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HEALTH FINANCING: A STRATEGY FOR THE AFRICAN REGION

Report of the Regional Director

EXECUTIVE SUMMARY

1. The manner in which a health system is financed affects its stewardship, input creation, service provision and achievement of goals such as good health, responsiveness to people's non-medical expectations (short waiting times, respect for dignity, cleanliness of physical facilities, quality meals) and fair financial contributions, so that individuals are not exposed to great financial risk of impoverishment.

2. Countries of the Region are confronted with a number of key challenges including low investment in health; low economic growth rates; dearth of comprehensive health financing policies and strategic plans; extensive out-of-pocket payments; limited financial access to health services; limited coverage by health insurance; lack of social safety nets to protect the poor; inefficient resource use; ineffective aid; and weak mechanisms for coordinating partner support in the health sector.

3. In order to reach the health-related Millennium Development Goals (MDGs) and achieve national health development objectives, national health systems in the African Region urgently need more money; greater equity in health services financing and accessibility; efficient use of health resources; and expanded coverage of health services, especially those targeting the poor. Countries are urged to institutionalize national health accounts to facilitate financial planning, monitoring and evaluation.

4. The aim of this strategy is to foster development of equitable, efficient and sustainable national health financing to achieve the health-related MDGs and other national health goals.

5. The Regional Committee is invited to consider this strategy and the attached resolution and adopt the recommended actions.

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INTRODUCTION

1. Health financing is one of the four functions of health systems. Health financing refers to the collection of funds from various sources (e.g. government, households, businesses, donors), pooling them to share financial risks across larger population groups, and using them to pay for services from public and private health-care providers.[1] The objectives of health financing are to make funding available, ensure choice and purchase of cost-effective interventions, give appropriate financial incentives to providers, and ensure that all individuals have access to effective health services.[2]

2. The performance of a health financing system depends among others on its capacity for equitable and efficient revenue generation; the extent to which financial risk is spread between the healthy and the sick, and the rich and the poor; extent to which the poor are subsidized; efficient purchasing of health inputs and services; and the prevailing macroeconomic situation, e.g. economic growth, unemployment, size of the informal sector compared to the formal sector, governance, etc.

3. There is ample evidence that the manner in which a health system is financed affects both the performance of its functions and the achievement of its goals.[3] The magnitude, efficiency and equity in health financing determine the pace at which individual countries are able to achieve national health development objectives and the Millennium Development Goals (MDGs).

4. Cognizant of the important role of financing in health development, African Heads of State, in 2001, committed themselves to taking all necessary measures to ensure that resources are made available and are efficiently utilized. In addition, they agreed to allocate at least 15% of their national annual budgets to improving the health sector;[4] this commitment was reaffirmed in the Maputo Declaration.[5] Recent resolutions[6] of the WHO Regional Committee for Africa urge Member States to honour the pledge made by Heads of State in Abuja.

5. In May 2005, the Fifty-eighth World Health Assembly adopted a resolution[7] that urges Member States to ensure that health financing systems include a method for prepayment of financial contributions for health care. This is aimed at sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of care-seeking individuals. The resolution also encourages planned transition to universal coverage and ensured, managed and organized external funds for specific health programmes or activities which contribute to the development of sustainable financing mechanisms for the health system as a whole.

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[1] WHO, *The world health report 2000: Health systems: improving performance*, Geneva, World Health Organization, 2000.

[2] Carrin G, James C, Social health insurance: Key factors affecting the transition towards universal coverage, *International Social Security Review*, 58(1): 45–64, 2005.

[3] Preker AS, Carrin G (eds), *Health financing for poor people: Resource mobilization and risk sharing*, Washington, D.C., The World Bank, 2004.

[4] OAU, *Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases*, Addis Ababa, Organisation of African Unity, 2001.

[5] AU, *Maputo declaration on HIV/AIDS, tuberculosis, malaria and other related infectious diseases*, Addis Ababa, African Union, 2003.

[6] AFR/RC52/R4, Poverty and health: A strategy for the African Region. In: *Fifty-second Session of the WHO Regional Committee for Africa, Harare, Zimbabwe, 8–12 October 2002, Final Report*, Brazzaville, World Health Organization, Regional Office for Africa, 2002 (AFR/RC52/19), pp. 11–13. AFR/RC53/R1, Macroeconomics and health: The way forward in the African Region. In: *Fifty-third Session of the WHO Regional Committee for Africa, Johannesburg, South Africa, 1–5 September 2003, Final Report*, Brazzaville, World Health Organization, Regional Office for Africa, 2003 (AFR/RC53/18), pp. 11–12.

