most MHOs tend to cover a similar level income group. Many MHOs are able to cover only a small portion of the necessary health services and continue to rely on government subsidies and financing of public services, or on external donor funding to support revenue generation. Moreover, given the continued high degree of user fees in many contexts, members of MHOs often continue to contribute OPPs to meet up to 40% of their health costs in addition to premium payments.

Owing to their small size, MHOs are prone to many organisational and managerial problems. As membership is voluntary, adverse selection is a potential problem, particularly as low-income individuals will often choose to invest their limited resources in insurance only if the threat of illness is tangible. Moral hazard also presents an obstacle: as the financial ability to cover service utilisation is limited, over-utilisation can quickly become a financial risk. Many MHOs suffer from low managerial and administrative capacity, owing to the largely voluntary nature of their management. While utilisation of pre-existing management structures has been known to counteract this in part, there is an inherent compromise between the community management benefits of these schemes and the need for technical expertise. Additionally, investment in training can transfer a high cost to the scheme without the necessary benefit return.

The equity considerations of enrolment patterns in MHOs are also of significant concern, particularly in view of their express aim of increasing coverage of vulnerable populations. Evidence from a recent analysis shows that, while health expenditure protection and increased service utilisation are achieved for MHO members, the poorest often remain excluded from membership owing to the continued financial barrier of the insurance premium. Fee waivers, vouchers and exemptions have been suggested as mechanisms for subsidising or eliminating premium costs for poor or vulnerable components of the population, such as pregnant women and children under five. However, as noted above, these systems in themselves present challenges in terms of administration and implementation.

CONCLUSIONS AND RECOMMENDATIONS

This analysis of the strengths and weaknesses of alternative health financing mechanisms in the context of West and Central Africa leads to the following overall conclusions and policy recommendations.

Prioritise user fee abolition in maternal and child health services

There is growing consensus that the removal of user fees can have a significant positive impact on service utilisation, especially by the poor, and that if well planned and managed, this need not compromise service quality. Nonetheless, given the limited fiscal space in all but a handful of oil-rich countries in the region, the

removal of user fees for all health services, although desirable, is unlikely in the poorest countries. This raises the question of priorities for the selective abolition of user fees. Health financing options should be pursued with the aim of reducing the burden of OPPs on the poorest and most vulnerable in society, thereby reducing the poverty impacts of high private health expenditure, increasing access to essential primary health care, accelerating progress towards the health-related MDGs and promoting human capital development.

From this perspective, the removal of user fees for essential maternal and child health services should be seen as the highest priority, given the very high rates of child and maternal mortality in West and Central Africa and the relatively low cost of providing essential maternal and child health services. Where possible, this could be part of a broader abolition of fees for primary health care services, leaving other approaches, such as health insurance, as a complementary form of financing for other more costly types of curative care.

Address the prerequisites for the successful removal of user fees

The successful abolition of user fees, which increases the demand for health services, hinges on careful planning and management on the supply side in order to ensure that health providers are able to meet the increase in demand. This is necessary even if user fee abolition is limited to essential maternal and child health care services and/or other relatively low-cost primary health care services.

Prerequisites for a smooth transition away from user fees include: strong leadership to initiate and sustain policy changes; an analysis of the existing role of user fees in health financing – particularly at sub-national level – as a basis for formulating measures to avoid the potential negative effects of their removal; supply-side investments in health services to meet increased demand and improve the quality and geographical coverage of services; an increase in the health budget to compensate for the loss in revenue from user fees as well as to meet increased demand; dialogue with health sector staff and, where necessary, improvements in staffing, to provide for increases in workload accompanying increases in service utilisation; buffer funds and pre-stocking of drugs to ensure availability; strengthening of public financial management systems so that funds reach health centres in a timely and predictable fashion; improvements in health sector efficiency and 'value for money' through a stronger focus on preventative health and simple curative services at primary health care level; and monitoring of the policy change, beginning with an accurate baseline assessment.

Strengthen budget management and the quality of health expenditure

In addition to careful advance planning for the removal of user fees for essential primary health care services and an increase in health sector expenditure, governments need to strengthen budget management and improve the overall quality of expenditure in the health sector through capacity building in budget planning and execution, which is relatively weak across the region. While there has been some improvement in the budget planning and advocacy skills of ministries of health in some countries in recent years, political constraints result in most government health resources being allocated to salaries, accompanied by a strong bias towards secondary and tertiary levels of health services.

There are also serious weaknesses at the execution stage of the budget cycle, owing to weak treasury and payments systems and, in some cases, problems with decentralisation. As a result, often only a small proportion of the government resources allocated to health effectively reach local-level primary health care providers, and these resources commonly arrive irregularly or late, particularly for non-salary recurrent expenditures. Efforts to remove user fees should therefore be integrated into a broader package of reforms,

including measures to strengthen planning, budgeting and financial management, and to improve the quality of expenditure, such as in achieving a better balance between primary, secondary and tertiary care and between salary and non-salary recurrent expenditure. This also requires effective monitoring and evaluation, and mechanisms to promote learning and improved practices over time. Given that sub-national level health facilities are often particularly reliant on user fees to provide resources for medical supplies and other non-personnel recurrent expenditure, special attention needs to be given to ways of addressing the blockages in resource flows from the central to district and community levels in the health sector.

Understand the potential (and limitations) of SHI and MHOs

SHI and MHOs offer important complementary strategies in health financing. However, the equity limitations of these systems must be recognised, making it unrealistic to rely on SHI or MHOs to ensure universal access to essential primary health care services. Given the high rates of poverty, the large proportion of the population in the informal sector and the weak administrative capacity in the region, the difficulties associated with implementing SHI schemes in West and Central Africa are formidable. Even when associated with MHO-type mechanisms for enrolling those outside the formal sector of the economy, SHI is unlikely to reach the poorest and most vulnerable members of the population.

Therefore, SHI should be pursued in conjunction with complementary strategies aimed at the inclusion and subsidisation of care for the poorest populations, coupled with selective user fee abolition for the most essential primary health care services. In principle, MHOs offer a complementary strategy for social protection for rural, informal sector populations. However, they have a number of weaknesses, including: difficulties in enrolling the poor (unless supported by contribution exemption mechanisms for the poorest subsidised by government or donor funding); low levels of risk pooling; dangers of adverse selection; low levels of health cost reimbursement; and high administration costs. In short, SHI and MHOs may play some role as complementary strategies for risk pooling and health expenditure smoothing, but they are unlikely to provide a major mechanism for social health protection for the poorest and most vulnerable in West and Central Africa. It would be valuable, however, to promote further research on the strengths and weaknesses of these complementary health financing mechanisms, and to document examples of good practice and lessons learned.

Build political will and good governance

To make progress along the lines set out above requires first and foremost political will. While fiscal space shapes the scope and timeframe for the removal of user fees and the complementary roles of other forms of social health protection, governments have to be committed at the highest level to achieving equitable access to essential health care services and to designing and implementing the necessary reforms in health sector financing. Clearly, this kind of commitment is most likely in countries with an open political culture and competitive electoral politics. Ghana, which has a well-functioning democracy, has made the most progress, abolishing all health service fees for children under 18, as well as for maternal health services, while also building up the largest national health insurance scheme in West and Central Africa.

Several other countries in the region, such as Benin, Mali and Senegal, all of which have pluralistic political systems (and have experienced peaceful transitions of power between rival political parties), have also made some progress in selectively removing fees for some high-impact services for children and women – and Mali has taken the additional step of announcing plans for a national health insurance scheme and a subsidisation fund for health care for the extreme poor.

Take advantage of favourable development partner policies and build on international momentum
National governments can capitalise on the new window of opportunity created by the increasing international interest in social protection in developing country contexts. The health needs of the poor and vulnerable have remained relatively constant over the past 25 years – and continuing gaps in access to basic, low-cost primary health care in fulfilment of the right to health are painfully clear. However, health financing policy has often been driven by the political and economic policy paradigms of the major international donors and development partners, as in the case of user fee systems for health services, which were born out of the dominant focus on economic and fiscal issues at the height of structural adjustment during the 1980s. Slowly, however, international opinion has evolved and there is now a growing consensus that user fees do not provide social protection and access to health services for the poor, but on the contrary have a negative impact on their health and well-being. In light of commitments to MDG 8's promise of a global partnership for development, donors could contribute to the extra revenue necessary for the removal of user fees for essential primary health care services.

There appears to be considerable scope to expand investment in this area to promote the right to health of the most vulnerable and to expedite progress towards the attainment of MDGs 4 and 5, although the current world economic crisis poses a new threat that could lead to cuts in overall aid flows. The shifting of donor health sector support from project-based aid to sector-wide and general budget support can also facilitate an increase in the proportion of health sector resources funded through government expenditure, as evidenced in particular by the successful examples of health sector-wide approaches (SWAps) in some countries. Within this framework of aid harmonisation, donors and development partners could also play an important role in policy dialogue by encouraging national governments to design and implement health financing reforms that tackle the coverage deficits in child and maternal health services.

1. INTRODUCTION

Health has been recognised as a universal human right for over 60 years, since the formation of the World Health Organization (WHO). The signing of the Alma Ata Declaration on Primary Health Care in 1978 promised the realisation of this right through 'health for all' by 2000. Children specifically are recognised as having the right 'to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health' according to the United Nations Convention on the Rights of the Child (UN CRC). Yet, every year, 9.2 million children under the age of five continue to die of preventable and treatable diseases (UNICEF, 2008).

Progress towards Millennium Development Goals (MDGs) 4 and 5 on child and maternal mortality has been slow at best in West and Central Africa. Without a major increase in resources and dramatically enhanced political will by governments and development partners alike, these goals will not be achieved by 2015. The 2008 MDG Countdown Report found that, of 68 priority countries, not a single country in West and Central Africa was 'on track' in terms of child mortality; disturbingly, of the 12 countries that had actually seen an increase in the average annual rates of under-five mortality (U5MR) from 1990 to 2006, five were in West and Central Africa: Cameroon, Central African Republic, Chad, Congo and Equatorial Guinea. Similarly, in the case of the maternal mortality rate (MMR), all but Togo and Gabon were rated in the most serious 'very high' category (Countdown Coverage Writing Group, 2008). More specifically, the region's average U5MR was 169 per 1000 live births in 2007, with Sierra Leone's U5MR as high as 262. The region's average MMR – at 1100 per 100,000 live births – is the highest globally. Indeed, West and Central Africa accounts for more than 30% of global maternal deaths, with 162,000 women reported to have died of pregnancy- or childbirth-related causes in 2005 (UNICEF, 2008).

1.1 THE RATIONALE FOR SOCIAL PROTECTION IN HEALTH

Widespread poverty, especially in rural areas, and financial barriers to access to health and social services are among the underlying causes of these high levels of mortality. Access to health care typically requires out-of-pocket payments (OPPs). Globally, every year, 150 million individuals in 44 million households face financial catastrophe as a direct result of health care costs. Some 25 million households were estimated to have been pushed into poverty in 2007 as a result of paying for health care services (Holst and Brandrup-Lukanow, 2007). According to the WHO (2008b), OPPs account for one-third of total health care spending in two-thirds of all low-income countries. In most West and Central African countries, the OPP amount is well above this average (Drechsler and Jütting, 2005). Such payments can lead individuals or households to reduce their expenditures for basic needs such as food, housing and clothing, to borrow money and to sell household and production assets. As a result of catastrophic health costs already impoverished families remain trapped in poverty; others are pushed into poverty. Furthermore, the OPP cost may block access to needed services or a full course of needed treatment, thereby contributing to the high levels of morbidity and mortality, particularly among children and women.

In addition, ill health, compounded by malnutrition, arrests child development and contributes to chronic poverty. It is conservatively estimated that more than 200 million children under the age of five fail in developing countries to reach their cognitive development potential as a result of the interacting effects of poverty, poor health and nutrition and deficient care. The long-term impacts on levels of health and poverty reduction are devastating, playing an intergenerational role in the transmission of poverty (Grantham-McGregor et al.,

2007). Malnutrition undermines children's ability to ward off infection, while disease itself worsens a child's nutritional status. Children suffering from malnutrition become trapped in a cycle of ill health, suffering up to 160 days of illness each year. Productivity in adulthood is reduced through both fewer years of schooling and less learning while in school, resulting in a projected 20% loss in potential income associated with growth stunting and poverty (ibid).

Access to affordable health services alleviates the financial burden of health care on households and improves their ability to generate income and a sustainable livelihood. Over the past decade, there has been an increasing focus on health insurance and other forms of social protection as a potentially promising way to deal more effectively with health risks in developing countries (e.g. Carrin, 2002; Deininger and Mpuga, 2004; Ekman, 2004), including in West and Central Africa (e.g. Atim, 1998; Berkhout and Oostingh, 2008). However, analysis of the extent to which social (health) insurance and other health financing and social protection mechanisms can play a role in reducing poverty and vulnerability among children and their carers is scarce (e.g. James et al., 2008; McPake et al., 2008). This report seeks to address this gap in West and Central Africa, drawing on existing secondary data as well as the findings from the five country reports produced as part of the larger study on social protection for children in West and Central Africa (see Preface).

1.2 CONCEPTUAL FRAMEWORK

Increasingly, social protection is conceptualised as a set of public actions that address poverty, vulnerability and risk throughout the lifecycle. Such actions may potentially be conducted in tandem with private initiatives – either formal private sector or informal individual or community initiatives. Building on the recognition that poverty has both monetary and non-monetary dimensions, vulnerability and risk are now also recognised as being multidimensional, including natural and environmental, economic, health, social and lifecycle axes. The distribution and intensity of these vulnerabilities are likely to be experienced differently, depending on the stage in the lifecourse (infant, child, youth, adult, aged), social group positioning (gender, ethnicity, class) and geographic location (for example urban/rural), among other factors.

For children, the experience of risk, vulnerability and deprivation is shaped by four broad characteristics of childhood poverty and vulnerability:

- **Multidimensionality** – related to risks to children's survival, development, protection and participation in decisions that affect their lives;
- **Changes over the course of childhood** – in terms of vulnerabilities and coping capacities (e.g. young infants have much lower capacities than teenagers to cope with shocks without adult care and support);
- **Relational nature** – given the dependence of children on the care, support and protection of adults, especially in the earlier parts of childhood, the individual vulnerabilities of children are often compounded by the vulnerabilities and risks experienced by their caregivers (owing to their gender, ethnicity, spatial location, etc.);
- **Voicelessness** – although marginalised groups often lack voice and opportunities for participation in society, voicelessness in childhood has a particular quality, owing to legal and cultural systems that reinforce their marginalisation (Jones and Sumner, 2007).

Owing to the relational nature of childhood risks, health, lifecycle and social vulnerabilities have clearly identifiable child-specific manifestations, which are mapped out in Table 1. Because of children's physical and psychological immaturity and their dependence on adult care and protection, especially in early childhood, risks in general affect children more profoundly than they do adults, and it is likely that the most detrimental effects of any shock will therefore be concentrated in infancy and early childhood.

Table 1: Vulnerabilities - Lifecycle and childhood manifestations

Type of vulnerability	Indicators	Child-specific manifestation
Natural/ environmental	Natural disasters/phenomena/ environmental (human-generated environmental degradation, e.g. pollution, deforestation)	Children more vulnerable owing to physical and psychological, and also possible spill-over economic vulnerabilities, as natural disasters may destroy family livelihoods
Economic	• Income (low returns to labour, unemployment, irregular salaries, no access to credit) • Inter-household inequality in access to land, rights and duties related to social standing, gender discrimination (access to productive assets)	As above + child labour, child trafficking, child sexual exploitation owing to conceptualisation of children as economic assets
Lifecycle	Age-dependent requirements for care and support (infancy through to old age)	Physical/psychological vulnerabilities compounded by political voicelessness
Social	• Family composition (high dependency, intra-household inequality, household break-up, family violence, family break-up) • Extra-family violence, social upheaval, social exclusion and discrimination • Gender discrimination (unequal access to productive assets, access to information, capacity-building opportunities) • Social capital (access to networks both within one's community and beyond (bonding and bridging social capital), access to community support and inclusion) • Education/information/literacy	Family and school/community violence, diminished quantity and quality of adult care, discrimination
Health	Age-specific health vulnerabilities (e.g. infancy, early childhood, adolescence, childbearing, old age), illness and disability	Under three years especially vulnerable, access to immunisation, malnutrition, adolescence and child bearing

In view of the particularly severe, multiple and intersecting deprivations, vulnerabilities and risks faced by children and their caregivers in the West and Central Africa region, we draw on Devereux and Sabates-Wheeler's (2004) transformative social protection framework for an analytical view that encompasses protective, preventative, promotive and transformative social protection measures. A transformative perspective relates to power imbalances in society that encourage, create and sustain vulnerabilities – extending social protection to arenas such as equity, empowerment and economic, social and cultural rights. This may include, for example, sensitisation and awareness-raising campaigns to transform public attitudes and behaviour along with efforts to change the regulatory framework to protect marginalised groups from discrimination and abuse.

Operationally, this framework refers to social protection as the set of all initiatives, both formal and informal, that provide:

- **Social assistance** to extremely poor individuals and households. This typically involves regular, predictable transfers (cash, vouchers or in-kind, including fee waivers) from governments and non-governmental entities to individuals or households, with the aim of reducing poverty and vulnerability, increasing access to basic services and promoting asset accumulation.
- **Social services** to marginalised groups that need special care or would otherwise be denied access to basic services based on particular social (rather than economic) characteristics. Such services are normally targeted at those who have experienced illness, the death of a family breadwinner/caregiver, an accident or natural disaster; those who suffer from a disability, familial or extra-familial violence, family breakdown; or war veterans or refugees.
- **Social insurance** to protect people against the risks and consequences of livelihood, health and other shocks. Social insurance supports access to services in times of need, and typically takes the form of subsidised risk-pooling mechanisms, with potential contribution payment exemptions for the poor.
- **Social equity measures** to protect people against social risks such as discrimination or abuse. These can include anti-discrimination legislation (in terms of access to property, credit, assets, services) as well as affirmative action measures to attempt to redress past patterns of discrimination.

These social protection instruments are used to address the vulnerabilities of the population in general, but can also be adapted to address the specific risks faced by children as mapped out in Table 2 below. Given the close actual and potential linkages between women's empowerment and child well-being (in what has been referred to as the 'double dividend' in the UNICEF State of the World's Children Report 2007), each of the general social protection measures could also usefully be assessed through a gender-sensitive lens.

