

6 HEALTH CARE FINANCE AND EXPENDITURE

6.1 Health Expenditure Data and Trends

The share of the Ministry of Health as a percent from the national budget has been decreasing over the past several years. It represents about 4-5% of the national budget as shown herewith below.

Budget Ministry of Health (% of National Budget)

1997	4.5
1998	5.7
1999	4.7
2000	4.4
2001	4.2

Nevertheless, even with this relatively small percentage, only 46% of the budget was effectively expended in 2001 and 60% in 2002! This under-spending cuts across all budget lines, suggesting that this may be related either to the non-availability of funds, or to a delay in approval of the budget or to over-planning or to a host of bureaucratic delays or to a combination of these and other factors. One will note that despite the fact that there is an outcry on the availability of medicines, heard across all reports and interviews, 30 and 23% of the pharmaceutical outlays were used in 2001 and 2002 respectively.

	<u>Budget</u> <u>2001</u>	<u>Effective</u> <u>2001</u>	<u>Budget</u> <u>2002</u>	<u>Effective</u> <u>2002</u>
Budget Ministry of Health (in Thousands DJF)				
Office of the Minister of Health	3350	2868	188650	234626
Office of Studies and Planning				
Directorate of Prevention	6657	1300	6657	1350
General Peltier Hospital	83356	69469	83356	67454
Balbala Hospital	1369		1369	204
Centre Paul Faure	5700	1373	25700	945
District of Djibouti	4668	1088	4668	631
District of Ali Sabieh	5722	3507	5722	5356
District of Dikhil	5662	4935	5622	4449
District of Tadjourah	5720	2777	5720	3810
District of Obock	5447	4175	5447	4289
Directorate of Pharmaceuticals	220360	68782	320360	75614
Directorate Administration & Finances	490	41	490	400
Centre Yonis Toussaint			2500	775
Totals	348501	160315	656261	399903

Most of the Manpower attached to the Ministry of Health serves in the Hopital General Peltier and the other Level IV facilities, as would be expected (see below). There has

been discussion with donors on the need to decrease the level of staffing in order to alleviate the budget allocated to employment in the Ministries across all sectors. However, as detailed under Government budget above, more employees will be employed in 2004.

Manpower Ministry of Health 2002

Ministry of Health	89
Hopital General Peltier	320
Dar Al Hanan Maternity	29
Balbala Hospital	63
Centre Paul Faure	38
Centre de Sante Communautaire	90
Health Post	12
DHEP	53
CMH Ali Sabieh	33
CMH Dikhil	26
CMH Obock	15
CMH Tadjourah	35
Others	45
Totals	848

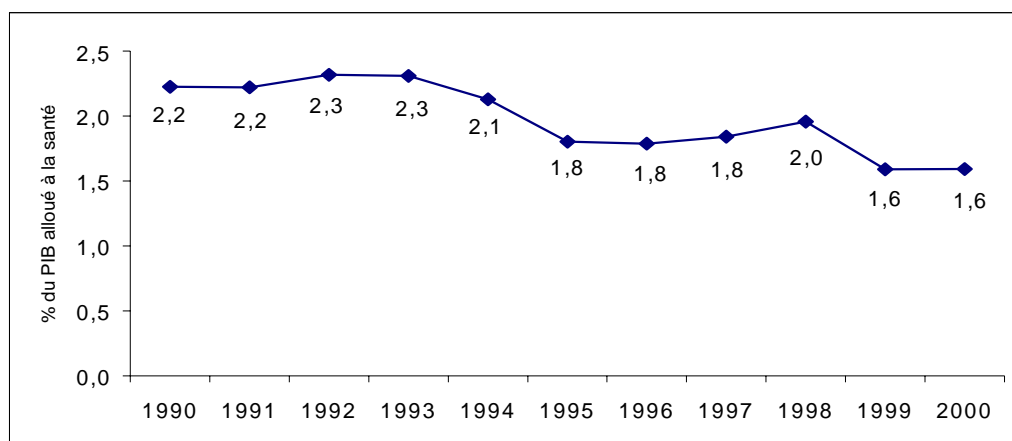
Health care Financing

As noted above, the financing of health care is provided through many sources, including the Treasury, OPS, households, donors. To a large extent, these sources are variable and may not be sustainable.

