



Financing Mechanisms to Mobilize the Private Health Sector

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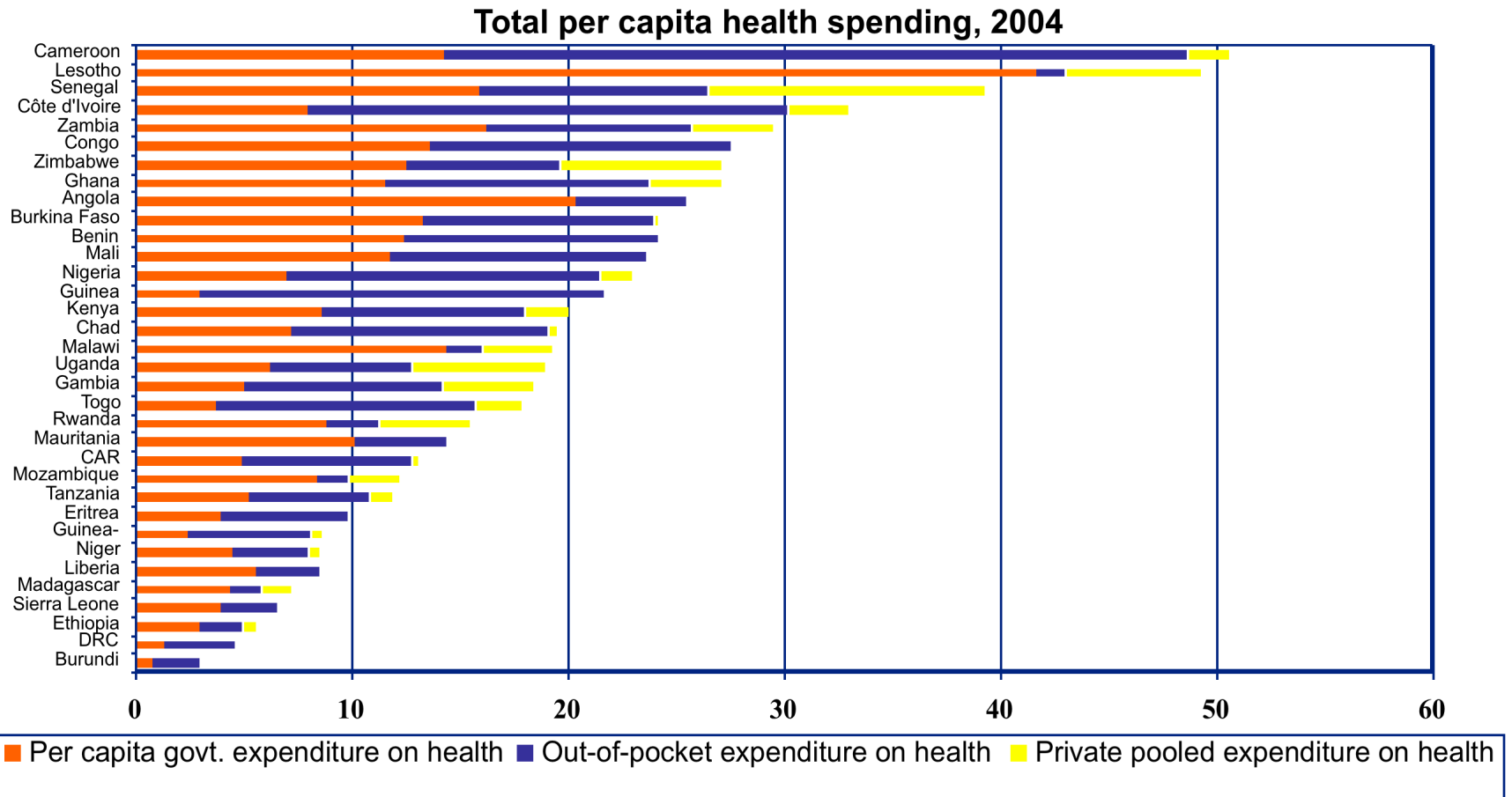
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Presentation outline