Table 2: Types of social protection and household and child-specific measures

Type of social protection	General household-level measures	Specific measures for children
Protective Social assistance	Cash transfers (conditional and unconditional), food aid, fee waivers, school subsidies, etc.	Scholarships, school feeding, cash transfers with child-related conditionalities, fee waivers for school, fee waivers for childcare
Social services	Distinct from basic services as people can be vulnerable regardless of poverty status – includes social welfare services focused on those needing protection from violence and neglect – e.g. shelters for women, rehabilitation services, etc.	Case management, alternative care, child foster systems, child-focused domestic and community violence prevention and protection services, rehabilitation services, reintegration services, basic alternative education for child labourers, etc.
Preventative Social insurance	Heath insurance, subsidised risk-pooling mechanisms – disaster insurance, unemployment insurance, etc.	Fee waivers for health insurance for children
Promotive Productive transfers	Agricultural inputs, fertiliser subsidies, asset transfers, microfinance	Indirect spill-over effects (positive and negative)
Transformative Social equity measures	Equal rights/social justice legislation, affirmative action policies, asset protection	Legislation and its implementation to promote child rights as victims (e.g. of violence, trafficking, early child marriage, etc.) and as perpetrators (special treatment and rehabilitation services for young offenders), efforts to promote children's voice and agency
Complementary measures Complementary basic services	Health, education, economic/financial, agricultural extension	Child-focused health care services; pre-, primary and secondary school; childcare services
Complementary pro-poor or growth with equity macroeconomic policy frameworks	Policies that support growth plus distribution	Policies that support progressive realisation of children's rights in line with macroeconomic growth indicators

We also apply analytical elements of both Hickey's (2007) politics of social protection framework and work by the United Nations Research Institute for Social Development (UNRISD) on the political economy of care (Razavi, 2007) in order to better understand the political and institutional context of social protection in the West and Central Africa region. The uptake of general and child-specific social protection instruments will be refracted through existing political institutions, political discourses about poverty and care and possibly national social protection systems that build on historical legacies of provision of the state to address poverty and vulnerability; the extent to which the intersection between poverty and social exclusion is recognised by the government officials responsible for designing and implementing social protection programmes; and the composition of the labour market, with the differential integration/positioning of men, women and children within it.

Such an analysis aims to identify appropriate policy entry points for strengthening social protection in the region, as well as to identify the processes and opportunities in which social protection can be politically sustainable as a basis for the development (and operationalisation) of a state–citizen contract that has citizenship rights at its centre.

1.3 APPLYING THE FRAMEWORK TO HEALTH

Ensuring access to health is a critical component of social protection. It is underpinned by the principles of solidarity and equity: that all individuals are guaranteed access to an adequate package of health care based on health needs rather than their ability to pay. Social protection in health offers the opportunity to:

- **Prevent** the poverty-inducing effects of ill health and catastrophic health costs;
- **Protect** vulnerable populations through relief from ill health and disease; and
- **Promote** real incomes and capabilities through smoothing the spending patterns on health and increasing productivity as a result of improved health.

Social health protection should be embedded within a broader framework of complementary policy and programming, aimed at enhancing social equity, especially to facilitate the healthy development of children.

1.4 STRUCTURE OF THE REPORT

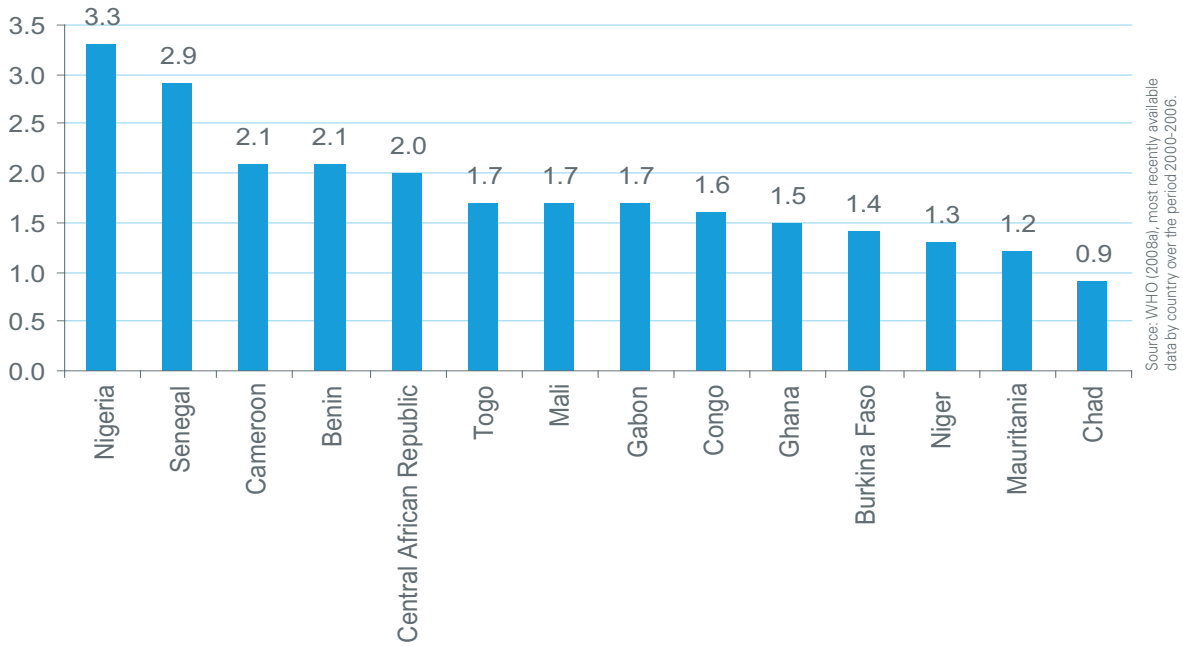
Following this introductory **Section 1**, which outlines the rationale for social protection in health and sets out the conceptual framework, **Section 2** presents an overview of the key health vulnerabilities of children and their carers in West and Central Africa. **Section 3** analyses current health financing patterns across the region, highlighting the key challenges that need to be addressed if equitable access to essential health services is to be achieved. A discussion of the comparative advantages and disadvantages of a range of health financing mechanisms for low-income countries is presented in **Section 4**. Finally, **Section 5** draws out the main conclusions of the analysis and presents a set of recommendations on health financing mechanisms and broader social and governance reforms needed to enhance social health protection for children and women in West and Central Africa.

2. CHILD AND MATERNAL HEALTH VULNERABILITIES IN WEST AND CENTRAL AFRICA

2.1 CHILD SURVIVAL

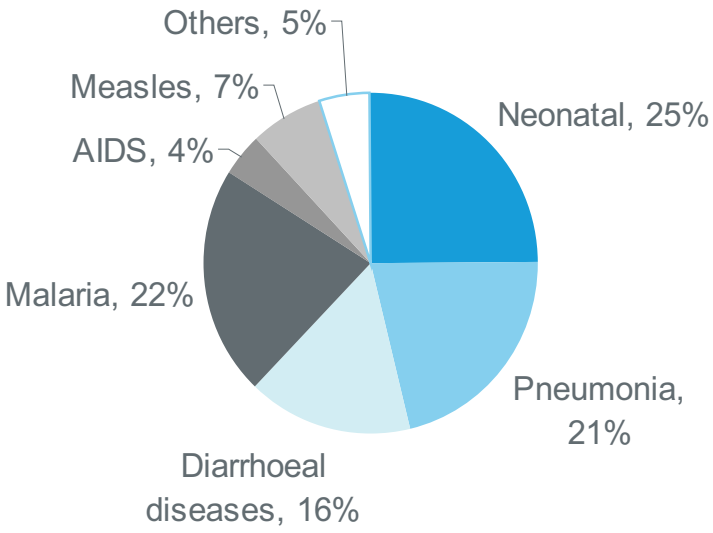
West and Central Africa currently has the highest regional U5MR in the world, at 169 (out of 1000 live births), with rates as high as 262 in Sierra Leone and 209 in Chad (UNICEF, 2009). From 1990 to 2007, the U5MR increased in Cameroon, Chad, Congo, Equatorial Guinea and the Central African Republic and remained stagnant in Gabon, Ghana and São Tomé and Príncipe. While there have been improvements in some other countries, overall the region is far off track to reach MDG 4 by 2015. Furthermore, national U5MRs mask large disparities in child mortality within countries. As shown in Figure 1, U5MRs are almost invariably much higher in the lowest wealth quintile. They are also higher in rural areas than in urban areas. In Nigeria, a child born in a household in the lowest quintile is 3.3 times more likely to die before reaching the age of five than a child born in the highest quintile.

Figure 1: Ratio of U5MR of lowest and highest quintiles in West and Central Africa



Neonatal conditions, malaria, acute respiratory infections, diarrhoea and malnutrition remain the leading causes of child mortality in the region. As Figure 2 shows, neonatal factors account for 25% of under-five mortality in West and Central Africa, followed by malaria (22%), pneumonia (21%) and diarrhoeal diseases (16%).

Figure 2: Distribution of under-five deaths by cause in West and Central Africa, 2000-2003



Source: Statistics and Monitoring Section, Division of Policy and Practice, UNICEF, December 2008.

Malnutrition, which is a crosscutting, indirect cause of child mortality, contributing to about one-third of under-five deaths globally, compounds this grim picture. In West and Central Africa, 28% of children under five are underweight and 36% are suffering from moderate to severe stunting; 15% of all infants are born with a low birth weight with devastating long-term child development effects (UNICEF, 2008). The percentage of children under five stunted in growth for their age ranges from 16% in Senegal to 54.8% in Niger, with a regional average of 48% (WHO, 2008a). The low levels of access to safe drinking water and sanitation facilities, in which the region has also shown little progress over many years (especially in the case of sanitation), is another key contributory factor behind the high child mortality rates in West and Central Africa.

2.2 MATERNAL SURVIVAL

Maternal mortality has remained stubbornly high in West and Central Africa, accounting for more than 30% of global maternal deaths. With 1100 maternal deaths per 100,000 live births, 162,000 women died of pregnancy- or childbirth-related causes in 2005 (UNICEF, 2008). No discernible progress has been made in reducing the ratio since 1990. Only Cape Verde has an MMR of less than 500, and one-third of countries in the region have an MMR of over 1000 (see Table 3). The 2008 MDG Countdown Report found that nearly two-thirds of maternal deaths in the region occur in the Democratic Republic of Congo, Niger and Nigeria, and that these three countries together account for approximately 20% of all maternal deaths worldwide. These high rates of maternal mortality are exacerbated by higher fertility rates, which mean that women are more frequently exposed to the risk of maternal death, and by the lowest levels of literacy internationally. West and Central Africa has the highest fertility rates in the world, with a total fertility rate of 5.6 and an average adolescent birth rate of 146 births per 1000 girls. Less than one-fifth of women aged 15-49 who are married or in union are using some method of contraception.

Table 3: Maternal mortality rates in West and Central Africa

Country	Deaths per 100,000 live births (2005 adjusted)
Benin	840
Burkina Faso	700
Cameroon	1000
Cape Verde	210
Central African Republic	980
Chad	1500
Congo, Republic	740
Congo, Democratic Republic	1100
Côte d'Ivoire	810
Equatorial Guinea	680
Gabon	520
Gambia	690
Ghana	560
Guinea	910
Guinea-Bissau	1100
Liberia	1200
Mali	970
Mauritania	820
Niger	1800
Nigeria	1100
São Tomé and Príncipe	-
Senegal	980
Sierra Leone	2100
Togo	510

Source: UNICEF (2008).

As in the case of child mortality, the high maternal death toll is also related to the overall low access to basic health services in the region, both geographically and financially, owing to insufficient levels of overall funding for the health sector and the inequitable composition of expenditure, including the heavy reliance on out-of-pocket expenditure. This report focuses on the barriers of access to health care and alternative policy responses to address these specific underlying causes of high maternal and child mortality.

2.3 HEALTH SERVICE UTILISATION

Basic health service access, as measured by maternal health services, immunisation rates and management of major childhood illnesses, is low across West and Central Africa, with important disparities within countries further diminishing access to care by rural and poor populations. For instance, in the case of Ghana (one of the case study countries), the share of hospital visits by the richest population quintile is almost four times that of the poorest quintile (see Table 4). These figures are exacerbated in rural deprived areas such as the Northern, Upper West and Upper East regions, which have the worst doctor to population ratios in the country (see Jones et al., 2009).

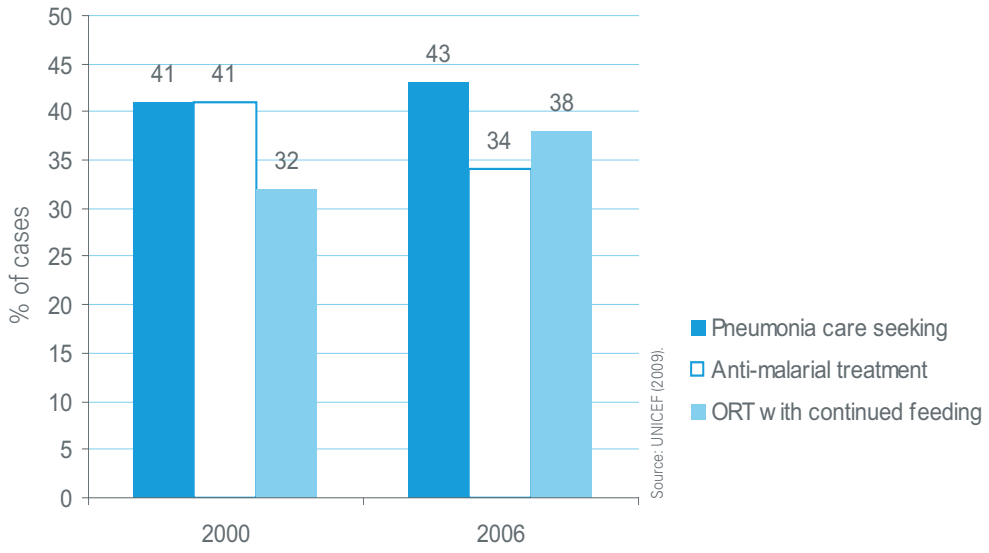
Table 4: Share of visits to public health facilities by quintile in Ghana

	Hospitals		Clinics	
Quintile	1991/1992	2005/2006	1991/1992	2005/2006
Poorest quintile	9.4	9.1	15.7	18.3
2nd quintile	14.2	15.0	17.1	20.0
3rd quintile	17.7	19.3	20.8	19.0
4th quintile	24.3	23.6	19.2	22.0
Richest quintile	34.4	33.1	27.2	20.8

Source: Coulombe and Wodon (2007).

While progress has been made in sub-Saharan Africa in improving the coverage of some specific, mainly vertical and preventative health interventions, such as the use of insecticide-treated bed nets, there has been little progress since 2000 in the case management of major childhood illnesses (see Figure 3). In West and Central Africa, only 29% of children under five with diarrhoea receive oral rehydration therapy (ORT) and continued feeding. Immunisation rates, as measured by completion of DPT3 in the vaccination schedule[2], are at 69% across the region (UNICEF, 2008), although a number of countries have immunisation rates below 60%.

Figure 3: Case management of major childhood illnesses in sub-Saharan Africa



[2] DPT3 (diphtheria–pertussis–tetanus) is commonly used as a proxy for access to basic child health services, given current patterns of immunisation scheduling. However, recent evidence suggests that girls who receive DPT3 as their last vaccination have higher mortality rates than girls who receive the measles vaccine as their last vaccination. Further research is necessary to clarify these observations, but one potential implication is that 'complete' vaccination should be measured by measles vaccination rates (for girls) rather than DPT3 (Aaby et al., 2006).

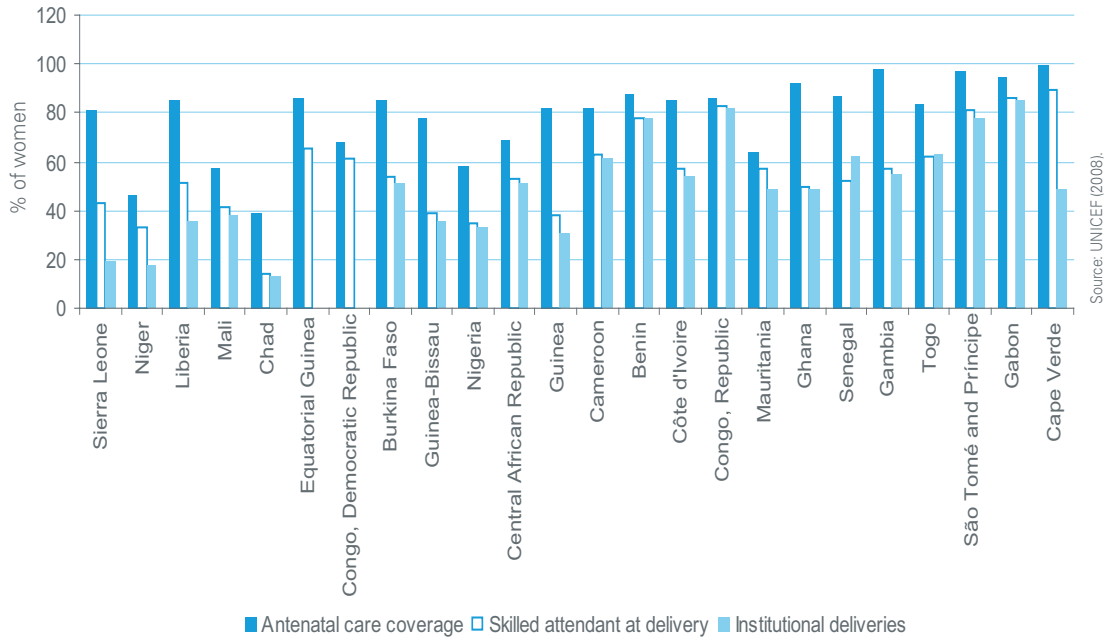
The countries that are the worst performers on child health care are also at the lower end of the spectrum for maternal health care service utilisation, underpinning the recognised connection between basic maternal and child health services and between maternal and child mortality, particularly in the neonatal period (see Table 5 and Figure 4).

Table 5: U5MRs and basic health service utilisation in West and Central Africa

	U5MR (per 1000 live births)	1-year-old children immunised for DPT3 (%)	Under fives with diarrhoea receiving ORT and continued feeding (%)	Antenatal care coverage (at least once, %)	Skilled attendant at delivery (%)
Sierra Leone	262	64	31	81	43
Chad	209	20	27	39	14
Equatorial Guinea	206	33	36	86	65
Burkina Faso	204	99	42	85	54
Guinea-Bissau	200	63	25	78	39
Mali	196	68	38	70	45
Nigeria	191	54	28	58	35
Niger	176	39	34	46	33
Central African Republic	172	54	47	69	53
Congo, Democratic Republic	161	87	17	85	74
Guinea	150	75	38	82	38
Cameroon	148	82	22	82	63
Liberia	133	88	-	85	51
Côte d'Ivoire	127	76	45	85	57
Congo, Republic	125	80	39	86	83
Benin	123	67	42	84	74
Mauritania	119	75	9	64	57
Ghana	115	94	29	92	50
Senegal	114	94	43	87	52
Gambia	109	90	38	98	57
Togo	100	88	22	84	62
São Tomé and Príncipe	99	97	63	97	81
Gabon	91	38	44	94	86
Cape Verde	32	81	-	98	78
West and Central Africa region	169	69	29	71	49

Source: UNICEF (2008).

Figure 4: Access to maternal health services



Note: Data refer to the most recent year available between 2000 and 2006.

Antenatal care provision across the region is 71% (at least one consultation), but less than half (49%) of births have a skilled attendant at delivery and only 44% of births are institutional deliveries (UNICEF, 2008). Urban women are twice as likely as rural women to give birth with skilled health personnel in attendance, and in some countries the gap is much higher, for example in Chad, where the difference is eightfold. Disparities based on household wealth are even greater. In 16 countries with these data, women from the richest quintile are three and a half times as likely as those from the poorest to be attended by a skilled health professional.

