

A WORLD BANK STUDY

POLICY NOTE

# Health Financing in the Republic of Gabon

Karima Saleh, Bernard F. Couttolenc,  
and Helene Barroy



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## Foreword

This is a policy note following from the book *Health Financing in the Republic of Gabon*. The book is a comprehensive assessment of health financing in the Republic of Gabon. The book reviews the health financing situation in light of the government's introduction of a national health insurance program and its commitment to achieving universal health insurance coverage in the medium term. The book provides a diagnostic of the situation in light of recent data from the demographic and health survey, updated national health accounts, and a review of public expenditures in the health sector. Additionally, it performs a benchmarking exercise to assess how Gabon performs in its health spending and health outcomes compared to countries of similar income and compared to countries in the region. A forthcoming household survey is expected to provide better information on financial protection against illness costs.

Universal health coverage has been defined as a situation where all people who need health services (prevention, promotion, treatment, rehabilitation, and palliative) receive them without undue financial hardships (World Health Report 2010). Universal health coverage consists of three interrelated components: (i) a need-based full spectrum of quality health services; (ii) financial protection from direct payments for health services when consumed; and (iii) coverage for the entire population. This book attempts to diagnose Gabon's current situation in regards to achieving universal health coverage. Gabon should be commended for its commitment to improving health indicators of the poor and the underserved.

The book shows that while the government has set an ambitious goal for itself, several challenges exist in meeting these objectives in the medium term. Resource mobilization efforts are a priority to sustain its programs financially; to prioritize resources for areas considered "value for money," to improve equity in access and delivery of health services, with particular focus on primary care, public health program, and quality of care; to increase the population's coverage under the national health insurance program, with focus on the poor and the informal sector workers; and to consider areas that would improve efficiency and reduce costs.

The book is timely, given that the government has recently produced “the Plan Social.” It provides a diagnostic of the health sector and provides key recommendations—options for the government to consider in the short to medium term.

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## Abbreviations

ARI	acute respiratory infection
CNAMGS	National Health Insurance Scheme (Caisse Nationale d'Assurance Maladie et de Garantie Sociale)
CNSS	Social Security Scheme (Caisse Nationale de Sécurité Sociale)
COSP	Monitoring Unit for Public Health, Ministry of Health (Cellule d'Observation de la Santé Publique)
DRG	diagnosis-related group
GDHS	Gabon Demographic Health Survey
GDP	gross domestic product
GEF	fund for the poor (Gabonais Economiquement Faibles)
GIS	geographical information systems
HIV	human immunodeficiency virus
ICT	information communication technology
IGR	internally generated revenue
MDG	millennium development goal
MOHPH	Ministry of Health and Public Hygiene
MMR	maternal mortality ratio
NHA	National Health Accounts
NHIP	National Health Insurance Program
OOP	out-of-pocket
ORT	oral rehydration therapy
PHC	primary health care
PND5	National Health Development Plan
PPP	purchasing power parity
RBF	results-based financing
ROAM	levies for the poor (Redevance Obligatoire à l'Assurance Maladie)
SSA	Sub-Saharan Africa
THE	total health expenditure

U5MR	under-5 mortality rate
UMIC	upper-middle-income country
WDI	World Development Indicators
WHO	World Health Organization
XAF	Central Africa CFA Francs (currency)

# Overview

## Background

The new president of Gabon, Ali Bongo Ondimba, who was elected in 2009, has a policy aimed at making Gabon an emerging country by 2025. One of his strategic focuses is the reduction of inequality, exclusion, and poverty. Poor health can push people into poverty or prevent them from escaping the poverty cycle. Improving the health of the population of Gabon is among the priorities for the country. The country has committed to achieving universal health coverage (National Health Development Plan 2011–15 [PNDS 2011]).

Having undertaken various health finance reforms over the years—ranging from user fees to free health care under a national health service—Gabon launched the national health insurance program (NHIP) in 2007. The country decided to separate the functions of payer and provider. A third-party agency—the Caisse Nationale d'Assurance Maladie et de Garantie Sociale (CNAMGS)—under the Ministry of Economy was designated as the payer, while the central and local-level public facilities and private facilities were contracted as the health providers. Since the introduction of the NHIP, the country has redirected its resources in favor of demand-side financing<sup>1</sup> and earmarked funds for health. This is a huge undertaking.

The country has demonstrated a greater commitment to health by increasing public sector allocations from about 5.5 percent of the government budget in 2008 to 7.2 percent in 2012. As much as 27 percent of public financing gets allocated to the NHIP. It is normal to see public financing rise as a country moves toward covering a larger segment of its population with publicly funded health services and goods. Indeed, public financing for NHIP is often critical for countries that have a significant population living below the poverty level and for countries with a small segment of its population working in the formal sector. Sustainability of public financing will be critical to achieving universal health coverage.

## Why This Policy Note

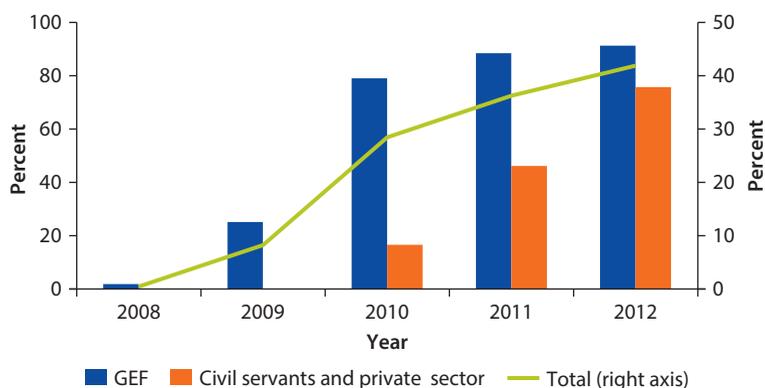
Because of its commitment to universal health coverage, certain segments are calling for additional resources for this sector. As a result, the country is grappling with the following: (i) How are existing resources being spent? (ii) Is there room for a more efficient allocation of current resources? (iii) Is there an urgent need to mobilize additional resources to meet this goal? The World Bank will publish a book on *Health Financing in the Republic of Gabon* (Saleh, Couttolenc, and Barroy, forthcoming). This policy note follows from that and attempts to diagnose the situation and offer additional information to enlighten and fuel the debate.

## The National Health Insurance Program—CNAMGS

The NHIP emphasized solidarity and inclusiveness. The poor were the primary focus of the program and the first group to be covered under the scheme for the poor (GEF, fund for the poor [Gabonais Economiquement Faibles]). CNAMGS claims to have achieved universal coverage (90 percent) among this scheme for the poor—the GEF. Early on, Gabon took the following steps to include the poor: (i) methodology to identify them and (ii) a subsidy to cover the benefit package for them. Gabon deserves to be commended for doing so.<sup>2</sup> See figure 1.

Overall, the NHIP has registered one-half of population (45 percent in 2012) including the beneficiaries under the GEF scheme and the scheme for the civil servants and formal sector; furthermore, it achieved those results in a short time. The remainder of the population belongs to the (nonpoor) informal sector, which includes the near poor. The NHIP has been unable to create a mandatory or noncompensatory scheme for the nonpoor who work in the informal sector. Registering this population is expected to be a challenge, especially because of

**Figure 1 CNAMGS Registration of Beneficiaries by Schemes in Percent, 2008–12**



Source: CNAMGS, 2013, in WHO. July 2013. Health Financing in the African Region, Issue 17 (special issue) page 17. <http://www.who.int/sites/default/files/ahm/reports/631/ahm1705.pdf>.

Note: GEF = Gabonais Economiquement Faibles.

adverse selection. CNAMGS understands this challenge. It is taking steps to learn from the experience of other countries and is committed to developing a strategy to address this dilemma.

The benefits package under the NHIP is comprehensive, but most of it applies to medical care and curative health care—not preventive care. This package is supposed to complement the benefits covered under the Ministry of Health and Public Hygiene (MOHPH). The expectation was that CNAMGS's benefit package would not constrain the people from accessing affordable health care when they were ill. Enrollees would be able to receive timely, appropriate, and affordable care that would result in better health outcomes. Childbirth was added to the benefit package; the care was free and contained full subsidies. The benefits package also includes “nonhealth” benefits for poor beneficiaries under the GEF scheme, features that are missing from traditional health insurance programs. This benefit package has not been costed out; its affordability, though critical, has yet to be assessed.