- ❖ What do we know about health sector financing in Africa?
- ❖ Mechanisms to engage private sector through financing
 - Insurance
 - Subsidies/vouchers
 - Tax policy
- ❖ Conclusions

Health financing levels are low across the continent

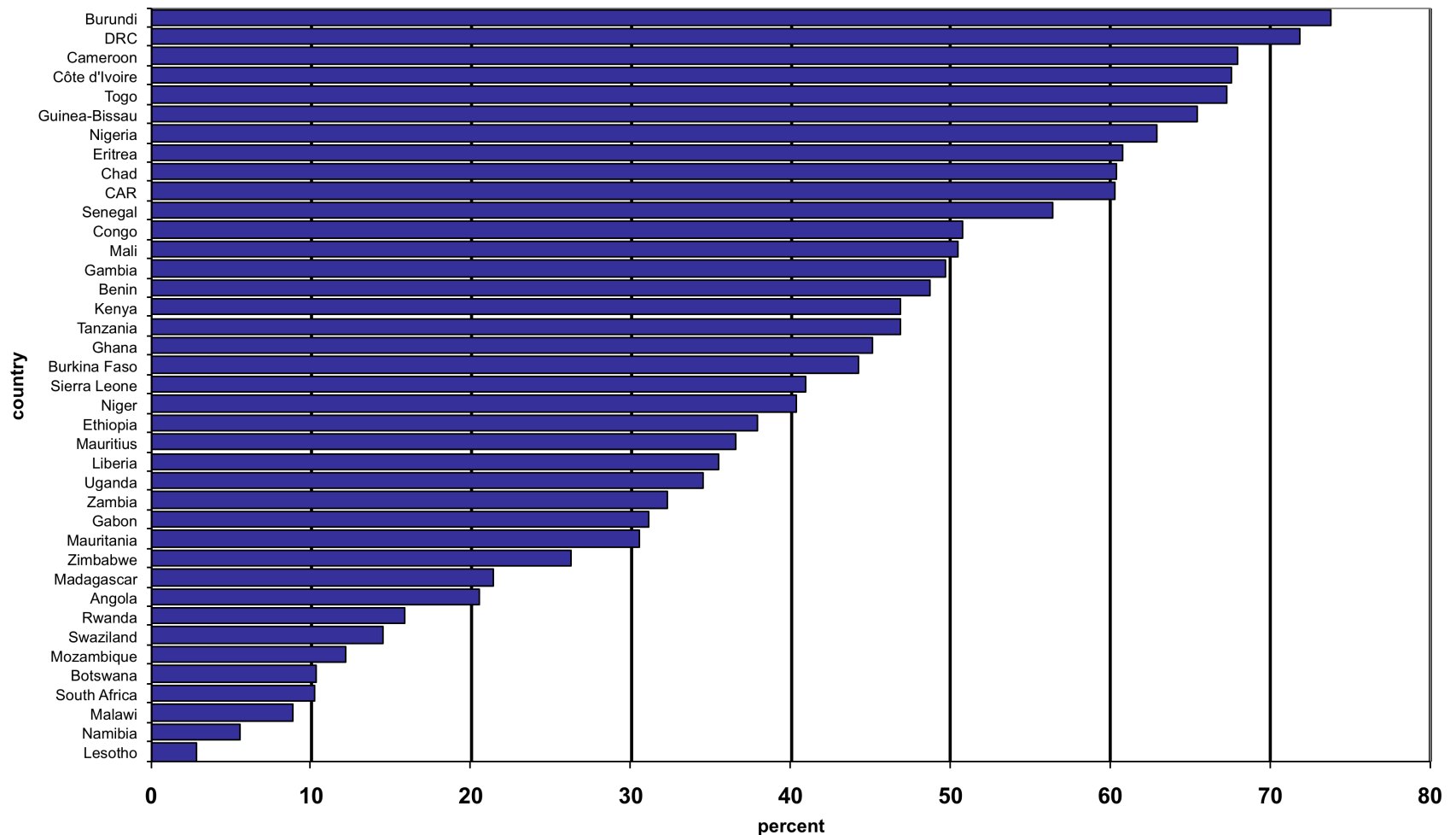


Source: WHO SIS

Note: Countries spending >\$90 total per capita on health were excluded to improve graph's readability. These countries are Swaziland, Mauritius, Namibia, Gabon, South Africa, and Botswana