[7] Resolution WHA58.33, Sustainable health financing, universal coverage and social health insurance, Geneva, World Health Organization, 2005 (WHA58/2005/REC/1).

6. This document briefly reviews the state of health financing in the Region; proposes priority interventions that could be implemented to strengthen national health financing systems; outlines roles and responsibilities for countries WHO and partners; and proposes a brief monitoring and evaluation framework. The proposed interventions should be urgently implemented to ensure the achievement of MDGs and other national health goals. This strategy document is consistent with the spirit of the Health-for-all Policy for the 21st Century in the African Region.[8]

SITUATION ANALYSIS

7. As of 2002, out of 46 countries in the WHO African Region, 15 countries spent less than 4.5% of their gross domestic product on health; in 29 countries, government expenditure per person per year was less than US$ 10 (see *Figure 1*); and 43 countries spent less than 15% of their national annual budget on health (see *Figure 2*). Thus, most countries are far from reaching the 15% target set by African Heads of State in 2001. In addition, 31 countries failed to meet the WHO Commission for Macroeconomics and Health (CMH) recommendation[9] of US$ 34 per capita expenditure for health (see *Figure 3*) needed to buy an essential package of health services. Indeed, estimates based on 2002 data show that even if all countries met the Abuja target, more than half of them would not have made much progress towards attaining the CMH and MDG targets.[10]

8. In 24 countries, 50% of the total health expenditure came from government sources; in 17 countries, 25% of total health expenditure came from external sources. Thus, the international community makes an important contribution to health financing in the Region. However, the recurrent cost implications of donor-supported capital investments are often not taken into account, which impacts negatively on their sustainability.

9. Private spending from households and businesses constituted over 40% of the total health expenditure in 31 countries. The bulk of private spending is from direct out-of-pocket household expenditures (see *Figure 4*), i.e. including the Bamako Initiative cost recovery schemes.[11,12] Prepaid health financing mechanisms (including mutual health insurance schemes and community-based health insurance schemes[13]) cover only a small proportion of populations in the Region. Prepaid financing mechanisms account for more than 72% of the private health expenditure in two countries. However, even in those countries, the proportion of the population that is covered in prepaid health schemes is relatively small.

10. Health personnel employed by governments and NGOs are often paid fixed salaries unrelated to workload. Financing of public services in most countries is done through inflation-adjusted historical budgets and transfer of funds from one government department to another with little strategy behind allocation decisions.[14]

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[8] WHO, Health-for-all policy for the 21st century in the African Region: Agenda 2020, Harare, World Health Organization, Regional Office for Africa, 2002.

[9] WHO, *Macroeconomics and health: Investing in health for economic development*, Geneva, World Health Organization, 2001.

[10] Atim C, Financial factors affecting slow progress in reaching agreed targets on HIV/AIDS, TB and Malaria in Africa, London, DFID Health Resource Centre, 2006.

[11] WHO, Report on the review of the implementation of the Bamako Initiative in Africa, Harare, World Health Organization, Regional Office for Africa, 1999.

[12] Mcpake B, Hanson K, Mills A, Community financing of health care in Africa: an evaluation of the Bamako Initiative, *Social Science and Medicine*. 36(11): 1383-1395, 1993.

[13] Ekman B, Community-based health insurance in low-income countries: a systematic review of the evidence, *Health Policy and Planning*,19(5): 249-270, 2004,

[14] Preker AS, Managing scarcity through strategic purchasing of health care. In: Preker AS, Langenbrunner JC (eds), *Spending wisely: Buying health services for the poor*, Washington, D.C., The World Bank, 2005, pp. 23–60.

11. Some progress has been made during the past few years in mobilizing more money for the health sector and addressing a number of equity and efficiency issues, including revenue pooling and risk management. There is also some understanding of the key issues related to resource allocation and purchasing of health services.

Challenges

12. The challenges related to efficient and equitable revenue collection include low investment in health; heavy reliance on out-of-pocket expenditures; low household capacity to pay due to widespread poverty; high unemployment; low economic growth; limited fiscal (budgetary) space; double burden of communicable and non-communicable diseases; high but declining population growth rates; erratic disbursement of donor funds; weak mechanisms for coordinating health partnerships.

13. Challenges in revenue pooling and risk management persist. For example, direct out-of-pocket household spending does not go through pooling mechanisms. Countries tend to rely only on one or two of the four risk management mechanisms (i.e. state-funded health care systems, social health insurance, community-based health insurance, and voluntary health insurance), which may not be adequate to meet all the health financing objectives. Limited reinsurance options make insurance schemes vulnerable to bankruptcy.[15] Risk management is also adversely affected by weak management capacities in the public sector, low quality of public health services, restrictive public benefit packages, weak cross-subsidization, and underpaid public health-care workers.