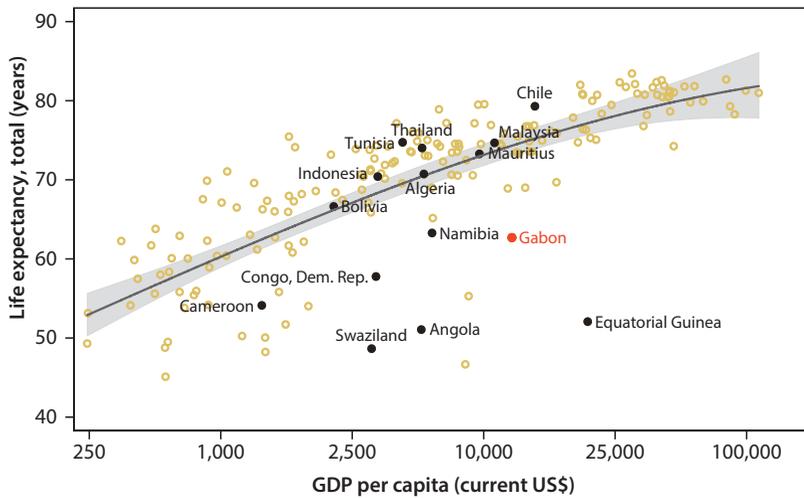
Gabon's resources for the NHIP come from various sources. For the GEF, resources come from general and earmarked taxes and levies. The latter comes from a 10 percent levy on mobile phone company revenues; these make up 80 percent of earmarked and indirect taxes<sup>3</sup> and a 1.5 percent levy on money transfers outside the CEMAC (the economic community of Central African states); they make up 20 percent of the earmarked and indirect taxes.<sup>4</sup> The formulation was progressive; subsidies were intended for the poor and for students. For the formal sectors (civil servants and private sector), resources come from private contributions. Private contributions through payroll contributions were also progressive; those with higher incomes contributed more than those with lower incomes. However, for the informal sector workers, there is no specific scheme at this time. They must register by paying a flat premium, considered to be regressive, as it is not income/affordability based.

## Gabon in Perspective

Gabon is an upper-middle-income country (UMIC) with reasonable spending on health. However, its health outcomes resemble that of a country that is low/low-middle income. Although a UMIC, Gabon shows a significant disparity in the population's quality of life. Life expectancy at birth is low (63 years, 2011) and close to figures found among low-income countries and much lower compared to other countries with similar incomes (74 years, 2011) (World Bank 2013). Health outcomes, such as those for under-5 years child mortality (65 per 1,000 live births) and maternal mortality (230–316 per 100,000 live births), are closer to figures seen in low-middle-income countries. The Gabonese are considered to be worse off than other countries with similar incomes. See figures 2 and 3.

Over the years, Gabon's efforts have resulted in improved health outcomes for its population, but further efforts are required, as it still falls short of countries of similar income. Gabon is likely to achieve millennium development goal

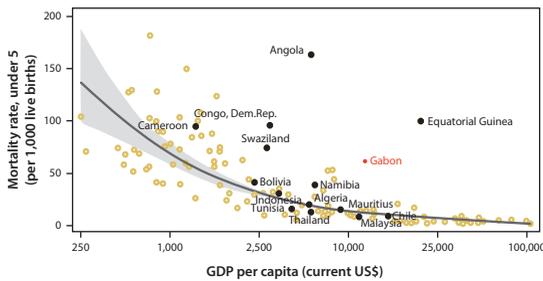
**Figure 2 Global Comparison of Life Expectancy at Birth for Countries with Similar Income, 2011**



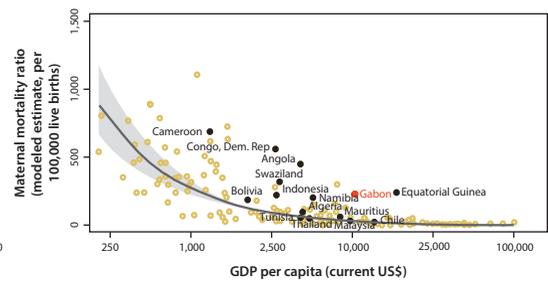
Source: World Development Indicators, WHO, updated in Apr 2014.  
 Note: x-axis log scale.  
 Gray area indicated 95% confidence interval for the fitted line.

**Figure 3 Health Outcomes Relative to Countries of Similar Income**

**a. Under-5 Mortality Rate**



**b. Maternal mortality ratio**

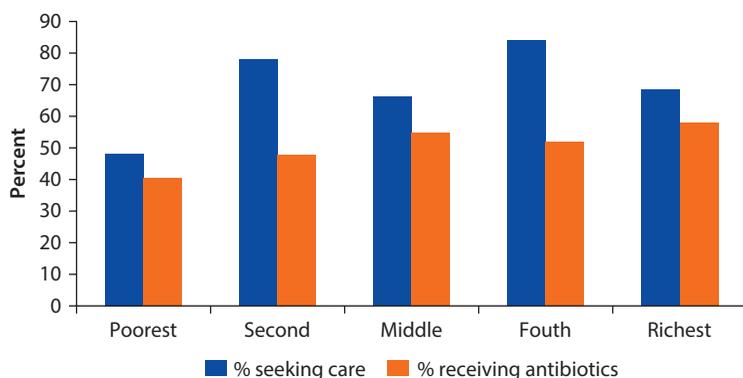


Source: World Development Indicators, WHO, updated in Apr 2014.  
 Note: x-axis log scale.  
 Gray area indicated 95% confidence interval for the fitted line.

(MDG) target 1B on child malnutrition—if its efforts are maintained and amplified. Communicable diseases remain the primary cause of morbidity and mortality. Although, improvements are seen in human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) incidence and tuberculosis (TB) incidence, the incidence of malaria remains high, and the country is not meeting MDG targets.

Furthermore, Gabon has not met its MDG targets for health and is unlikely to do so by 2015. Nevertheless, the country has made efforts to improve access to health services and has been able to attain increased coverage for some

**Figure 4 Health Service Use and Quality of Care among Children Under 5 Years of Age with Fever, 2012**

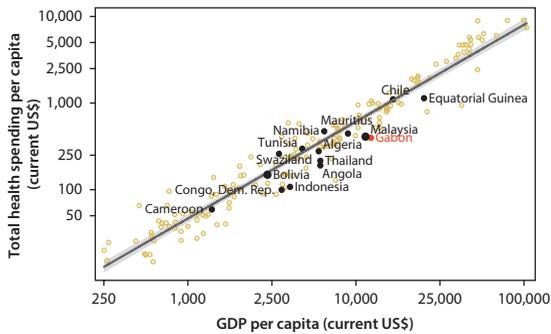
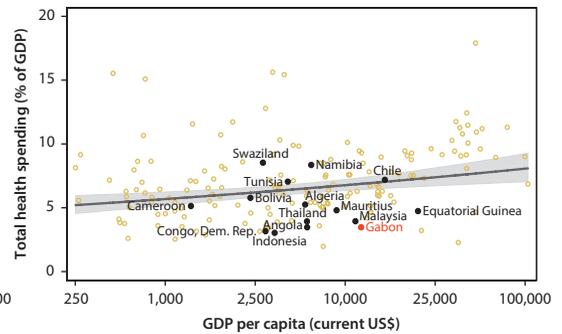


Source: GDHS 2013.

maternal health outputs, such as antenatal care (95 percent, Gabon Demographic Health Survey [GDHS 2013]). In addition, there have been improvements in levels of institutional delivery (90 percent, GDHS 2013). However, quality of care remains low and thereby maternal mortality ratios are still high. Improvements have also occurred in the use of child health service use, such as immunization coverage and the use of some treatments (for example, acute respiratory infection [ARI] treatments). However, knowledge and use of other treatments and services lag, such as limited knowledge and thereby use of oral rehydration therapy to prevent children incurring dehydration from diarrhea. Child mortality reductions have slowed because of insufficient attention to prenatal and neonatal care. Generally, there is inequity in access, and the quality of health care is poor all over the country, including the public sector (figure 4). This is especially true for the services used by the poor and those living in rural areas. (See appendix A).