UNICEF (2008) points to the strong correlation between coverage indicators and under-five mortality, noting that such a correlation is weaker for maternal mortality. While there has been some progress in antenatal care coverage and the percentage of births attended by skilled personnel, this is not yet reflected in a decline in the overall maternal mortality ratio. This suggests that coverage, although a necessary condition for impact, may not be sufficient when care is substandard. More specifically, the lack of access to emergency obstetric care (including delivery via Caesarean section) and postpartum checkups is a serious concern, especially during the 24 hours following delivery, the period when complications are most likely[3].

According to data from demographic and health surveys (DHS) in nine countries in the region[4], the main obstacles expressed by women in accessing health services are finding the money for treatment (55.8%), distance to health facilities (39.5%) and having to take transport to reach health services (37.4%)[5]. All obstacles were

[3] Data may also in part be reflecting a time lag, as MMRs are often measured only every 10 years.

[4] West and Central African countries for which DHS data were available are: Benin (2001), Burkina Faso (2003), Cameroon (2004), Ghana (2003), Guinea (2005), Mali (2001), Niger (2006), Nigeria (2003) and Senegal (2005).

[5] Weighted averages are based on the population of women surveyed in each country.

of greater issue in rural areas: the obstacle of finding money to cover treatment costs was seven percentage points higher in rural areas, whereas the obstacles of distance to health facilities and having to take transport were each nearly 10 percentage points higher (see Figure 5). Among those countries for which data are available, the obstacle of getting money for treatment is highest in Guinea, Cameroon, Niger and Burkina Faso (Figures 6 and 7).

Figure 5: Obstacles to women's health service access in urban and rural areas in West and Central Africa

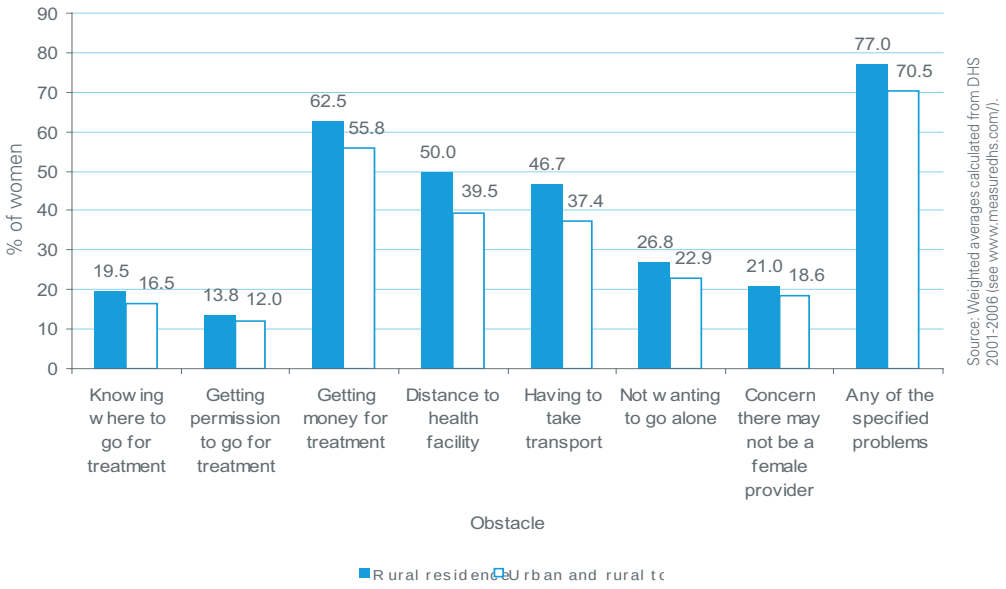


Figure 6: Obstacles to accessing health services by country - Getting money to access health treatment

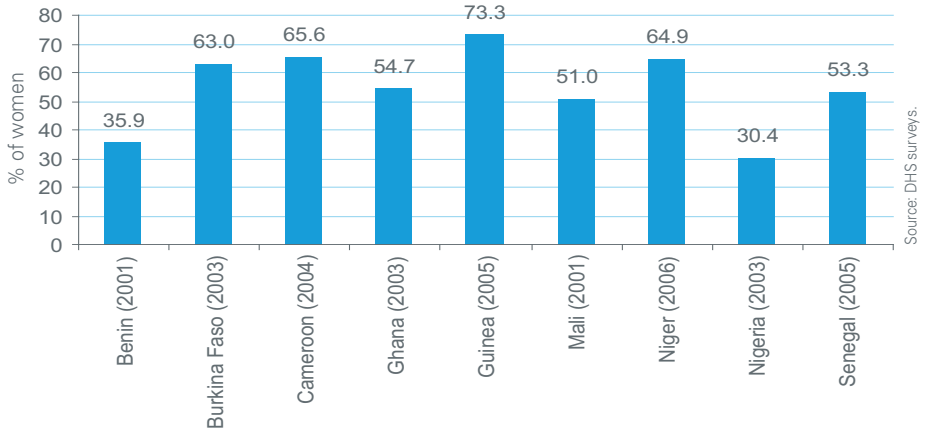
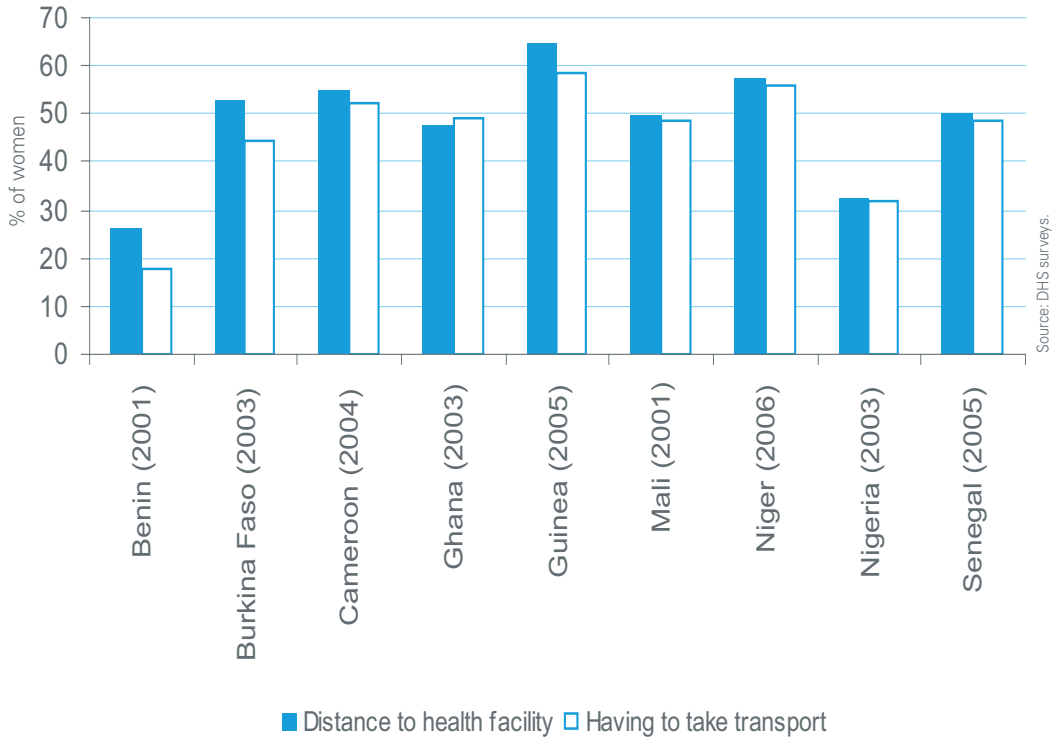


Figure 7: Distance-related obstacles to accessing health services by country - Rural areas



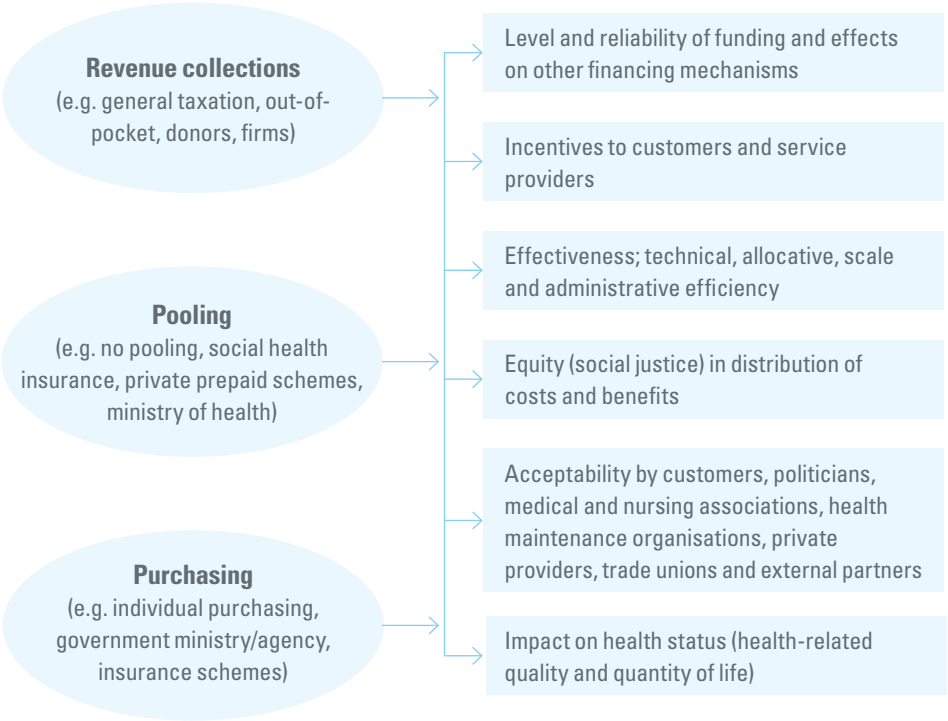
3. HEALTH FINANCING PATTERNS IN WEST AND CENTRAL AFRICA

Health financing mechanisms have profound impacts on the functioning of the health sector, particularly regarding the equity of the financial burden of health care and the accessibility of health services for different groups of the population. Health financing must fulfil three critical functions:

- Collecting sufficient revenue to provide sustainable and adequate health services in response to the population's needs;
- Pooling mechanisms that distribute the burden of risk across a population, decreasing the financial burden of health risks and treatment for any actor in the system; and
- Purchasing health services from care providers (Kirigia et al., 2006).

The health financing mechanisms utilised for these three functions have an impact on the effectiveness, efficiency and equity of the health sector, and should be evaluated by all three criteria. The WHO framework below illustrates these various functions and related effects (Kirigia et al., 2006).

Figure 8: Health financing conceptual framework



Source: Kirigia et al. (2006).

The following analysis is based on WHO National Health Accounts data for 2006 (WHO, 2008b) and provides an overview of the composition of health expenditure in West and Central Africa, with implications for the current equity, effectiveness and efficiency of the health sector.

3.1 ANALYSIS OF HEALTH EXPENDITURE LEVELS

Total health expenditure remains low across the region, with a weighted average of US$28 per capita total health expenditure and US$10 per capita government expenditure on health (at average exchange rates). Out of 24 countries in the region, government expenditure on health is less than US$10 per capita in 11 countries and between US$10 and US$20 per capita in nine countries (Figure 9). This is of significant concern, as the WHO Commission for Macroeconomics and Health (2001) has estimated that a minimum government expenditure of US$34 per capita per year is necessary to provide a minimum package of essential health services in order to meet the health-related MDGs. African heads of state set a target in the Abuja Declaration (2001) to allocate 15% of their annual budgets to the health sector. This commitment was reaffirmed by the Maputo Declaration (2003), but only two countries in West and Central Africa allocated 15% or more of their budgets to health, with six countries allocating as little as 0-5% of their budgets to the sector (Figure 10).

Given the importance of health for human capital and development as a whole, the percentage of countries' gross domestic product (GDP) spent on health is an important indicator of the priority attached to health, but is also influenced to an extent by the level of GDP (Kirigia et al., 2006). In low-income countries, to ensure basic health care coverage, a relatively higher percentage of GDP is necessary than in countries with higher GDP levels. Nevertheless (as shown in Figure 11), with the exception of São Tomé and Príncipe, all countries in West and Central Africa spent less than 7% of GDP on health in 2006, and half of the countries in the region spent less than 4.5% (WHO, 2008b).

Figure 9: Per capita health expenditure in West and Central Africa

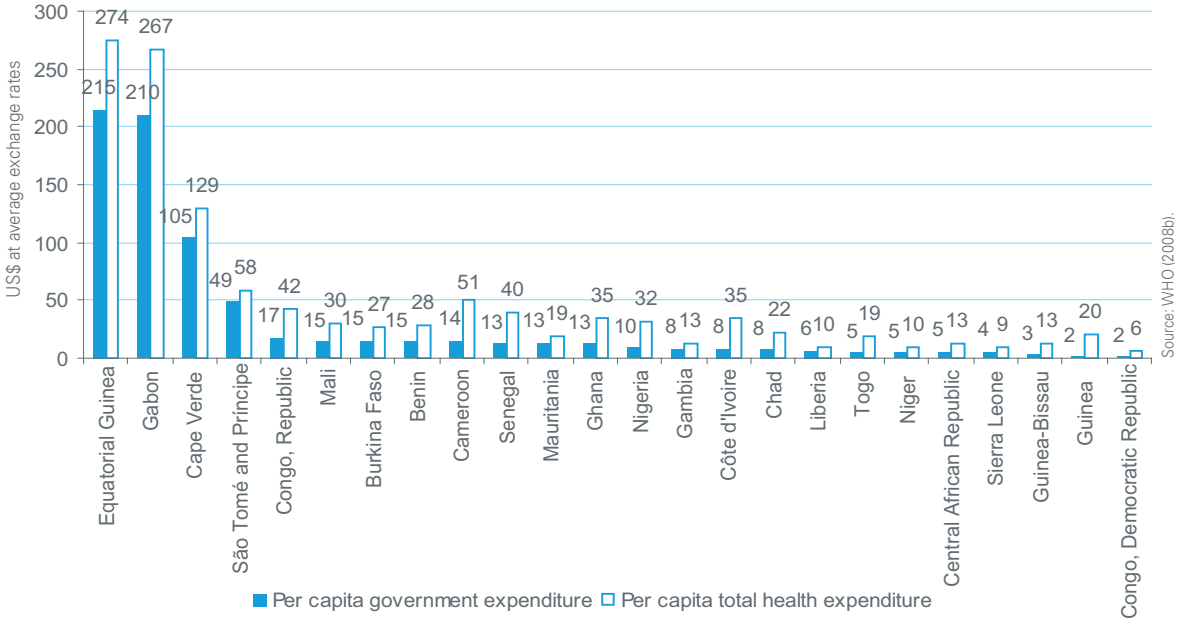
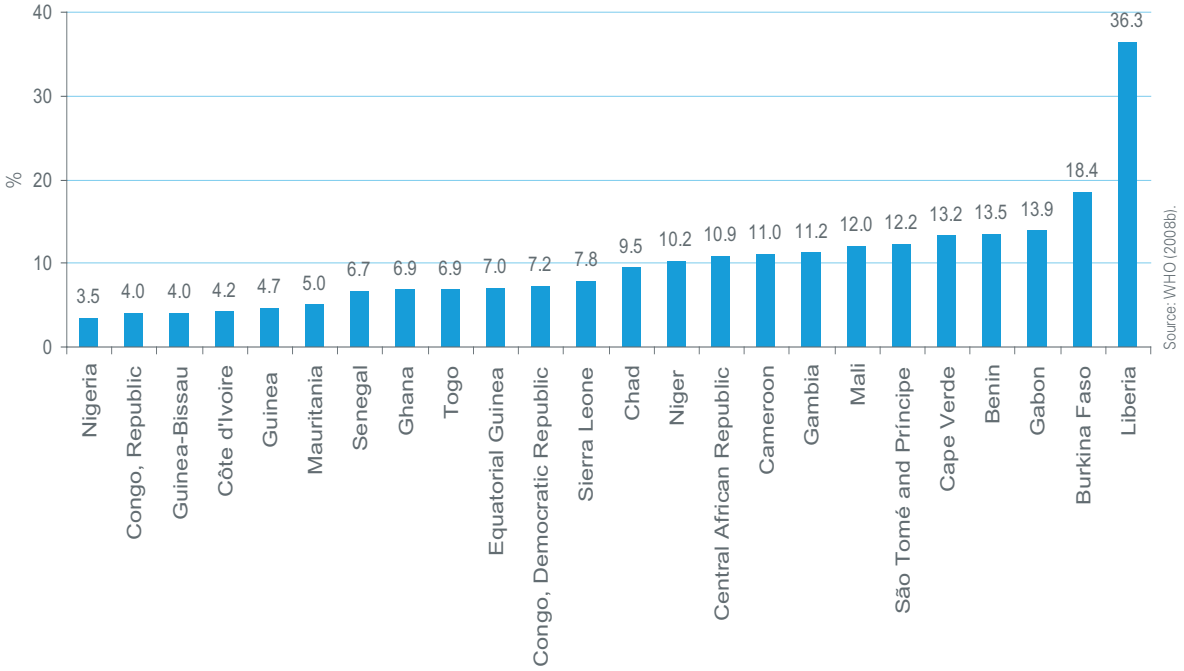
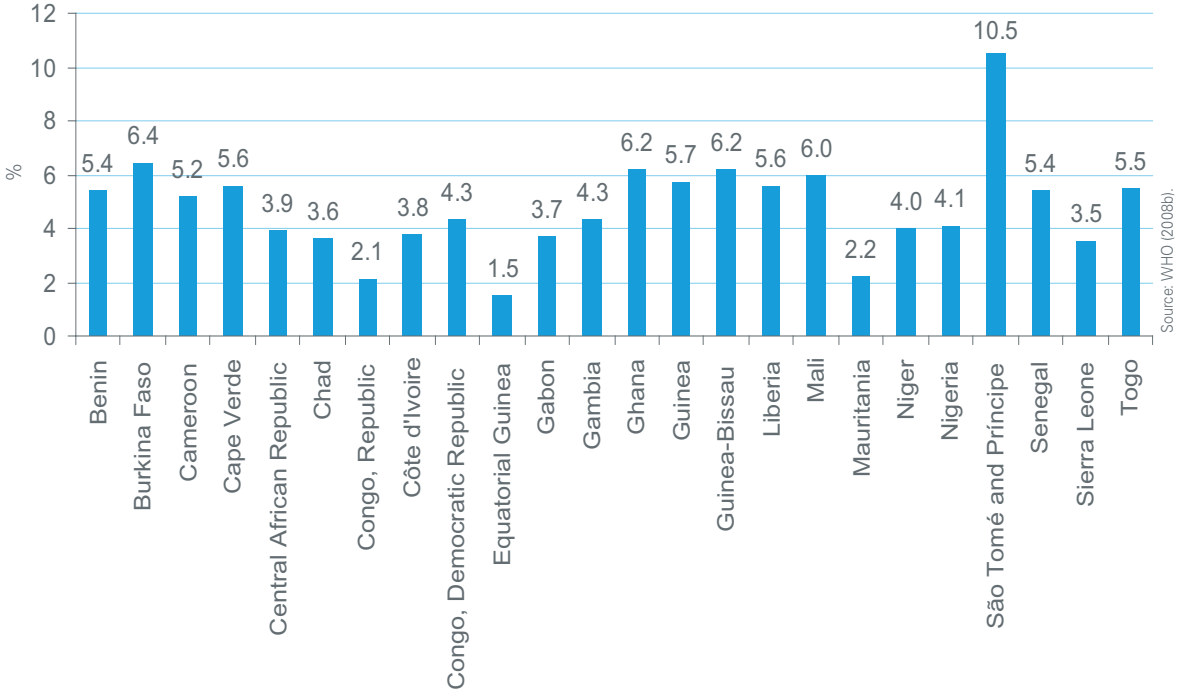


Figure 10: Health share of total government expenditure, 2005



Note: Data for Nigeria may be misleading, as most health expenditure is not by central government (at federal level), but by state government and local government authorities.

