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Strengthening Social Protection for Children

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Maternal and child health: the social protection dividend in West and Central Africa

The equitable provision of affordable and accessible primary health care is central to human development, critical to meeting the health-related Millennium Development Goals (MDGs) and a basic human right. Yet much of the population of West and Central Africa does not have access to essential basic health services, either because adequate services are not available or because those services are not accessible to the poor.

Attention to the equity dimension of health care is especially important in this region because of its widespread poverty, extremely high under-five and maternal mortality rates, low levels of basic health care utilisation and the financial obstacles to health care, especially among rural and lower quintile population groups (see Box 1).

This briefing paper, which is based on a research report on social protection and health equity in West and Central Africa, assesses the extent to which existing health financing mechanisms in the region are addressing maternal and child health vulnerabilities in an equitable manner and discusses alternative approaches to ensuring access to maternal and child health services by the poor[1].

[1] The study was part of a broader research programme on social protection and children in West and Central Africa, sponsored by the West and Central Africa Regional Office of UNICEF and carried out by the Overseas Development Institute (ODI) in London with the participation of researchers from the region. This briefing paper is based on a report on 'Maternal and Child Health: The Social Protection Divided', written by Cora Walsh and Nicola Jones, and published jointly by UNICEF and ODI in June 2009.

Box 1. **The challenge of child and maternal survival in West and Central Africa**

Children have 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. Yet West and Central Africa currently has the highest regional under-five mortality rate in the world (169 per 1,000 live births) and accounts for more than 30% of global maternal deaths, according to UNICEF's State of the World's Children report for 2009. Moreover, in some countries (Cameroon, Central African Republic, Chad, Congo and Equatorial Guinea), maternal and child mortality indicators have actually worsened since 1990.

The underlying causes of these extremely high mortality rates include widespread poverty, illiteracy and poor nutrition, gender inequalities, low levels of access to safe water and sanitation, low levels of basic healthcare provision, quality and utilisation and serious financial obstacles, including service charges and transport costs, that block access to essential health services, especially among rural and lower quintile population groups. Without a major increase in resources for health care, measures to overcome barriers to health care access by the poor and dramatically enhanced political will by governments and development partners alike, the MDGs on child and maternal mortality (Goals 4 and 5) will not be achieved in this region by the target date of 2015.

odi Overseas Development Institute

unicef

Health financing in West and Central Africa

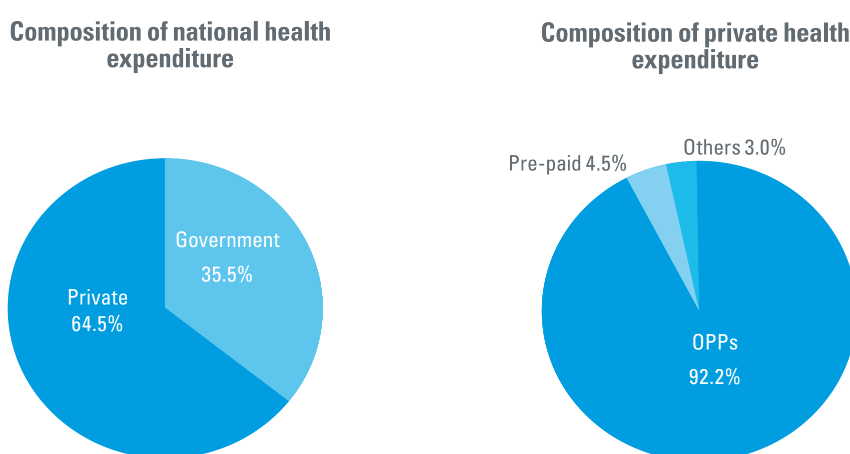
Total health expenditure is low across West and Central Africa, and well below international recommendations. WHO data for 2006 indicate a weighted average of US$28 per capita total health expenditure in the region, with just US$10 per capita government expenditure on health. This is of serious concern, as the WHO Commission for Macroeconomics and Health has estimated that government expenditure of at least 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.