14. There are a number of challenges related to resource allocation and purchasing of health services. Many governments still provide all their health services through the public sector, despite the presence and popularity of NGO and private sector facilities. Donor funds are often earmarked for priority diseases and thus cannot be used to strengthen health systems. Some subsidies to health-care providers are benefiting the rich rather than the poor. Current salaries in the health-care sector in most countries in the Region do not create performance incentives, and payment mechanisms in public health institutions discourage maximum output and cost containment. Health facilities continue to make inefficient use of resources.[16]

Opportunities

15. Countries could take advantage of various opportunities. These include the impetus provided by the MDGs; commitment by African Heads of State to significantly increase health spending; commitment by the donor community (e.g. International Financing Facility, G8, European Union, Organisation for Economic Co-operation and Development) to significantly expand aid instruments (e.g. Global Fund to Fight AIDS, Tuberculosis and Malaria; Global Alliance for Vaccines and Immunization; highly-indebted poor country initiative) and increase aid effectiveness;[17] increased willingness of partners in countries to participate in sector-wide approaches (SWAps). Other opportunities are the increased determination of the African Union, in the context of the New Partnership for Africa's Development, to promote governance, transparency and accountability in the region; the increased evidence and awareness of the pivotal role of health in development; inclusion of a health component in national poverty reduction

[15] Dror DM, Preker AS (eds), *Social reinsurance: A new approach to sustainable community health financing*, Washington, D.C., The World Bank and the International Labour Organization, 2002.

[16] Kirigia JM, Emrouznejad A, Sambo LG, Measurement of technical efficiency of public hospitals in Kenya: Using data envelopment analysis, *Journal of Medical Systems*, 26 (1): 29–45, 2002; Asbu EZ, McIntyre D, Addison T, Hospital efficiency and productivity in three provinces of South Africa, *South African Journal of Economics*, 69 (2): 336–358, 2001.

[17] WHO, *Paris declaration on aid effectiveness: Ownership, harmonization, alignment, results and mutual accountability*, Geneva, World Health Organization, High-Level Forum, 2005.

strategies (including Poverty Reduction Strategy Papers [PRSPs]) and the Medium-Term Expenditure Frameworks (MTEF); existence of potential for increasing availability of resources through efficiency improvements; and increased knowledge-sharing in health financing.[18]

THE REGIONAL STRATEGY

Objectives

16. The general objective of this strategy is to foster development of equitable, efficient and sustainable national health financing to achieve the health MDGs and other national health goals.

17. The specific objectives of this strategy are:

(a) to secure a level of funding needed to achieve desired health goals and objectives in a sustainable manner;

(b) to ensure equitable financial access to quality health services;

(c) to ensure that people are protected from financial catastrophe and impoverishment as a result of using health services;

(d) to ensure efficiency in the allocation and use of health sector resources.

Guiding principles

18. The choice and implementation of priority health financing interventions will be guided by the following principles:

(a) ***Country ownership*** must ensure that all health financing processes are led and owned by countries.

(b) Provision of health-care services should aim at fostering ***equity in access*** among all population groups; with special attention to vulnerable groups (e.g. the poor, women and children). ***Equity in financing*** must ensure that contributions to the funding of the health system are made according to ability to pay and long before health care is needed in order to protect families from impoverishment.

(c) ***Efficiency*** must ensure that maximum health benefits are derived from scarce available resources, with particular attention to both immediate operating expenditures and the long-term recurrent cost implications of major human resources and capital investments.

(d) ***Transparency*** in a high degree must be seen in all financial procedures and mechanisms and in actual spending.

(e) ***Risk sharing*** mechanisms must be expanded to increase the proportion of the health budget that is pooled and reduce the proportion that comes as out-of-pocket payments.

(f) ***Evidence-based decision-making*** should be practised on a day-to-day basis, align with health financing reforms, rely on best practices, and be economically viable.

(g) ***Partnerships*** should involve all health-related sectors, various levels of government, the private sector, international development organizations, communities and civil society.

[18] Preker AS, Langenbrunner JC (eds), *Spending wisely: Buying health services for the poor*, Washington, D.C., The World Bank, 2005. More health financing information can be found at: *http://www.who.int/health_financing; www.who.int/evidence/cea;* http://www.who.int/contracting; *http://www.worldbank.org*.

Priority interventions

19. The proposed priority interventions are centred around **strengthening** the three functions of health financing: revenue collection; revenue pooling and risk management; and resource allocation and purchasing.