Figure 11: Percentage of GDP spent on health in West and Central Africa, 2006

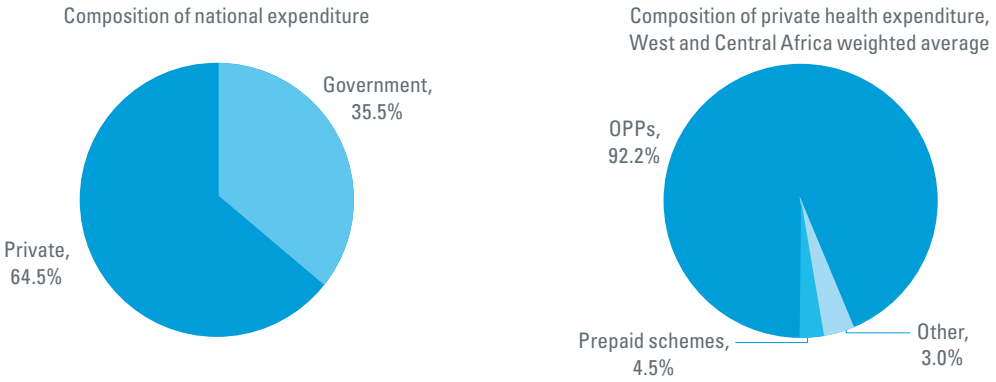


3.2 HEALTH FINANCING AND EQUITY

The composition of sources of health financing is an important marker for the equity of the system, with implications for the ability of the poorest to afford access to critical health services. In West and Central Africa, on average, private health expenditure (64.5% of total health expenditure) is higher than government health expenditure (35.5%: WHO, 2008b). In a region where the proportion of people living below the poverty line of US$1 per day ranges from 15% in Côte d'Ivoire to 90% in the Democratic Republic of Congo, the negative equity impacts of this degree of private health expenditure are significant, as will be discussed in greater detail in Section 4. Furthermore, on average in the region, 92.2% of private expenditure comes from OPPs made at the point of service [6]. On average, only 4.5% of private health expenditure is through prepaid mechanisms such as insurance schemes. The important exceptions are: Côte d'Ivoire (12.2% of private expenditure), Niger (11.7%), Senegal (8.7%), Nigeria (6.7%), Ghana (6.2%) and Gambia (4.6%), where prepaid mechanisms make up a slightly higher proportion of private expenditure on health (WHO, 2008b).

OPPs incurred by the lowest wealth quintiles comprise a greater percentage of household expenditure than in upper wealth quintiles (Gilson and McIntyre, 2005). Studies have found a positive correlation between levels of OPPs and the degree of catastrophic health expenditure (defined as greater than 40% of household expenditure), pushing households below the poverty line or deeper into poverty. In half the countries in the region, a greater proportion of health expenditure comes from OPPs than from government expenditure (Figure 12).

Figure 12: Composition of health expenditure in West and Central Africa, 2006



Source: WHO (2008b).

While OPPs currently represent a large percentage of health sector expenditure, this should be considered relative to the overall low level of total health expenditure relative to GDP, and the low share of government health expenditure in total health expenditure (Table 6).

[6] OPPs are defined as all categories of health-related expenses incurred at the time the household received the health service, including doctor's consultation fees, purchases of medication and hospital bills and spending on alternative and/or traditional medicine. Expenditure on transport to receive health care services is excluded. Any health reimbursements (e.g. from insurance companies) are deducted from the OPP amount. User fees are defined as direct charges applied by governments to users for health services. Policies differ widely between countries as to which services are subject to user fees, including charges for registration, patient visits, procedures/care and drugs. Fees often vary by the level of care at which they are charged (e.g. primary care facilities vs. hospital care). User fees comprise OPPs made for public health services.

Table 6: Comparative composition of health expenditure - government; OPPs; prepaid

	General government health expenditure as % of THE	Private health expenditure as % of THE	OPP expenditure as % of THE	Prepaid private health expenditure as % of private health expenditure
Benin	55.5	44.5	44.5	0.1
Burkina Faso	56.9	43.1	39.4	2.1
Cameroon	28.1	71.9	68.2	-
Cape Verde	81.5	18.5	18.4	0.3
Central African Republic	35.6	64.4	61.4	-
Chad	35.6	64.4	62	0.4
Congo	40.8	59.2	59.2	-
Côte d'Ivoire	23.0	77.0	67.6	12.2
Congo, Democratic Republic	37.1	62.9	62.9	-
Equatorial Guinea	78.3	21.7	16	0.0
Gabon	78.7	21.3	21.3	-
Gambia	58.3	41.7	29.3	4.6
Ghana	36.5	63.5	50	6.2
Guinea	12.3	87.7	87.3	0.0
Guinea-Bissau	24.7	75.3	44.7	0.0
Liberia	63.9	36.1	35.7	0.0
Mali	51.7	48.3	48.1	0.5
Mauritania	68.6	31.4	31.4	0.0
Niger	52.7	47.3	40.3	11.7
Nigeria	30.1	69.9	63.2	6.7
São Tomé and Príncipe	85.4	14.6	14.6	0.0
Senegal	31.5	68.5	61.9	8.7
Sierra Leone	49.0	51.0	51	0.0
Togo	27.8	72.2	61.2	4.2

Source: WHO (2008b).

Note: THE = total health expenditure.

Levels of financial health protection in West and Central Africa can be tentatively grouped as shown in Table 7 below into three broad clusters[7] – higher, medium and lower – based on (i) the absolute level of THE; and (ii) the percentage share of OPPs in total health expenditure. 'Higher' is defined here as total health expenditure above the WHO recommended US$34 minimum per capita expenditure threshold and OPPs below 25% of THE. 'Medium' and 'lower' both have THE below the WHO recommended minimum (below US$34 for medium and below US$25 for lower), and have OPPs above 25% of THE – in most cases,

[7] Based on available data for each of the countries in the region.

much higher than this. Together, this serves as a proxy measure for the progressivity of a country's health financing, although we recognise that average per capita figures can hide significant social (e.g. class and ethnic) differences. Although affordability remains only one measure of the accessibility of health services, it is the most significant obstacle to health service utilisation in West and Central Africa and so financing progressivity can play a powerful role in shaping the degree of protection for vulnerable populations from health expenditure shocks and ensuring access by children and women to health services.

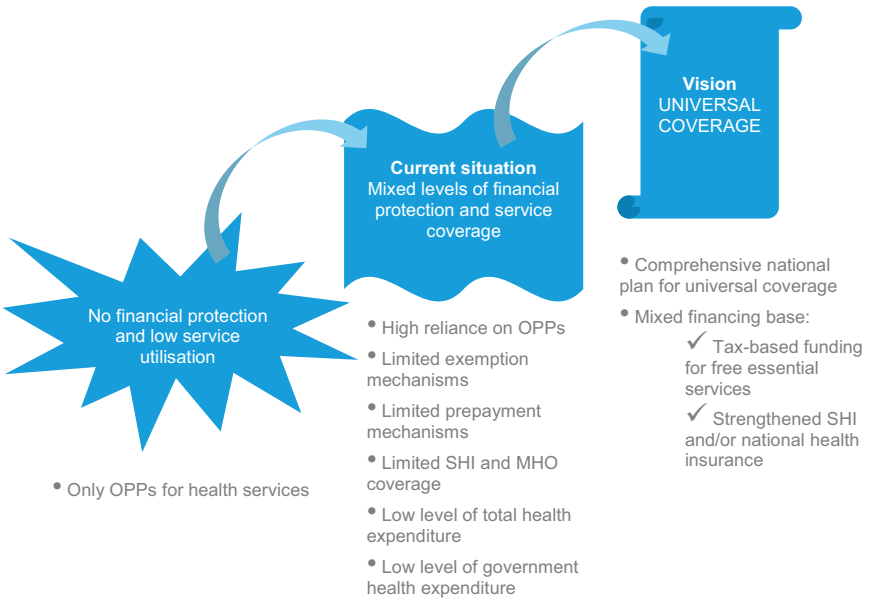
Table 7: Financial health protection in West and Central Africa

	THE per capita per year (US$)	Government health expenditure per capita per year (US$)	OPPs as % of THE
Higher			
São Tomé and Príncipe	58	49	14.6
Equatorial Guinea	274	215	16.0
Cape Verde	129	105	18.4
Gabon	267	210	21.3
Medium			
Burkina Faso	27	15	39.4
Benin	28	15	44.5
Ghana	35	15	50.0
Congo	42	17	59.2
Senegal	40	13	61.9
Nigeria	32	10	63.2
Côte d'Ivoire	35	8	67.6
Cameroon	51	14	68.2
Lower			
Gambia	13	8	29.3
Mauritania	19	13	31.4
Liberia	10	6	35.7
Niger	10	5	40.3
Guinea-Bissau	13	3	44.7
Togo	19	5	61.2
Central African Republic	13	5	61.4
Chad	22	8	62.0
Guinea	-	2	87.3

Source: WHO (2008b).

These groupings can usefully be viewed in the context of a progression towards universal coverage in health care, as Figure 13 below illustrates. Currently, much of West and Central Africa falls to varying degrees in a category of middling to low degrees of social protection in health financing, with a wide variety of mixed health financing mechanisms, including: social health insurance (SHI), mutual health organisations (MHOs), user fees and tax-financed government expenditure. It is important to note that the countries with higher levels of protection have the highest total investment in health as well as the lowest overall OPPs. Moreover, with the exception of Equatorial Guinea, countries with higher social health protection also have significantly better U5MR, MMR and antenatal care indicators (see Annex 1).

Figure 13: Progression towards universal health coverage



Part of the gap in health financing is being addressed by donor support, including from bilateral donors, multilaterals such as the World Bank, WHO and UNICEF, and public/private partnerships such as the Global Fund and the GAVI Alliance (Global Alliance for Vaccines and Immunisation). A recent assessment of progress towards MDGs 4 and 5 reported that international development assistance levels have been increasing for maternal, newborn and child health, with a 28% increase worldwide in 2005 (UNICEF, 2008). The volume of official development assistance (ODA) to child health increased by 49% and to maternal and newborn health by 21%. However, a closer look at aid flows to West and Central Africa in these areas suggests a more mixed picture. Of the 22 West and Central African countries included in the analysis, only half saw increases in funding for child health; the other half experienced declines. Only 55% received an increase in ODA for maternal health in the same year (UNICEF, 2008), as highlighted in Table 8.

Table 8: ODA to child, maternal and newborn health in West and Central Africa

Recipient country	ODA to child health per child[8] (2005 US$)		ODA to maternal and neonatal health per live birth (2005 US$)	
	2004	2005	2004	2005
Benin	9.93	7.36	13.32	3.76
Burkina Faso	6.06	8.17	7.23	6.72
Cameroon	4.20	6.87	3.41	4.45
Cape Verde	-	-	-	-
Central African Republic	8.57	6.72	9.14	5.49
Chad	4.34	4.22	3.11	5.41
Congo, Republic	12.13	2.42	4.28	2.73
Côte d'Ivoire	3.98	2.90	1.53	1.63
Congo, Democratic Republic	6.56	3.21	3.82	2.97
Equatorial Guinea	10.75	14.28	11.87	12.73
Gabon	11.04	17.09	15.57	20.65
Gambia	7.50	17.79	5.80	11.05
Ghana	12.74	11.24	14.63	12.01
Guinea	3.65	6.17	2.75	11.34
Guinea-Bissau	5.73	6.27	18.49	11.87
Liberia	12.91	7.81	14.32	7.54
Mali	6.69	6.51	6.23	13
Mauritania	3.38	3.20	9.74	7.59
Niger	4.15	5.32	2.77	5.32
Nigeria	1.91	2.23	1.12	2.99
São Tomé and Príncipe	-	-	-	-
Senegal	9.56	9.83	11.44	16.73
Sierra Leone	5.79	5.48	5.30	5.64
Togo	5.07	5.72	6.89	4.63

Source: UNICEF (2008).

Note: Increased funding over time indicated in grey.

[8] ODA figures represent total ODA allocated to child, maternal and neonatal health. A degree of these aid flows falls outside of reported THE, as aid flows are in part directly to vertical programming outside of ministry of health-channelled expenditure.

3.3 HEALTH EXPENDITURE AND PUBLIC EXPENDITURE MANAGEMENT

In a broader analysis of the fiscal space opportunities and challenges for child-sensitive social protection in West and Central Africa conducted as part of this study, Handley (2009) argues that 'securing fiscal space is only part of the story … ensuring that it is put to good use is also important'. Countries with relatively strong institutional environments and in particular with strong public expenditure management (PEM) systems are more likely to have the safeguards and management procedures in place to ensure that funds are spent efficiently and effectively. Efficiency can be understood both in allocative terms (the extent to which budget outturns reflect national policy priorities) and in operational terms (the extent to which outputs are maximised or unit costs minimised for a given input).

The Country Policy and Institutional Assessment (CPIA) scores released by the World Bank in 2005 rate a country's policy and institutional framework for fostering poverty reduction, sustainable growth and effective use of development assistance, using a scale of 1 (weakest) to 6 (strongest)[9]. The system has evolved over time and now comprises 16 criteria grouped in four equally weighted clusters: (i) economic management; (ii) structural policies; (iii) policies for social inclusion and equity; and (iv) public sector management and institutions. Annex 2 provides data for a selection of key CPIA indicators for PEM, as well as overall CPIA scores for West and Central African countries in 2007. The annex shows that only two countries in the region (Ghana and Cape Verde) have a score of 4 or more.

They are also countries with 'medium' and 'higher' scores by our measure of financial health protection. However, the other two countries with 'higher' financial health protection scores, Equatorial Guinea and São Tomé and Príncipe, have much lower overall CPIA scores (3 or less), showing that broader policy and institutional factors are likely to affect the quality of health services and actual social protection in health. Many West and Central African countries have low CPIA scores between 2 and 3, which means that the policy and institutional framework is weak in addition to the low absolute levels of health expenditure per capita and high dependence on OPPs.

The country case studies developed as part of our study on social protection have highlighted a number of other dimensions of public financial management that need to be considered.

(i) Cross-ministerial coordination is a major challenge. Ensuring broad agreement among ministries of finance and planning on the one hand, and ministries of health on the other, on the importance of investment in the health sector is of critical importance. For health sector planners, the brain drain in human resources is a key concern, especially in remote rural areas, whereas officials from ministries of finance are often more concerned about reining in the wage bill in the interests of fiscal prudence. As Jones et al. (2009) argue, in the case of Ghana, while initiatives need to be undertaken within the context of civil service reform to increase efficiency and attract highly skilled workers, one of the constraints facing the delivery of basic services, especially in rural areas, is the shortage of personnel. Even by African regional standards, Ghana is understaffed in the health sector. This suggests that

[9] International Development Association (IDA)-eligible countries had a per capita income in 2006 of less than US$1065 and lack the financial ability to borrow from the International Bank for Reconstruction and Development (IBRD). The six point CPIA ratings scale is as follows: 1 Unsatisfactory for an extended period; 2 Unsatisfactory; 3 Moderately Unsatisfactory; 4 Moderately Satisfactory; 5 Good; 6 Good for an extended period.

viewing the wage bill as a non-productive recurrent cost instead of an essential part of investing in human capital development may be creating a false dichotomy.

(ii) In the context of a broader move among the donor community towards multi-donor budget support, there is concern that health sector officials generally lack the technical and negotiation skills to defend budgets with ministries of finance and therefore may not get all the resources they require (Jones et al., 2000; Pereznieto and Diallo, 2009). These capacity constraints may also affect the implementation of the medium-term expenditure framework (MTEF) in the health sector. The emergence of a number of vertical funds such as the Global Fund and the GAVI Alliance has arguably exacerbated these weaknesses in some ways by providing health ministries with significant amounts of funding outside the national budget process, thereby cushioning officials from the need to be more proactive in advocating for increased resources within national institutional channels (Jones et al., 2009).

(iii) A related concern is the fragmentation of existing health services and financing systems which risks duplication of resources and high administrative costs. In the case of Senegal, for instance, Pereznieto and Fall (2009) highlight the proliferation of health provider schemes and the absence of parliamentary audits of public expenditure since 1990 to improve transparency. As such, they support current government plans to move towards a more consolidated management system.

(iv) Finally, there are considerable problems relating to the flow of resources from the central government to the sub-national level health service providers. Taking Senegal as an example again, based on interviews with the International Monetary Fund (IMF) and the World Bank, Pereznieto and Fall (2009) report significant leakages in the transfer of resources from central level down to the service delivery facilities, as well as significant gaps between planned budgets and actual expenditure.

4. IMPLICATIONS OF HEALTH FINANCING OPTIONS FOR VULNERABLE POPULATIONS

In order to address health financing gaps and to improve service coverage, including among vulnerable populations, developing countries are increasingly considering a variety of social health protection mechanisms. These range from the free provision of tax-funded national health services, to vouchers and cash transfer schemes, contribution-based mandatory SHI and mandated or regulated private non-profit health insurance schemes, as well as mutual and community-based non-profit health insurance schemes. The insurance-based mechanisms involve the pooling of risks among persons covered – and in some cases include cross-subsidisation between the rich and the poor. This section begins by reviewing the benefits and drawbacks of user fees, and possible options for removing them, and then provides an overview of SHI and MHOs in West and Central Africa. The role of cash transfers in improving access by the poor to essential health services is considered more particularly in one of the other technical reports produced for this study (Holmes and Barrientos, 2009).

4.1 USER FEES: CAUSING UNNECESSARY INEQUITY?

The health expenditure analysis in Section 3 showed that the majority of countries do not have a large-scale system of social security or prepaid coverage for medical care, and fall substantially below recommended levels of government expenditure in the health sector. Because of a need for cost recovery, user fees were instigated in many West and Central African countries, often in response to pressure from international organisations such as the World Bank and the IMF (Gilson and McIntyre, 2005). By 1993, a survey of 37 African countries found that 33 had user fee systems. As of 2004, 20 out of 24 African countries analysed in a study by Save the Children UK (2005) were found to have user fees in place at the primary level of care.