Compounding the low levels of total expenditure is the degree to which health financing is derived from private expenditure, rather than publicly sourced. On average, private health expenditure (at 64.5% of total health expenditure) is higher than government health expenditure (35.5%), according to WHO national health accounts. In a region where the proportion of people living below the international poverty line of US$1 per day ranges from 15% in Côte d'Ivoire to 90% in the DRC, the burden that private expenditure places upon the poor is significant[2]. Of this private expenditure, almost all (92.2%) comes from out-of-pocket payments (OPPs)[3] made at the point of service usage (see Figure 1).

One of the implications of this heavy dependence on OPPs is that cost is a major barrier to health care access. Indeed, this is cited as a reason for non-utilisation of health services by 56% of women in West and Central Africa, according to Demographic and Health Survey (DHS) reports. This figure is even higher in the rural areas (63%) and in some individual countries (see Figure 2).

As a result, utilisation of health services is much higher in the higher than the lower quintiles. For example, the proportion of top quintile women receiving skilled attendance at delivery is between 1.4 times higher (Gabon and Congo) and 15.4 times higher (Chad) than for bottom quintile women, according to WHO data. The proportion is 4-5 times higher in countries such as Ghana, Mali and Senegal.

Figure 1. **Composition of health expenditure in West and Central Africa, 2006**

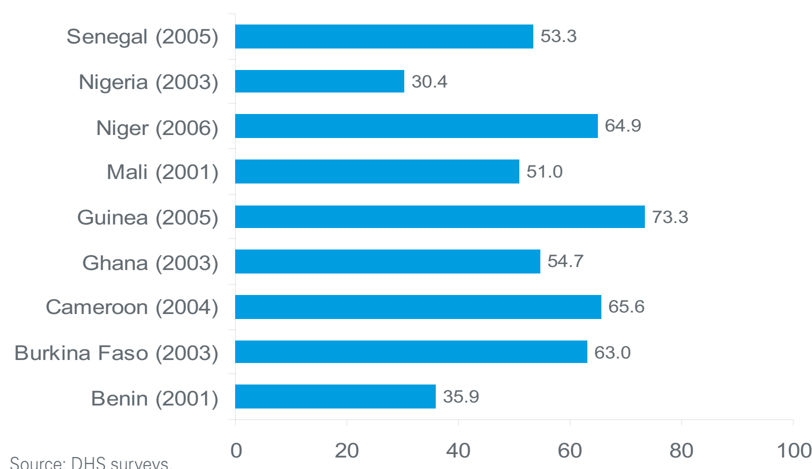


Source: WHO (2008), National Health Accounts Data by Country (for 2006).

2 This international poverty line was raised to US$1.25 in 2008.

3 OPPs are defined as all categories of health-related expenses incurred at the time the household receives the health service, including doctor's consultation fees, purchases of medication and hospital bills and spending on alternative and/or traditional medicine. Within this category, user fees comprise the fees charged by public health providers for service provision, in other words the OPPs encountered at any public health care facilities.

Figure 2. **Percentage of women citing need for money to receive treatment as reason for not utilising health facilities**



Source: DHS surveys.

Social protection implications of health financing

Health financing mechanisms have profound impacts on the functioning of the health sector, including the equity of the financial burden of health care, and thus on access to services by the poorest. This section reviews the existing mechanisms in West and Central Africa and assesses alternative social protection approaches.

In order to address health financing gaps and improve service access and coverage, developing countries are turning to 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, mandatory social health insurance (SHI) and private non-profit health insurance schemes, as well as mutual and community-based non-profit health insurance. The insurance-based mechanisms involve the pooling of risks among persons covered – and in some cases include heavy government subsidies and/or cross-subsidisation between the rich and the poor. Currently, most countries in West and Central Africa have medium 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.

User fees: increasing financial vulnerability

User fees became widespread in West and Central Africa following the 1987 Bamako Initiative and as a result of the significant decrease in health sector public expenditure at the time of structural adjustment[4]. As of 2004, 20 out of 24 African countries surveyed by Save the Children were found to have user fees in place at the primary level of care[5].

Although the Bamako Initiative sought to introduce an element of community participation and management into user fee schemes, their adverse equity impacts have now been well documented. 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. It has been 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[6]. Conversely, the removal of user fees has demonstrated the potential for substantial positive impacts on health care outcomes, as long as it is well prepared and accompanied by adequate financing and human resources to meet the consequent surge in demand (see Box 2).