### Where Is Gabon Spending for Health?

In per capita terms, Gabon's overall health spending is reasonable; in 2012, it was PPP (I\$)558 or exchange rate US\$397. It approximates the averages seen in countries of similar income and exceeds regional averages of PPP\$153. However, as a share of gross domestic product (GDP), which was, 3.5 percent in 2012, total health spending has not expanded in Gabon in the past decade. Furthermore, it is below regional and global averages, whose GDP share for health exceeds 6 percent. This has much to do with its low public spending on health (1.7 percent of GDP in 2012). However, it represents a small percentage of the total government budget (7.2 percent in 2012). It is reported to be about one-half of the country's total health spending (51 percent in 2012, National Health Accounts [NHA], World Health Organization [WHO 2013]). See figure 5.

**Figure 5 Gabon's Total Health Spending as Compared to Other Countries with Similar Income, 2010****a. Per capita health spending, US\$****b. Health spending as share of GDP, %**

Source: World Development Indicators, WHO, updated in Apr 2014.

Note: x-axis log scale.

Gray area indicated 95% confidence interval for the fitted line.

### Concerns about the Current Situation

Although Gabon has increased its overall resources allocated to health, there are concerns about where the funds are going. Thus far, these funds have not resulted in better health outcomes. In addition, although one-fourth of public funds have gone to the NHIP (2012), more than 70 percent of the budget still goes toward supply side purchasing, such as staff remuneration, capital investment, procurement of drugs, and so on. This section highlights some areas where efficiency gains can be realized. (See appendix B for a summary of key findings.)

First, the country has a hospital-centric health delivery system. Primary health care clinics and public health programs are underresourced. Staff are concentrated in hospitals and in urban regions. As a result, some critical care, such as communicable disease controls, is not getting the attention or the resources the people need. Nearly 80 percent of public resources are allocated to curative care; 20 percent goes toward preventive care. Efficiency gains can be realized.

Second, the country has a high percentage of public health spending allocated for capital investment—as much as 40 percent of public health spending in 2012. This is much higher than in other countries. Significant investments are going into building more sophisticated hospitals and buying more sophisticated medical equipment. Gabon already has more hospital beds than it needs for a country with its burden of disease. After the introduction of the NHIP, bed population ratios grew dramatically from 2.5 beds per 1,000 population in 2008 to 6.3 in 2011. Meanwhile, many existing hospitals remain underutilized; their bed occupancy rates are low. Hospitals receive 58 percent of public resources compared to primary health care that receives 16 percent; public health programs receive 13 percent in 2012. Efficiency gains can be realized.

Third, personnel are not rewarded based on their performance, and their productivity is expected to be low. Of the recurrent health budget, a significant

amount goes toward personnel costs (over 50 percent in 2012), which is controlled centrally. Funds for personnel costs derive from on-budget and off-budget. The latter resources come from internally generated revenue (IGR, user fees, reimbursements through public and private health insurance). Staff base salary is considered reasonable; however, overall remuneration can be significant. While staff bonuses/incentives are in existence, they are not performance based. Although the number of health personnel in the country is reasonable in some categories and short in others, staff distribution remains a challenge. Further, staff have little incentive to improve their performance or to assume positions in underserved areas. Accountability mechanisms remain weak. Exploring performance-based incentives is warranted to improve governance.

Fourth, facility operations rely heavily on off-budget sources of financing. Resources for nonpersonnel costs within the recurrent health budget are limited. Although such resources fund drugs and medical supplies (procured centrally), the budget does not provide sufficient allocations for these. Further, there is hardly any budget for maintenance, outreach activities, and so on. There is great reliance on off-budget, IGR. For example, at a regional hospital, IGR may constitute as much as 32–50 percent of its financing in 2012. If these funds and flows are inconsistent and/or are delayed, facility operations could be in jeopardy.

IGR is, however, not reported or centrally pooled. Regulations, although they exist, are not enforced. IGR can be significant. Having more information about it could help in budgetary considerations as well as cross sharing. A more effective budget planning and monitoring process could help align budgets with needs. A better understanding of IGR and its policy implications could also assist in resource mobilization and allocation.

Fifth, budget preparation is historical and input based. Spending has shown significant volatility in recent years. Budget allocations are inconsistent; moreover, budget execution, budget flow, and budget controls are limited. There is also a lack of transparency in payment methods, for example. Often funds are not released ontime; planning and budgeting are frequently lacking. Consequently resources are underallocated or underspent. Although the health sector is supposed to be decentralized, often the local levels have limited ability to determine their own resource allocations.

Sixth, under the CNAMGS the provider payment mechanism for all types of care at clinics and at hospitals is fee-for-service. This mechanism has a tendency to increase services. Given data limitations, little analysis could be done to determine where CNAMGS resources are being spent, but it is highly likely that more resources are going to hospitals. Many patients bypass lower-level health facilities in favor of higher-level health facilities to receive a better quality of care. Hospital care is more expensive than the same service at primary health care clinics. Spending for pharmaceuticals has also increased since the introduction of the CNAMGS program. Moreover, some information suggests that over time procedures such as cesarean (C-section) have gone up. However, it is not clear if the increase in C-sections is a result of CNAMGS reimbursement structure; reimbursements for C-sections are higher than those for normal deliveries. However,

the fee-for-service payment mechanism is known to result in supplier-induced demand. Therefore, reviewing the cost drivers and developing mechanisms to control costs is critical.

Seventh, to reduce moral hazard, CNAMGS imposes copayments. However, these copayments could be a barrier for some: (i) All of the insured in every income group have copays and (ii) all of the noninsured have user fees. The recent GDHS (2013) suggested that cost of care was a barrier to health care. There is a need to understand household out-of-pocket health spending and where it is going.

Eighth, CNAMGS administration costs seem high (above 30 percent in 2012). There could be an opportunity to gain from economies of scale by merging the various health insurance schemes, which now operate independently, under CNAMGS.

Ninth, there is a concern within the CNAMGS that the scheme for the poor—the GEF—is not financially sustainable. The growth in health spending is higher than the growth in income. Pooling and cross-subsidization could help. A feasibility analysis could also help project the flow of income and expenditures over time. And it could also bring forth recommendations to ensure the financial sustainability of this new program.

Tenth, although the NHIP is gaining traction, Gabon's health delivery system lags. Many private health facilities under CNAMGS are not accredited for a variety of reasons, including poor standards as well as administrative challenges. Public facilities are accredited, but they operate under a blanket accreditation. The intent of demand side financing was that resources would follow patients. However, both the payer/purchaser and the patient alike have expressed a concern about the quality of care. Many patients bypass lower-level facilities in favor of higher-level facilities. Scant investment has gone to primary health care and public health. These activities remain underresourced, and they also create unnecessary costs.

Eleventh, Gabon relies heavily on household surveys to monitor progress in the health sector. Institutional information systems exist, but their data are limited. The MOHPH has established a department of health management information system (COSP); efforts are underway to strengthen population-based and geographical information systems (GIS). An electronic health (ehealth) strategy is required before surveillance systems as well as facility-based information systems can be enhanced. CNAMGS contains an ehealth feature to register its beneficiaries, but an electronic claims (eclaims) system would help improve the efficiency of insurance claims management and the timely reimbursement of covered claims.

Twelfth, over time, out-of-pocket health expenditures as a share of total health spending have declined, but they are still significant (41 percent in 2012). Households still incur high health care costs. That means households have limited financial protection when they become ill. A significant proportion (55 percent) of the population does not have any financial protection (CNAMGS 2013). Many households continue to complain about health care costs (GDHS 2013). The

medical and nonmedical cost drivers faced by these households need to be better understood. Addressing the limited financial protections of this program is critical.

