

NATIONAL HEALTH ACCOUNTS
CONCLUSIONS AND IMPLICATIONS
DJIBOUTI

MAY 2000

By:

Dr. Hatem

Mr. Sillaye Abdallah

Mr. Soultan

With help from Dr. Sabri, WHO-EMRO

Abbreviations

CREDES	Center for Research and Studies for Health Development
DINAS	National Department of Statistics
EDAM	Djibouti Household Survey/Study
FDJ	Djibouti franc
INSP	National Institute of Public Health (Tunisia)
MS or MOH	Ministry of Health
OMS	World Health Organization
ONG	Non governmental organization
OPS	Office of Social Protection (Social Security)
PIB	Gross National Product
PNUD	UN Development Programme
SMI	Intersectoral Medical services

This report was written by a team composed of a regional advisor from WHO/EMRO Dr. Sabri during a mission to Djibouti in February 2000; Dr. Mahyoub, technical advisor from the Ministry of Health and head of the World Bank Health project; Mr. Ali Sillaye, Finance and Administrative Director of the Ministry of Health; and Mr. Idriss Sultana, head of the study and survey department at the Statistics department. This report is the first of its kind. The results and recommendations are solely the authors and should not be attributed to the Ministry of Health or the WHO or anyone else.

Table of Contents

- A. Introduction
- B. National Health Accounts: principle conclusions
 - 1. Sources of financing
 - 2. Financing by the of foreign aid
 - 3. Financing in private sector
 - 4. Financing of health insurance
 - 5. Financing of health care services by households
- C. Implications and Conclusions of NHA
- D. Processes and Lessons Learned
- E. Institutional Arrangements for the NHA Analysis
- F. References

A. Introduction

The NHA analysis for Djibouti began in 1999/2000 using as a reference point data from the 1996 Djibouti Household Survey (EDAM.) The data analysis relied on the reading of different reference documents and from field visits by the Office of Social Protection (OPS) and certain managers of health care facilities. Estimates of household expenditures were made using as a population base 450,000 inhabitants estimated by the EDAM in 1996. The census of the population programmed for 2000/2001 will give a more precise idea of the number of the total population of Djibouti. For now, the data has been exploited by NHA relative to actual medical expenses by the private sector and public sector from 1990 followed by an annual inflation rate of 3%. The analysis was made by a national team consisting of:

- Dr. Mohamed Mahyoub Hatem, health economist and advisor to the Minister of Health,
- Mr. Idriss Ali Soultan, statistician and head of the bureau of studies and surveys at the National Statistics bureau,
- Mr. Ali Sillaye Abdallah, finance and administrative director at the Ministry of Health.

Country Information

Located in the corner of Africa at the entrance of the Red Sea, the republic of Djibouti, which proclaimed its independence on June 27, 1977, is a small country of 23,200 square kilometers. According to the data from 1996 from DINAS, the GNP per inhabitant is estimated at 142,000 Djibouti francs or \$802 US dollars. The contribution of the primary sector to the formation of GNP is negligible and is around 3% while the participation of the *tertiary sector* to GNP is 82%. This economic structure reveals its weakness considering the external hazards and especially disruptions which affect the surrounding countries.

The health system of Djibouti is characterized by free health care services and by relative accessibility. It is clear that public financial resources allocated to health have decreased in real value these past few years because of the economic crisis and the domestic political situation. The state of health of the population, although clearly better than in the surrounding countries, resembles that of the greater part of African countries with weak economies. The life expectancy from birth is on the order of 50 years of age. Mortality remains very high – particularly infant and maternal mortality. Malnutrition poses an on-going problem preoccupying the public health sector and representing the tenth leading cause of outpatient consultations in the Republic of Djibouti according to the 1997 data from the Ministry of Health.

Types of available services	Special coverage and criteria of selection	Principal sources of financing	Relations between financing and service providers
<p>Government services:</p> <p>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 foreigners.</p>	<p>All citizens recognized as poverty-stricken by the order of a certificate from the Minister of the Interior. The poor who are ill are hospitalized in the third category of health care service of the state.</p>	<p>Taxes and revenues of the government in the budget of the Ministry of Health. The government recovers a portion of the costs of hospitalization and of outpatient consultation of the sick who are not poor. The outside aid passes through the MOH. This aide may be paid <i>in kind</i>; for example the purchase direct of medicines and medical equipment</p>	<p>The budget of the Ministry of Health goes to pay the salaries of the officials and international health initiatives. (conventionnes)</p>
<p>Services of the Office of Social Protection (OPS:)</p> <p>OPS assures health services to its affiliates through local medical dispensaries (SMI) which provide only outpatient consultations.</p>	<p>The employees in the government sector and private sector and their families pay a contribution of at least 7.2% of their salary paid through their employers.</p>	<p>The takings or income of OPS comes from the employee contributions making it possible for the government to pay no more than its contribution for a long time now.</p>	<p>Service providers in nature. However, OPS does not reimburse the costs of hospitalization outside of an accident in the course of work. Certain businesses in charge of the health services provide for public and private service providers.</p>
<p>Private health sector:</p> <p>Services are provided by the private facilities for consultations, hospitalization and for private pharmacies. There is no private insurance.</p>	<p>Citizens not covered by the government or OPS, in particular the privileged classes and foreigners.</p>	<p>Payment made directly by users of services and households.</p>	<p>Payment at the time of services rendered.</p>

B1. National Health Accounts: Principal Conclusions -- See email.