Percent of the GDP allocated to health care 1990 - 2000

Households

As documented in the National Health Accounts, Households contribute up to 24% of the total health expenditures



The Treasury contribution to health expenditures 1986 – 2003

Years	Overall state budget in Djibouti Francs	Ministry of Health budget in Djibouti Francs	Percent of health budget to total budget
1986	22 851 267 000	1 751 778 000	7.7
1987	22 113 950 000	1 657 999 000	7.5
1988	23 116 900 000	1 784 954 000	7.7
1989	23 709 200 000	1 719 115 000	7.3
1990	23 968 100 000	1 807 013 000	7.5
1991	25 872 597 000	1 841 939 000	7.1
1992	27 008 900 000	1 984 076 000	7.3
1993	28 320 669 000	1 979 292 000	7
1994	32 485 898 000	1 933 542 000	6
1995	31 636 158 000	1 632 814 000	4.3
1996	34 907 350 000	1 577 540 000	3.5
1997	36 808 634 000	1 650 631 000	4
1998	31 561 442 000	1 784 272 000	5.6
1999	35 174 000 000	1 500 053 000	4.3
2000	35 862 000 000	1 568 856 000	4.4
2001	38 232 122 000	1 769 460 000	4.6
2002	39 559 000 000	1 831 199 000	4.6
2003	41 187 000 000	1 804 657 000	4.4

Table 6-1 Health Expenditure

Indicators	1990	1995	2000	2002
Total health expenditure/capita,	-	-	-	-
Total health expenditure as % of GDP	-	-	-	7
Investment Expenditure on Health	-	-	-	-
Public sector % of total health expenditure	-	-	-	4.6

Source:

Table 6-2 Sources of finance, by percent

Source	1990	1995	2000	2002
General Government	-	-	-	27
Central Ministry of Finance	-	-	-	-
State/Provincial Public Firms Funds	-	-	-	-
Local	-	-	-	-
Social Security	-	-	-	-
Private	-	-	-	-
Private Social Insurance	-	-	-	-

Health Systems Profile- Djibouti	Regional Health Systems Observatory- EMRO			
Other Private Insurance	-	-	-	-
Out of Pocket	-	-	-	24
Non profit Institutions	-	-	-	-
Private firms and corporations	-	-	-	20
External sources (donors)	-	-	-	29

Source:

Trends in financing sources

Information on the various sources of health care financing is available in the National Health Accounts of Djibouti (NHA) 200017, undertaken in the year 1999-2000. The NHA used the 1996 household survey (EDAM) as well as information received from the providers of health care financing, most notably the Ministries of Health, Interior, Defense and the Office of Social Protection (OPS). Estimates of household expenditures were made using a population base 450,000 inhabitants estimated by the EDAM in 1996.

A follow up of the NHA accounts was undertaken in March 200318. The report of this mission states that the NHA exercise of the year 2000 had the merit of introducing the NHA methodology to the stakeholders and to get an initial approximation of the health expenditures. It was noted nevertheless that the exercise did suffer from several lacunae. These were detailed in the consultant report of March 2003. Moreover, the institutionalization of the NHA team has not been formally established despite the passage of three years already. Certain stakeholders had been sensitized though in an informal manner. The needs for information have not been entered into the information system. No discussion or dissemination of the results had taken place and finally no follow up has been executed.

The government assures free public health care services and health care services for primary, secondary and tertiary levels of care. Since 1986, the state does not anymore take care of treatment abroad. These Government services benefit in particular all citizens who are recognized as poverty-stricken (Obtain a "certificate d'indigence" from the Minister of the Interior). The poor who are ill are hospitalized in the third category of health care service of the state.

The budget of the Ministry of Health derives from the taxes and revenues collected by the Government (Ministry of Finances) in addition to grants from external donors. The government recovers (or attempts to recover) a portion of the costs of hospitalization and of outpatient consultations. This aide may be paid in kind; for example the purchase direct of medicines and medical equipment. The budget of the Ministry of Health serves also to pay the share of the government in international health initiatives (conventions)

The Office of Social Protection (OPS)

OPS provide health services to its beneficiaries through its own local medical dispensaries (SMI) which provide only outpatient consultations (at the tune of 150,000 visits per year). The insured include the employees in the government sector and private sector (and their families). The enrolled pay a contribution of about 7.2% of their salary paid through their employers. The employees of the Civil Service are not covered. The funds of OPS are derived from the employee contributions. It is believed that the government has not paid its dues to OPS for many years. OPS do not reimburse the costs of hospitalization unless it is work-related. Certain businesses do cover these medical services whether either with public or private providers.

Some important efforts were undertaken to improve the management of resources at OPS and to increase the control over the expenses of drugs/medicines. The efforts used by the pharmacies of OPS to reinforce the consumption of generic products and to improve the management of medical stocks, supported by an international NGO, will provide for a more rational use of available drugs. Important education efforts regarding prescriptions should be made in order to better meet the objectives of the OPS in control of medications.

Private Health insurance

Private health insurance is practically non-existent. It would be helpful if efforts were to be expanded to enlarge the pool of coverage of the social health insurance (OPS) and to develop the mechanisms for controlling health costs. The initial NHA analysis doesn't allow for using the data obtained to project trends and models for developing social health insurance.

Private health sector

Services are provided by the private facilities for ambulatory consultations, hospitalization and medicines purchased from private pharmacies. There is no private insurance. Citizens not covered by the government or OPS, in particular the privileged classes and foreigners do use the private sector for their medical needs. Payment is made directly out of pocket. Reimbursement is on the basis of fee-for-service.