4.1.1 RATIONALE FOR USER FEES

User fees are a subset of OPPs, which themselves more broadly encompass all private health-related expenses incurred at the point of service delivery, including doctor consultation fees, purchases of medication and hospital bills, as well as spending on alternative and/or traditional medicine. User fees are the fees charged by public health providers for service provision, in other words the OPPs encountered at any public health care facilities. These official fees are distinct from unofficial fees (e.g. under-the-counter payments) that may be incurred by health service beneficiaries in particular contexts (James et al., 2008). User fees can consist of either flat rate or variable charges based on the degree of utilisation (i.e. the more services a patient requires, the higher the fee).

User fees were introduced as a source of revenue based on the rationale that they would improve the equity and efficiency of health financing. They were expected to:

- **Increase revenue** with high efficiency on the assumption that individuals would continue to pay for the provision of health services disproportionately to increases in price, thus providing a source of

additional revenue for the health sector in a context where reducing spending or increasing taxes was not feasible;

- **Counteract moral hazard** – by charging individuals at the point of service, unnecessary service usage would be reduced, thereby freeing up resources for those most in need;
- **Improve the quality and coverage of services** by increasing the revenue available for investment in the sector as well as introducing competition between service providers, including private sector competition with public sector services at similar fee rates;
- **Rationalise the pattern of health care-seeking behaviour** by scaling user fee rates according to desired patterns of care (e.g. setting primary care fees lower in health posts and health centres than in hospitals to encourage usage of primary services);
- **Safeguard equity through exemptions for the poor** such that payments made by the better-off would cross-subsidise care of the poor and improved primary health care services (James et al., 2008; Save the Children UK, 2005; Schieber and Maeda, 1997).

The Bamako Initiative, introduced in 1987 by African health ministers with support from the World Bank, UNICEF and WHO, sought to introduce an element of community participation and management into user fee schemes, through the retention of funds at the community level. This was viewed as a means of improving quality and responsiveness of services to community demand, and ensuring that user fees went towards maintaining a sustainable health service and drug supply at the community level (see Box 1 below).

Several case studies of the implementation of the Bamako Initiative in Guinea and Benin over the course of 1989-1993 have examined the impact of this intervention on cost recovery, cost effectiveness, utilisation of services and health-seeking behaviour patterns. As outlined below (see Box 1), the initiative was implemented in a context of severely declining resources for health. For example, the health budget in Benin declined from US$3.31 per capita in 1983 to US$2.69 in 1986, out of which over US$2 per capita was earmarked for paying salaries (Knippenberg et al., 2003). Following the scale-up of Bamako Initiative community retention and management of funds, evaluations of the running costs of 400 district health centres in Benin and 350 in Guinea found the operating costs associated with the delivery of essential health care interventions at the district level to be highly cost effective. In Benin, average annual operating costs per health centre amounted to US$11,327, with a cost per capita of just under US$1. Similarly, in Guinea, the mean cost per health centre was US$8989 (1993), with the cost per capita amounting to between US$0.6 and US$0.8.

Moreover, a cost effectiveness analysis conducted in 1993 reflects curative care utilisation rates of 0.24 and 0.34 curative care visits per capita per year in Benin and Guinea, respectively. Greater cost effectiveness was further linked to expanding coverage, so even at these relatively low per capita health visits annually, this analysis provided evidence of the cost effectiveness of district-level essential health service delivery, with the scope for increasing cost effectiveness of delivering basic health services at increasing rates of coverage (Soucat et al., 1997a).

Further cost recovery analysis of these health centre networks in Guinea and Benin showed that revenue from user fees retained within district health centres provided on average a cost recovery ratio of 0.6 for total operating costs in Benin, and in Guinea an average of 0.4 cost recovery. However, within such figures, it is important to take note of regional disparities (e.g. in Benin cost recovery ratios ranged from 0.3 to 2.4) and that the greatest cost recovery occurred for drug supplies (3.7 cost recovery ratio Benin, 2.8 Guinea) (Soucat et al., 1997c). The cost recovery for drugs, helping to maintain essential medicine stores, has been linked

with the increased utilisation rates observed in Guinea and Benin over the years of implementing the Bamako Initiative (1989-1993) and statistically significant increases in antenatal care utilisation (from 53% to 65% in Benin and 49% to 63% in Guinea) (Soucat et al., 1997b).

Although the principles of community participation underpinning the Bamako Initiative had benefits in terms of the delivery of care at a community level, it is important to disentangle the various threads of the argument in support of user fees in what has become a much-debated issue. First, the Soucat studies illuminate more about the cost effectiveness of providing basic health services than about the benefits of financing from users. As state resources increase (and as Handley, 2009 argues, equally importantly, as political commitments to greater public investment also increase) public funding could result in the same if not greater health service uptake given what is known about the deterrent effect that user fees often have on service access (see discussion below). A key variable in these case studies was the fact that medical supplies were made available at district-level health facilities for the first time during the structural adjustment period, and this was likely an important motivating factor in clinic visits. Even so, the levels of per capita visits were still low and the equity implications of financial barriers to access remained (see discussion below). In short, timing was important in producing the positive results in the Benin and Guinea case studies, but one should be cautious in applying this argument to other contexts.

4.1.2 CRITICISMS OF USER FEES IN PRACTICE

Since their implementation, user fees have been subject to debate regarding their effectiveness and equity in practice, as well as their potential impacts on health service utilisation and ultimately health outcomes.

WHO estimates that worldwide 178 million people each year – particularly women – are unable to pay for the services they would need to restore their health (Wieczorek-Zeul, 2007). It is estimated that at least 5% of the African population has never had sufficient resources to afford access to primary health care, and that some 25-35% of the population with unstable incomes have faced periodic exclusion from accessing primary health services (Huber et al., 2003). User fees, in which service users pay according to the level of service utilisation (i.e. the degree and frequency of illness) rather than their ability to pay, are the most regressive form of health financing: health expenditure payments comprise a larger percentage of household expenditure for the poor than the better-off (Gilson and McIntyre, 2005).

The multilayered impoverishing impacts of OPPs (including user fees) have been well documented: the selling of assets (e.g. land or animals); a shift in household expenditure towards health service payments in lieu of other necessary expenditures (e.g. school fees); the contracting of loans; and indirect costs resulting from lost labour time owing to the lack of treatment of illness. Additionally, analysis of the socioeconomic profile of health service users following the introduction of user fees has indicated a significant decrease in usage by poorer populations, who have often sought unregulated private providers (including pharmacists) as an alternative first point of care (Jacobs and Price, 2004).

Concurrently with their poverty-inducing effects, user fees have been found to decrease equity through their negative impact on the ability of the poor to access services, undermining the prevention and treatment of childhood illness (Jacobs and Price, 2004). A decrease in health-seeking behaviour is a significant co-factor in childhood mortality: poor or delayed care seeking has been identified as a contributor in up to 70% of child deaths (WHO, 2001). The decreased ability to access services is compounded by the fact that health indicators are worse for poorer populations, indicating a greater need for health services (Gilson and McIntyre, 2005). Large increases

Box 1: Historical emergence of user fees and the Bamako Initiative

The structural adjustment policies of the 1980s and a subsequent massive decrease in health sector expenditure saw a marked decrease in the revenue available for the provision of health services, and the decline of the free primary health services that had been established in much of post-independence Africa. The decline in government expenditure resulted in the loss of health personnel and reduced supplies of drugs and medical equipment. The introduction of user fees for services was seen as an unavoidable policy response. In some cases, while official user fee policies were yet to be fully implemented, the deregulated transition period left wide variations in the informal OPPs charged by service providers. Beneficiaries, particularly in poor communities, had little control over the provision of health services, and were left paying high OPPs owing to both unofficial fees and the introduction of official user fees, despite the dwindling quality of services and insufficient drug supplies. As the international community pledged to reach 80% rates of immunisation by 1990 and the goals of the 1978 Alma Ata Declaration on Primary Health Care for All, policymakers in Mali, Benin and Guinea, recognising the practical collapse of government health service provision, turned to a strategy of community-owned and managed health centres to achieve these goals.

In 1987, at the WHO regional committee meeting in Bamako, African ministers of health, supported by UNICEF, WHO and the World Bank, developed the Bamako Initiative to empower communities as managers and decision makers in their own health care provision. The initiative aimed to decentralise decision making and management of health services; introduce community cost sharing through community retention of user fees; develop a degree of accountability of providers to community purchasers of care; and ensure the availability of essential medicines in communities. The revitalisation of health centres serving 5000-15,000 people was promoted, with an emphasis on low-cost interventions with a proven impact on child mortality. Revolving drug funds were established: generic drugs provided low-cost medication and generated a source of revenue that could be retained by the community for the management of health centres. Immunisation and ORT were provided free of charge, whereas curative child care and antenatal care were heavily subsidised. Exemptions from fees were left to the discretion of community management bodies. Governments and donors provided the investment needed for buildings, vehicles and the training of health professionals; national governments were responsible for covering staff salaries.

Following this initiative, U5MRs were seen to decrease in Benin, Mali and Guinea, along with decreases in the rich/poor gap in U5MRs owing to the focus on delivery of care to poor rural populations. The revenue generated through the community generally met less than 20% of the total recurrent costs of local health services, but was instrumental in ensuring the uninterrupted provision of at least minimal basic health services. Some of the key advantages of the Bamako Initiative were achieved through the health care delivery innovations introduced: increased community involvement fostering greater understanding of and responsiveness to demand-side needs; greater accountability to communities; and influence on the quality of services through community-financed health centre staff incentives. Ensuring the availability of essential medicines and a renewed focus on basic health services for rural populations were also key benefits. However, the fees incurred were still found to be prohibitively high for the poorest in the population.

Source: Knippenberg et al. (2003).

in service utilisation have occurred in contexts where user fees have been abolished, confirming the substantive nature of financial barriers (Yates et al., 2008)[10]. Further studies have shown that service usage increases more within poorer quintiles than richer quintiles when such fees are abolished[11], with concurrent reductions in household expenditure on health in the poorest quintiles[12].

In Burkina Faso, primary-level health centres charging fees (through the Bamako Initiative) experienced an average 15.4% annual decrease in new consultations for curative care, compared with a 30.5% average annual increase in new consultations for those centres not charging fees (James et al., 2006). Recent Médecins sans Frontières (MSF) interventions which have allowed project-specific removal of user fees have also demonstrated a significant increase in health service utilisation. In Burundi[13], where a transition was made from a low-cost flat rate for services (with an exemption scheme for the most vulnerable) to a new policy ensuring free care for pregnant women and children under five, the number of deliveries in the health centres doubled, and utilisation of services by children under five increased by 40% (MSF, 2008). Conversely, in the Democratic Republic of Congo, following the introduction of user fees, service utilisation fell by 40% from 1987 to 1991, despite concurrent improvements in the quality of services, drug availability, staff skills and medical equipment (Haddad and Fournier, 1995). Box 2 provides evidence from Uganda.

Recent research highlights the direct linkages between the removal of user fees (with subsequent increases in service utilisation) and the potential reduction in child mortality. It is estimated that, with the removal of user fees in 20 African countries, 233,000 under-five deaths could be prevented annually, amounting to 6.3% of under-five deaths in those countries[14]. Given the high U5MR in West and Central Africa, the current reliance on OPPs and the significance of financial obstacles to accessing health services, user fees and their equity impacts continue to pose a significant concern[15].

4.1.3 FACILITATING THE REMOVAL OF USER FEES

Estimating the resource requirements

While the negative equity impacts of user fees are clear, resistance to the removal of user fees often stems from the perceived loss of revenue expected to occur. User fees in practice, however, have generated less revenue than was expected with their original introduction. While OPPs comprise a large percentage of total health expenditure in-country, these figures include all private expenditures, including those made to private health care facilities and informal fees paid. User fees on average generate only 5-10% of countries' recurrent health care budgets (James et al., 2008); studies of the WHO African Region have found user fees only contribute 1-20% of ministry of health budgets. Therefore, despite patterns of health expenditure that

10 In Uganda, the removal of user fees in 2001 was followed by an immediate surge in demand for health services, indicating the powerful effect of user fees on the suppression of demand. An 84% increase in outpatient attendances occurred between 2000/2001 and 2002/2003, with some districts experiencing a doubling in outpatient service utilisation. A shift occurred within the poorest quintile of the population, which registered the largest decrease in usage of private facilities, accompanied by the largest increase in usage of public facilities (Nabyonga et al., 2005).

11 In Uganda, the increase of usage in hospital services among the poorest two quintiles was double that among the richest quintile (Deininger and Mpuga, 2004).

12 Analysis of household expenditure data in Uganda between 1999/2000 and 2002/2003 shows that, in the poorest two quintiles, there was a statistically significant reduction in the monthly expenditure on health from US$1.71 to US$1.49 for the poorest quintile and US$3.13 to US$2.55 for the second lowest quintile (Deininger and Mpuga ,2004).

13 Intervention was for 10 MSF-supported health centres and referral hospitals in Karuzi province, in 2003-2006.

14 Based on previously observed changes in utilisation following the removal of user fees, a simulation model was generated by James et al. (2006) for the increased uptake of 26 health care interventions.

15 The majority of deaths averted are expected to occur through increasing access to simple, curative services (e.g. antimalarials and antibiotics). Therefore, the removal of user fees offers the potential to increase equity in health service access for the most vulnerable populations and provide a 'quick win' towards achieving the child health MDGs.

Box 2: Removal of user fees - the case of Uganda

The case of Uganda demonstrates that removing user fees can have an important positive effect on service utilisation but also that such an initiative needs to be part of broader health care system reforms if household vulnerability to high health care costs is to be tackled effectively.

Prior to user fee removal, OPPs by households in Uganda were approximately 40-45% of total health expenditure, while the revenue garnered from user fees at public health facilities supported on average just 5% of facility-level expenses (Xu et al., 2006). After the abolition of user fees in 2001, utilisation in Uganda of public health services over the period from 2000 to 2003 rose among the poor from 23.0% to 33.7%, but decreased among the non-poor from 24.0% to 22.7%. Private health service utilisation over the same period increased non-significantly for the poor, from 32.0% to 34.5%, compared with the substantial increase in utilisation from 24.88% (1997) to 32.0% (2000) in the period prior to user fee removal (Xu et al., 2006).

However, this case also illustrates the importance of monitoring the level of OPPs as a measure of whether abolition of user fees is removing cost barriers across the continuum of service provision. Catastrophic health payments actually did not decrease among the poor[16]. This was linked to the limited availability of drugs at public health centres, which pushed populations to purchase from private pharmacies, thereby incurring high OPPs (and counteracting to some extent the reduced levels of OPPs required with the availability of free health services). While there was a statistically significant increase in drug availability in public health facilities over the period, this increase was insufficient to address the concurrent increase in service utilisation and thus proportionally more patients suffered from a lack of drug availability. The problem of demand outstripping supply was compounded by district-level bureaucratic hurdles, which saw inefficient flows of drugs to primary care facilities (Nabyonga-Orem et al., 2008). This meant that the increased budget allocation set aside by the Ministry of Finance for districts to purchase drugs was not as effective as anticipated in meeting the increased demand.

The Uganda case suggests that user fee removal must be undertaken within a holistic approach to health financing reform and supportive quality improvements in order to ensure that the potential adverse effects of user fee removal are minimised, particularly among the most vulnerable groups. These adverse effects can be anticipated by understanding the means by which user fee revenue is utilised at the district level before abolition, and designing context-specific reimbursement processes and quality support measures.

are largely composed of OPPs, in most cases only a relatively small proportion of this expenditure provides revenue to governments. Meanwhile, the introduction of user fees without prepayment schemes forced the population deeper into OPP health expenditure patterns, the equity implications of which have been discussed above. In order to reduce the high rates of under-five and maternal mortality in West and Central Africa, the revenue implications of the removal of user fees should be considered relative to the negative effect of user fees on health service utilisation and health outcomes.

However, the removal of user fees requires not only the replacement of this lost revenue by increased government health expenditure, but also increased government expenditure to respond to the increase

[16] Catastrophic health payments were found (through the comparison of simple proportions) to have actually increased from 2.4% of households (2000) to 3.1% (2003). However, on logistical regression analysis (controlling for confounding variables), this difference was found to be non-significant. Therefore, the critical finding from this study is that catastrophic health expenditures did not significantly decrease among poor households.

in service utilisation that can be expected to result from user fee removal. Experience suggests that the necessary increase in revenue is of a manageable degree. For example, from 2000/2001 to 2004/2005, following removal of user fees in Uganda, the total level of health financing increased by 18% – this was equivalent to an increase from US$7.0 to US$8.4 per capita in order to provide basic health care services (Yates et al., 2008; Nabyonga et al., 2005).

Analysis of representative case study countries in West and Central Africa conducted as part of this study illustrates that significant potential fiscal space exists in oil-rich economies, such as Congo and Equatorial Guinea, which also exhibit currently the lowest levels of social sector spending relative to GDP[17]. In these countries, the removal of fees for essential health services for child and maternal survival would be easily affordable. Indeed, this is also possible in more aid-dependent countries, as illustrated by the example of Ghana, which has introduced free access to maternal and child health services. More generally in the aid-dependent economies, where public spending is already close to the thresholds for macroeconomic sustainability and fiscal space is therefore more constrained, abolition of user fees for essential maternal and child health services will require a reorientation of expenditure priorities and gains in expenditure efficiency.

District-level implications

It is critical to understand which services are funded by revenue from user fees, what revenue is retained at local or facility level and how much revenue local service providers risk losing as a result of the removal of fees. For instance, fees may be used at the local level to support non-salary recurrent expenditures, such as pharmaceutical provision. Witter et al. (2007) found that, in Ghana's implementation of exemptions for all women from child delivery fees, government reimbursement of revenue lost from the removal of fees at the local district level was critical, as the income from fees (especially for child delivery services, a relatively expensive procedure) provided flexible funding for drugs and other non-salary expenditures. While informal payments to health workers may increase in the short term during a health financing transition to compensate for lost revenue, in Ghana such payments were reported to decline with time (ibid).

Data from Africa on the proportion of district health financing that is funded by user fees are scarce. A 2004 Tanzanian study estimated that the proportion of district health resources provided by user fees was on average 10.5% (Lataveer et al., 2004). In Zambia, a study in a single district, Tsholotsho, found very low levels of cost recovery from user fees (0.5% of total revenue), but a higher proportion in the case of expenditure on drugs and medical supplies (Plaetse et al., 2005). With increased service utilisation expected from user fee removal, it is therefore critical that governments ensure that budget lines for these non-salary inputs are adequately financed.

In addition to ensuring that the volume of lost revenue is replaced and that provision is made for increased expenditure to meet the rise in demand, Bossert and Beauvais (2002) argue that issues concerning the 'level of decision space' are also important. Local health facilities must be able to use the increased transfers of resources they receive from government as flexibly as the user fee revenue they retained under the previous system.