B2. Foreign Aid Financing

According to studies, foreign aid constitutes the biggest 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 deficiencies of the planning functions of the Ministry of Health, combined with the lack of coordination of donor agencies, leaves the task of coordinating this particularly difficult. According to information in the UNDP 1999 report, the distribution 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 the health care financing effort poses a serious problem of **sustainability** of financing in light of the weaknesses in the general structure of financing and the external hazards. Knowing the general tendency of decreasing foreign aid, even if the other health programs are not reduced considerably, it is legitimate or important to think of alternative solutions to ensure risk free financing. From now on it is important to simulate sustainable financing scenarios, which represent the gradual decline in foreign aid, with the goal of promoting a policy of rationalization of health expenses.

Knowing that this tendency in financing is going to maintain itself in the short or long term, it is imperative to channel the foreign aid to the health sector in order to avoid duplicating the different interventions and to permit the centralization of efforts of different donors regarding MOH priority objectives. This will undoubtedly reinforce national capacity in health planning and improve of the growth and planning process overall. The new organigram of the Ministry of Health includes a health planning department, which will be, among other things, responsible for the coordination of international donors and aid.

B3. Public Sector Financing

The financial resources of the public sector account for the government budget. The budget is divided up into the budget allocated to the Ministry of Health (1,496,919,000 Djibouti francs) as well as relative contributions from the Ministry of National Education (school health: 2,500,000 FDJ), from the Ministry of Defense (family dispensaries: 8,500,000 million FDJ) and finally the contribution of the semi-private-public institutions estimated at 128,000,000 FDJ. This last estimate was made after a declaration on the state of affairs by 10 important commercial businesses in 1990 and which was corrected by inflation. Being public and private businesses, their contribution to health services is assimilated in the public budget or financing. Knowing of the general tendency regarding the **privatization of the industrial sector**, the contribution of these businesses will be gradually move toward the services of the OPS.

Finally, it is not possible to have **an exact idea of the financing at the French military hospital** which contributes greatly to the delivery of secondary and tertiary level services as well as for the

soldiers and their families who form a block of citizens in return for payment. If the information will be ultimately usable, the financial data should be added with the name, "other ministries."

The development of the budget does not take into account the needs and priorities. Often it is a matter of updating (a renewal) of the previous budget increased by rise in prices which reflects the consumer price index. The resource allocation problem poses a more acute problem for the majority of the health systems in developing countries than in developed countries. This situation is also made difficult by the importance of the outstanding payments to the government leaves the Ministry health care services only a little solvent and which gives the budget a fictional character. Regarding this effect, the team of NHA analysts have often used the **real budget** for different parts of the health sector and not the **approved budget**. For example, the budget of the General Peltier Hospital doesn't arrange for a line of credit for drugs or medicines last year!!! Also the public health system doesn't arrange for a compatible analysis at different levels of services, which in turn doesn't allow for a good development and good monitoring of the budget. In addition, there are no incentive measures for managers in order to improve the management process and to adopt visible measures to control the costs of health services.

The program seeks to transform the General Peltier Hospital from an independent health establishment in order to develop a direction plan and to launch compatible analysis for sustainable improvements in the management process and to refine the planning of financial resources. An important effort must be made to develop national capacity in the area of hospital management and for health services. It goes with out saying that these changes must made beforehand in order to find a solution to the **unrecovered expenses** of this important establishment which serves as a national resource.

B4. Health Insurance Financing

The financing of the Office of Social Protection (OPS) was mandated by legislation requiring employees to contribute 7.2% of the gross salaries for the good of the health care system. This method of taking charge transformed operations from the previous few years but the important problems still exist in large part because the deficit of the system of retirement and the **outstanding payments of charges of the government for the public sector employees**. The effects of the latter represent approximately half of the total group of employees of the Ministry of Health.

Also the range of services offered by insurance of OPS is limited owing to the use of complimentary charges as well as the public services (General Peltier Hospital) which are private consultations or at the military hospital Francis Bouffard. The management of SMI services shows the inefficiencies caused by the lack of qualified personnel in health care management. Some important efforts were undertaken to improve the management of general resources on the basis of pricing at OPS and for controlling more the occasional expenses of drugs/medicines. The efforts used by the pharmacies of OPS to reinforce utilization of generic products and to improve the management of medical stocks, often by an international NGO, will allow for the contribution to a 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 is practically non-existent but it would help the important efforts to enlarge the coverage of the social insurance and to develop the mechanisms of controlling health costs. The initial NHA analysis doesn't allow for using the data obtained for projecting trends

and models for developing social health insurance. A more refined study will allow for better analysis of the profiles of health insurance and for proposing necessary improvements.