### **Next Steps in Gabon's Path to Universal Health Coverage**

Given that the country has moved towards a modality for NHIP, and aims to achieve universal health coverage, it is critical that priorities be set to address some of the next steps in Gabon's path to universal health coverage. Some key questions that need to be addressed are:

- Is the NHIP financially feasible: how are resources pooled, who pays and what sources of financing needs to be insured for its financial sustainability?
- Who benefits from the NHIP, and who is left out? How can the enrolment of those left out be insured to achieve universal health insurance coverage? What are the challenges and how to overcome?
- Is the benefits package offered under the NHIP financially affordable: who provides towards it, and who benefits from it?
- Are the entitlements under NHIP easily accessible and of acceptable standards?
- Is the purchasing mechanism under NHIP helping avoid moral hazard and supplier induced demand? Is the purchasing mechanism allowing improved performance?
- Are the administrative processes under NHIP leading to greater efficiency, equity, quality control standards and cost containment?

### **Reform Options**

There is a need to ensure some or all of the following for a more efficient, affordable, and financially sustainable health program that delivers on its commitment to universal health coverage. This section highlights some issues and reform options for consideration by the government in the medium term (refer to table 2 later in this section for a summary, and to Appendix C.).

#### ***Issues and Reform Options under CNAMGS***

##### ***Revenue Source***

*Increase public revenue from sources that are progressive:* Gabon is looking at various options to increase revenue. It is critical to have higher-income groups contribute more than lower-income groups. General and earmarked taxes and levies finance the coverage of the poor under the GEF, and payroll taxes cover the nonpoor formal sector workers. The financing for the NHIP in Gabon is regarded as a progressive tax. However, there is concern that the financing source for the GEF is not sustainable, and other options need to be considered. Conversely, premiums are considered regressive—unless they are income related.

*Improve enrollment compliance and the collection of premiums:* Enrollment remains incomplete. If it can be increased, it will automatically generate additional

resources and reduce the administrative costs associated with CNAMGS's operations. Although the transfer of CNSS (Caisse Nationale de Sécurité Sociale or the Social Security Scheme) to CNAMGS posed a major obstacle (politically, financially, and technically) to the successful enrollment of the private sector, apparently both parties are ready to move forward. It is anticipated that additional resources will be forthcoming by 2015. Still, the scope of contributions from the private sector remains uncertain. Given that Gabon has a small proportion of its population in the formal sector, private contributions can be limited. It is essential that the government quantify potential gaps in CNAMGS's budget.

*Source of financing for the coverage of informal sector workers under CNAMGS:* The NHIP has been unable to create a mandatory or noncompensatory scheme for the nonpoor who work in the informal sector. Many informal sector workers are in good health. They have the financial means, but they do not enroll in NHIP (adverse selection). Having them enroll in NHIP could diversify the risk pool even more. As a way to encourage their enrollment, incentives could be offered in the form of a more attractive term under a group premium. How could the enrollment of informal sector workers in CNAMGS be increased and how will it be financed: would it be supported through subsidies or cost sharing? One solution could be to include this subgroup under public financing. A strategy would help with the assessment and steer the debate. An actuarial analysis of the benefits package would help identify the appropriate premium rate.

### ***Type of Pooling Funds***

*Cross subsidization:* CNAMGS has three different schemes: (i) for the poor, (ii) for civil servants and the formal sector, (iii) for the informal sector. The NHIP was established to ensure universal coverage. Coverage has been greatly and successfully expanded. Nevertheless, the schemes are fragmented and there are no clear plans for a pooling mechanism to allow cross-subsidization. With such institutional arrangements, it is unlikely that risk will be shared and effective cross-subsidization between the rich and poor and the healthy and the sick will occur. To ensure both progressivity and efficiency, it is highly recommended to (i) pool the risks for the general population and the poor, or (ii) set up formulas for cross-subsidization transfers between the different pools. The CNAMGS administrative costs are significant, given that each of the schemes is run independent from the other.

*Financial sustainability of health insurance:* Furthermore, there is a lack of consistent cost estimates and no systematic actuarial study to ensure that each scheme is sustainable. As CNAMGS moves forward to establish new insurance schemes for population groups that are still not covered and it seeks to identify additional sources of funding for them, CNAMGS should first consider a comprehensive actuarial study of the current and proposed schemes and consider an actuarially estimated premium.

*CNAMGS reserve policy should be firmed up.* Resources under NHIP's various schemes are not pooled, and it is difficult to determine how much NHIP has in its reserves. Its reserves policy is not clear. Actuaries often recommend that

reserves for a more mature health insurance program should have funds amounting to about four to six months of anticipated claims. A more thorough actuarial analysis would more accurately reveal what is in this reserve fund and it might offer some policy suggestions on the amounts that should be in reserve.

### ***Population Covered***

*Eligibility of low-income groups:* To be eligible for a health insurance subsidy, an adult must earn less than 80,000 XAF a month (\$160), equal to the monthly minimum wage in Gabon. A national census was used to elaborate on the list of beneficiaries. Because means tests were difficult to administer, the current list reportedly contains errors and is likely to include wealthier quintiles. There is also discussion around changing eligibility criteria, including the possibility of an entire household, rather than individual incomes. Proposals to target government subsidies to the truly indigent are not only commendable but they also free up resources and reinforce equity and financial protections.

*Consider introducing mandatory coverage of the informal sector:* While CNAMGS appears to be moving quickly to register the poor, civil servants, and workers in the private sector, there is little momentum to cover informal sector workers; no specific scheme is in place for them, nor is one planned. Registration of informal sector workers is voluntary, and there is little incentive for them to enroll. Lessons from other countries suggest that coverage of informal sector workers may be a challenge. More than 70 percent of Gabon's population comes from the informal sector. Often countries like Ghana and the Philippines have had registrations stalled because workers in the informal sector are hard to reach. Thailand on the other hand decided to subsidize the premiums of all informal sector workers under general taxes. There are pros and cons, and subsidizing informal sector could motivate the formal sector to increase informality (as seen in the Philippines); (partial or full) subsidies, however, may help increase enrollment. Gabon will have to figure out how to offer an incentive for these workers to register. Critical questions that might help CNAMGS develop a policy are as follows: Is there a demand, who will pay the premiums, will there be government subsidies, how much, and what will be the source of financing? CNAMGS plans to develop a strategy in 2015 and 2016 for covering informal sector workers.

### ***Commodity Purchased***

*The benefit package:* The benefit package under CNAMGS is comprehensive (outpatient, inpatient, and drugs), but curative in nature. It excludes those goods and services that are communicable, covered by the MOHPH or through external grant financing. It is imperative to ensure public health objectives are equally met and its coverage accelerated. Further, the benefit package under CNAMGS includes nonhealth coverage, such as a childbirth bonus and school spending for children up to 18 years of age. Should the non-health benefits be part of the health insurance scheme? The CNAMGS premiums are not based on an actuarial estimate, and so it not clear whether sufficient revenue is collected to cover

the costs of care. However, an actuarial and financial sustainability analysis is planned for 2015 and 2016.

### ***Purchasing Mechanism***

*Provider payment mechanism and the incentives for supplier-induced demand:* CNAMGS uses a fee-for-service payment mechanism for services and for drugs at all types of facilities (health clinics to hospitals). This mechanism is known to result in supplier-induced demand. Service use has gone up; however, specifics are yet to be determined. This study was unable to collect information on how the pattern of services has changed. However, claims expenditures have increased significantly as a share of total CNAMGS spending and in per capita terms. Incentives arising from payment mechanisms are often distorted; for example, the high level of C-sections is clearly linked to the fact that providers receive a higher amount for them than normal deliveries. Other provider payment mechanism options can be considered such as capitation at primary health care and case-mix payment at hospitals (table 1).

*Is gatekeeping an option:* The existing payment system for the 80 contracted hospitals and health centers is based on fixed tariffs for every service delivered.<sup>5</sup> In the absence of a clear cost-monitoring and regulatory mechanism, it is likely that this payment system will reinforce the fiscal fragility of the CNAMGS. Introducing a hybrid payment system, through case-mix activity-based payment and fixed support budgets, could be a solid strategy for controlling costs. Encouraging clients to use primary care as an entry point (through gatekeepers for example) is another potential means to free up resources. However, in both case, the primary attention will need to be given to upgrading quality of care.

*Reduce moral hazard:* The provider payment system creates incentives for patients to use more services, while the copayments may result in reduction in moral hazard. The influence of copayments on the use of services by the poor need to be better understood. Does it create adverse effects?