The sources of financing care

According to the information available, health expenditures amounted to 6,051,589,000 FDJ in 2000. This would represent 7% of the Gross Domestic Product, if we retain the calculations of DINAS. These numbers ought to be treated with caution given the uncertainty of the data related to the size of the population. Nevertheless, one should note that the cost of services in the private sector is elevated due to the regulations relative to the importation of medications and the poor regulation of the private market.

The respective share of the financing of medical care is as follows:

External assistance	29%
Public Funds	27%
Households	24%
Employers	20%

Financing Medical Care

(Thousands of FDJ)

	External Cooperation	Employers	State	Households	Totals	Percent
Other						
Ministries			139000		139000	2.2
Households				1440450	1440450	23.7
Ministry of Health	1777000		1496919		3273919	54.0
OPS		1205220			1205220	19.85
Totals	1777000	1205220	1635919	1440450	6058589	100
Percent of Totals	29.33026	19.89275	27.00165	23.77534	100	

According to studies in 2000, foreign aid constitutes the main source of financing of the health sector. Of each 100 Djibouti francs, 27 come from foreign bilateral or multilateral aid and from NGOs which operate in the country. The difficulties faced by the Ministry of Health, combined with the lack of coordination of donor agencies, leave the task of coordinating this particularly difficult.

According to information in the UNDP 1999 report, the shares of principal donors of foreign funds are:

France	35 %
Spain	32 %
Italy	7.8%
WHO	7.8%

The NGO contribution, which has become very important in the last few years, is difficult to measure in the absence of a national coordinating body for foreign aid. The important role of foreign aid in health care financing highlights the problem of sustainability. The new organizational structure of the Ministry of Health includes a planning department, which will be, among other things, responsible for the coordination of international donors and aid.

Other sources of financing

The contribution of the semi-private-public institutions has been estimated at 128,000,000 FDJ in the 1999 NHA accounts. This last estimate was made after a declaration on the state of affairs by ten important businesses. The Ministry of Interior covers the police force and their dependents estimated at 15,000 persons. This population engenders 2,214 inpatient admissions, 670 deliveries and 45,000 ambulatory visits) The Ministry of Defense covers the Military and their dependents as well (8.5 million DJF). School health expenditures are about 2.5 million DJF.

Finally, the health expenditures incurred at the French military hospital, CHA Bouffard (56 beds- 22,000 ambulatory visits) ought to be taken into consideration. This facility is an important source of secondary and tertiary level services. This facility is contracted to provide medical care to the Djiboutian army personnel and their dependents, in addition of course to the French Army positioned in Djibouti and their families. Many families from the middle and upper classes do use the facilities of CHA Bouffard in return for payment. A figure of 6 millions euros has been advanced as the amount of free care provided by the hospital in 2003!¹⁹

Household Expenditures on Health Care

Households assume an important part of total health expenditures. This has been acknowledged both in the NHA and in the more recent population-based surveys.

Households purchase medications and health services either directly from the private providers or through the disbursement of a co-payment at General Peltier Hospital. It is estimated that the total amount spent on medications is 850 million FDJ. The purchase of medications represents 58% of the household expenses. It is important to note that the individual importation of medicines by the pharmacies in small quantities doesn't allow for the competitive pricing.

The total annual expenses for outpatient consultations is estimated at 400 million FDJ, including consultations at the practices of traditional healers who represent 12% of the providers. According to the data from the household survey, hospitalization expenses are 164 million FDJ. The cost of transportation for sick people is estimated at 65 million FDJ or 4% of the total expenses.

Health expenditures by Households

Ambulatory care	24
Hospitalization	11
Medicines	58
Transportation	4
Others	3
Totals	100

The recently completed EDAM 2002 survey has only released part of its findings. In response to the question *«Combien le ménage a-t-il dépense au cours des 12 derniers mois pour les soins de santé, pour l'ensemble des membres? »*i.e. *“How much did the household spend on the health care of its members over the past 12 months”*, an average amount of 10,500 DJF was obtained with a median household expenditure of 5,000 francs only. The standard deviation was however (as expected) quite large (26,000+ DJF), which indicates wide variation in the cost of care financed by households.

More information is to be made available as well from the PAPFAM survey.

Household expenditures on Health (EDAM 2002) Cumulative

Expenditures up to 800 DJF per year per household %	40
Expenditures up to 5000 DJF per year per household %	50
Expenditures up to 7000 DJF per year per household %	60
Expenditures up to 10000 DJF per year per household %	70
Expenditures up to 12000 DJF per year per household %	75
Expenditures up to 15000 DJF per year per household %	80
Expenditures up to 25000 DJF per year per household %	90
Average Expenditures per year per household	10569
Median Expenditures per year per household	5000
Standard Deviation	26104

It is important to emphasize that the household surveys are the principal source of information concerning the consumption of health services by households. These will need to be updated to provide information on private medical care. An effort to train personnel must be made particularly in the areas of general accounting and cost analyses for health care services (See below please).