Implementation challenges of exemption policies

The positive effects of removing user fees have been demonstrated in several countries outside West and Central Africa, including Uganda and South Africa. The majority of countries in West and Central Africa

[17] See Handley (2009) for a more detailed examination of fiscal space for social protection.

either charge for all services or in certain cases provide limited exemptions for specific services and/or for particular segments of the population. However, management of selective exemptions is prone to costly and complex administrative procedures, particularly when organised by socioeconomic categorisation (vs. blanket exemptions for particular health services such as prenatal care), and has been shown to be open to corruption, with no incentive for service providers to enforce the exemptions, owing to the potential loss of revenue this represents for them (Marcus et al., 2004). The country case study reports produced as part of the study on social protection and children in West and Central Africa show that segmented exemptions (e.g. by income categories) can create confusion within the population as to which services are free and which are not, limiting the level of increase in service utilisation, even for those services included in the exemptions. However, exemption mechanisms for the poor and particularly vulnerable populations requiring health services (e.g. pregnant women and children under five) are essential as a means of mitigating the negative equity impacts of user fee systems as a step towards developing more progressive health financing systems. Table 9 provides examples for the case study countries included in this study.

4.2 SOCIAL HEALTH INSURANCE

This report follows the definition of SHI by Carrin et al. (2005) as 'a mechanism for financing and managing health care through the pooling of health risks of its members on the one hand, and the financial contributions of enterprises, households, and the government, on the other. It is generally perceived as a financial protection mechanism for health care, through health risk-sharing and fund pooling for a larger section of the population.'

4.2.1 CHARACTERISTICS AND THEORETICAL BENEFITS OF SHI

SHI is a progressive means of health financing with the objective of universal coverage for a population regardless of income or social status. Contributions are collected from workers, the self-employed, enterprises and the government, and are then pooled into a single 'social health insurance fund'. Universal coverage is achieved when contributions are made on behalf of each member of the population and the entire population is covered for service access (Evans, 2007). The pooling mechanism is redistributive, as contributions typically constitute a percentage of income. SHI is thus underpinned by the values of equity and solidarity in risk sharing. Membership in SHI schemes is mandatory and, as such, avoids the adverse selection problems typically associated with voluntary schemes, in which those in perceived good health opt out of the health insurance scheme, thus overburdening insurance schemes with high-risk individuals (Carrin, 2002; Diop, 2007).

In order to reach universal coverage, SHI often relies on a combination of funding sources – compulsory contributions and tax-based subsidies, with the government often stepping in on behalf of individuals unable to cover their own contributions (Evans, 2007). Arguments in favour of SHI highlight the positive benefits of fostering collective responsibility for individual welfare (by the state, employers and individuals); ensuring a basic social minimum in services for all; creating a sense of entitlement to benefits when people pay into a system, and promoting in this way greater political sustainability in the face of strong pressure against abolition (Carrin, 2002). Furthermore, SHI supporters argue that it offers the opportunity for a health purchaser–provider split, redistributing some control over the health sector away from the ministry of health, thus introducing greater efficiency into the health care system (Schieber and Maeda, 1997).

Table 9: User fee exemptions currently in effect in case study countries

Case study country	User fees removed/exempted currently[18]
Mali	• Free immunisations • Free malaria care for children under five and pregnant women • Free Caesarean interventions (but not free transport to secondary health clinics) • Free tuberculosis and antiretroviral treatment and preventative care for leprosy and other 'neglected' diseases • Bed nets given as incentives for pre/postnatal care for women and for health care for children (but pre/postnatal care not free) • Beginning discussion of providing free basic services for children under five
Ghana	• Exemption from payment of all maternal deliveries in all district health facilities • Free maternal health care • Since June 2008, exemptions for all children under 18 years, regardless of whether or not their parents are registered with the National Health Insurance Scheme (NHIS) • Since June 2008, exemptions for post-partum mothers for the first six weeks, irrespective of NHIS enrolment • Subsidies provided by the National Health Insurance Fund (which is financed out of a 2.5% contribution of the Social Security and National Insurance Trust – SSNIT) for the following categories of people: (i) formal sector workers who contribute to SSNIT; (ii) people over the age of 70; (iii) SSNIT pensioners; and (iv) the 'indigent'
Congo, Republic	• Ministry of Health, Social Affairs and the Family provides some assistance for medical care to the 'indigent' who solicit it
Equatorial Guinea	• Selected free services for pregnant women and children under five (significant confusion among population regarding implementation; some peripheral costs may still be incurred by beneficiaries) • Malaria treatment reported as free for pregnant women and children under 10
Senegal	• Sesame Plan: free health coverage to all persons over 65 years of age, with mixed funding from the state (70%) and the social security fund (30%) • Initiative for free deliveries and Caesarean sections: Caesarean sections currently free in all regions except Dakar; deliveries free in five regions (Kolda, Tambacounda, Ziguinchor, Fatick and Matam), financed by state subsidies • Subsidised co-payment for costly health treatments (e.g. cancer, tuberculosis, diabetes, HIV and AIDS) by state and donors through health care subsidies • National solidarity funds: funds for social services including health care targeted to victims of shocks and catastrophes • Medical assistance from the Directorate of Social Assistance: some medical expenses paid for the 'needy' • Coverage of individuals with a certificate of destitution: beneficiaries receive free care at public health facilities • Free antimalarial treatment for children and pregnant women, free immunisation • No broader free health care for children (unlike the Sesame Plan for the elderly)

[18] For greater detail, see country case study reports produced as part of this study.

SHI is ideally suited to the needs of formal sector workers: contributions are usually linked to payrolls and workers are able to participate in and influence health care provision through organised trade unions and other governance mechanisms. Under ideal conditions, all insurance scheme members are provided guaranteed and effective access to health care, household expenditure on health is smoothed and protection from catastrophic expenditures is achieved (Diop, 2007). Indeed, insurance coverage in practice has been associated with increased service utilisation rates and a decrease in catastrophic expenditures, given an adequate benefit package and large-scale coverage (Xu et al., 2006).

4.2.2 CHALLENGES OF SHI

While SHI has of late been widely promoted as a promising health financing mechanism for the developing world (Holst and Brandrup-Lukanow, 2007; Wagstaff, 2007), it is critical to note the difficulties associated with its implementation, particularly in the context of West and Central Africa, as well as its limits as a health financing mechanism.

Given the nature of SHI contribution collections (primarily through employees' incomes), the most significant disadvantage to SHI is the difficulty of covering those populations with unreliable or limited incomes, in particular those working in the informal sector and agriculture and the chronically unemployed and underemployed. In West and Central Africa, this presents a substantial obstacle to the equitable implementation of SHI, as only about one-tenth of the working population is employed in the formal sector. In many African countries, the rural sector employs the majority of the population (Huber et al., 2003), and a large proportion of the urban population is employed in informal sector activities. In West and Central Africa, the vast majority of the poor depend for their livelihoods on small-scale subsistence farming, petty trade or other informal economic activities (see Holmes and Braunholtz-Speight, 2009). Contributions from these populations must be cross-subsidised in order to ensure their inclusion in health insurance schemes. Administratively, it is also extremely difficult to extend SHI to those working in the informal economy.

As a result, the SHI schemes in West and Central Africa were set up initially as part of broader social security systems for workers in the public sector and the formal private sector, with very limited enrolment of workers in the informal sector. They remain far from achieving universal coverage (Ouattara and Soors, 2007). A comparative analysis by Scheil-Adlung et al. (2006), covering Senegal, Kenya and South Africa, confirms that enrolment in social health insurance schemes is lower among the poorer quintiles, and that this inequity in coverage among income groups does not necessarily decrease with increases in overall national coverage rates. For example, in Kenya, 2.3% of the poorest quintile was found to be covered by SHI, whereas the richest quintile was covered at 24.7%. Moreover, the existing social security systems in West and Central Africa cover at best between 10% and 20% of the population, and only some of these schemes include a health insurance component (Holmes and Braunholtz-Speight, 2009).

The one major exception to this pattern has been the recent development of the NHIS in Ghana, which was established in 2004 and has succeeded in extending health insurance coverage to about half of the population. Even in this case, there are concerns that the scheme may not be reaching many of the poor, despite subsidies to enrol some ultra-poor Ghanaians who cannot make premium contributions (see Box 3). In January 2009, the government of Mali also announced the launching of a national health insurance scheme, the Compulsory Health Insurance Programme (AMO), accompanied by a fund to subsidise participation by extremely vulnerable individuals and families, the Medical Assistance Fund (FAM).

Box 3: Case study - Ghana National Health Insurance Scheme

In Ghana, the NHIS has made major inroads in improving health care coverage. Set up in 2004, the NHIS is compulsory for all residents of Ghana. It is funded jointly by:

- SHI contributions from formal sector employees;
- MHO-type contributions from those working outside the formal sector;
- Tax-based fiscal transfers (to subsidise contributions of those exempted from contributions by the criteria below) (Appiah-Denkyira and Preker, 2007)[19].

Formal sector employees contribute via the SSNIT, which transfers 2.5% of its participants' social security contributions to the National Health Insurance Fund. This fund finances health care services for the following categories of people: (i) formal sector workers who contribute to SSNIT; (ii) children under 18 years whose parents are both card holders; (iii) people over the age of 70; (iv) SSNIT pensioners; and (v) 'indigents', who are defined as people who are unemployed, have no visible source of income or support and lack a fixed place of residence. The fund also receives tax-based fiscal transfers to subsidise the coverage of those who are exempted from premium payments, such as the children of paid-up members, SSNIT pensioners and the 'indigent'.

In addition, since the creation of the National Health Insurance Authority in 2004, 142 district MHOs have been established and, by 2006, 136 were providing benefits to members. Although a progressive scale of premiums was proposed initially, in practice the premium payment for those contributing through MHOs has been a flat Ghanaian Cedis 9 plus 2 for a booklet and photo (equivalent to approximately US$9.50 at 2008 exchange rates).

In just four years, by mid-2008, about half of the population was registered with the NHIS (Schrofer and Sultan, 2008), indicating that Ghana had achieved rapid rollout of this ambitious programme. Rates in some regions were even higher. Overall, Ghana now has by far the most extensive health insurance coverage in West and Central Africa, and one of the highest in the whole of sub-Saharan Africa, possibly exceeded only by Rwanda, where coverage has reportedly reached 95% of the population. In the eastern region of Ghana, NHIS data indicate that, with the introduction of subsidies, by 2005 the majority of those covered (62.5%) were from the categories exempted from premium payments (Appiah-Denkyira and Preker, 2007). However, while the mixed funding base of the NHIS has broadened the rates of enrolment and health coverage across wealth quintiles, further equity considerations remain.

First, an analysis of coverage rates by wealth quintile demonstrates that fewer people from lower wealth quintiles are enrolling owing to cost barriers. This is exacerbated by the fact that the MHO premiums are set at a flat rate rather than linked to income on a sliding scale. Importantly, however, aside from cost, the way in which the NHIS is implemented does appear to be addressing demand-side issues, according to a recent survey. These findings suggest that, regardless of quintile, people are aware of the scheme, distance does not constitute a major obstacle in terms of registration and there is satisfaction with the service, as registered people are re-enrolling (Asante and Aikins, 2007).

Second, because of the stringent criteria used to assess 'indigents', only 2.3% of all members were classed as 'indigent', which is much lower than the estimates from the Ghana Living Standards Survey 5 (GLSS 5) that 28.5% are living below the poverty line and 18% living below the extreme poverty line (Asante and Aikins, 2007).

Third, although more than half of the subsidy-receiving NHIS members (64% of the total) were children under 18 years, there was strong concern on the part of child rights advocates, including UNICEF, that children's access to health care services should be de-linked from their parents' registration in the NHIS.

In response to concerns about Ghana's limited progress towards MDGs 4 and 5 on child and maternal mortality, the President of Ghana issued a directive in May 2008 de-linking children from their parents' membership status in the NHIS, thereby exempting all children under 18 from fees for health services, and also declared an exemption for post-partum women in the first six weeks after giving birth. These are clearly important policy measures to address equity concerns and it will be important to monitor their implementation and their impact on child and maternal health outcomes.

[19] For further details, see the Ghana case study by Jones et al. (2009).

SHI and the process of cross-subsidisation are designed to be equity enhancing, through the redistributive effect of higher earners' greater contributions subsidising the care of the worse off and the pooling of resources into a single health insurance fund. In practice, however, SHI may produce 'sustainable inequity' if vulnerable populations among the informal sector and chronically unemployed are excluded from the scheme, as the better-off will be the main beneficiaries (Huber et al., 2003).

Other arguments have been made that initiating SHI with the formal sector of a population will 'free up' remaining budgetary resources for the poor. However, the insured population in the formal sector tends to consist of the better-off and better-organised social groups, who often also have better political connections. This throws into question whether additional resources will really be transferred to the poor, as this would require the SHI to be self-financing. There is little evidence in low-income countries of the 'freeing-up' of resources occurring in practice (Kutzin, 2007).

SHI implementation furthermore requires economies of scale for effective risk pooling, and thus a reasonably large resource base in terms of numbers of members and contribution levels, as well as considerable administrative capacity to enrol members and manage contributions and reimbursements (Huber et al., 2003). But poverty levels are high in West and Central Africa, making it difficult for the poor to enrol without substantial government subsidies, which in turn are subject to fiscal constraints in most countries, apart from a few oil producers. These problems are compounded by poor governance and weak administrative capacity in many countries of the region, as well as the inherent administrative difficulties of enrolling and managing contributions from large numbers of people outside formal employment payroll systems.

For all these reasons, the enforcement of SHI contributions is difficult, even when national health insurance is formally obligatory, as in Ghana and, as announced, in Mali. The lack of credible mechanisms for collecting information on incomes outside the formal sector also makes it impossible to apply a progressive scale of income-related contributions, as the Ghana example shows. Indeed, such problems may even arise within the formal sector if salaries are underreported (Carrin, 2002)[20]. Such evasions lead to a significant under-collection of expected revenue, with severe negative effects on health sector financing and service provision.

Service provision itself must be available and of sufficient quality, so members can be guaranteed acceptable benefits in return for their contribution. If health services are not provided or are of poor quality, the solidarity of the scheme risks being undermined. Additionally, even if health services are available, weak administrative capacity in SHI schemes may make service providers wary of providing services to SHI members without payment at the time of use, for fear of the impact on their own income, or they may refuse care without under-the-table payments (Carrin, 2002)[21]. Such implementation factors may put at risk vulnerable populations' access to affordable health services.

Finally, the success of SHI schemes hinges on solidarity within a population – in other words, willingness to contribute to a national funding pool in order to share risks and benefits. In low-income countries with substantial inequalities in incomes and assets, contributions to such schemes will differ vastly between

[20] For example, in the Vietnam SHI, a bank in one province reported that all employees – from the cleaning staff to the senior-level bankers – were earning the same nationally defined minimum wage.

[21] It has been documented in the Vietnam scheme that doctors, used to receiving under-the-table payments, have refused to give care to insured patients (Carrin, 2002).

members of the population, if there is a progressive scale of contributions. There is a potential problem in any welfare scheme that populations may resist the cross-subsidisation of services by the rich for the poor (Carrin, 2002).

Although these obstacles and implementation difficulties are not insurmountable, and the potential equity gains are considerable, it is crucial in West and Central Africa for SHI schemes to take fully into consideration the implications of the predominance of the informal sector, the high rates of poverty, the supply-side problems of low health service availability and quality and the weaknesses in institutional and administrative capacity. Box 4 provides a comparative analysis of SHI implementation in three African countries: Kenya, Senegal and South Africa.

Box 4: Social health insurance in practice in sub-Saharan Africa

In a comparative analysis by Scheil-Adlung et al. (2006), various SHI mechanisms in three African countries were found to have positive impacts on access to health care, health expenditure and levels of poverty. While all three countries studied – Kenya, Senegal and South Africa – have significant tax-based components in the financing of their health care systems, each has also implemented an SHI component covering 7% (Kenya), 11.4% (Senegal) and 17% (South Africa) of the population. Utilisation of outpatient services was higher in all three countries among insured populations than among the uninsured. In both Senegal and South Africa, regression analyses controlling for income, education, age, sex, employment status, urban/rural location, health condition and ethnic group found that insurance was positively associated with the use of more health services. The same was true in Kenya for inpatient services, as the main insurer does not cover outpatient services. Furthermore, in all three countries, levels of catastrophic expenditure on health were lower among the insured than among the uninsured.

However, regression analysis also showed that, while the insured in Senegal were less likely to face catastrophic expenditure than the uninsured, in South Africa this was only the case for the richest quintile and in Kenya there was no significant association. These differences are probably explained by the differences in benefit packages associated with the insurance schemes. In South Africa, the richest quintile enjoys a package that provides coverage for a broader range of health services. In Kenya, the main employee-based insurance scheme covers only inpatient services at a high contribution rate, with the result that many health costs are left uncovered, leaving insured populations at a continued risk of catastrophic health costs. Further on this point, in Kenya, free services are provided for children under five, so households with children under five are less likely to face high health costs, whereas in Senegal, where care is not free for under fives, families with children in this age range are more likely to face such costs.

Source: Scheil-Adlung et al. (2006).

4.3 COMMUNITY-BASED FINANCING SCHEMES

4.3.1 RATIONALE

Given the problematic nature of covering informal sector, rural and poor populations with SHI, community-based health insurance (CBHI) schemes – commonly termed MHOs – have been developed to serve as complementary social health protection and financing systems for these populations in West and Central Africa. These schemes aim to mobilise revenue and provide the protection of health insurance while smoothing expenditure patterns on health for vulnerable populations typically excluded from SHI. There is a variety of models for the design of MHO/CBHI schemes (see Table 10), with a common distinguishing feature being the degree to which they are based on a participatory or provider-driven model.

4.3.2 CHARACTERISTICS

MHOs are defined as voluntary, private non-profit insurance schemes, formed on the basis of mutual aid, solidarity and the collective pooling of risks. The formation of a scheme usually involves a participatory, bottom-up planning process, and members participate directly in the management and administration of the scheme, often on a voluntary basis. They are often involved in decisions regarding the benefit package offered, collection of premiums and negotiations with care providers. Beneficiaries own the scheme themselves and are therefore the financial risk bearers (Atim, 1998; Huber et al., 2003).

4.3.3 THEORETICAL BENEFITS OF MHOS

MHOs emerged in the context of user fees, as a complementary mechanism to SHI and as a means of promoting the participatory inclusion of beneficiaries in the management of primary health care, as advocated by the Alma Ata Declaration (1978) and the Bamako Initiative (1987). Given the perceived necessity of cost recovery, but the subsequent negative impacts of user fees on vulnerable populations, MHOs were envisioned as a means of smoothing expenditure patterns on health, while mobilising needed revenue and, through prepayment and risk pooling within communities, decreasing the risks of catastrophic health expenditure and non-use of health services (Scheil-Adlung et al., 2006; Carrin et al., 2006; Ekman, 2004).

While MHO/CBHI schemes still rely on private expenditure, they aim to counteract some of the negative effects of private expenditure on user fees. MHOs aim to mobilise the revenue needed to ensure their members access to community-level health services and (to varying degrees) access to secondary and tertiary referral services. By channelling expenditure through a prepayment mechanism, expenditure is smoothed into a predictable pattern. Furthermore, the community management of MHOs provides the flexibility to structure payment plans according to the income patterns of their members: for example, members may contribute every three months or more frequently during harvest periods (Carrin et al., 2005). As discussed above regarding SHI, through prepayment, MHO members are protected from high health care costs owing to the decrease in OPPs, provided that benefit packages are set appropriately (Marcus et al., 2004). Financial prepayment also allows for the pooling of risks and the associated benefits of lowered individual risk and financial cost (Carrin et al., 2005).