*Copayments and their effect on offering financial protection against the cost of illness:* The country still does not offer financial protection. Much more is expected of a UMIC that aims to achieve universal health coverage. CNAMGS claims to have achieved universal health insurance coverage among the poor. However, CNAMGS's policy on copayments for medical services and drugs needs further assessment. Although the policy was introduced to reduce moral hazard, it could also result in significant household spending on health, especially by the poor and near poor. It is noteworthy that many of its beneficiaries are visiting hospitals for consultations instead of clinics. Travelling to urban centers to access hospitals adds to travel costs. Charges for similar consultation services at hospitals are higher than at clinics. Balance billing also exists in private health facilities. Although most of the poor do not use private health facilities, when they do, their health care costs could be even higher. Given the lack of household income-expenditure surveys, it is not clear what households spend on health. A benefit incidence analysis would provide an even better understanding of who benefits

**Table 1 Provider Payment Mechanisms: Payment Method, Effects, and Country Examples**

	<i>Payment method</i>	<i>Effects</i>	<i>Country examples</i>
Primary health care	Line-item budget: fixed amount for inputs	Strong cost control; risk for underprovision	The United Kingdom in the 1980s, former Soviet Union republics, currently: Egypt, Arab Rep., the Philippines, Vietnam, Bangladesh, Mozambique
	Fee-for-service: payment based on the number of services delivered (with agreed fee schedule or retrospective cost-based payment)	Incentive for overprovision and costly services	France, Canada, China, Japan, Korea, Rep., the United States (under indemnity plans), Austria, Germany, most African countries
	Capitation: predefined rate for each resident enrolled	Output based; can attract additional enrollees; cost control; risk for underprovision; risk for patient selection	The United Kingdom, Spain (for GPs)
Hospital and acute care	Global budget: determined by historical expenditures	Cost control; risk for underprovision; no incentive for productivity; facility deficits	Formerly France (for public hospitals), Ireland (case-mix adjustment to global budgets)
	Case-mix payment: reimbursed per diagnosis-related groups <sup>a</sup>	Incentive for volume; can improve efficiency (length of stay); shift to ambulatory strategies, risk for selection of low-cost patients, question for appropriateness of care)	The United States (first diagnosis-related group [DRG] system), Australia, France (since 2007), Germany, Switzerland, Brazil, Thailand, Hungary, Slovenia. Pilots in Indonesia, Vietnam, Korea, Rep., and China.
	Per-diem payment: daily payment	Increase length of stay and number of admissions	Formerly Germany, Brazil (in the 1970s), Estonia (coupled with budget cap)

Source: Adapted from Langenbrunner, Cashin, and O'Dougherty 2009 and Park et al. 2007.

a. DRGs are a patient classification system developed to classify users into groups economically and medically similar, expected to have similar use of healthcare service and related costs.

from government subsidies, but that analysis is not possible given limited information. However, a poverty survey at the household level is expected to be conducted in 2015 and could help with a benefit incidence analysis.

### ***Expenditure Management***

Except for cost sharing, revenue enhancements do little to improve spending efficiency; an increase in spending needs to be accompanied by improvements in the system's allocative and technical efficiency.

*Timely release of resources.* Releases from the treasury and tax departments are reportedly delayed. These delays affect the credibility of the funds, particularly for the poor and for civil servants. This subsequently effects the timely reimbursement from CNAMGS to the health providers.

*Claims processing:* CNAMGS has introduced electronic health systems (ehealth) to register beneficiaries. However, it has not yet introduced a comprehensive system that includes an electronic claims (eclaims) management system. Claims are processed manually. Providers indicate that reimbursements are often delayed. These delays could be a result of multiple factors: low releases from the treasury to CNAMGS, insufficient reserves, or manual claims processing. Because many providers rely heavily on off-budget for their operating costs, a delay in reimbursement can be very disruptive to a facility. Further assessment is required. That includes the development of an audit/fraud management cell to ensure the validation of claims.

**Table 2 Some Summary Reform Options for CNAMGS**

<i>Issues</i>	<i>Options</i>
Population covered— Increase enrollment	<p>Ensure those enrolled in GEF are those who are the poor (means/proxy means tested). Ensure premium subsidies can be maintained for GEF beneficiaries.</p> <p>Identify informal sector workers, incentives for them to register and/or government subsidies for their premiums.</p> <p>Ensure private sector workers regard enrollment in the public scheme as beneficial. They have other options that may provide better health services.</p>
Cost controls/efficiency gains	<p>Supplier-induced demand is a result of fee-for-service payment. Monitor how it is affecting the use of services and prescription practices.</p> <p>Consider capitation for primary health care.</p> <p>Release reimbursements on a timely manner.</p> <p>Conduct validation/technical audits of claims.</p> <p>Pool schemes to reduce unnecessary administrative costs associated with running separate schemes.</p> <p>Promote generics and ensure prices approximate international drug reference pricing.</p> <p>Increase accreditation of private providers.</p> <p>Improve the quality of care (and thereby actual accreditation) of public providers.</p> <p>Reassess the benefits package and its costs. It is comprehensive. Should the non-health benefits be part of the health insurance scheme?</p> <p>Review the policy on tariffs.</p> <p>Improve ICT for claims management.</p>
Financial sustainability	<p>Conduct an actuarial and financial sustainability analysis.</p> <p>Ensure the timely release of funds from treasury to CNAMGS. This matter is of special concern for the sustainability of the two funds—GEF Fund and the civil servant's Fund—both of which rely on public sector contributions.</p> <p>Ensure sources of financing are sustainable in light of growth projections.</p> <p>Premiums charged are based on actuarial estimates.</p> <p>Ensure a policy is in place for reserves.</p>
Financial protection	<p>Reconsider copayment policies for GEF beneficiaries.</p> <p>Regularize NHA.</p> <p>Improve monitoring systems.</p>

*Note:* See appendix C for elaboration of this summary table. CNAMGS = Caisse Nationale d'Assurance Maladie et de Garantie Sociale; GEF = Gabonais Economiquement Faibles; ICT = information communication technology; NHA = National Health Accounts.

*Upgrading the quality of service and reorienting budget subsidies:* Inadequate quality of service creates unnecessary costs for the system (bypassing, follow-up visits, false prescribing patterns, overuse of high-cost services) and ultimately for patient's health outcomes. Gabon has made significant investment in responding to concerns of low quality care. It is necessary to elaborate on those efforts by focusing on primary and preventive care. To improve service coverage may require redistributing some of government health spending to lower levels of care (that is, primary and preventive) so that those who are worse off may benefit more from government subsidies than is true today. Performance-based payments may also be an option for boosting the quality of service. Accreditation may be another; few nonpublic facilities in Gabon are accredited. This would improve efficiency in spending.

### ***Some Other Options***

#### ***Resource Allocation***

*Use equity-based principles to guide the allocation of funds to the regions.* The formula used by MOHPH in allocating resources to regions and districts seems to be influenced by hospitals rather than by health outcomes or gaps in service. No equity-based formula is employed for the allocation of funds. For example, the Northern region has the worst health outcomes; it also receives the lowest per capita health allocations from MOHPH. This formula should be reconsidered.

*Base public spending on rational principles and efficiency.* Capital investments are skewed, medical equipment is lacking, and many vehicles are outdated and nonfunctioning, especially at lower-level facilities. These reforms will require costly investments; however, gains in efficiency can be realized from a better rationale of capital investments. For example, a rationale of investments (such as hospitals versus primary health clinics) might include decentralization, pooling, improved standards, administrative processes, and monitoring.

#### ***Performance-Based Incentives***

*Reduce fragmentation in the financing of public health.* Although the government has separated provider payer functions from the agencies responsible for them, it continues to finance some services directly. MOHPH has retained financing for staff remuneration, preventive services and for public health goods (vaccines, drugs, commodities); funding for these services comes from general taxes and external financing. NHIP finances recurrent spending for curative services and drugs, and it reimburses providers, and yet little thought is given to offering incentives for reducing costs or boosting the quality of care. Both payment systems (MOHPH and NHIP) have different incentives. Various ways can be identified to deal with this problem: (i) MOHPH retains financing for preventive and public health goods; however, NHIP offers incentives (such as through performance-based payments) to providers to focus on preventive over curative care, or (ii) MOHPH pools financing for preventive and curative care under the NHIP fund, and NHIP includes these incentives in its benefit package. These options

could create the right incentives for providers and consumers to demand preventive over curative care.