Health expenditures by category

Djibouti's government budget allocation to the health sector is relatively low compared to other countries, at less than 2 percent of GDP. The public health share as a percentage of GDP is showing a disturbing downward trend, falling from 1.70 percent in 1996 to 1.5 percent in

2002. Since the early 1990% resources allocated to health through a voting system have decreased nominally. This decrease was further compounded by lower external aid receipts which fell from USD 11million in 1998 to USD 7 million in 1999, which is a significant 36 percent decline.

Public health expenditure has fluctuated over the past decade and continues to do so. In 1996, the government spent USD 8.42 million which rose to USD 9.12 million in 2000. It then declined to U S D 8.74 million in the following year and increased to USD 9 million in 2002. The share of current expenditure allocated towards health has averaged around 5 percent for the last 5 years decreasing from over 7 percent during the second half of the 1980s, whereas the international standard is around 10 percent. Djibouti's share of total health expenditure to GDP is relatively larger when compared to African countries its size and Sub-Saharan Africa, it falls behind in the proportion of total public expenditure spent on health.

Within the health budget, expenditure on personnel has on average formed 78% of the total public health bill between 1996 and 2001. However, a near doubling of expenditure on equipment from U S D 1.96 million in 2001, to U S D 3.68 million in 2002, lowered the personnel share to 64 percent, which remains high. The delivery of health services depends critically on an adequate level of material or equipment and the low levels of spending on health equipment in Djibouti continues to remain a concern.

On a per-capita basis, public health expenditure declined from USD 14.52 in 1996 to USD 11.4 in 2002, which is not keeping pace with the growing population. A declining share of the health budget in GDP, a rapidly expanding population, together with the continued provision of free health care is leading to a deterioration in health infrastructure and fall in the quality of care.

Djibouti is among the relatively higher GDP per capita African countries that also has high health care costs. Djibouti's external aid for health is one of the highest in Africa. Despite these high expenditures, however, Djibouti's health indicators are among the worst in Africa.

Table 6-3 Health Expenditures by Category

Health Expenditure	1992	1995	2000	2002
Total expenditure: (only public)	-	-	-	-
Per capital expenditure	-	-	-	-
% By type of service:	-	-	-	-
Curative Care	-	-	-	-
Rehabilitative Care	-	-	-	-
Preventive Care	-	-	-	-
Primary/MCH	-	-	-	-
Family Planning	-	-	-	-
Administration	-	-	-	-
% By item	-	-	-	-
Staff costs	-	-	-	-
Drugs and supplies	-	-	-	-
Investments	-	-	-	-
Grants Transfer	-	-	-	-
Other	-	-	-	-

Source

6.2 Tax-based Financing

Levels of contribution, trends, population coverage, entitlement

Key issues and concerns

6.3 Insurance

Table 6-4 Population coverage by source

Source of Coverage	1990	1995	2000	2002
Social Insurance	-	-	-	-
Other Private Insurance	-	-	-	-
Out of Pocket	-	-	-	-
Private firms and corporations	-	-	-	-
Government	-	-	--	-
Uninsured/Uncovered	-	-	-	-

Health insurance, provided through the OPS, is only open to workers in the private sector and contractual workers in the public sector. Civil servants do not have health insurance (they use the public hospital services). The President of the Republic of Djibouti has recently requested that the OPS assess the viability of extending health insurance coverage to them.

Primary care is provided through two OPS health centers, one for families and another for employees. Hospitalizations are referred to the public hospital Peltier, where employers are supposed to finance costs.

While the health branch at present is generating an operational surplus, current financing arrangements are not based on technical valuation of unit costs and utilization patterns across the insured population. Health expenditures (including those related to work-related accidents) currently represent 5 percent of the total non-administrative expenditures of the OPS (less than 0.1 percent of GDP). Since the health branch is financed by a 6.2 percent contribution rate, in theory it has revenues of DF 1.17 billion-10 times current expenditures. In reality, part of the surplus of the health branch is financing the deficit of the pensions branch, where revenues (resulting from 8 percent contribution) represent only 80 percent of expenditures.

Current statistics of primary health services suggest reasonable utilization rates. No data is available regarding the utilization of tertiary services. There are, on average, 6 visits per plan member (contributors, beneficiaries, and families). Of these, roughly 50 percent require medical attention, costing on average DF 1,548 (USD 9). With this level of utilization and average cost, expanding coverage to the 6,900 civil servants and retirees (assuming similar family sizes and utilization patterns) would cost additional DF 31 million (28 percent of current expenditures). These costs, however, do not include hospitalization, which is likely to be an important, and currently unaccounted item.

An actuarial valuation of the health insurance branch of the OPS is required urgently. The OPS is preparing terms of reference to launch an initial phase of this study, which would consist of collecting detailed data on utilization and costs. Technical assistance for this study could be financed through the Health Sector reform project currently under implementation. Indeed, the second phase of this project has a component on health financing, with a budget set aside for studies.