Yet out-of-pocket spending substantial in most African HHs

Out-of-pocket spending as % of total health expenditures, 2004



Source: World Bank World Development Indicators 2007

Possible financing mechanisms

- ❖ Risk pooling through insurance
- ❖ Subsidies and vouchers
 - Supply side and demand side financing mechanisms
- ❖ Tax exemptions, tax incentives?

Types of insurance

Providers	Source of funding		
	Public	Mixed	Private
Public	Indonesia: health card scheme Tanzania	Burundi: Carte d'assurance maladie Rwanda CBHI	Mali: CBHI schemes
Mixed	Columbia: social health insurance scheme	Philippines Ghana NHIS Nigeria SHI Germany	Senegal: CBHI schemes
Private	US Medicaid system	US Medicare system	Many schemes in South Africa, Nigeria, Namibia DRC: Bwamanda Hospital Insurance Scheme

FP and insurance – strange bedfellows?

- ❖ Insurable risk argues against insuring FP as stand-alone benefit
- ❖ FP can be efficiently packaged with other benefits
- ❖ Role for incentives and advocacy to include preventive services like FP
 - Improves health status
 - Makes HH financing for health more predictable

Why choose insurance?

- ❖ Organizes consumers
 - Provides financial protection, improves financial access
- ❖ Organizes providers, creates leverage on quality, efficiency
- ❖ Incentive for providers; more (regular) business, less risk, permits better planning

Why choose insurance? (2)

- ❖ Can be used as a policy tool
 - If public funding, mandate inclusion of preventive services like FP
 - If private funding, advocate or target subsidies for those services

Selecting insurance strategies

❖ Community-based health insurance

- Pros: mobilize resources, provide financial protection, quality gains, pro-poor and pro-rural
- Cons: small risk pools, financial sustainability is questionable, low population coverage

❖ National health insurance schemes

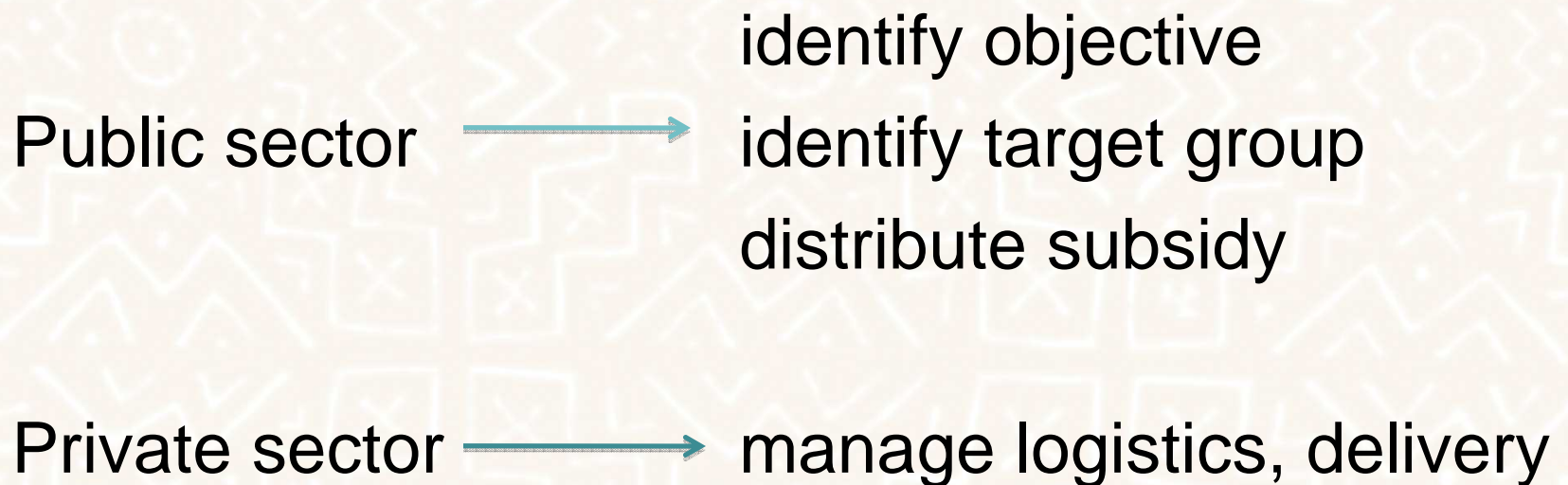
- Pros: can cover large population groups, can build on community-based schemes, rapid growth possible (Rwanda, Ghana)
- Cons: difficult to extend coverage to poor and informal sector, financial sustainability questionable