4 L. Gilson and D. McIntyre (2005), 'Removing User Fees for Primary Care in Africa: The Need for Careful Action', British Medical Journal, 331: 762–5.
5 Save the Children UK (2005), 'An Unnecessary Evil? User Fees for Health Care in Low-income Countries'. London: Save the Children.
6 G. Huber, J. Hohmann and K. Reingard (2003), Mutual Health Insurance (MHO): Five Years' Experience in West Africa: Concerns, Controversies and Proposed Solutions. Bonn: GTZ.

Box 2. **Impact and challenges of user fee removal**

There is a growing evidence base on the positive impacts of user fee removal, although there are a number of prerequisites for success. Recent Médecins sans Frontières interventions in Burundi allowing for a shift from supposedly 'affordable' low flat-fee rates to a new policy ensuring free care for pregnant women and children under five resulted in a doubling of the number of deliveries in MSF targeted health centres and a 40% increase in under fives' service utilisation. Further recent research by the London School of Hygiene and Tropical Medicine and Save the Children has 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.

Successful user fee removal requires not only the replacement of the relatively small amounts of income lost (typically not more than 5-10% of the total resources of government health services and sometimes much less), but also an increase in resources to meet the increase in demand resulting from the lowering of access barriers. Reforms in public financial management mechanisms are also often required to ensure that adequate resources reach front-line service delivery facilities, as user fee income has often been retained at facility level and been a significant source of revenue for paying local recurrent costs. Adequate health staff and medical supplies also have to be in place to meet the increase in demand. If these measures are not taken, user fee abolition can simply lead to the undermining of service quality, which is already low in many West and Central African countries.

Sources: MSF, 2008; James et al., 2006.

Social health insurance

Given the negative effects of user fee policies on access to health services, SHI constitutes one of several social protection mechanisms to make health care affordable. SHI finances health care through the pooling of health risks among those insured and is financed by a combination of contributions from members, their employers and the government.

While SHI has been widely promoted as a promising health financing mechanism for the developing world[7], a significant disadvantage is the difficulty of covering populations with unreliable or limited incomes, or working in the informal sector and subsistence agriculture. In West and Central Africa, this presents a substantial obstacle, as only about one-tenth of the working population is employed in the formal sector. High poverty levels in West and Central Africa make 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. SHI has therefore been very limited in this region.

However, Ghana has launched a National Health Insurance Scheme, which combines elements of SHI with mutual health insurance, and has used special tax measures to finance substantial subsidies and exemptions (see Box 3). This scheme had succeeded in extending health insurance coverage to 45% of the Ghanaian population by the end of 2008, a level of coverage unprecedented in the region.

Community-based mutual health organisations

Given the problematic nature of covering the informal sector, rural and poor populations with SHI, MHOs have been developed to serve as a complementary means of providing social protection against health risks. These voluntary, private non-profit insurance schemes are usually self-managed, with members participating directly in their administration. While MHOs still rely on private contributions, they aim to counteract some of the negative effects of user fees by channelling expenditure through a predictable prepayment mechanism.

MHOs have been promoted with much optimism. Yet the limitations surrounding their operations raise questions

[7] A. Wagstaff (2007), Social Health Insurance Re-examined. Policy Research Working Paper 4111. Washington, DC: World Bank.

about their potential role in ensuring access to essential health care for vulnerable populations. Not only do they contribute only about 25% of total local health service costs[8], but, given the limited service coverage of these schemes, members often continue to contribute OPPs to meet up to 40% of their health costs in addition to premium payments[9]. Investment in training can also be highly cost inefficient, as training individuals in management for such small coverage rates transfers a high cost to the schemes. MHO coverage rates are very low – less than 1% in the majority of countries – with the exceptions of Mali and Senegal at 3.92% and 2.46%, 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 and pro-child results they achieve[10].

Box 3. **Ghana National Health Insurance Scheme**

The Government of Ghana established the National Health Insurance Scheme (NHIS) in 2003 with the aim of providing equitable health insurance for all. A distinctive feature is that the scheme is financed mainly from taxed-based transfers (from a 2.5% addition to VAT and import duties known as the National Health Insurance Levy, as well as transfers from the Ministry of Health). Formal sector employees also contribute via their social security deductions, while those in the informal sector contribute through local mutual health insurance schemes.