The mobilisation of resources, managed by the community, aims to provide sustainable, increased access to basic health services (Ekman, 2004). Given the participatory element of community retention of financial resources

Table 10: MHO models

	Characteristics	Benefits	Constraints
Pilot project model	• Agency or state tests community-based financing mechanisms, in response to limitations of solely focusing on supply-side investments at regional/district levels • Intent is to provide proven model for generalisation and scaling-up at a later time	• Well-documented research and process of development • Comprehensive feasibility studies conducted • Provides opportunity for evaluation and reflection	• Costly • Requires highly qualified staff
Government agency model	• State actively promotes and administers the development of MHOs (often through creation of special agency) • Government agency promotes health insurance, monitors and regulates MHO activities, conducts training activities and co-finances health insurance • Balance between participatory and state-supported elements	• Government subsidisation (in part or in full, or with donor support) of the premiums of the poorest • Promotes decentralisation of decision-making space surrounding district health financing • State provides enabling environment for MHOs	• Risks of insufficient government follow-up, bureaucracy or excessive interference by the state • Possible negative community reactions to sense of state co-optation
Regional coordination	• Development of networks of local MHOs coordinated at regional level	• Supports administration and management activities of local MHOs • Allows for lesson learning, capacity building and training across the system • Network utilised to promote and develop new MHOs • Offers potential of 're-insurance' for wider pooling of risks to reduce costs for individual MHOs	• Requires sufficient number and functionality of existing local MHOs
Development agency facilitation of MHOs	• MHOs evolve independently through civil society, with development agencies playing a technical advisory role	• In contexts of weak state public administration, allows for distance from the state, while maintaining technical support • Agency provides political support	• Fosters dependence on external resources • Risks becoming parallel structure to state-provided services
Provider–purchaser co-development model	• Develops quality of contracted health services, along with insurance mechanisms	• Generates attractive health services, stimulating demand side • Develops health services in response to community needs • Often facilitated by development agency as well (technical support)	• Schemes may become very provider oriented • Tension between what is beneficial for health provider and for community
Entrepreneurial approach	• MHOs start by purchasing technical expertise from higher-level institution	• Lessens start-up transaction costs and facilitates gradual community ownership • Develops standardised insurance products and administrative procedures • Promotes efficient scaling-up	• Extra cost for MHOs • Removes degree of community-specific individuality

Source: Huber et al. (2003).

and community management and decision making, MHOs offer the advantage of making services more responsive to the specific needs of the community and allowing the benefit package to be set accordingly (Carrin et al., 2005). Community participation and voice are meant to be exercised through the power of purchase and exit imbued on MHOs with respect to providers, although this depends on the degree of purchaser–provider split. MHOs are ideally able to exert a level of accountability on providers regarding service delivery (Mehrotra and Jarrett, 2002). This is often termed strategic purchasing, where payments to providers are utilised as an incentive tool to generate better quality services (Carrin et al., 2005). Furthermore, the participatory element of MHOs builds upon and generates greater social capital within communities (Campbell and Jovchelovitch, 2000). MHOs often utilise pre-existing solidarity groups, such as burial associations and microfinance organisations, as the basis for health insurance, as these groups offer prior experience with management and administration, as well as already established trust among members. This also serves to reduce the administration and transaction costs of collecting premiums, as collection can take advantage of structures already in place (Wheeler et al., 2002).

MHOs have grown exponentially in sub-Saharan Africa over the past decade, from 76 active schemes in 1997 to 199 in 2000 and 366 in 2003, with another 220 schemes in the early stages of development. In total, this amounts to coverage of almost two million people, although this is only a very small proportion of the estimated population of 900 million (Berkhout and Oostingh, 2008).

4.3.4 LIMITATIONS OF MHOS/CBHI

MHOs have been promoted with much optimism regarding their ability to provide access to health services for those vulnerable populations most often excluded from SHI schemes and negatively impacted by user fees. While they do offer much potential, however, the limitations surrounding their operation in practice draw into question the relevance and feasibility of MHOs for vulnerable populations.

The reimbursement rate of MHOs is substantially limited. A recent meta-analysis of MHO evaluations found the average cost recovery ratio to be about 25% of total health service costs, with only two (out of 36 schemes reviewed) achieving a cost recovery ratio greater than 50% (Ekman, 2004). While the level of financial contribution is a significant determinant of the attractiveness of MHO membership (given the voluntary basis of membership), it is essential to the sustainability of schemes that sufficient revenues are collected. If not, schemes are unable to cover high-cost treatments that are largely responsible for catastrophic health expenditure, leaving patients still paying significant OPPs in addition to their MHO contributions (Carrin et al., 2005). The 'catch-22' here is that those members of the insurance scheme most in need of protection from these catastrophic health expenditures are the poorest members, who are also those least able to pay the higher premiums necessary to subsidise coverage of high-cost treatments.

Given the regressive nature of flat-rate contributions between members, many schemes have implemented scaled contributions. Cross-subsidisation across income groups is low, though, as most MHOs tend to cover a similar level income group. Ultimately, revenue must be generated in order to sustain service coverage. Many MHOs are able to cover only a small portion of the necessary health services and continue to rely on government subsidies and financing of public services, or on external donor funding to support revenue generation (Carrin et al., 2005). Moreover, given the continued high degree of user fees in many contexts, members of MHOs often continue to contribute OPPs to meet up to 40% of their health costs in addition to premium payments (Berkhout and Oostingh, 2008).

Owing to their small size, MHOs are prone to many organisational and managerial problems. As membership is voluntary, adverse selection is a potential problem, particularly as low-income individuals will often choose to invest their limited resources in insurance only if the threat of illness is tangible (Schneider, 2004). The increased financial burden of adverse selection is more threatening than in other schemes owing to the small size of MHO insurance pools (Carrin et al., 2005). Moral hazard also presents an obstacle: as the financial ability to cover service utilisation is limited, over-utilisation can quickly become a financial risk. Furthermore, MHOs have been known to predispose members to increased expectations for service access, adding to the risk of moral hazard or, if expectations are not met, the risk of members choosing to opt out of the scheme (Huber et al., 2003).

Many MHOs suffer from low managerial and administrative capacity, owing to the largely voluntary nature of their management. While utilisation of pre-existing management structures has been known to counteract this in part, there is an inherent compromise between the community management benefits of these schemes and the need for technical expertise. Given low incomes and other pressures on the communities these schemes seek to insure, the availability and capacity of human capital for voluntary management of schemes is often low, with adverse impacts on the effectiveness of the schemes. Furthermore, investment in training can be highly cost inefficient, as training individuals in management for such small coverage rates transfers a high cost to the scheme, often without the necessary benefit return. For example, schemes commonly may be responsible for about US$1500 in contributions each year, with each administrator responsible for only US$300 a year, yet a significant amount of training might be required for this small degree of coverage (Huber et al., 2003). Hiring technical expertise is often put forward as a potential solution. However, the cost of such expertise is likewise often too high for the limited turnover of these schemes. Some practitioners have suggested the separation of community responsibilities and technical administration, grouping individual schemes for technical administration at a higher level (ibid).

These are all salient concerns for West and Central Africa. As Table 11 shows, MHOs currently cover very low proportions of the population – less than 1% in the majority of countries – with the exceptions of Mali and Senegal at 3.92% and 2.46% coverage, respectively. With such typically low coverage rates, it is pertinent to ask what returns are gained on the high investment and administrative costs involved in MHOs and, particularly, what pro-poor or pro-child results they achieve.

The equity considerations of enrolment patterns in MHOs are also of significant concern, particularly in view of their express aim of increasing coverage of vulnerable populations. Evidence from a recent meta-analysis of MHOs shows that, while health expenditure protection and increased service utilisation are achieved for those who are members of MHOs, the poorest often remain excluded from membership, owing to the continued financial barrier of the insurance premium (Ekman, 2004). An evaluation by Oxfam similarly found that financial constraints were the reason cited by the majority of non-participants (79%) for not joining CBHI schemes (Berkhout and Oostingh, 2008).

Table 11: Population coverage by MHOs in selected West and Central African countries

	Population (million)	Community health schemes	Members ('000)	Members per scheme	% of population covered
Benin	8.1	120	41	345	0.51
Burkina Faso	14.3	60	15	248	0.10
Cameroon	18.1	30	16	532	0.09
Chad	9.9	11	2	161	0.02
Guinea	9.9	90	85	942	0.85
Côte d'Ivoire	18.1	47	528	11,227	2.93
Mali	12.0	102	470	4,606	3.92
Mauritania	3.3	5	13	2,611	0.40
Niger	12.9	19	50	2,625	0.39
Senegal	12.5	130	309	2,374	2.46
Togo	5.7	12	20	1,668	0.35
Total	125.0	626	1,548	2,473	1.24

Source: Ouattara and Soors (2007).

Fee waivers, vouchers and exemptions have been suggested as mechanisms for subsidising or eliminating premium costs for poor or vulnerable components of the population, such as pregnant women and children under five. However, these systems in themselves present challenges. Waivers are administratively very costly, in terms of both monetary and time resources, and are open to corruption, including, for example, the risk of the poor having to pay bribes to obtain waiver entitlements. Additionally, the incentives for service providers to grant the waivers are low: if funds are not compensated elsewhere, provision of free care for the exempted means a decrease in revenue for the health facility (Marcus et al., 2004)[22].

Finally, it is important to note that the research and evidence base regarding the impact of MHOs and CBHI on poverty and health outcomes is currently limited. Moreover, there is a lack of comparative research regarding the costs and benefits of implementing a CBHI programme, compared with an alternative intervention with the same equity, efficiency and effectiveness intents, such as the removal of user fees or a cash transfer programme.

[22] For example, in Rwanda, experience from a scheme in Uyui district has shown that, when exempted families are expected to be identified by the community, and the extra funds gathered by the community on behalf of those exempted, exemptions unsurprisingly are often not implemented (interview with R. Dhillon, 30 May 2008).

5. CONCLUSIONS AND RECOMMENDATIONS

The equitable provision of affordable and accessible primary health care is central to human development, critical to meeting the MDGs and a basic human right. Health care provision forms a cornerstone of social protection as a protective, preventative and promotive element of the livelihood and well-being of vulnerable populations. Attention to the equity dimension of health care is especially important in West and Central Africa, in view of the region's extremely high U5MRs and MMRs, low levels of basic health care utilisation and serious obstacles in accessing care, especially among rural and lower quintile population groups.

This report has reviewed the relative effectiveness of the different types of health financing mechanisms from the perspective of equity and the aim of achieving universal access to essential health services. The findings are summarised in Table 12, which outlines the strengths and weaknesses of each of the mechanisms: user fees, CBHI/MHOs, SHI and tax-based government financing.

Drawing on this analysis, our findings point to the following six broad policy implications for child-sensitive social health protection in West and Central Africa.

5.1 BUILD POLITICAL WILL AND GOOD GOVERNANCE

To make progress in achieving greater health equity requires first and foremost political will. While fiscal space shapes the possibility and timeframe in which user fees can be removed, our analysis underscored that health sector spending across the region is correlated with good governance and social sector expenditure patterns rather than national income levels. Indeed, the potential for broad and significant change even in low-income countries is evidenced in the case of Ghana, where the introduction of national health insurance was a key pillar of the president's electoral platform. Faced with limited progress in improving the health status of the population, despite impressive progress in stimulating economic growth and reducing monetary poverty, the government of Ghana took the bold initiative of launching the NHIS and then introducing exemptions to facilitate enrolment of the poorest. It has not only built by far the largest national health insurance system in West and Central Africa, reaching about half of the population, but in recognition of the continued difficulties of extending health insurance to the rest of the population, has taken important complementary measures, providing free access to health care for children and for pregnant and post-partum women. It has also used the Livelihood Empowerment Against Poverty (LEAP) cash transfer programme as an additional complementary mechanism, by automatically enrolling LEAP beneficiaries in the NHIS.

Clearly, this kind of commitment is most likely in countries like Ghana, with an open political culture and competitive electoral politics. Several other countries in the region, such as Benin, Mali and Senegal, all of which have pluralistic political systems and have experienced peaceful transitions of power between rival political parties, have also made some progress in selectively removing fees for some high-impact services for children and women – and Mali has taken the additional step of announcing plans for a national health insurance scheme and a subsidisation fund for health care for the extreme poor.

In the short to medium term, as plans are developed to remove user fees, if MDGs 4 and 5 are to be met, our findings indicate that it is critical to secure political will to eliminate user fees for at a minimum maternal health services and children under five years, and for those living beneath the extreme poverty line, in order to ensure that catastrophic health costs do not exacerbate the deprivation faced by such households and consequent effects on child well-being.

Table 12: Summary of strengths and weaknesses of health financing mechanisms

Financing mechanism	Definition	Strengths in regional context	Weaknesses in regional context
User fees	Official fees charged by public health providers for service provision. Aim to provide cost recovery for services and can be set as a flat fee or variable fees for different services. Sometimes implemented with fee exemptions for the extremely poor and vulnerable.	• Some (modest) revenue generation, sometimes accompanied by the application of Bamako Initiative principles on the retention and management of funds at community facility level	• Most regressive form of financing • Decrease in service utilisation, with the most negative impacts on the poorest quintiles • Negative impact on health outcomes • Impoverishing effects of catastrophic health expenditure • Limited revenue generation (usually about 5-10% of recurrent health budgets)
CBHI/MHO	Voluntary, private non-profit insurance schemes, formed on the basis of mutual aid, solidarity and collective pooling of risks. Incorporate a participatory, bottom-up planning process; members participate in management and administration (often on a voluntary basis), decision making on the benefit package, collection of premiums and negotiations with care providers. Beneficiaries own the scheme and are the financial risk bearers.	• Potential to include persons depending for their livelihoods on the informal sector • Smoothes health expenditure and provides a degree of social protection for scheme members • Risk pooling (on a modest scale) • Facilitates community involvement in health service financing and negotiation with health service providers • Promotes greater accountability and responsiveness of service providers to the community • Builds on and generates solidarity and social capital	• Exclusionary financial barrier for poorest populations (with limited scope for exemptions) • Limited membership and low premiums, resulting in limited risk pooling, exclusions to health services covered, low levels of reimbursement of health service payments and continued significant OPPs • High start-up, administrative and management costs, owing to diseconomies of scale • Weak management, owing to low managerial capacity and reliance on voluntarism in communities • Constraints resulting from limited solidarity in some communities affected by ethnic or other cleavages/conflict • Adverse selection owing to voluntary character of CBHI/MHOs – those least at risk of illness may opt not to join, undermining the scheme's feasibility

Financing mechanism	Definition	Strengths in regional context	Weaknesses in regional context
SHI	Compulsory insurance based on pooled contributions from workers, employers, the self-employed, enterprises and government. Premiums are based on income level and not related to risk levels.	• Progressive financing: is redistributive, with contributions based on ability to pay • Risk-pooling on much larger scale than MHOs/CBHI • Prepayment (through premiums) smoothes health expenditure and provides protection from catastrophic expenditure • Associated with increased service utilisation • Mandatory membership avoids problems of adverse selection • Multiple funding sources are pooled and used to cross-subsidise premiums for those unable to contribute • Purchaser–provider split increases efficiency	• High proportion of rural smallholders, informal sector workers and unemployed limits enrolment, especially by the poorest and most vulnerable, and limits SHI's revenue base • State has limited capacity to ensure enrolment, especially by the poor, despite some subsidies in certain countries to pay premiums for the 'indigent' • Low enrolment perpetuates and reinforces inequity if the state subsidises schemes that de facto primarily benefit the non-poor • Low-quality services in the health sector reduce the benefits of membership and thus the incentives to enrol • May require supplementation with additional funding sources (e.g. tax-based public expenditure or MHOs) if initial start-up fund is insufficient
Tax-based financing	Government-raised revenue through either direct taxes on individuals, households, companies (including income, corporate and payroll taxes) or indirect taxes on commodities (including sales taxes, value-added tax and 'sin taxes' such as taxes on cigarettes). Resources are allocated to and expenditure executed in the health sector through the government budget system.	• An important financing source, especially for preventative public health services, and essential curative services, with prospects for expansion as administrative and tax revenue capacity improves • Redistribution through utilisation of revenue generated from the better-off to subsidise public health services for the poor • In some cases, specific taxes may be earmarked to finance health insurance coverage or fee exemptions for the poor (e.g. Ghana NHIS) • 'Sin taxes' on socially harmful goods, such as tobacco and alcohol, increase revenue while decreasing consumption	• Much lower revenue collection as percentage of GDP (and much lower levels of GDP) than in high-income countries, owing to low levels of economic development and the large size of the informal (non-tax-paying) economy • Low percent of government funding allocated to health and weak health budget execution in most countries of the region

All policy choices should in turn feed into the development of national plans of action to achieve universal coverage in health, based on a package of health care reforms that pay attention not only to cost barriers to access but also to cultural, service quality and information barriers.

5.2 PRIORITISE USER FEE ABOLITION IN MATERNAL AND CHILD HEALTH SERVICES

There is growing consensus that the removal of user fees can have a significant positive impact on service utilisation, especially by the poor, and that, if it is well planned and managed, it need not compromise service quality. Nonetheless, given the limited fiscal space in all but a handful of oil-rich countries in the region, the removal of user fees for all health services, although desirable, is unlikely in the poorest countries. This raises the question of priorities for the selective abolition of user fees.

Health financing options should be pursued with the aim of reducing the burden of OPPs on the poorest and most vulnerable in society, thereby reducing the poverty impacts of high private health expenditure, increasing access to essential primary health care, accelerating progress towards the health-related MDGs and promoting human capital development. From this perspective, the removal of user fees for essential maternal and child health services should be seen as the highest priority, given the very high rates of child and maternal mortality in West and Central Africa and the relatively low cost of providing essential maternal and child health services. Where possible, this could be part of a broader abolition of fees for primary health care services, leaving other approaches, such as health insurance, as a complementary form of financing for other more costly types of curative care. The WHO Commission for Macroeconomics and Health (2001) has estimated that a minimum government expenditure of US$34 per capita per year is necessary to provide a basic package of essential health services in order to meet the health-related MDGs. This is clearly affordable if governments give priority to essential health care for the reduction of mortality and reflect this priority in their budget planning.

5.3 ADDRESS THE PREREQUISITES FOR THE SUCCESSFUL REMOVAL OF USER FEES

The successful abolition of user fees, which increases the demand for health services, hinges on careful planning and management on the supply side in order to ensure that health providers are able to meet the increase in demand[23]. This is necessary even if user fee abolition is limited to essential maternal and child health care services and/or other relatively low-cost primary health care services. The following are some of the prerequisites for a smooth transition away from user fees:

[23] In South Africa, the removal of user fees (1994), announced by the President merely days before the implementation of the policy, left health sector managers and workers unable to plan for the transition; the subsequent rapid increase in utilisation quickly exhausted drug supplies and led to the frustration and alienation of implementing health workers. Conversely, in Uganda, a US$5.5 million buffer fund was established to support the loss of revenue and its effect upon drug availability (Gilson and McIntyre, 2005).