❖ Employer-sponsored health insurance

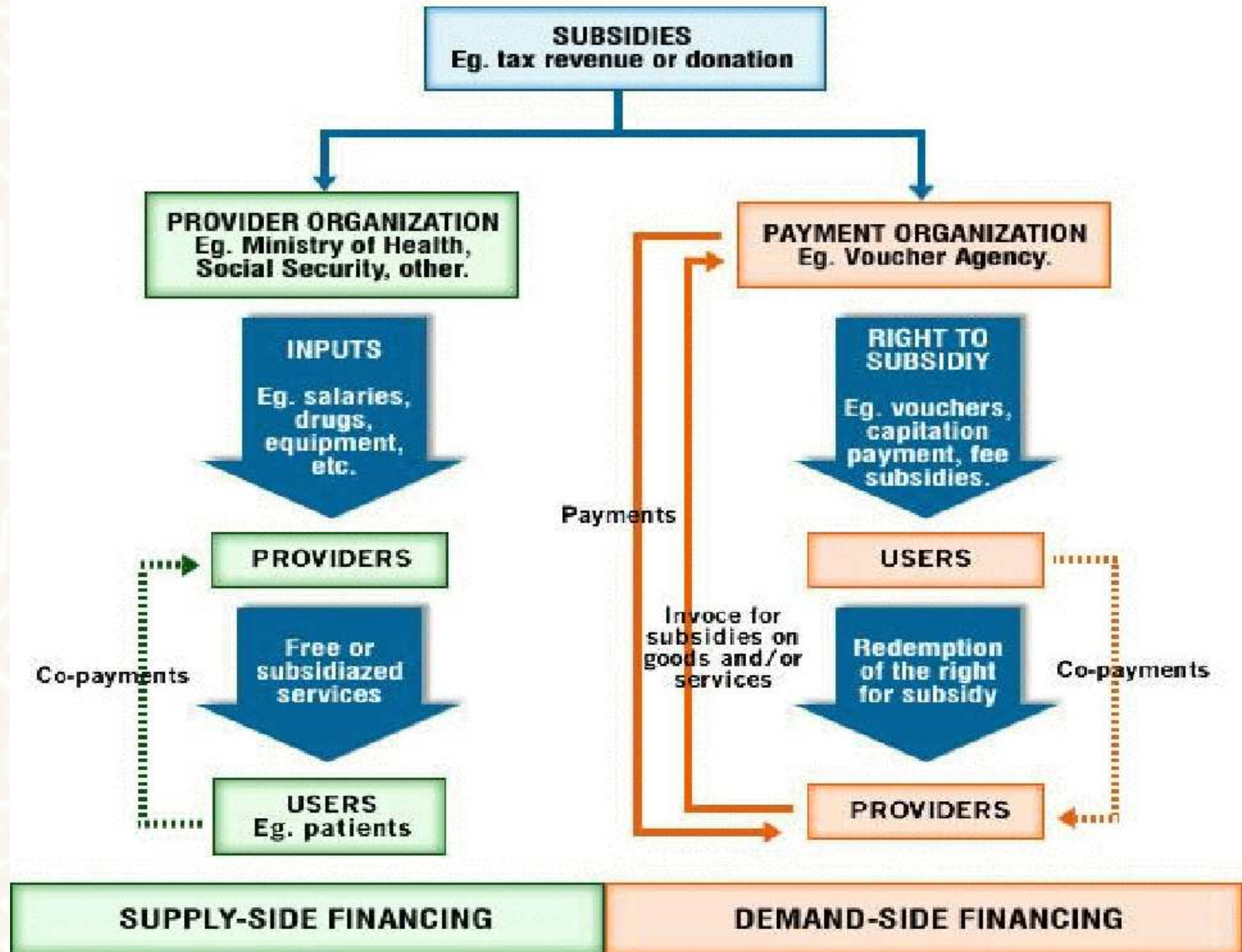
- Pros: coverage of ARVs, in-house clinics
- Cons: limited to those employed through the formal sector; take-up rates for benefits low for HIV services; moral hazard