In the context of the health sector reform project, a study should be conducted to assess the potential of the OPS to become the core of the health insurance system in Djibouti. This study will first explore the financial implications of extending current services to the population of civil servants. A second component of the study will assess the appropriateness of the benefit package, contractual arrangements with providers, payment systems, financing mechanisms, and management and information systems. The study will propose a multi-year program to strengthen and expand the health insurance system in Djibouti as well as the needs in terms of technical assistance

Trends in insurance coverage

Social insurance programs: trends, eligibility, benefits, contributions

Social insurance programs are designed to mitigate risks such as disease, disability, death, longevity, and unemployment. In Djibouti, social insurance comprises old-age, disability, and survivorship pensions (available to all workers in the formal sector) and health insurance (only available to workers in the formal private sector and contractual workers in the government). No unemployment insurance program is available.

The newly created Conseil National de Securite Social (CNSS) is the governing body of the social insurance system. The CNSS houses the Organisme de Protection Social (OPS) and the Caisse National de Retraite (CNR). The OPS provides health insurance, insurance against work-related accidents, family allowances, and old-age, disability, and survivorship pensions to private sector employees and contractual workers in the public sector. The CNR only provides pension benefits to civil servants, parliamentarians, and the police. The military are covered by a separate regime, the Caisse Militaire de Retraite (CMR), which is part of the Ministry of Defense.

Altogether the social insurance system costs 5.1 percent of GDP and covers 23 percent of the workforce. Pension expenditures amount to 3.8 percent of GDP. The OPS is the largest scheme, with close 20,400 plan members, revenues of DF 4.1 billion (4 percent of GDP), and reserves of DF 4.6 billion (4.5 percent of GDP). Pension expenditures in the OPS account for 45 percent of the total.

Private insurance programs: trends, eligibility, benefits, contributions

New initiatives: Micro-insurance and private health insurance (Mutuelles)

The Ministry of Social Affaires and National Solidarity (MSANS) is considering the

Development of a micro-insurance system to provide health insurance coverage to those outside the formal economy. The rationale put forward is that, given financial constraints, the public health system can no longer provide free health care to the whole population. While formal cost-recovery fees are not yet in place, those demanding health services - particularly low-income groups - face hidden costs. It is estimated that only 30 percent of the population has access to the public health system. MSANS is

currently seeking technical assistance to assess the feasibility of this initiative, including an assessment of the potential population of beneficiaries, institutional arrangements, and financing mechanisms. If this initiative moves forward, the idea is to start with one or two pilot projects, before a more aggressive expansion of the system.

There is also an initiative championed by the Ministry of Health (with support from the African Development Bank) to develop private health insurance schemes. These institutions would be designed following the model of the French mutuelles, which complement the social security system.

The main concern of the World Bank is that this type of initiatives should be part of a coherent, integrated strategy for health financing in Djibouti. Before considering the introduction of new institutions, it is recommended to carefully look at the potential offered by the public system (OPS). As previously discussed, resources and technical assistance currently are available through the health reform project.

6.4 Out-of-Pocket Payments

(Direct Payments) Public sector formal user fees: scope, scale, issues and concerns

Much of what is known about distributional impact of public health spending for Djibouti is based on a household survey conducted in 1996 known as EDAM or (Enquete Djiboutienne aupres des Menages) . Households shoulder a large share of total health expenditure. The very poor are households that could not afford to purchase the food basket needed to maintain a minimum amount of calorie consumption of 2015 per adult equivalent. The poor are classified as individuals who not able to meet basic needs compromising of food and non-food items. Those in the highest 20 percent income quintile are classified as better-off.

On average, each household spends an equivalent of USD 87.35 per year for drugs. When considering only those with positive expenditure, the average expenditure on drugs jumps to USD 178, which a significant 50 percent of a household's health budget. The average expenditure of the richest quintile was USD 282.5, and the average expenditure of the poorest 20 percent of households was USD 102.2. Almost everybody who had a positive expenditure for health care paid for drugs. This strongly supports the conclusion that drugs are not free.

The average per-capita private health expenditure of USD 17.83 in 1996 is close to the 1993 level of USD 19. Private per-capita health expenditure for the poorest household was USD 3.48 compared to USD 52.31 for the richest households.

Health expenditures

last 12 months

sedentary households	All Quintiles	First Quintile	Second Quintile	Third Quintile	Fourth Quintile	Fifth Quintile
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Purchase Medications

Average per household	15625	3074	8343	11261	16460	35231
Average per individual	2335	454	1167	1585	2362	6211

Ambulatory services

Average per household	2886	385	1009	1294	3451	7405
Average per individual	431	57	141	182	495	1305
Average per consultation	781	156	252	332	841	1859

Hospitalizations

Average per household	1229	12	690	1536	1621	2135
Average per individual	184	2	97	216	233	376
Average per patient-day	364	3	292	567	793	380

Traditional practitioners

Average per household	715	356	239	625	1112	1157
Average per individual	107	53	33	88	160	204
Average per consultation	4008	3251	2491	2189	7654	4744

Cost of transport for health care

Average per household	965	241	523	1263	1373	1363
Average per individual	144	36	73	178	197	240

All costs

Average per household	21420	4068	10804	15979	24018	47291
Average per individual	3201	600	1512	2249	3447	8337