*Incentivize providers and health care consumers to help meet MDG targets.* Gabon would benefit if their publicly financed programs targeted the poor and vulnerable more than the nonpoor. These programs could target communicable diseases, public health programs, public goods, and cost-effective community interventions as well as clinics and primary referral networks. Performance-based incentives (such as results-based financing) to providers and supervisors could create the appropriate financial incentives to focus on MDGs, prevention, and the quality of care. Further, incentives (such as conditional cash transfers) could also be offered to consumers to boost the use of MDGs and preventive services and timely access to appropriate care.

*Incentivize health workers to move to venues other than hospitals and urban centers.* The maldistribution of health workers is a huge challenge. In addition to a shortage of certain cadres of health workers, the distribution of health workers is skewed in favor of urban areas and hospitals. A need exists to evaluate and learn from other incentive schemes that exist in Gabon. What additional incentives could be offered?

*Incentivize health workers to improve productivity.* The government has offered bonuses with the goal of improving productivity. Although evaluations of this effort have been scant, evidence suggests that input-based payments with no performance agreements will not change behavior. One answer may be to test a modality of performance-based bonuses (for example, results-based financing) to incentivize an increase in productivity.

### ***Accountability***

*Ensure public and social accountability.* Accountability in the health sector remains weak, and reporting and assessment of expenditures are limited. Reporting of health service indicators, such as user profiles and quality of care, is also limited. Further, civil society has little information about public sector activities. Mechanisms could be developed to improve accountability, including contractual agreements between purchaser and provider and payments based on results, performance, and reporting. Civil society could also be engaged in planning, monitoring, and evaluation. Information could be widely disseminated through websites and community gatherings.

*Improve access to reliable information for decision making.* The private sector offers little information about quantity and quality of care. Comprehensive planning and decision making requires comprehensive information. A need exists to integrate the private sector in reporting, planning, and monitoring. A need is also seen to incentivize the private sector to carry out timely and reliable reporting. The provider and private sector associations could coordinate this effort. To advance its reform agenda, the government of Gabon could embark on significant reforms in the following areas: (i) decentralization and governance, (ii) health service delivery, (iii) public health, and (iv) health financing. It could also set up a holistic and accountable health reform process as it transitions to universal coverage.

## Going Forward: What Options Does Gabon Have to Increase the Fiscal Space for Health?

Gabon has committed to achieving universal health coverage. The public sector will need additional resources to improve household financial protection and to strengthen the health delivery system. The cost of this reform is not clear. However, a rough estimate to scale up enrollment under CNAMGS for the informal sector by 60 percent (the total population would increase from 45 percent in 2012 to 74 percent in 2018) suggests that an additional Central Africa CFA Francs (XAF) 30 billion may be needed by 2018. These funds would contribute an additional 0.3–0.5 percent to GDP by 2018. Where will these funds come from?

A fiscal space analysis explored options for additional health resources. Significant savings can be achieved by improving efficiencies in allocations and in spending. Additional resources may also be gained from an increase in economic growth, establishing new priorities for health, from earmarked funds, and from borrowing.

*Economic growth alone may not provide additional resources needed to achieve universal health coverage.* Between 2012 and 2020, Gabon's economic growth is expected to average about 6 percent. Past government health spending patterns suggest that the health sector is likely to receive proportionate shares in the growth of GDP (for example, if GDP grows by 1 percent, government health spending is likely to grow by 1.8 percent). The author's conducted a simulation of what additional resources may be required to increase coverage of population under CNAMGS. The author's simulation suggests that annual increases of about 3 percent (instead of 1.8 percent) in government health spending are desired in order for government to provide sufficient resources to expand population coverage under the universal health coverage reform. Economic growth alone, therefore, is insufficient to accommodate the additional resources that will be needed by the health sector over the medium term.

*Prioritization of budget for health could be an option.* Additional resources could be available if the country established different priorities and the budget contained more money dedicated to achieving universal health coverage. At this point, budget allocation for health is low and there is room for further allocations if the government sought health as one of their key priorities.

*Improve budget execution is likely to add additional resources.* Past trends reveal a lot of volatility in public financing, the release of funds, and the use of released funds. However, if funds can be maintained and the execution rate goes up, those factors can add resources to the budget in the medium term.

*Non-budget sources of financing may be an option.* Gabon has already earmarked funds for health. The existing source of earmarked funds (through mobile phones and remittances) may however not show sufficient growth over the years. So, what other avenues can be sought? One option is to consider new avenues, such as tobacco taxes. An increase in excise taxes (and the price) of tobacco/alcohol could lead to decreased consumption of these substances. It would also help raise revenue that could be earmarked for health. Further assessment is required to consider this option.

*Improve access to internally generated revenue.* Several off-budget resources for financing have not been broken out, but they can add to public sector financing on both the demand and supply sides. Despite existing regulations, IGR is not tracked, centrally pooled, or enforced. IGR can be significant. It could help in budgetary considerations as well as cross subsidization.

In summary, Gabon is most likely to gain additional resources for health from economic growth and by establishing different budget priorities for this sector. Efforts to strengthen health systems should be in parallel with those to secure additional resources through efficiency gains and reduce unnecessary spending.

## Conclusion

Universal health coverage has been defined as a situation where all people who need health services (prevention, promotion, treatment, rehabilitation, and palliative) receive them, without undue financial hardship (World Health Report 2010). Universal health coverage consists of three interrelated components: (i) the full spectrum of quality health services according to need; (ii) financial protection from direct payment for health services when consumed; and (iii) coverage for the entire population. While Gabon aims to achieve universal health coverage, the elements above are still to be achieved.

This policy note has demonstrated that the existing resources in Gabon are not being efficiently spent. WHO states that as much as 20–40 percent of resources in the health sector are wasted due to inefficiencies. Gabon therefore needs to take immediate action to diagnose the problem and come up with solutions for cost savings.

The policy note also shows that in the short term, immediate action could be taken to gain from efficiency in several areas, such as, developing a health financing strategy, rationalizing on investment plans, with reallocation of capital investment towards primary health care and public health, refining the provider payment mechanisms and the incentives it creates for provider and consumer behavior, and others. (See appendix C.)

The policy note suggests that additional resources will need to be mobilized to deliver on the promise of universal health coverage and universal health insurance coverage. While the population's enrollment into the CNAMGS is critical to achieve universal health insurance coverage, an effective health delivery system is critical for the population to benefit from the promised entitlement. This has to go hand-in-hand to see better health outcomes. CNAMGS is in its early stages of development. Reforms need to bolster those earlier efforts in ways that will improve coverage and the program's effectiveness.

The World Bank is in dialogue with the government. Given the Bank's vast global knowledge and its support for technical assistance to countries, it can assist Gabon in adopting future strategies in the following areas: (i) to help CNAMGS strategize to improve coverage of informal sector workers, (ii) to help CNAMGS

refine its provider payment mechanisms that offer incentives to improve performance and render appropriate care and services, and (ii) to help CNAMGS conduct a feasibility and financial sustainability study and develop ideas that would sustain the national health insurance program. Gabon has come a long way and has embarked on an ambitious goal that many larger countries have yet to establish. The World Bank would like to assist Gabon in realizing its dream of universal coverage for all of its people.

## Notes

1. Demand-side financing is a way in which the government can finance private consumption of certain goods. In contrast to supply-side financing, where public money goes directly to suppliers, consumers receive a certain amount of money for specific expenditures under demand-side financing. It emphasizes consumer choice; the consumer decides where public money will go. <http://www.seor.nl/media/publications/economics-demand-side-financing.pdf>.
2. Many countries initiating NHIP began by offering a benefit package for the formal sector and registering them because they are easier to identify. Furthermore, contributions can be collected through payroll deduction. Later, however, these countries often experienced challenges in offering the same package of benefits to and registering the poor. This was especially true when there were constraints in subsidizing the package for the poor.
3. The Social Guarantee Fund is funded by an indirect tax called the Mandatory Health Insurance Fee (Redevance Obligatoire à l'Assurance Maladie, ROAM), Ordonnance 0022/2007.
4. The levies are collectively called the redevance obligatoire à l'assurance maladie (ROAM) or mandatory health insurance levy.
5. In addition, the 20 percent copay will continue to be a direct source of revenues for providers.