B5. Household Financing of Health Services

Households assume an important part of total health expenditures according to the NHA analysis. Households purchase medications and health services either through direct after private consultations or in paying for medical benefits at General Peltier Hospital . Concerning the latter, it was proven by the analysis of cost recovery at General Peltier Hospital that the receipts for expenses in the last few years barely accounts for 35 millions of FDJ, which represents a small minority of the 3 percent of expenses estimated for households. The important positions of expenses are represented by the **purchases of medications** and by **the outpatient consultations and hospitalizations** in the private sector.

Including the importation of medications in 96 by the pharmacy stock of the Ministry of Health, by the SMI and by the collection of private pharmacies, it seems that the total spent on medications is estimated at 850 million FDJ and considering that the profit margin of private pharmacies is compensated by the exclusion of 35% of the foreign clientele represented by diplomats and expatriates. The purchase of medications represents 58% of the household expenses. It signals that the individual importation of medicines by the pharmacies in small quantities doesn't allow for the competitive pricing which would contribute to the high cost of pharmaceuticals in Djibouti. Also and for these obvious reasons of profit, private pharmacies do not have interest in importing more expensive generic products.

The levels of household health expenditures is represented by the cost of outpatient consultations, laboratory examinations and diagnoses, dentistry, opticians and hospital care. The total annual expenses for outpatient consultations is estimated at 400 million FDJ, including consultations by private traditional healers who represent 12% of the cadre of service providers. According to the data from the household consumption 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.

In light of the importance of the position of medications in the household expenses, it is important to reflect that for these programs it seems to improve the **importation routes** in recovery, for example the group purchases by the pharmacy stock for all the cadre of pharmacy operators. This effort of reinforcement of importation, based on a better information of prescriptions and as well as public and private will bring better control of medical expenses. This work of rationalizing the consumption of medicines must be made in the framework of a global policy of continuing training for health care personnel.

C. Implications of NHA Conclusions – See email

D. Processes and Lessons Learned

The national team charged with the NHA analysis, composed of a team from the MOH and DINAS, completed the following activities:

- Study of the public reports related to financing of health services and of the health sector in general;
- Working meetings with the officials of OPS and with certain managers of the health sector;
- Development of working theories for the missing or incomplete data;

- Attempts to validate these theories after filling in the data gaps; and
- Discussions of the final report structure of NHA with the WHO regional technical advisor supervising the activity.

The development of the preliminary analysis was assisted by the WHO regional supervisor with the participation of a WHO short-term consultant, Dr. Nouredine Achour of the National Institute of Statistics in Tunisia. This was as a result of the lack of participation by the Djibouti team at the first regional ANE NHA workshop in Tunisia in January 1999.

It is important to emphasize that the completion of the household survey was the principal source of information concerning the consumption of private health services. The use of the data from this study as well as the relative precise and detailed information about the importation of medications for private sector needs, was able to improve the understanding of the systems of the private health care services, particularly those concerning outpatient consultations and hospitalizations.

The work of the national team in Djibouti suffered a lack of official decree for the members of the team in order to justify their contribution to their respective administrations as well as the MOH and DINAS. It is recommended that the Minister of Health could officially declare the existence of the NHA team and inform his colleague at the Ministry of Finance.

It is also important to ensure the appropriate logistical support for the NHA team in order to complete objectives in normal working conditions and to facilitate access to necessary documents.

E. Institutional Arrangements for NHA Analysis

The following recommendations are the result of the experiences of developing the first NHA in Djibouti. Recommendations concerning institutionalization include:

- It would be desirable to entrust the responsibility for the NHA activity and analysis to Dr. Mahyoub given his training in health economics and his responsibilities at the MOH. He would be assisted by two other members of the team, However, the other members could also rejoin him if he desires.
- Concerning the household consumption study which served as the principal source of information regarding consumption of private sources, it would be desirable to update the study/survey at regular intervals. The design of the questionnaire relative to the health care services would greatly improve with the assistance of health professionals at the private and public sector levels.
- The support and daily work of the NHA team will be ensured by the members of the NAH team in light of new data and information. The development of accounting in the public health care services would allow for the allocation of expenditures by level. This allocation would merit the promise of expenses and utilization and would allow for a precise idea about the study of cost control in health care services.
- An effort to train personnel must be made particularly in the areas of general accounting and cost analyses for health care services. Also it would be useful to provide members of the NHA team recent publications concerning NHA methodology and especially documents concerning the WHO methodology of planning and preparing NHA in collaboration with World Bank, Harvard University and PHR experts and USAID.

- The data of the first NHA analysis will improve with feedback from principal technical experts. The NHA team asks for their input and suggestions for improving the presentation of available data.
- It would be equally important to inform all the partners of the preliminary results of the NHA analysis in the form of a national seminar bringing together the principal partners at the MOH, DINAS, OPS and representatives of the private health sector.