Information only from households that provided information; if one or more info is lacking, households have been excluded

(Direct Payments) Private sector user fees: scope, scale, type of provider involved, issues and concerns

Given the importance of drugs in the household's health budget, further efforts should be made to determine programs that can reduce cost through group purchases and better information for both private and public drug providers. The public sector provides most of the curative medical services in Djibouti. The non-poor are more likely to turn to the private sector for professional health services. On average, less than 6 percent of the households have used a traditional healer in the last 12 months. Nearly 58 percent of households have used a public health facility in the last 12 months, and 17 percent of households have used a private health facility in the same period. The results show that the demand for different kinds of health care providers is correlated with household income. The use of health facilities increases with economic well-being. The poor did not use private facilities, but one third of the richest 20 percent of households used private health facilities.

The 1996 data also informs us that the type of health treatment varies with the material standing of a family. If medical treatment is sought, many poor families choose to go to a dispensary. Nationally, almost two-thirds of the very-poor sought professional treatment from a dispensary. Among the non-poor only half of sick used a dispensary. It is clear that richer people tend to use hospitals, while the poor and the very-poor make larger use of dispensaries and traditional healers. In the past, the free provision of health services induced many people to switch from traditional healers to Government facilities. However, the 1996 Participatory Poverty Assessment (PPA) stated that the unavailability of drugs, meager economic resources, and a recent introduction of a cost sharing mechanism induced many households to revert to herbs and other traditional medicines which are less expensive than at a health facility.

Many households are not satisfied with the quality of the dispensaries which are mainly utilized by the poor: 33 percent of the inhabitants of Djibouti consider the system poor, and 33.4 percent consider the system only average. There seems to be no difference in the perceived quality of services for rural and urban locations. According to the 1996 PPA, people are very dissatisfied with the services offered by Government dispensaries because the basic infrastructures needed to ensure quality is missing. The other two main concerns are the low quality of personnel and the sporadic availability of drugs. In contrast, the refugee population living in camps can use the services of a well-organized dispensary run by an NGO.

Public sector informal payments: scope, scale, issues and concerns

Cost Sharing

6.5 External Sources of Finance

Since the public sector is the largest provider of health care in Djibouti, the quality of care is determined to some degree by the national budget allocation towards health. It was already noted the amount spent by the government on health per person is declining. Thus, the population is forced to contribute to the cost of care in order to stay in reasonable health. According to the 2004 PRSP, the total health care bill for the country is financed by the state (27 percent), external aid (29 percent), households (24 percent) and by assessment on employers and wages (20 percent). Foreign aid constitutes the primary source of financing health care. Based on a 1999 United Nations Development Report (UNDP), the major donors are France (35%), Spain (32%), Italy (7.8%) and the World Health Organization, WHO (7.8%).

Levels, forms, channels, use and trends

The World Health Organization has been an active partner of the Ministry of Health in the conduct of its development and reform plans. At the present, the projects supported by WHO within the biennium plan consist of the following:

- Support to the health policy and strategic plan
- Support to the development of nursing and paramedical personnel
- Support to the PHC services

- Support to sustainable development through the empowerment of women and community initiatives
- Support to the pharmaceutical policies based on the essential list of medications
- Support to the Public Health laboratories and health technologies
- Promotion of healthy lifestyles and health education
- Support to Mental health
- Support to the anti-tobacco campaign
- Support to the anti-Blindness campaign
- Support to the Non-Communicable Diseases program
- Support to the Reproductive Health and safe Motherhood Program
- Support to Child Health
- Support to water quality and sanitation
- Support to the Expanded Program of Immunization
- Support to the anti-Tuberculosis, Malaria, HIV/AIDS and STD programs
- Support to the Epidemiologic Surveillance function

It is evident from the WHO program that it encompasses most of the sectors and activities that will require support within the health sector reform activities and the poor policies of the Ministry. In fact, the recommendations suggested in this report are remarkably similar to the support already provided by WHO.

Given the amount of funding provided by the donors, WHO's contribution is focused principally as a technical partner to the MOH in the planning, implementation and evaluation of the programs of external assistance. WHO is a respected technical agency of the United Nations and has the experience needed to support the Ministry in these programs. It is trusted by the donors, many of whom will need partners to implement their plans. WHO may wish to consult with the Ministry to provide additional support and guidance to the health sector reform principally to the recommendations related to the forward vision of the role of the Ministry of Health, the development of the community health workers program, to health manpower development and to the options for financing health care. WHO has already provided useful input into these four programs and may consider continuing this support, as a partner to the Ministry of Health.

Development Partners

External assistance is critical to the reform and the further development of the health sector, as well as to the Government strategies to combat Poverty. Donors provide more than 30% of the budgetary requirements for the health sector. While it remains difficult to note the support given by all donors, a compilation has been approximated and appears in the table herewith.