## APPENDIX A

# Health-Related Indicators for Gabon

<i>Indicators</i>	<i>2000 (GDHS 2001)</i>	<i>2012 (GDHS 2013)</i>
Infant mortality rate, per 1,000 live births	57	43
Under-5 mortality rate, per 1,000 births	84	65
Maternal mortality ratio, per 100,000 live births	519 (GDHS 2001); 420 (WHO 2000)	316 (GDHS 2013); 230 (WHO 2010); 520 (PNDS 2010)
Contraceptive use	33% (12% modern)	31% (19% modern)
Prenatal care visits (%)	94%	95%
Postnatal care visits (%)		66%
Institutional deliveries (%)	85%	90%
		Urban 94%; rural 70%
Children (12–23) with full immunization coverage (%)	17%	32%
	(measles = 55%)	(measles = 74%)
Children U5 with ARI symptoms	13%	8%
Children U5 with Malaria (fever)	29%	24%
Children U5 with diarrhea	16%	16%
Children U5 with ARI receiving treatment (%)	48%	68%
	(urban 52%, rural 34%)	(urban 71%, rural 52%)
Children U5 with diarrhea receiving ORT (%)	33%	37%
Children U5 with fever seeking treatment (%)	62%	67%
Children U5 with fever taking antimalarials (%)	—	26%
Children U5 sleeping under a mosquito net (%)	—	51%

Source: Gabon Statistical Service. Gabon Demographic Health Survey, 2001, 2013; WHO, 2010.

Note: ARI = acute respiratory infection; ORT = oral rehydration therapy; — = not available.



## Key Messages from “Health Financing in the Republic of Gabon”

### Key Message from Chapter 2—Health Outcomes and Use of Health Services

- It is highly likely that Gabon will achieve its millennium development goal (MDG) target 1B on child malnutrition if its efforts are maintained and amplified.
- Gabon is however less likely to meet its millennium development goal (MDG) targets for maternal and child health by 2015.
- Based on countries of similar income and health spending, Gabon is not meeting its health outcome levels.
- Communicable diseases remain the primary cause of morbidity and mortality. Although, improvements are seen in human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) incidence and tuberculosis incidence, malaria incidence remains high, and the country is not meeting MDG targets.
- The country has made efforts to improve access to health services and has been able to attain universal coverage in use of some maternal health outputs, such as antenatal care. There are improvements in levels of institutional delivery. However, quality of care remains low, and thereby maternal mortality ratios are still high.
- While improvements are also seen in child health service use, such as immunization coverage and improved use of acute respiratory infection (ARI) treatments, however, knowledge of use of others remain behind. Child mortality reductions have slowed down, given low attention given to prenatal and neonatal care.

Further, health services continue to face challenges. The country experiences economic and geographical inequities in the use of health services.

- Most of the population relies on public facilities for health care, regardless of their economic status.
- Generally, the quality of health care is poor all over the country, including in the public sector. This is especially true for the poor and those living in rural areas.

- Gabon has a well-developed health service delivery system; however, its primary health network is not widespread.
- Gabon has more hospital beds than it needs for a country with its burden of disease profile.
- Although the numbers of medical and paramedical personnel are reasonable, they are not distributed equitably across the country. Furthermore, their performance could be enhanced.
- Health systems and staff accountability mechanisms are limited.

### **Key Messages from Chapter 3—Health Financing**

- Gabon’s health spending as a share of GDP (3.5 percent in 2012) is lower than average when compared to countries within the region and countries of similar income.
- Health spending in the public sector as a share of GDP (1.7 percent in 2012) and as a share of total health spending (51 percent in 2012) is also lower than averages seen in countries of similar income and in countries within the region.
- Gabon’s per capita total health spending (PPP (I\$) 558 or \$397 in 2012) is significantly higher than neighboring countries. However, it is slightly below average when compared to other countries of similar income.
- Household out-of-pocket as share of total health spending is relatively high (41 percent in 2012), and it shows little evidence of offering financial protection against the costs associated with illness.
- Overall, health spending has grown. The public sector contributes at least one-half of total health spending, due in part to the introduction of Caisse Nationale d’Assurance Maladie et de Garantie Sociale (CNAMGS).
- Budget execution rates in the public sector for health have been at unacceptable levels.
- There are concerns about allocative inefficiency in the public sector for health. Much of public health resources in Gabon go for curative care and to hospitals.
- Over time, capital investment as a share of the budget has crept upward. In recent years, it has represented about 40 percent of total public sector health spending.
- At least one-half of recurrent health spending goes for personnel. Additionally, some off-budget also gets allocated to personnel.
- Over time, on-budget resources for “operations” appear to have declined; meanwhile, off-budget resources for “operations” have grown.
- The geographic distribution of health resources is inequitable and does not reflect the real needs of the people.

### **Key Messages from Chapter 4—National Health Insurance Program**

- The impetus for CNAMGS was to bring various schemes under one umbrella agency. Nevertheless, the three schemes run independently from each other: There is no pooling of resources or cross-subsidization.

- CNAMGS has earmarked resources for its funding. So far, about 45 percent (2012) of it comes from contributions from formal sector workers’ (civil servants and private sector); the other half (55 percent) comes from between general and earmarked taxes.
- CNAMGS claims to have registered about 45 percent of the population by 2012.
- One of the greatest challenges is how to cover informal sector workers under CNAMGS.
- As a share of total spending, CNAMGS administrative expenses are significant.
- On a per capita basis, claims spending has increased. Claims expenditures make up about one-half of CNAMGS’s total spending. The provider-payment mechanism and its impact needs further review.
- No financial or sustainability analysis is in place for CNAMGS. Steps to ensure the financial sustainability of the program are critical to its success.

### **Key Messages from Chapter 5—Assessing the Costs and Options for Bridging the Coverage Gap**

- There is a need for additional public resources to cover the remaining population and meet the goal to expand coverage under CNAMGS.
- Economic growth is likely to inject additional funds to the health sector. However, since economic growth has slowed, the growth in resources for health is conservative.
- Prioritization of the budget for health and an improved execution of the budget is likely to inject additional resources for health. Nevertheless, additional resources will likely depend on reprioritizing and a more efficient and effective execution of the budget.
- With earmarked and indirect taxes as well as contributions from employers and employees, the country has injected additional funds for health in the CNAMGS program. Although some of this could be sustained, additional resources are unlikely. The challenge going forward is that the population subgroup of informal sector workers are unlikely to be in a position to make a financial contribution.
- New earmarked taxes are unlikely to be introduced or to be increased as a new source of revenue for Gabon’s health sector. The political window for the introduction of new taxes has to be reconsidered.
- There are two areas by which external financing could be injected into the health sector. The first is Official Development Assistance. However, the prospect is not good for two reasons: Traditionally, the amount is low and Gabon is an upper-middle-income country (UMIC). Borrowing and increasing debt for health could be an option. Whether the government would be willing to reopen its debt to increase government spending—particularly for health—is to be discussed.

- Finally, large gains in efficiency could be realized. World Health Organization (WHO) notes that in general 20–40 percent of spending on health is wasted because of such inefficiencies. There are areas that could be considered for cost controls, improved allocative efficiency, and investment in interventions that could result in greater value for the money (for example, primary health care).

## APPENDIX C

# Short- and Medium-Term Reform Considerations

<i>Diagnostics</i>	<i>Recommendations</i>	
	<i>Short term (1–3 years)</i>	<i>Medium term (3–5 years)</i>
<b><i>Health financing</i></b>		
No comprehensive strategy exists	Develop a health financing strategy, that would consider some of the following aspects: - Sources of financing - Support demand-side financing initiatives. - Reduce fragmentation in health financing flows and funds.	
Devolution of financing functions not addressed	- Devolution of financing functions.	Firm up plans for devolution of financing functions (if feasible).
Resource tracking for better accountability	Improve expenditure management and tracking systems and support NHAs.	
Internally generated revenue (IGR).	Review the situation of internally generated revenue, its reporting, and enforcement of the policy.	Reconsider IGR policy and ways for its enforcement.
<b><i>Health service delivery</i></b>		
Poor access to public health programs and outreach	Intensify strategy for public health programs and outreach.	Implement various models of outreach and community-based programs.
Poor access to primary health care	Diagnose the problem in-depth and develop strategy to improve the access to health services	Improve access to primary health care services, with appropriate emergency care referrals, and so on with special emphasis to rural and poorer regions.
Poor quality of health care	Diagnose the problem in-depth and develop strategy to improve the quality of health services.	Test innovative ways to incentivize and improve service delivery performance.