Public subsidies to mobilize the private sector

- ❖ Subsidies focus public spending on cost of subsidy rather than management and logistics of delivering the service



Public subsidy mechanisms



Types of subsidies

- ❖ Supply-side:
 - ❖ Subsidy transferred to provider for a set of free or subsidized services
- ❖ Demand-side:
 - ❖ Consumer-led – subsidy transferred to consumer
 - vouchers, cash transfer payments
 - ❖ Provider-led – subsidy based on contract with funding agent linking resources directly to output
 - capitation payments, performance-based contracts, output-based aid

Choosing subsidies

❖ Pros:

- Increase technical efficiency of service provision
- Stimulate demand for priority services
- Leverage quality improvements

❖ Cons:

- Setting up complex, takes time
- Higher transaction and administrative costs
- Supply-side subsidies can be difficult to target, reduce incentives

Innovative supply-side subsidy

- ❖ Government of Uganda partnership with private company-based clinics
 - Assistance from Business PART project
 - MOH donates first-line ARVs to private clinics with the caveat that they are provided to patients free-of-charge
 - Target those who can't afford market price: dependents, contract workers, community members, not employees eligible for medical benefits
 - Clinics must be certified by MOH

Financing and beneficiaries

- ❖ Program launch heavily dependent on brokering and donor support
 - partner companies covered approximately 44% of start-up costs
- ❖ Companies cover all recurrent costs, which match value of MOH-donated ARVs
- ❖ 80% beneficiaries community members, 20% dependents

Lessons from Ugandan experience

- ❖ Limited potential for scale-up
 - But can absorb “spare” clinical capacity in company-run clinics
- ❖ Brokering role critical
- ❖ Not all companies candidates – careful selection important
- ❖ Government commitment to work with private sector essential
- ❖ Free and reliable drug supply key

Tax policies to encourage private sector participation in health

- ❖ Put in place policies to ensure that certain health care goods or inputs are tax-deductible or tax-exempt for firms employers or individuals
- ❖ Examples in Africa are few, but include:
 - Removing VAT taxes on contraceptives, drugs, ITNs
 - Tax credits to employers subscribing to medical insurance for employees

Selecting tax policy as strategy

❖ Pros:

- ❖ May provide incentive for investments in health
- ❖ Potential to stimulate demand for services

❖ Cons:

- ❖ Less effective as a tool in places where the informal sector is large
- ❖ Responsiveness to price changes may be modest
- ❖ Little documentation of effects

Lessons learned

- ❖ Government can play a strategic role by setting up market dynamics
- ❖ Financing mechanisms can be powerful
 - Provide incentives to encourage private sector participation in FP, RH, HIV/AIDS
 - Organize consumers and providers
 - Leverage quality, equity and efficiency improvements
- ❖ Advocate/provide incentives for inclusion of FP or HIV/AIDS in financing strategies