20. This strengthening of functions may require training and hiring new categories of staff with skills in actuarial analysis; health economics; financial and asset management; information technology; insurance management and prepayment programmes; and planning, monitoring and evaluation.

Revenue collection

21. *Strengthening of financing mechanisms.* In the long term, the aim should be to develop prepaid mechanisms such as social health insurance, tax-based financing (including earmarked taxes on alcohol and tobacco) of health care, or some mix of prepayment mechanisms (with maximum community participation) to achieve the universal coverage goal. During the transition to universal coverage, countries are likely to use a combination of mechanisms to effectively manage financial risk. These include subsidies (taxes and donations), compulsory insurance (e.g. social health insurance coverage for specific groups), voluntary insurance (community-, cooperative- and enterprise-based), reinsurance, savings and limited direct spending.

22. *Honouring of past regional commitments.* Political action is now needed to ensure that African Heads of State honour their commitment to allocate 15% of their national budgets to health. This requires ambitious but realistic increases in allocations to the health sector under each country's Medium-Term Expenditure Framework. In addition, budgets approved through appropriate government processes should be fully executed.

23. *Monitoring multi-donor budgetary support.* There is a need to closely monitor multi-donor budgetary support to ensure that the shift from sectoral to general budgetary support does not decrease donor contribution to the health sector.

24. *Removing or reducing out-of-pocket payments.* Countries that choose to remove or reduce out-of-pocket payments must ensure that an alternative source of financing is available to continue providing high quality services.[19]

25. *Improving efficiency in revenue collection.* Revenue collection mechanisms should avoid wasting scarce resources through high administrative costs and maximize resources from both the formal and informal sectors.

Revenue pooling

26. *Developing prepayment systems.* Countries should introduce or expand prepayment systems, where funds are collected through taxes and/or insurance contributions. Such systems allow people to access services when in need and protect the poor from financial catastrophe by reducing out-of-pocket spending. When designing such systems, policy-makers will need to involve all other stakeholders.[20]

[19] Gilson L, McIntyre D, Removing user fees for primary care in Africa: The need for careful action, *British Medical Journal*, 331: 762–765, 2005.

[20] WHO, Designing health financing systems to reduce catastrophic health expenditure, Technical Briefs for Policy-Makers, Number 2, Geneva, World Health Organization, 2005 (WHO/EIP/HSF/PB/05.02).

27. *Establishing new health financing agencies.* Because of the complex links between risk management and both revenue collection and purchasing of health services, many countries may choose to establish new health financing agencies to ensure proper coordination of the three health financing functions. The governance arrangements of the new health financing agencies should include representation from all relevant stakeholders. Whatever institutional arrangements are made, issues relating to quality of care, range of benefits, provider payment mechanisms and staff remuneration should be addressed in a manner that supports revenue pooling and risk management.

28. *Strengthening safety nets to protect the poor*. The effectiveness of exemption mechanisms could be enhanced through increased community awareness of the exemption policy; issuance of exemption cards to poor people long before the need for health care arises; decreased direct (including transport) and indirect costs to poor people; strengthened administrative capacity for monitoring, supervising, interpreting and applying exemptions; compensation to health facilities for revenue lost through granting of exemptions; increased funding to health facilities where the poor are concentrated; and strengthened political support for exemptions.[21] In addition, when almost entire communities are living under the poverty line, governments will need to provide subsidized services; where community-based health insurance exists, government involvement will still be needed in terms of subsidies and re-insurance mechanisms.

Resource allocation and purchasing

29. *Financing the strengthening of health systems.* Existing and additional funding from both national and international sources for the health sector needs to focus on both overall systems strengthening as well as specific disease programmes.

30. *Using priority disease resources to strengthen health systems.* In order to ensure that priority disease programmes are implemented effectively, there is an urgent need to strengthen the underlying health system, including management capacity and integrated care (e.g. primary care and Integrated Management of Childhood Illness).

31. *Contracting the private sector and nongovernmental organizations.* Significant resources exist through NGOs and the private sector in the African Region. These resources can be harnessed to meet public policy objectives through contracts with the public sector, but many countries need to create the necessary enabling environment with suitable policy and legislative frameworks. Governments should be encouraged to contract services to nongovernmental and private providers especially in areas where they have a comparative advantage and ensure mechanisms are in place to provide access to high-quality health services to the poor.

32. *Incorporating demand-side targeting mechanisms.* Some countries have tried demand-side targeting mechanisms such as conditional cash transfers, vouchers and subsidized insurance premiums. Where relevant and feasible, these mechanisms should be complementary to underlying broader financing mechanisms. These demand-side mechanisms could be used more widely throughout the Region to lower the financial barriers to health-care service access.