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<i>Diagnostics</i>	<i>Recommendations</i>	
	<i>Short term (1–3 years)</i>	<i>Medium term (3–5 years)</i>
<b>Human Resources</b>		
Inequitable distribution of human resources	Diagnose the problem in-depth and develop strategy to improve the staffing distribution to rural areas and to underserved areas.	Test innovative ways to incentivize redistribution
Weak staff accountability	Develop mechanisms to improve accountability, for example, technical audits, and reporting.	Pilot test some accountability mechanisms.
Low staff performance	Develop mechanisms to improve staff performance, for example, bonus/ payments based on performance.	Pilot test some performance-based payment mechanism.
<b>Drugs</b>		
	There is an existing policy that drugs can only be available at health facilities in the presence of pharmacists. Many health facilities therefore do not have drugs. This policy needs to be reviewed and its practicality assessed.	
<b>Areas for efficiency gain</b>		
Too high a budget share for capital investment	Need a capital investment rationalization plan based on need.	
Too many hospital beds and underutilization	Need a hospital rationalization plan based on need.	
Bypassing of PHC in favor of hospitals	Review the PHC quality of care— consider conducting a service delivery performance assessment	Reconsider strategy to improve quality of care: including human resources for health, drugs, and so on.
<b>CNAMGS</b>		
<b>Low financial protection</b>		
	Develop strategy for scaling up and incentivizing enrollment (including considering challenges for adverse selection).	Increase enrollment into the NHIP/ CNAMGS.
	Review the current mechanisms for identification of the poor, and consider refinement.	Identify those who are the poor and provide free coverage.
	Develop a strategy for identification and incentivizing enrollment of the informal sector (including consideration of adverse selection challenges).	Identify those who are in the informal sector, and suggest ways to improve incentive for their enrolment.

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<i>Diagnostics</i>	<i>Recommendations</i>	
	<i>Short term (1–3 years)</i>	<i>Medium term (3–5 years)</i>
	Review the situation on household spending (OOP) on health.	Reconsider who should be charged copayments: poor, informal sector workers, formal sector, and so on.
	Review the situation of balance billing and pricing amounts with private sector.	Reconsider pricing and performance-based contract with the private sector, and the balance billing situation.
<b><i>Unknown financial sustainability of the CNAMGS scheme</i></b>		
	Cost out the benefits package using actuarial methods.	
	Conduct actuarial analysis, and estimate premiums (prorated) by income levels.	
	Assess funds needed based on actuarial and financial sustainability analysis	Consider pooling of resources of the various schemes under CNAMGS, and consider cross-subsidization between schemes.
		Reconsider sources of financing: general taxes, indirect taxes, earmarked taxes, payroll taxes, premiums, copayments, and others.
<b><i>Efficiency</i></b>		
Claims management	Develop strategy for eclaims, including costing of the eclaims package and readiness at CNAMGS and at service facilities.	Introduce phase 1 of the electronic claims management (eclaims).
Provider payment mechanism	Review the provider payment mechanisms and its effect on costs and on service use.	
	Develop strategy for refinement of the provider payment mechanism.	Refine the provider payment mechanism so that it improves efficiency, including capitation, case mix.
Population identification mechanism	Refine the mechanism for identification of the poor under the CNAMGS.	
Contractual pricing for services and drugs	Reconsider pricing for drugs (how do they fare in comparison to international reference pricing) under the CNAMGS package. Review issues of economies of scale and generic drug policies.	

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<i>Diagnostics</i>	<i>Recommendations</i>	
	<i>Short term (1–3 years)</i>	<i>Medium term (3–5 years)</i>
	Reconsider pricing for services (public and nonpublic) under the CNAMGS package. Who should pay for staff? What can be done about the balance billing in private sector service pricing?	
	Claims for drugs have been going up under CNAMGS. Is this a result of drug prescribing behavior?	Refine strategy, including possibility of bundling services, and drugs under reimbursement.
Cost containment	<ul style="list-style-type: none"> <li>• Improve audits for fraud prevention.</li> </ul>	<ul style="list-style-type: none"> <li>• Improve gatekeeping to reduce unnecessary use of services or reduce the use of primary services at higher-level facilities.</li> </ul>
Administrative reforms	<ul style="list-style-type: none"> <li>• Use data to support evidence-based policies and systems.</li> </ul>	<ul style="list-style-type: none"> <li>• Review and integrate the CNAMGS beneficiaries' database with the claims reimbursement database.</li> </ul>
Provider payment reforms	<ul style="list-style-type: none"> <li>• Review the current fee-for-service, which separates services from drug reimbursement.</li> </ul>	<ul style="list-style-type: none"> <li>• Implement payment systems that encourage efficiency, quality, cost-effective service utilization, and better coordination across the continuum of care. Options include the appropriate mix of capitation, other bundled payment systems, blended payment systems, various managed care approaches, and modern pay-for-performance systems.</li> </ul>
CNAMGS eligibility changes	<ul style="list-style-type: none"> <li>• Review the pricing structure under the fee-for-service payment system.</li> <li>• Review incentives and their effect on utilization patterns, including drug use.</li> <li>• Focus on the poor (support and scale up targeting mechanism).</li> <li>• Consider refining the eligibility for the exempt group.</li> <li>• Develop incentives to encourage enrollment.</li> </ul>	
CNAMGS benefits package	<ul style="list-style-type: none"> <li>• Reassess the basic benefits package on the basis of its cost effectiveness, financial protection, and financial sustainability.</li> </ul>	

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<i>Diagnostics</i>	<i>Recommendations</i>	
	<i>Short term (1–3 years)</i>	<i>Medium term (3–5 years)</i>
	<p>The benefits package is comprehensive and not costed out. It also includes no-health benefits (not traditionally found in health insurance schemes in other countries). Need an actuarial analysis to assess the affordability of this benefits package.</p> <ul style="list-style-type: none"> <li>• Consider developing cost sharing, at least for certain services and for certain beneficiary groups such as the nonpoor.</li> <li>• Improve coordination with vertical public health programs.</li> </ul>	
CNAMGS revenue sources	<ul style="list-style-type: none"> <li>• Assess the situation under the earmarked taxes and levies to finance the GEF scheme.</li> </ul> <p>Conduct a feasibility of the other sources of financing (e.g., tobacco and alcohol taxes)</p> <ul style="list-style-type: none"> <li>• Consider exemption of beneficiaries based on means testing.</li> </ul> <p>Create further incentives to encourage enrollment of informal sector workers.</p> <ul style="list-style-type: none"> <li>• Consider income-related premiums.</li> <li>• Assess the role and appropriate level for the reserve fund.</li> </ul>	<ul style="list-style-type: none"> <li>• Introduce tobacco and alcohol taxes, if feasible, or options for diversifying sources of financing that are sustainable</li> </ul>

*Note:* CNAMGS = Caisse Nationale d'Assurance Maladie et de Garantie Sociale; GEF = Gabonais Economiquement Faibles; NHA = National Health Accounts; NHIP = National Health Insurance Program; OOP = out-of-pocket; PHC = primary health care.



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Gabon is an upper-middle-income country with reasonable spending on health. However, its health outcomes resemble that of a country that is low- to middle-income. It faces low life expectancy (63 years) and a high burden from communicable diseases. In addition, it is grappling with the need for resources to support the universal health coverage that it provides. Some of the questions facing the country are how resources are being spent, whether there is room for a more efficient allocation of existing resources, and whether additional resources need to be mobilized.

*Health Financing in the Republic of Gabon* reviews the situation in the country in light of health financing principles: revenue mobilization, risk pooling, and purchasing services. It also estimates the fiscal space in health, looking at options that could increase resources for health within a macroeconomic and fiscal context. The book will be of interest to policy makers and development practitioners in the health sector.

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