POLICY DIALOGUES

Distributional Effects of Healthcare Spending: Lessons from Burkina Faso, Malawi, and Zambia

December 2020 – No. 19 | UE-AFD Research Facility on Inequalities

MAIN MESSAGE

The distribution of both public healthcare spending and overall healthcare spending has become increasingly egalitarian in Burkina Faso, Malawi, and Zambia, according to a new study. Nevertheless, there remain significant regional differences within countries. In addition, limitations in data availability make it difficult to assess the extent of evolving forms of inequalities.

Policy interventions are required both to tackle inequalities in spending, and to invest in improving data quality for more accurate analysis to inform decision-making.

CONTEXT & MOTIVATION

Across sub-Saharan Africa, countries are investing in reforming their health financing policies to achieve Universal Health Coverage (UHC). These actions respond to the global appeal to 'leave no one behind', which means that expansions in coverage need to embrace measures to include the most vulnerable groups, notably the very poor.

UHC-oriented health financing reforms include targeted and non-targeted user fee exemption mechanisms, performance-based financing, and state-subsidized health insurance schemes. These reforms aim to increase equity in access to quality healthcare services. In turn, equity in access rests first on an equitable distribution of resources. This means that all socio-economic groups should benefit equally from public and overall spending in the healthcare sector.

This study uses the tool of Benefit Incidence Analysis to examine the distribution of healthcare spending over time in three sub-Saharan countries.

METHODS

The study combines data on health service utilization rates by socio-economic group with data on the unit cost of healthcare services to assess the extent to which spending has been distributed in an egalitarian manner.

The study considers two kinds of spending on health: public spending (including recurrent government spending) and overall spending on health (including donor and private spending) – and two sets of services: curative services and maternal care services.

To capture changes over time, the study repeats the analysis at three points in time for each country. The study uses descriptive geo-spatial analysis to visualize disparities in both public and overall health spending across regions, provinces, or districts within a country.

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Key words Health, curative, maternal, standing, inequality

Geography Burkina Faso, Malawi, Zambia

Themes Health Financing; Health Inequality; Health Spending; Curative Healthcare; Institutional Delivery

Find out more about this project: afd.fr/en/carte-des-projets/assessing-equity-health-spending-sub-saharan-africa

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RESULTS

Lesson 1: Across countries, the distribution of both public and overall spending has become increasingly egalitarian over time. This suggests that implementation of UHC reforms, such as public subsidies and user fee removal policies, has been effective in increasing the proportion of health financing resources reaching poorer segments of society.

Lesson 2: Across countries, the distribution of public spending has tended to be more egalitarian or pro-poor than the distribution of overall spending. This highlights the importance of public spending. It is likely to reflect the fact that the analysis of overall spending includes private spending, where the least poor spend more on healthcare services. The analytical tool used in this study does not account for the regressive nature of private spending, but only for its total value across socio-economic groups.

Lesson 3: Across countries, the distribution of both public and overall spending has been more egalitarian at lower levels of care (health centers) than at higher levels (hospitals). This is likely to reflect health service utilization patterns, in which poorer segments of society use primary care near where they live, while less poor ones are able to seek secondary or tertiary care, even if this choice entails additional costs.

Lesson 4: In both Burkina Faso and Zambia, but not in Malawi, there has been greater inequality in spending on institutional delivery services than on curative services. This is indicative that user fee removal policies may be effective in increasing health service utilization and ensuring an egalitarian distribution of financial resources more for curative services than for maternal care services.

Lesson 5: Across countries, but especially in Burkina Faso and Malawi, there are remarkable differences across regions, provinces, or districts that cannot easily be explained by the reach and content of the UHC reforms being implemented. This suggests that analysis at the aggregate national level runs the risk of overshadowing internal disparities.

Lesson 6: Data acquisition is challenging in all countries, particularly in relation to data extraction from National Health Accounts (NHA). The structure of NHA data differs across countries, making it impossible to generate fully comparable analyses. For example, only in Malawi it is possible to generate analysis that captures spending on private health facilities. In all other countries, private (and donor) spending on private facilities is not traceable.

Lesson 7: Health service utilization data differ substantially across countries. First, none of the countries provide nationally representative service utilization data more recent than for 2017. This means that inevitably the results produced do not truly reflect today's reality in relation to the distributional incidence of healthcare spending.

Second, surveys follow different sampling and data collection strategies, so it is not possible to capture exactly the same information and generate exactly comparable results. In particular, only in Malawi service utilization data can be traced all the way to the district level, making truly disaggregated analysis of distributional incidence feasible.

Lesson 8: NHA data do not provide allocation values disaggregated by regions, provinces or districts. This means that heterogeneity and the matching geo-spatial analysis serve only as an initial insight into the magnitude of the disparities within a country. A more accurate analysis based on data reflecting the actual allocation of financial resources across regions, provinces, or districts is needed.

RECOMMENDATIONS

- Public investment is needed in measures to close data gaps – for example, by promoting continuous monitoring of health service utilization patterns by socio-economic status and detailed tracing of spending in the healthcare sector.
- More evidence is needed on the sources of geographical disparities across settings and measures implemented to close existing gaps.
- Policy attention is required to the inequalities in the distributional incidence (which is particularly persistent in maternal healthcare spending) to understand their sources and address them with adequate measures.

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Legal deposit 4th quarter 2020
ISSN in process | © AFD

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