33. *Reforming provider payment mechanisms.* Provider payment mechanisms can be used to create incentives for greater productivity, efficiency and equity.[22] Countries need to ensure that

[21] Masiye F, Analysis of health care exemption policy in Zambia: Key issues and lessons. In: Audibert M, Mathonnat J, de Roodenbeke E (eds), *Le financement de la sante dans les pays d'Afrique et d'Asie a faible revenu*, Paris, Karthala, pp. 139–159, 2003.

[22] Mills AJ and Ranson K, The design of health systems. In: Merson MH, Black RE, Mills AJ (eds), *International public health: Diseases, programs, systems, and policies*, Sudbury, Mass., Jones and Bartlet Publishing, 2005, pp. 515-558.

remunerations, promotions and contracts for health personnel are directly linked to performance. Significant payment reforms often require parallel civil service reforms in order to achieve the desired policy goal of maximizing health benefits from available resources.[23]

34. *Other interventions exist for reducing resource wastage*. They include allocating resources on the basis of assessed need for health services; improving input procurement (e.g. through competitive tendering), distribution systems and prescribing practices; perfecting financial management systems; and strengthening the costing, budgeting, planning, monitoring and evaluation capacities at all levels of the health system. Equally beneficial are improved referral systems, institutionalized equity and efficiency monitoring, health sector coordination mechanisms (e.g. SWAps) and an essential service package based on priority setting and choice of interventions agreed by society.

ROLES AND RESPONSIBILITIES

35. Securing increased financial resources at the country level in an equitable and efficient manner will be critical to meeting the regional objectives of accelerating progress towards reaching the MDGs and protecting populations from the impoverishing effects of illness. Because the health financing strategy will play a critical role in meeting these objectives, adequate human and financial resources are necessary for its successful implementation.

Countries

36. National political will, commitment and support are crucial for successful implementation of this strategy. In addition, the technical leadership of the ministry of health is essential for its implementation. Therefore, each country will:

(a) strengthen the leadership capacity of the ministry of health and its collaboration with the ministry of finance, ministry of labour and other relevant ministries and stakeholders;

(b) strengthen or develop a comprehensive health financing policy and a strategic plan which become essential parts of the national health policy and health development plan; in addition, the strategic health financing plan should have a clear roadmap for achieving the MDG targets and eventually universal coverage;

(c) incorporate its health financing strategic plan into national development frameworks such as PRSP and MTEF;

(d) secure statutory protection for minimum health financing allocations to the health sector;

(e) fulfil the commitment made by African Heads of State to allocate at least 15% of the national budget for health development;

(f) mobilize additional resources and utilize existing opportunities for funding to reach internationally agreed targets (e.g. the MDGs);

(g) strengthen health sector stewardship, oversight, transparency, accountability and mechanisms for preventing wastage of health resources;

(h) strengthen financial management skills, including competencies in accounting, auditing, actuarial science, health economics, budgeting, planning, monitoring and evaluation;

[23] WHO, *Paris declaration on aid effectiveness: Ownership, harmonization, alignment, results and mutual accountability*, Geneva, World Health Organization, High-Level Forum, 2005.

(i) strengthen the national health financing system, including financing structures, processes and management systems as well as building or strengthening prepayment systems (including health insurance) with community participation;

(j) institutionalize efficiency and equity monitoring and national and district health accounts within health information management systems;

(k) reinforce capacities for health financing (including cost) evidence generation, dissemination and utilization in decision-making.

World Health Organization and partners

37. WHO in close partnership with the World Bank, International Monetary Fund, International Labour Organization, African Development Bank, regional economic communities, European Union, bilateral donors, other relevant UN agencies (e.g. UNICEF), and other public and private donors will provide technical and financial support to countries of the Region to implement this strategy. There will be need to tailor technical and financial support to the special needs of countries. In addition, WHO and partners will:

(a) prepare regional guidelines for developing comprehensive health financing policies and strategic plans, and for monitoring and evaluating their implementation;

(b) provide technical support to Member States, as appropriate, for developing tools and methods for evaluating different practices in health financing, including collection of revenue, pooling and purchasing (or provision) of services as they move towards universal coverage;

(c) create networking and mechanisms to facilitate the continuous sharing of health financing experiences and lessons learnt;

(d) support health financing research, disseminate the research findings and use them in decision-making;

(e) ensure that the key recommendations in this regional strategy become a central part of the health contents of all relevant action plans.