The tax-based fiscal transfers subsidise the scheme, making it possible to provide payment exemptions for the children of registered NHIS members, pregnant and lactating women, formal sector pensioners and the 'indigent'.

In just four years, by the end of 2008, 54% of the population was registered with the NHIS. Despite this progress, equity problems remain. An analysis of coverage rates demonstrates that fewer people from lower wealth quintiles are enrolling owing to the cost of registration and premium payments. There have also been reports of second-class treatment of patients using their NHIS cards rather than cash to access services in health facilities.

In May 2008, the government announced another exemption, of particular importance for children. It pledged to enrol in the NHIS all children under 18, regardless of their parents' registration status. This was a welcome development, given the high child mortality rates in Ghana, but the exemption has not yet been put into effect.

Conclusions and policy implications

Given the strengths and weaknesses of alternative health financing mechanisms in the West and Central African context, there are six key policy implications:

1. Prioritise user fee abolition in maternal and child health services. There is a 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, it need not compromise service quality. Nonetheless, given the limited fiscal space in all but a handful of oil-rich countries in West and Central Africa, the removal of user fees for all health services, although desirable, is unlikely in the poorest countries in the short term. 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. From this perspective, the removal of user fees for essential maternal and child health services should be seen as among the highest priorities, given very high child and maternal mortality rates 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.

2. Address the prerequisites for the successful removal of user fees. The successful abolition of user fees, which increases demand for health services, hinges on careful planning and management on the supply side. Prerequisites for a smooth transition away from user fees include: i) strong leadership to initiate and sustain policy changes; ii) an analysis of the existing role of

8 B. Ekman (2004), 'Community-based Health Insurance in Low-income Countries: A Systematic Review of the Evidence', Health, Policy and Planning, 19 (5): 249–70.

9 E. Berkhout and H. Oostingh (2008), Health Insurance in Low-income Countries: Where is the Evidence that it Works? Joint NGO Briefing Paper. Oxford: Oxfam.

10 O. Ouattara and W. Soors (2007), 'Social Health Insurance in French-Speaking Sub-Saharan Africa: Situation and Current Reform', in G. Huber, J. Hohmann and K. Reingard (2003), Mutual Health Insurance (MHO): Five Years' Experience in West Africa: Concerns, Controversies and Proposed Solutions. Bonn: GTZ.

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; iii) supply-side investments in health services to meet increased demand and improve the quality and geographical coverage of services; iv) an increase in the health budget to compensate for the loss in revenue from user fees as well as to meet increased demand; v) dialogue with health sector staff and, where necessary, improvements in staffing; vi) buffer funds and pre-stocking of drugs to ensure availability; vii) strengthening of public financial management systems so that funds reach health centres in a timely and predictable fashion; viii) improvements in health sector efficiency and 'value for money' through a stronger focus on preventative and primary health care; and ix) monitoring of the policy change, beginning with an accurate baseline assessment.

3. Strengthen budget management and the quality of health expenditure. In order to maximise scarce resources, 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. 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.

4. Understand the potential and limitations of SHI and MHOs. SHI and MHOs offer important complementary strategies in health financing, but the equity limitations of these systems must be recognised. 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 and MHO schemes in West and Central Africa are formidable, particularly in reaching the most vulnerable. It should therefore 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. This is in practice the approach that has been taken in Ghana, where major exemptions have been introduced for free access to services in tandem with insurance mechanisms.

5. Build political will and good governance. Progress in promoting more equitable health care access will depend strongly on political will. While fiscal space shapes the scope and timeframe for the removal of user fees, 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. This kind of commitment is most likely in countries with an open political culture and competitive electoral politics.

6. Build on international momentum. National governments can capitalise on the new window of opportunity created by increasing international interest in social protection in developing country contexts, as highlighted by the African Union's adoption of a Social Policy Framework in 2008 and the G20's commitment in April 2009 to strengthen funding for social protection in developing countries as part of the response to the impact of the global crisis on the poor. This should include a strong focus on assisting governments in developing countries to strengthen social protection for health in particular, in order to ensure equitable access to essential health services by the poor and accelerate progress towards the health-related MDGs.

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