Republic of Djibouti- Selected donors to the health sector²¹

As of January 2004

	Millions \$			
UNDP	23.9	20	Combat HIV/AIDS	Support the establishment of regional committees to combat HIV/AIDS Establish a national multi-sectorial team Support the implementation plans, the training of NGO, follow up of efforts
European Union	16	48	Sanitation	Urban environment; water systems;
UNFPA	2.448	60	Reproductive Health	Gender issues; genital mutilation;
World food program	5.1	18	Nutrition	Beneficiaries 43,000 persons poorly nourished children, lactating and pregnant mothers, AIDS patients, orphelins, refugees
Save the Children		36	HIV/AIDS	Reduce the rates of transmission of HIV AIDS in the high risk corridor Truckers, dockers, prostitutes
USAID	12	36	MCH	
UNICEF		48	Children and HIV	
World Bank	12	60	CCD	Support systems of prevention of communicable diseases
World Bank	5.4		HSR	
WHO	3.2	24	HSR	
French Cooperation	6	30	HIV AIDS	
French Cooperation	16		HSR	Cooperation with the World Bank
French Cooperation	0.35	48	Anesthesia	Emergency Medicine
Totals	102.398			

The World Bank Institutions

Djibouti joined the World Bank in 1980. Since then, the focus of the World Bank assistance has been to foster sustainable economic growth and reduce poverty in the country. In March 2005, the World Bank adopted its second Country Assistance Strategy for Djibouti covering the period 2005 -2008. The CAS, developed in close partnership with the Government of Djibouti, serves as a roadmap for World Bank assistance to the country. The CAS program for Djibouti in support of the Poverty Reduction Strategy Paper (PRSP) involves several interconnected actions, building on the investment and structural adjustment programs started under the previous CAS. Specifically, it involves:

1. Moving a step further in addressing fiscal consolidation, improving competitiveness, and income distribution--this would be carried out through a combination of further wage bill adjustments to create more fiscal room to expand priority public services and transfers to the poor, and through the restructuring of utility sectors (power and water) to reduce the costs of doing business and improve access of the poor to these essential public services;
2. Sustaining development and improved management of the Ethiopia Djibouti transport infrastructure in support of port activities, the economic backbone for growth and employment; and
3. Vocational training to enable local work force take advantage of spillover activities related to the expansion of the port.

As of July 2005, the World Bank has financed 17 operations in the country for a total original commitment of US\$ 155.5 million. The World Bank's current portfolio, as of July 2005, in Djibouti comprises five active investment projects, namely.

1. Flood Emergency Rehabilitation
2. Public Works and Social Development rehabilitation
3. HIV/AIDS, Malaria and Tuberculosis Control Project
4. Health Sector Development Project
5. Djibouti Social Development and Public Works Project

Health Sector Development Project

The purpose of the Health Sector Development Project is to support the Government of Djibouti's long-term health sector development program in order to meet the Millennium Development Goals for the reduction of under-five child mortality and maternal mortality rates. There are four main components.

1. The first component improves health services by improving the physical and human capacity of health facilities; establishing Integrated Management of Childhood Illness (IMCI) programs in all facilities; reinforcing the malaria control program; and supporting immunization.
2. The second component improves the availability of trained personnel by increasing capacity and improving the curriculum of Centre de Formation des Personnel de la Sante Publique (CFPS); and by improving service conditions for qualified paramedics.
3. The third component improves the availability of drugs and medical consumables by supporting the stocking of drugs in emergency health facilities; establishing a self-sustaining independent drug fund (CAMME); and supporting the development of community pharmacies that buy generic drugs from CAMME and sell them at a low cost to patients.

4. The fourth component improves sector management through capacity building in the health ministry and supports administrative autonomy of Hopital Peltier.

The support from US AID²²

The underlying force behind the contribution from USAID is to assist in the development of a healthy, literate and skilled workforce that could sustain the transformation of Djibouti into a modern commercial state. The USAID support is focused on the social sectors with programs in Education, Health, Food security and Regional livestock marketing.

1. Education

The goal is to assist the MOE in the reform of its programs throughout the country. The program focuses on basic education (Grades 1-12) and has four elements:

1. Increased access to basic education
2. Improved quality of teaching and learning
3. Increased opportunities for girls
4. Provide sustainable employment for graduates, particularly girls

The strategies rely on the provision of new information and communication technology in addition to basic educational principles. This will entail the preparation of teachers (Teacher Training), the improvement of the curriculum, the preparation and dissemination of textbooks, the physical rehabilitation of schools and radio-assisted education.

The International Foundation for Education and Self-Help (IFESH) will begin its Teachers for Africa Program in Djibouti. Seven experts in the training in English Language will be placed in MOE and the private sector to promote the mastery of the English language. IFESH has been registered as an NGO and will place volunteers to teach English.