38. Furthermore, WHO and partners will work with Member States to ensure that:

(a) an increasing share of national budgets is allocated to the health sector and other critical sectors in order to accelerate progress towards the health MDGs in line with the commitments reaffirmed by African Heads of State in Maputo in 2003;

(b) the funds allocated to the health and health-related sectors from international donors and other development partners should be additional to, and not a substitute for, national resources and should remain consistent with macroeconomic and growth objectives;

(c) the donation commitments made at various international forums[24] are fulfilled, including the commitments made in the Paris Declaration on aid effectiveness.[25]

MONITORING AND EVALUATION

39. The overall objective of monitoring and evaluation for the financing strategy is to assess progress towards achieving the objectives of the strategy and to aid informed decision-making.

[24] World Bank, IMF, Aid financing and aid effectiveness, Washington, D.C., Development Committee of the World Bank and International Monetary Fund, 16 September 2005 (DC2005-0020).

[25] WHO, *Paris declaration on aid effectiveness: Ownership, harmonization, alignment, results and mutual accountability*, Geneva, World Health Organization, High-Level Forum, 2005.

40. Member States, with support from WHO and other development partners, should conduct regular national health accounts exercises and develop a monitoring and evaluation framework based on:

(a) sources of financing: level, distribution and execution rates;

(b) pooling: population coverage through pooling mechanisms;

(c) spending: expenditure tracking; benefit incidence of spending.

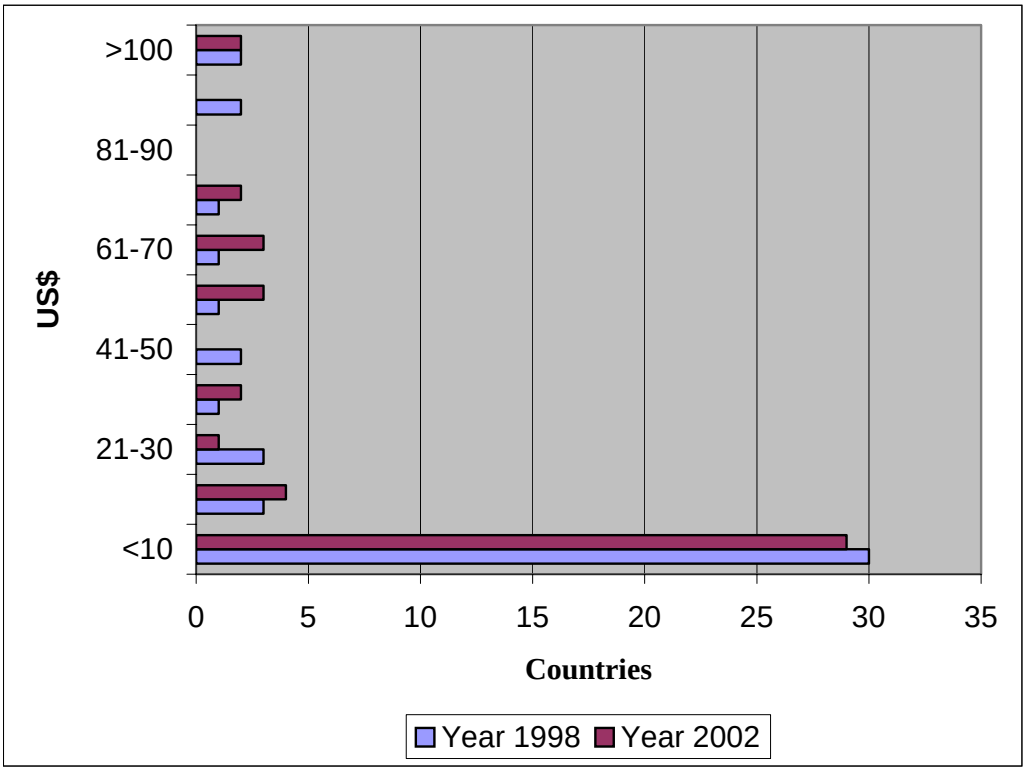
41. WHO will propose a set of global indicators for intercountry comparability. In addition, countries will agree on a set of indicators to be used for monitoring the implementation of the strategy's objectives and priority interventions. With support from WHO and other partners, countries will collect information on the implementation of the strategy continuously, and carry out intercountry evaluation of health financing performance every three years.

CONCLUSION

42. In order to achieve the health-related Millennium Development Goals, national health development objectives and expanded coverage of health services, especially those targeting the poor, countries in the African Region urgently need increased funding; greater equity in financing and access to health services; and improved efficiency in the use of health resources.