- **Strong leadership** to initiate and sustain the policy changes associated with the removal of user fees[24];
- An **analysis** of the existing role of user fees in health service financing, especially at the sub-national level, in order to formulate measures to avoid the potential negative effects of their removal[25];
- **Supply-side investments in health services** to meet the increase in demand and improve the quality and geographical coverage of services[26];
- An **increase in the health budget** to compensate for the loss in revenue from user fees as well as provide the supply-side support needed to meet the increase in demand;
- **Dialogue with health sector staff** and, where necessary, **improvements in staffing** so that increases in the utilisation of services resulting in increases in workload will not undermine staff morale;
- **Buffer funds and pre-stocking of drugs** to offset the potential negative impacts on availability following an increase in utilisation;
- **Strengthening of public financial management systems** so that funds reach health centres in a timely and predictable fashion;
- **Improvements in health sector efficiency** (and thus 'value for money') through a stronger focus on preventative health and simple curative services at primary health care level[27];
- **Monitoring of the policy change**, beginning with an accurate baseline assessment (Gilson and McIntyre, 2005).

5.4 STRENGTHEN BUDGET MANAGEMENT AND QUALITY OF HEALTH EXPENDITURE

In addition to careful advance planning for the removal of user fees for essential primary health care services, such as child and maternal health care, governments need to strengthen budget management and improve quality of expenditure in the health sector. In other words, in addition to an increase in governments' health sector expenditure, user fee abolition needs to be accompanied by capacity building in budget planning and execution, which is relatively weak across the region.

There has been some improvement in the budget planning and advocacy skills of ministries of health in some countries in recent years, stimulated in part by the incentive to present well-formulated proposals to external sources of funding such as the Global Fund, the GAVI Alliance and the United States' PEPFAR programme (US President's Emergency Plan for AIDS Relief). Nonetheless, political constraints result in most

[24] If managed well, however, evidence from past cases, such as Uganda, illustrates that the removal of user fees can be a strong buoying factor for political capital. Leadership can be catalysed through the generation of demand and linking of the policy to related political benefits (e.g. the popularity of the removal of user fees contributed significantly to the re-election of President Museveni). For successful follow-through on the policy, though, this top-level ownership must be genuine (Nabyonga et al., 2005).

[25] One suggestion has been to support implementation with locally controlled, flexible operational funds.

[26] While these supply-side reforms are essential to sustaining the benefits accrued through demand-side initiatives, research on the Ugandan case indicates that decisive action on the removal of user fees may act as a catalyst on the system, inducing investment in supply-side factors as demand increases (Yates et al., 2008).

[27] Expenditure patterns underline that ensuring provision of health services at the primary level of care is cost saving compared with higher-level facilities and curative services. Average curative care contact with health services: US$3; average cost of first antenatal care contact: US$2; average cost repeat antenatal care contact: US$1.4 (July 1997 to December 1998) (Plaetse et al., 2005).

government health resources being allocated to salaries, accompanied by a strong bias towards secondary and tertiary levels of health services. There are also serious weaknesses at the execution stage of the budget cycle, owing to weak treasury and payments systems and, in some cases, problems with decentralisation. As a result, often only a small proportion of the government resources allocated to health effectively reach local-level primary health care providers, and these resources commonly arrive irregularly or late, particularly for non-salary recurrent expenditures.

Efforts to remove user fees should therefore be integrated into a broader package of reforms, including measures to strengthen planning, budgeting and financial management, and to improve the quality of expenditure, in order, for example, to achieve a better balance between primary, secondary and tertiary care and between salary and non-salary recurrent expenditure. This also requires effective monitoring and evaluation, and mechanisms to promote learning and improved practices over time. Given that sub-national-level health facilities are often particularly reliant on user fees to provide resources for medical supplies and other non-personnel recurrent expenditure, special attention needs to be given to ways of addressing blockages in resource flows in the health sector from the central to district and community levels and to ensure that the latter retain discretionary powers and flexibility in the use of resources.

5.5 UNDERSTAND THE POTENTIAL (AND LIMITATIONS) OF SHI AND MHOS

SHI and MHOs offer important complementary strategies in health financing. However, the equity limitations of these systems must be recognised, making it unrealistic to rely on SHI or MHOs to ensure universal access to essential primary health care services. Given the high rates of poverty, the large proportion of the population in the informal sector and the weak administrative capacity in the region, the difficulties associated with implementing SHI schemes in West and Central Africa are formidable. Even when associated with MHO-type mechanisms for enrolling those outside the formal sector of the economy, as in Ghana's NHIS, SHI is unlikely to reach the poorest and most vulnerable members of the population. Therefore, SHI should be pursued in conjunction with complementary strategies aimed at the inclusion and subsidisation of care for the poorest populations, coupled with selective user fee abolition for the most essential primary health care services, as in Ghana, where the NHIS provides exemptions for the poorest and waives fees for children under 18 and all pregnant and post-partum women.

In principle, MHOs offer a complementary strategy for social protection for rural, informal sector populations. However, they have a number of weaknesses: difficulties in enrolling the poor (unless supported by contribution exemption mechanisms for the poorest subsidised by government or donor funding); low levels of risk pooling; dangers of adverse selection; low levels of health cost reimbursement; and high administration costs.

In short, SHI and MHOs may play some role as complementary strategies for risk pooling and health expenditure smoothing, but they are unlikely to provide a major mechanism for social health protection for the poorest and most vulnerable populations in West and Central Africa. It would be valuable, however, to promote further research on the strengths and weaknesses of these complementary health financing mechanisms, and to document examples of good practice and lessons learned.

5.6 TAKE ADVANTAGE OF FAVOURABLE DEVELOPMENT PARTNER POLICIES AND BUILD ON INTERNATIONAL MOMENTUM

Finally, national governments can capitalise on the new window of opportunity created by the increasing international interest in social protection in developing country contexts. The health needs of the poor and vulnerable have remained relatively constant over the past 25 years – and continuing gaps in access to basic, low-cost primary health care in fulfilment of the right to health are painfully clear. However, health financing policy has often been driven by the policy paradigms of the major international donors. User fee systems for health services were born out of the dominant focus on economic and fiscal issues at the height of 'structural adjustment' during the 1980s, and even supported by international organisations that were otherwise driven by equity concerns for the poor and vulnerable (Périn and Attaran, 2003). Slowly, owing to demonstration of the negative effects of user fees on utilisation of essential primary health care services, combined with the poor functioning of exemption mechanisms, international consensus has evolved to recognise that user fees do not provide social protection and access to health services for the poor; on the contrary, they have a negative impact on their health and well-being. This growing international consensus is highlighted in Annex 3 on international agency policy positions on health sector financing and user fees.

In light of commitments to MDG 8's promise of a global partnership for development, donors could contribute to the extra revenue necessary for the removal of user fees for essential primary health care services. Donors currently contribute a regionally weighted average of 16% of total health expenditure in West and Central Africa and as much as 40% in some of the poorest countries, such as Liberia and Sierra Leone. While approximately half of the countries in the region have recently received increased support for maternal and child health care needs, the other half have suffered declines. There therefore appears to be considerable scope to expand investment in this area to promote the right to health of the most vulnerable and to expedite progress towards the attainment of MDGs 4 and 5, although the current world economic crisis poses a new threat that could lead to cuts in overall aid flows.

The potential high impact of the removal of fees for essential health services on the health status and survival of children and women should be weighed alongside the returns from other patterns of donor spending. The shifting of donor health sector support from project-based aid to sector-wide and general budget support can facilitate an increase in the proportion of health sector resources funded through government expenditure, as evidenced in particular by the successful examples of health sector-wide approaches (SWAps) in countries such as Ghana and Burkina Faso (Sida, 2004). Within this framework of aid harmonisation, donors and development partners could also play an important role in policy dialogue by encouraging national governments to design and implement health financing reforms that tackle the coverage deficits in child and maternal health services.

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ANNEX 1. LEVEL OF SOCIAL HEALTH PROTECTION WITH U5MR, MMR AND HEALTH CARE INDICATORS

	THE per capita per year (US$)	Gov health expenditure per capita per year (US$)	OPPs as % of THE	U5MR	DPT3 coverage (1 year olds)	ORT and continued feeding (U5s with diarrhoea)	MMR (per 100,000 live births) 2005	Antenatal care coverage	Skilled attendant at birth
Higher social health protection									
São Tomé and Príncipe	58	49	14.6	96	99	63	-	97	81
Equatorial Guinea [28]	274	215	16	206	33	36	680	86	65
Cape Verde	129	105	18.4	34	72	-	210	99	89
Gabon	267	210	21.3	91	38	44	520	94	86
Medium social health protection									
Burkina Faso	27	15	39.4	204	95	42	700	85	54
Benin	28	15	44.5	148	93	42	840	88	78
Ghana	35	15	50.0	120	84	29	560	92	50
Congo, Republic	42	17	59.2	126	79	39	740	86	83
Senegal	40	13	61.9	116	89	43	980	87	52
Nigeria	32	10	63.2	191	54	28	1100	58	35
Côte d'Ivoire	35	8	67.6	127	77	45	810	85	57
Cameroon	51	14	68.2	149	81	22	1000	82	63
Lower social health protection									
Gambia	13	8	29.3	113	95	38	690	98	57
Mauritania	19	13	31.4	125	68	9	820	64	57
Liberia	10	6	35.7	235	88	-	1200	85	51
Niger	10	5	40.3	253	39	43	1800	46	33
Guinea-Bissau	13	3	44.7	200	77	25	1100	78	39
Togo	19	5	61.2	108	87	22	510	84	62
Central African Republic	13	5	61.4	175	40	47	980	69	53
Chad	22	8	62	209	20	27	1500	39	14
Guinea	-	2	87.3	161	71	38	910	82	38

Source: UNICEF (2008); WHO (2008a); WHO (2008b).

Notes: Higher is defined as THE above the WHO recommended US$34 minimum per capita expenditure threshold and OPPs below 25% of THE. Medium and lower both have THE below the WHO recommended minimum (below US$34 for medium and below US$25 for low), and have OPPs above 25% of THE.

[28] Notably, each of these countries is among the lowest U5MR in the region, except for Equatorial Guinea, which contradictorily has some of the highest rates of per capita health expenditure, density of health professionals and proportions of government financing for health, yet has failed to translate these investments into a decrease in the U5MR.

ANNEX 2. SELECTED CPIA SCORES FOR WEST AND CENTRAL AFRICAN COUNTRIES, 2007

	Macroeconomic management	Fiscal policy	Debt policy	Equity of public resource use	Social protection and labour	Quality of budget and financial management	Efficiency of revenue mobilisations	Quality of public administration	Transparency, accountability and corruption in public sector	IRAI
Benin	4.5	4.0	3.5	3.0	3.0	3.5	3.5	3.0	3.5	3.6
Burkina Faso	4.5	4.5	4.0	4.0	3.5	4.0	3.5	3.5	3.0	3.7
Cameroon	4.0	4.0	3.0	3.0	3.0	3.5	3.5	3.0	2.5	3.2
Cape Verde	4.5	4.5	4.5	4.5	4.5	4.0	3.5	4.0	4.5	4.2
Central African Republic	3.5	3.0	2.0	2.0	2.0	2.0	2.5	2.5	2.5	2.5
Chad	3.0	2.5	2.5	3.0	2.5	2.0	2.5	2.5	2.0	2.6
Congo, Democratic Republic	3.5	3.5	2.5	3.0	3.0	2.5	2.5	2.5	2.0	2.8
Congo, Republic	3.0	2.0	2.5	2.5	2.5	2.5	3.0	2.5	2.5	2.7
Côte d'Ivoire	3.0	2.5	1.5	1.5	2.5	2.0	4.0	2.0	2.0	2.6
Equatorial Guinea	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Gabon	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Gabon	4.0	3.5	2.5	3.0	2.5	3.0	3.5	3.0	2.0	3.2
Ghana	4.0	4.0	4.0	4.0	3.5	4.0	4.5	3.5	4.0	4.0
Guinea	3.0	3.5	2.5	3.0	3.0	3.0	3.0	3.0	2.5	3.0
Guinea-Bissau	2.0	2.5	1.5	3.0	2.5	2.5	3.0	2.5	2.5	2.6
Liberia	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Mali	4.5	4.0	4.5	3.5	3.5	3.5	4.0	3.0	3.5	3.7
Mauritania	3.5	3.0	4.0	3.5	3.0	2.5	3.5	3.0	3.0	3.4
Niger	4.0	3.5	3.5	3.5	3.0	3.5	3.5	3.0	3.0	3.3
Nigeria	4.0	4.5	4.5	3.5	3.5	3.0	3.0	3.0	3.0	3.4
São Tomé and Príncipe	3.0	3.0	2.5	3.0	2.5	3.0	3.5	3.0	3.5	3.0
Senegal	4.5	4.0	4.0	3.5	3.0	3.5	4.0	3.5	3.0	3.7
Sierra Leone	4.0	3.5	3.5	3.0	3.0	3.5	2.5	3.0	2.5	3.1
Togo	2.5	2.5	1.5	2.0	2.5	2.0	2.5	2.0	2.0	2.5

Source: http://www1.worldbank.org/operations/IRAI/2007/IRAI2007table1.xls.

Note: IRAI = IDA Resource Allocation Index.

ANNEX 3. INTERNATIONAL DEVELOPMENT AGENCY POLICIES ON USER FEES

France (AfD)	AfD does not regard 'fee for service' systems as equitable and thus its strategy focuses on extending social protection systems. It endorses health insurance schemes but recognises that they are not viable for the poorest who 'must benefit from specific protection systems'. AfD is willing to support governments to introduce either compulsory or voluntary health insurance schemes in the context of broader efforts to strengthen health systems (see www.afd.fr/jahia/Jahia/lang/en/home/Portail-Projets/PortailSante/pid/1543).
Germany (GTZ)	Based on evaluations of health care systems in sub-Saharan Africa, GTZ has come to realise that whereas 'for a long time, experts assumed that poor population groups would automatically benefit from an extended network of health care services and better qualified nursing staff, … now we know that isn't enough … and poorer people in particular hardly use the health care facilities improved in the 1990s … What the evaluations of the past few years have taught us is that the nationwide availability of health services does not automatically benefit the destitute' (Hammer, quoted in Holst and Brandrup-Lukanow, 2007). GTZ now seeks to support financing mechanisms that promote the integration of the poorest population groups in particular into the health care system (ibid). (see www.gtz.de/en/themen/soziale-entwicklung/soziale-sicherheit/21177.htm).
GTZ–ILO–WHO Social Health Protection Consortium	In November 2004, GTZ, ILO and WHO signed a joint letter of agreement on cooperation in the field of social protection in health, sustainable health financing systems and efficient contracting. The GTZ–ILO–WHO Consortium is a joint effort to coordinate the work of the participating organisations and to collaborate at country, regional and global levels with the aim of extending social health protection coverage in developing countries. It is open to various options for financing access to health care, including tax-based financing, community-based, private and social health insurance or a combination of these options. Each financing option generally involves the pooling of health risks and subsidies from rich to poor between and within risk pools. The objectives of the Consortium are to: strengthen and increase the impact of technical support by jointly providing resources; create synergies and savings through complementary activities; and increase the quality and scope of sustainable and comprehensive health care financing in partner countries, including by sharing experiences and building consensus based on results. (see www.gtz.de/de/dokumente/en-gtz-ilo-who-consortium-factsheet.pdf).
ILO	Global expenditure on health reveals a large amount of out-of pocket expenditure paid at the point of service delivery. A high share of OPPs indicates global inequity and lack of coverage for social health protection. OPP is the most inefficient way of financing health-care spending. It weighs most heavily on the poor and is associated with a high risk of household impoverishment through catastrophic costs. ILO therefore advocates for 'minimising out-of-pocket payments' (ILO, 2008). The ILO's ultimate objective in the field of social health protection is to achieve universal coverage, defined as effective access to affordable health care of adequate quality and financial protection in case of sickness. This is part of the minimum social protection package that ILO recommends should be available to all in every country.

MSF	MSF advocates for abolition of user fees, citing evidence that this has quadrupled utilisation rates for basic health services, such as malaria treatment, that are critical to child health and development (MSF, 2008b)
Oxfam	Oxfam has argued that building public services is at the heart of fighting poverty. User fees exclude the poor from services, particularly women and girls, and so their abolition would have an immediate beneficial impact on the uptake of services (Emmett, 2006).
Save the Children UK	Save the Children UK advocates for abolition of user fees as they generate minimal revenue and have a negative impact on basic health service utilisation, particularly among the poor. To achieve this, Save UK (2005) proposes five key steps: (i) country situational analysis; (ii) estimation of how removal of fees will affect service utilisation; (iii) estimation of impacts on human resources and the demand for drugs; (iv) mobilisation of additional funding; and (v) communication of the policy change to health sector professionals and the public (McPake et al., 2008). Save UK has also challenged UNICEF's position on user fees (2008).
UK (DFID)	DFID (2006) argues that user fees decrease service utilisation, particularly among the poor, and that donors should support the removal of user fees.
UNICEF	User fees have negative impacts on access to services by the poor, although this is offset to some extent by improvements in the quality of services. Fees are not the only barrier to access faced by the poor. UNICEF has continued to support the principles of the Bamako Initiative, including community retention and management of user fee revenue. The removal of fees must be offset by increases in health sector budgets (IRIN, 2008; James et al., 2006; UNICEF, 2008).
WHO	WHO has argued that user fees discourage service utilisation, and that there is clear evidence of reduction in utilisation following increases in fees, particularly among the poor. These effects can be counteracted to some extent by the increased quality of services. WHO has added that, in the absence of exemption policies or other forms of financial protection, user fees price the poor out of the market for health care (WHO, 2008a).
World Bank	In the World Development Report 2001, the World Bank argued that 'few developing countries … have successfully implemented price discrimination in health services through sliding scale fees. In most African countries, such exemptions tend to benefit wealthier groups (such as civil servants)' (World Bank, 2000). In response to pressure from the US Congress to remove user fees for health and education services from any multilateral development bank loan provisions, in 2001 the World Bank issued a revised user fees policy, acknowledging that fees have prevented poor people from accessing primary schools and health clinics … and stated that the Bank 'is now opposed to user fees for primary education and basic health services for poor people' (quoted in World Bank, 2009). However, the 2004 World Development Report on Services for the Poor (World Bank, 2003), recognises the impoverishing effects of OPPs, including user fees, for health care, but emphasises the need for a country-specific analysis. It recommends that 'six sizes fit all', whereby two key dimensions are considered as follows: (i) the type of health care system in place: population-oriented health services, family-oriented support to self-care or individual-oriented clinical services; and (ii) whether or not the political system can be characterised by pro-poor politics. Depending on where a country falls along these two dimensions, the World Development Report suggests that tax-based financing, social health insurance, vouchers, co-payments and/or micro-insurance schemes may be appropriate.

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HAEMOPHILUS TYPE
CONJUGATE VACCINE
VACUNA CONJUGADA
HAEMOPHILUS TIPO
10 doses / dosis
Intramuscular route
Vía intramuscular
See leaflet / Véase prosp
Sanofi Pasteur


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