It is expected that the project will benefit up to 135,000 children between the ages of 6 to 15 years. This component has a budget of \$ 14 millions over the period 2003-2006 (3 years). EQUIP has been awarded the contract to improve basic education. EQUIP is a worldwide project that focuses on the improvement of basic education. An office has been set up for EQUIP in Djibouti. Two schools which serve over 3,000 children have already been rehabilitated namely

2. Health

The goal is to support the development of the health sector, increase access particularly for the poor population, increase the quality and efficiency of care in order to reduce infant, child and maternal mortality. The program calls for the provision of an essential package of services that will include child health programs to address acute respiratory illnesses, control diarrheic diseases, improve nutrition and immunization and promote reproductive health. In addition, focused activities will be undertaken at the district level to prevent infectious diseases including tuberculosis, malaria, HIV/AIDS. This program will consist in the physical upgrading of health facilities to provide the essential basic packages, support quality care and train community health workers. The local communities will be engaged in the process as well.

It is anticipated that the project will benefit approximately 120,000 people, mainly women and children. The sum of \$ 12 millions have been earmarked over the period of 3 years. The implementation is likely to be entrusted to local partners and UNICEF. The French Cooperation and the World Bank have agreed to participate in the technical evaluation committee that will select the contractor(s).

3. Food security

The Famine Early Warning System will consist of a network of country offices throughout East Africa and the Horn of Africa to monitor food security. The system monitors a basket of indicators and reports on the status of food availability and nutrition deficiencies in countries and regions. The program will be monitored from the regional office in Nairobi. One million \$ have been earmarked for this component.

In addition, Djibouti is considered a country with a chronic food deficit requiring about 13,000 metric tons of food annually. In cooperation with the World Food Program, USAID will develop an operation to provide rural Food for Work activities and urban institutional feeding, in addition to providing relief to Somali refugees in Djibouti. The target group is expected to amount to 43,000 persons (including about one third of refugees). In 2003, 4,000 metric tons were distributed.

4. Livestock project

The project consists of a regional activity to develop a Livestock marketing (export) health certification facility in Djibouti. A facility will be built for the large scale holding and health certification of all types of livestock for shipment to the Middle East. The facility will include holding pens, quarantine facilities and modern veterinary services. This project will be a private sector operation. It is expected that over one million head of livestock will be exported to the Gulf States per year. Four million \$ have been obligated for 2004.

US AID Health sector

As of January

2004

	Millions \$	Three year Program 2003-2006
Facilities	2.5	Renovation, rehabilitation of water supply
Equipment	1.5	
Systems and Training	2.5	Strengthening of systems and training at facility level
Training	1.5	Center for training health professionals Certificate and non certificate training programs
Community mobilization	2.5	
Program Management	1.5	
Totals	12	

6.6 Provider Payment Mechanisms

The issues that relate to the financing of health care ought to be reviewed and dealt with once the MOH and Government have adopted a vision for the nature of the health care system of Djibouti in the medium and long terms. The vision will clearly delineate the principal functions of the MOH and that of the other partners, such as the civil society, the private sector, the employers, the donors and other stakeholders.

In the domain of health financing, Djibouti has made an ideological beginning by espousing and legislating the establishment of the Office of Social Protection (OPS). In other terms, Djibouti has opted for a social security system, based on solidarity amongst the population. The current OPS has had difficulties in its finances and accounts that seem to be over at the present time given the effective administrative and financial measures that have been implemented in the last few years. It may be opportune at this time to consider the further development of the OPS.

The Social Security system is typically a "public" organization that has the managerial flexibility of the private sector. It has usually several funds that must be totally and absolutely separate from each other and from the Government budget. The funds are typically those of retirement and end of service, sickness, workman's compensation and occupational injuries, and family allocations.

The Sickness Fund is a social health insurance scheme. It derives its funding from employers, employees and Government, a tripartite funding. It is pegged to a proportion of the salary (or estimated income); hence the wealthier individuals would contribute proportionately more than the poorer segments of the population.

The issue that will be faced by the Government is the payment of the contribution (or premium) by the poor, the unemployed and the people with special needs (the handicapped). The Government could provide for this contribution in association with Charity, religious institutions (such as the Zakat fund). Additional funds for the poor could be levied through "sin" taxes such as earmarked taxes on cigarettes, liquor, "khat", airline travel, compulsory car insurance and other venues deemed acceptable by the Government. The percent of contribution on salaries and income could also be increased to provide for the poor. This would be in line with the concepts espoused by the Macroeconomics and Health Commission as well as the Millennium Development Goals. The issue of equity in Finance must be addressed by the proposed study.

The merger of all sectors into one social security system would increase the pool of the population that is covered, spread the risks, provide for better provider payment mechanisms (public and private in the future). Thus civil servants, the uniformed forces and other groups ought to be consider for enrollment within the proposed social security scheme, as it develops.

The enrollment within the social security scheme will finalize the status of health care as a human right, as a citizen right, rather than a "gift" or "give-away" from the paternalistic government. This will lead to an improvement in the quality of care and service provided in the facilities since the service is already pre-paid for through the contributions. This will support the autonomy status that has been bestowed on the Level IV facilities and will support their respective finances. A detailed study and analysis is recommended to be undertaken by the Government to consider options for the development of the social security system, based on the existing OPS.