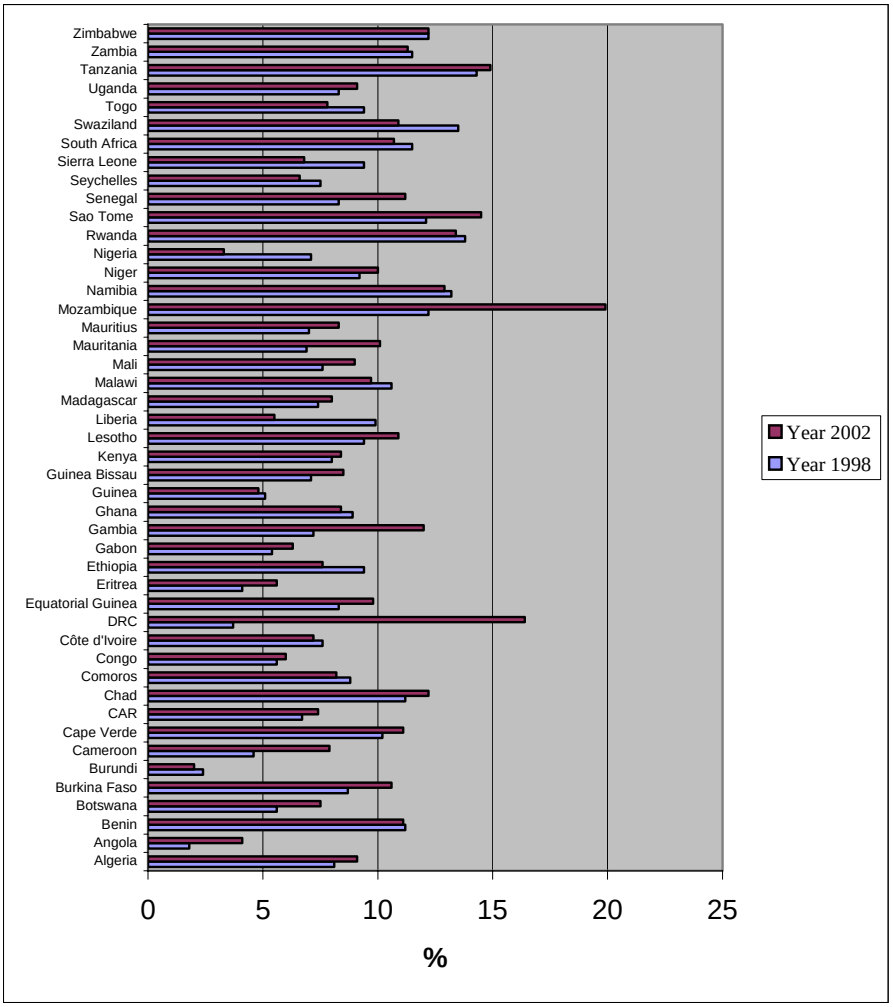
43. The WHO Regional Committee for Africa is invited to consider this strategy and adopt the proposed attached resolution.

Figure 1: Per capita government expenditure on health at average exchange rate (US$), WHO African Region



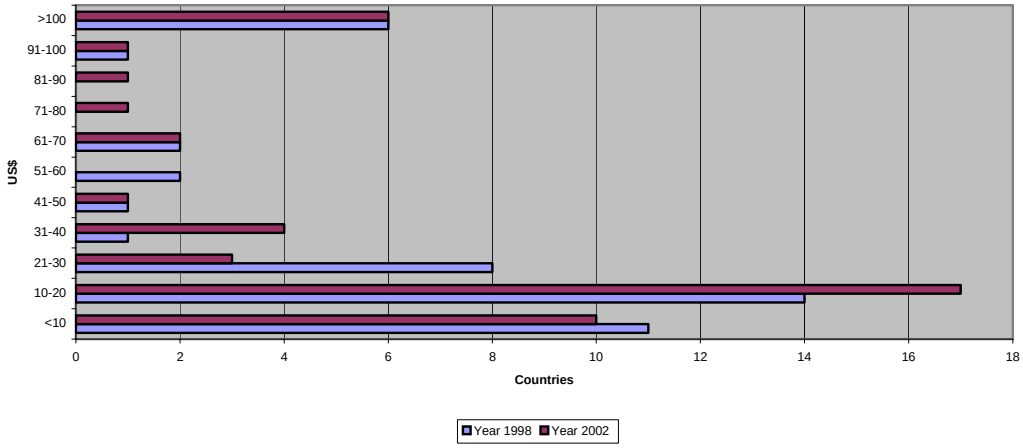
Source: Compiled from data in WHO, *The world health report 2005: Making every mother and child count*, Geneva, World Health Organization, 2005, Annex Table 5.

