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REPORT OF ROUND TABLE 3

Health financing

INTRODUCTION

1. The round table meeting on health financing was held on 11 October 2002 under the Chairmanship and Vice-chairmanship of Mr Maina Touka Sahawaye, Minister of Health of Chad, and Prof. Julius Meme, Head of the Kenyan delegation, respectively. A total of eighty delegates participated in the meeting.

DISCUSSION

2. After an introductory statement on the subject by Dr Rufaro Chatora, Director, Health Systems and Services Division, WHO Regional Office, the Chairman outlined the context and framework for the discussion on health financing in Africa and the major challenges that Africa was facing, all of which made the subject a highly topical issue. After the Chairman's presentation, the facilitators of the round table provided clarifications on the information paper that had been distributed to participants and particularly on the following questions:

(a) How can reliable data on health financing be produced in the African Region?
(b) Is there a minimum amount to be spent on health each year, by each country, in the Region?
(c) How can Member States ensure equitable health financing and at the same time continue to increase the mobilization of additional resources?
(d) How can exemption mechanisms be mapped out to enhance access of the poor to health services?
(e) How can direct out-of-pocket payments be minimized and prepayment schemes optimized?
(f) How can the efficiency and effectiveness of donor funding be enhanced?
(g) What are the institutional changes embarked upon by countries to improve equity and effectiveness in the use of existing funds?

3. In response to these questions, delegates recounted their country experiences and the results that they had achieved in recent years.

4. Many of the country delegates stressed the inadequacy of health financing data and the limited reliability of data provided by international agencies. Some countries had prepared or were preparing their national health accounts while others had reviewed their public expenditures. The data gathered were used to assist the process of decision making.

5. On the question of the minimum amount that needed to be spent on health, delegates felt that it depended on the specific situation of each country and that account should be taken, in that respect, of parameters such as the disease burden, the existence of potential resources and as well as resource mobilization capacity.

6. As regards the mechanisms for exemption of the poor, delegates expressed the conviction that establishing a free health care system would necessarily imply cost-bearing by a third party. Furthermore, they deplored the difficulty in determining who is poor so that interventions would be better targeted. The reported experiences included the setting up of schemes by local councils for financing health care for the very poor, as well as the establishment of exemptions systems that were specific not only to certain diseases but also to certain services provided for identified vulnerable groups.

7. Concerning the maximization of the use of funds provided by donors and funding agencies of the health sector, interesting experiences were reported such as the establishment of common funds in the context of sector-wide approaches. Unfortunately, in many cases, health development partners were facing difficulties in fitting their interventions within national priorities and in meeting national policy requirements. Delegates also raised the issue of donations of inappropriate equipment that demanded very huge recurrent expenditures.

8. On the question of establishing schemes for reducing direct out-of pocket payments, participants in the round table said they were worried about the effects of cost recovery systems as they tended to reduce the use of health services. However, in many countries, it was still a means of complementing or supplementing public resources which had kept dwindling in recent years.

9. Participants also expressed concern about the establishment of social insurance or social security schemes and the scaling up of experiments on voluntary health insurance schemes. They said they were aware of the complex nature of this task and requested support to enable countries to undertake the needed reforms.

10. As regards the enhancement of equity and effectiveness in the allocation and use of financial resources, delegates expressed worries about delays in the provision State budgets and the huge gaps noted between funds budgeted and fund actually allocated. They stressed the need to better target expenditures intended for vulnerable groups and to maximize the use of funds by opting for highly cost-effective interventions accessible to people living in peripheral areas. As regards these approaches, the delegates suggested that contractual arrangements be made with the private sector and NGOs for the provision of certain services.

LESSONS LEARNED

11. In most of the countries, the main provider of health financing was the State drawing upon taxes and levies.

12. Community involvement in health financing which was promoted under the Bamako Initiative had helped mobilize substantial resources for health financing. However, widespread poverty was hampering the possibility of contribution by communities, hence the need to review and adapt community participation in health financing.

13. The countries needed to have better understanding of financial flows for purposes of budget planning and rational use of funds.

14. Widespread poverty and the increase in prevalence of diseases such as HIV/AIDS were major factors affecting the level of financing.

15. Although several health initiatives had been promoted in recent years, they had not been sufficiently used notwithstanding their great potential to help finance health actions.

RECOMMENDATIONS

The Round Table recommended

16. *To Member States:*

(a) To give special attention to the production of health financing data possibly by using multidisciplinary teams.

(b) To draw maximum benefit from new initiatives such as HIPC, GAVI, Global Fund, etc, and to mobilize the maximum of resources to finance actions that benefited people in greatest need.

(c) To consider the use of common baskets in the context of sector-wide approaches as a means of improving health financing, while at the same time ensuring that existing national capacities were mobilized for vulnerable groups and peripheral health services (health districts).

(d) To establish health financing monitoring mechanisms that had appropriate indicators such as national health accounts.

(e) To carry out studies for use in categorizing the poor and the very poor so that interventions would be better targeted.

17. *To WHO:*

(a) To provide support to facilitate the process of designing implementing and evaluating social insurance and social security systems and develop appropriate guides;

(b) To organize, as soon as possible, a meeting bringing together financing experts so that they would identify the approaches most suited to the context of countries of the Region. The World Bank, International Monetary Fund and African Development Bank should send representatives to attend that meeting.