Figure 2: General government expenditure on health as % of total government expenditure, WHO African Region



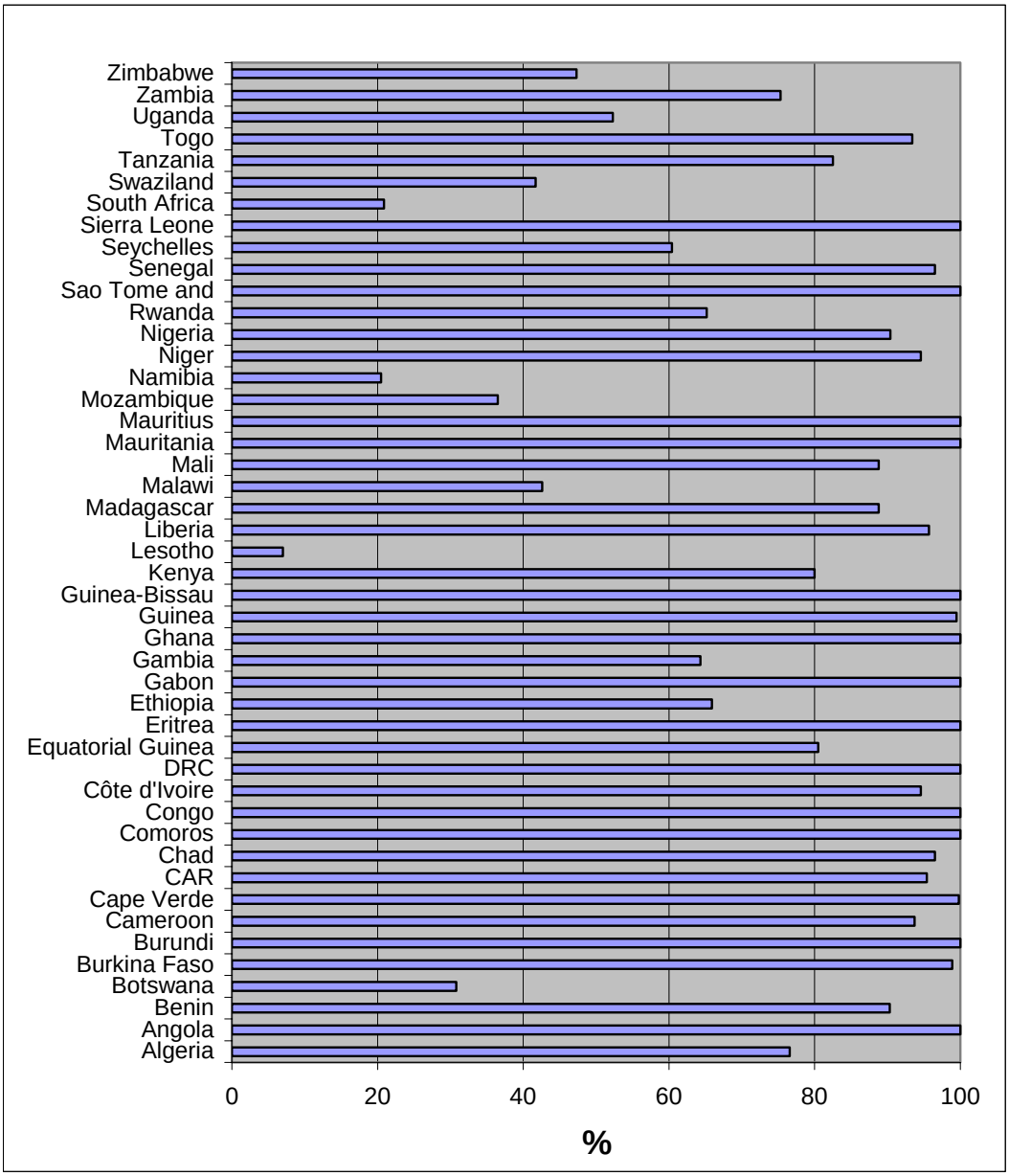
Source: Compiled from data in WHO, *The world health report 2005: Making every mother and child count*, Geneva, World Health Organization, 2005, Annex Table 5.

Figure 3: Per capita total expenditure on health at average exchange rate (US$), WHO African Region



Source: Compiled from data in WHO, *The world health report 2005: Making every mother and child count*, Geneva, World Health Organization, 2005, Annex Table 5.

Figure 4: Out-of-pocket expenditure as % of private expenditure on health, 2002, WHO African Region



Source: Compiled from data in WHO, *The world health report 2005: Making every mother and child count*, Geneva, World Health Organization, 2005, Annex Table 5.